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Medicaid, SCHIP, and Other Health Provisions in H.R. 4954: The Medicare Modernization and Prescription Drug Act of 2002, and S. 3018: The Beneficiary Access to Care and Medicare Equity Act of 2002

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Summary

Medicaid is a joint federal-state entitlement program that pays for medical assistance primarily for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Within broad federal guidelines, each state designs and administers its own program. The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. The State Children's Health Insurance Program (SCHIP) is another joint federal-state program that allows states to extend coverage to children in families with income that is too high to qualify for Medicaid coverage.

Two bills under consideration in the House and the Senate would make important changes to Medicaid and SCHIP. The *Medicare Modernization and Prescription Drug Act of 2002* (H.R. 4954), passed the House on June 28, 2002. On October 1, 2002, the Senate Committee on Finance introduced the *Beneficiary Access to Care and Medicare Equity Act of 2002* (S. 3018). While the bills are very different from each other, both are largely comprised of provisions affecting the Medicare program, and both include important changes to Medicaid, SCHIP and other health programs. Among the Medicaid provisions, both bills would increase annual disproportionate share hospital (DSH) allotments to states beginning in FY2003, but use different methods to achieve those increases. S. 3018 would also temporarily increase the federal Medicaid matching rate for certain states and would provide additional funds to states for fiscal relief through the Social Services Block Grant program, a program that funds a wide variety of social services programs. With respect to SCHIP, S. 3018 would significantly change the method by which unspent federal funds are redistributed among states. Finally, with respect to both Medicaid and SCHIP, S. 3018 places on both states and the Secretary of HHS certain public notice and hearing requirements, as well as requirements regarding receipt and consideration of public comments in the waiver development, review and approval process. It also clarifies other parameters of the Secretary's waiver authority.

The following side-by-side comparison provides a brief description of current law and the changes that would be made to Medicaid, SCHIP and other health programs under H.R. 4954 and S. 3018. These provisions can be found in Title IX of H.R. 4954, and Titles VII and VIII of S. 3018. The other titles of both bills are devoted to major changes to the Medicare program (not described here). In addition, Medicare provisions in Title VIII of S. 3018 are not described here.

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Introduction

Medicaid is a joint federal-state entitlement program that pays for medical assistance primarily for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children. Within broad federal guidelines, each state designs and administers its own program. The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate to states with lower per capita incomes. In FY2001, federal matching rates ranged from 50% to 76.8% of a state's expenditures for Medicaid items and services. The State Children's Health Insurance Program (SCHIP) is another joint federal-state program that allows states to extend coverage to children in families with income that is too high to qualify for Medicaid coverage. As with Medicaid, each state designs and administers its own program and the federal government shares in state's costs by matching state spending. The SCHIP matching formula is based on the Medicaid matching formula, but results in higher matching rates that ranged from 65% to 83.8% in FY 2001.

Two bills under consideration in the House and the Senate would make important changes to Medicaid and SCHIP. The *Medicare Modernization and Prescription Drug Act of 2002* (H.R. 4954), passed the House on June 28, 2002. On October 1, 2002, the Senate Committee on Finance introduced the *Beneficiary Access to Care and Medicare Equity Act of 2002* (S. 3018). While the bills are very different from each other, both are largely comprised of provisions affecting the Medicare program, and both include important changes to Medicaid, SCHIP and other health programs. Among the Medicaid provisions, both bills would increase annual disproportionate share hospital (DSH) allotments to states beginning in FY2003, but use different methods to achieve those increases. S. 3018 would also temporarily increase the federal Medicaid matching rate for certain states and would provide additional funds to states through the Social Services Block Grant program, a program that funds a wide variety of social services programs. With respect to SCHIP, S. 3018 would significantly change the method by which unspent federal funds are redistributed among states. Finally, with respect to both Medicaid and SCHIP, S. 3018 places on both states and the Secretary of HHS certain public notice and hearing requirements, as well as requirements regarding receipt and

consideration of public comments in the waiver development, review and approval process. It also clarifies other parameters of the Secretary's waiver authority. The following sections describe the recent legislative changes as well as the major proposed amendments in H.R. 4954 and S. 3018.

Disproportionate Share Hospital (DSH) Payments Under Medicaid. Since 1981, states have been required to recognize, in establishing their payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and low-income patients. These payments are referred to as DSH payments or DSH adjustments. The DSH adjustment was intended to offset the costs to hospitals of treating uninsured, low-income patients, and to protect access to care for vulnerable populations. Under broad federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to each. States that contract with health maintenance organizations (HMOs) or other prepaid managed care providers may include DSH expenses in the payment rates to contractors.

DSH payments became a significant part of the program after 1989 when they grew from just under $1 billion to almost $17 billion by 1992. During that time, states' Medicaid budgets were facing a number of upward pressures while states were learning about financing techniques that made it easier to collect increased DSH payments from the federal government.

In 1991, Congress intervened to control the growth of these expenditures by limiting DSH payments by state and setting national limits. The new law was successful. After 1992, DSH payments increases slowed considerably although the level of national DSH payments remained high at just under $19 billion in 1995.

Significant reductions in DSH payments were included in the Balanced Budget Act of 1997. BBA-97 lowered DSH payments by establishing "allotments" or ceilings on DSH payments for each state. The allotments were specified for fiscal years beginning in 1998 through 2002. For most states, those amounts declined over the 5-year period. Thereafter, the DSH allotment for a state was to equal its allotment for the preceding fiscal year increased by the percentage change in the consumer price index for all urban consumers (CPI-U) as estimated by the Secretary for the previous fiscal year, subject to a ceiling of 12% of the total amount of expenditures for Medicaid benefits during the fiscal year.

Subsequently, the Medicare, Medicaid and SCHIP Balanced Budget Refinements Act of 1999 (BBRA-99, P.L. 106-113) included provisions increasing the Medicaid DSH allotments for certain states and the District of Columbia. Then under Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA-2000, P.L. 106-554), new rules governing federal DSH payments for FY2001 and FY2002 were established. The "special rule" directed that DSH allotments for the two years be based on FY2000 allotments increased by inflation - instead of on the declining amounts specified in BBA-97. Allotments for FY2003 and thereafter were to revert to amounts calculated based on the methodology specified in BBA-97. BIPA-2000 also extended a special hospital-specific DSH limit that had previously applied only to certain public hospitals in California to such hospitals in all states for a 2-year period. Finally, additional funds were provided for

certain state public hospitals not receiving DSH payments that have a low-income utilization rate in excess of 65%.

Legislation. During economic downturns states' Medicaid eligibility rolls often expand at the same time as tax receipts, which help to fund those programs, contract. Recognizing this increased fiscal pressure that states are under since the economic slowing began over one year ago, both bills include provisions to increase annual state DSH allotments for fiscal years beginning in 2003. Each bill, however, uses different methods to achieve those increases. H.R. 4954 would raise DSH allotments for FY2003 by setting those amounts equal to FY2001 allotments (as specified in BBA-97), increased by the percentage change in the CPI-U for FY 2001. Allotments for FY2004 and thereafter would be equal to the allotment for the previous year, increased by 1.7% unless the Secretary determines that the allotment under this provision would equal (or no longer exceed) the allotment for that state that would have been in effect under prior law. For these states, beginning in the first fiscal year that their allotment would equal or no longer exceed the prior law levels, their allotment would be equal to the allotment for the previous year increased by the percentage change in the CPI-U for the previous year.

S. 3018 would raise DSH allotments by specifying that 2003 allotments would be calculated to be equal to FY2002 allotments under BIPA-2000 increased by the percentage change in the CPI-U for FY2002; for 2004 they would be equal to FY2003 allotments increased by the percentage change in the CPI-U for FY2003; and for 2005, they would be equal to FY2004 allotments increased by the percentage change in the CPI-U for FY2004. For FY2006, allotments would be based on the amounts specified in BBA-97 for FY2002 increased by the percentage change in the CPI-U for fiscal years 2002 through 2005. For FY2007 and thereafter, allotments would be calculated based on the previous years' amount increased by percentage change in the CPI-U for the previous fiscal year. In addition, for FY2003 through FY2005, S. 3018 would increase allotments for the District of Columbia and for certain extremely low DSH states. The bill specifies special formulas for these purposes.

Redistribution Rules Under the State Children's Health Insurance Program (SCHIP). SCHIP, created under BBA-97, is the largest publicly funded effort to provide health insurance to children since Medicaid was enacted in 1965. The program offers federal matching funds for states and territories to provide health insurance coverage to uninsured, low-income children in families whose annual incomes are higher than states' Medicaid eligibility thresholds.

The original enactment appropriated federal matching grants totaling $39.7 billion for SCHIP for FY1998 through FY2007. Allotment of funds among the states is determined by a formula set in law. Each annual allotment is available to states for a period of 3 years. Under current law, allotments not spent at the end of the applicable 3-year period will be redistributed by a method to be determined by the Secretary of HHS to states that have fully exhausted their original allotments for that year. Redistributed funds not spent by the end of the fiscal year in which they are reallocated will expire.

BIPA-2000 created a special rule for the redistribution and availability of unused FY1998 and FY1999 SCHIP allotments. The change decreased the amount available for redistribution to states that had exhausted their original allotments for those years by allowing states that had not spent their full allotments to retain a portion of their unspent funds. Specifically, out of the total pool of unspent funds for a given year, states that exhausted their allotments were given amounts equal to their excess expenditures. Then states which had not exhausted their allotments received an amount equal to their proportional contribution to the pool of unspent funds.

S. 3018 builds upon BIPA-2000 by establishing a method for redistributing unspent allotments for FY2000 forward. For each of FY2000 through FY2003, states that exhaust their original allotments would receive amounts equal to their excess expenditures, subject to specific annual caps (60% - FY2000 and FY2001; 70% - FY2002; 80% - FY2003) on unspent funds. The distribution method for such funds among these states, should the pool of available funds be insufficient to cover all excess expenditures, is left to the Secretary to determine. For FY2004 forward, redistribution among such states would be the same as provided under BIPA-2000. For each of FY2000 through FY2003, the remaining unspent funds would be distributed among states that do not use their full allotments, subject to specific annual floors (40% - FY2000 and FY2001; 30% - FY2002; 20% - FY2003) on unspent funds. Each such state would receive an amount equal to the ratio of its contribution to the total pool of unspent funds to the remaining available funds. Again, for FY2004 forward, redistribution among such states would be the same as provided under BIPA-2000. For FY2004 forward, S. 3018 also would establish a caseload stabilization pool to provide certain states with additional SCHIP funding. Any remaining unspent redistributed dollars beginning with the FY1998 appropriation would become part of this pool. In addition, the bill specifies that unspent funds in the pool would remain in the pool (i.e., they do not expire). Eligible states include those whose total cumulative spending through the end of the previous fiscal year exceeds their cumulative original allotments for the same time period. These states would receive an amount equal to the ratio of such state's original allotment (for the previous fiscal year) to the total original allotments of all eligible states (for the same prior fiscal year).

Waivers under Medicaid and SCHIP. Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to conduct research and demonstration projects under Medicaid (and five other programs). Under this authority, the Secretary may waive provisions in Section 1902 of Medicaid statute (usually freedom of provider choice, comparability of benefits, and statewideness).[1] Most large-scale statewide waivers are approved for a 5-year period. The costs of such waivers are allowable expenditures under the applicable program. SCHIP is not identified in Section 1115. However, the SCHIP statute states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP but does not specify which sections may be waived.

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[1] Other sections in Medicaid statute allow waiver of other provisions under certain circumstances.

Congress has twice changed Section 1115 authority as it applies to the Medicaid waiver review and approval process. First, BBA-97 provided a process for a 3-year extension of Medicaid statewide comprehensive Section 1115 waiver projects beyond the initial 5-year term. Second, BIPA-2000 defined a process for approving extensions beyond initial 3-year extensions.

Much of the detail surrounding the policies and procedures for reviewing and approving Section 1115 waiver proposals has been issued by the Secretary of HHS through written guidance. For example, in 1994, the Secretary published a notice in the *Federal Register* outlining requirements with respect to public notification and involvement during the development phase of proposed waiver projects under Medicaid. (SCHIP did not yet exist at that time.) Since that time, the Secretary has provided other waiver guidance. In a July 25, 2001 letter to the House Committee on Energy and Commerce, HHS described its public notification requirements for the 3-year waiver extensions provided by BBA-97. In other letters to state Medicaid directors and to state health officials, the Secretary has described policy with respect to overall budget neutrality requirements, coverage of childless adults under SCHIP, as well as further details on public notice and involvement requirements. Most recently, under the current Bush Administration, a new Health Insurance Flexibility and Accountability (HIFA)1115 Waiver Initiative for Medicaid and SCHIP was established and guidance and technical information for this initiative was made available to states through postings to the agency's website. The initiative encourages states to develop statewide projects that coordinate Medicaid and SCHIP with private health insurance coverage and target uninsured individuals with income below 200% of the federal poverty level.

S. 3018 responds to recent concerns that some approved waivers exceed the statutory authority of the Secretary and that explicit statutory procedures would improve the waiver approval process. The bill places on both states and the Secretary of HHS certain public notice and hearing requirements, and requirements regarding receipt and consideration of public comments in the waiver development, review and approval process. It would clarify that: (1) the waiver of a specific section under a given title must promote the objectives of that title, (2) the requirements under Medicaid's early and periodic screening, diagnostic and treatment program for children may not be waived, and (3) the Secretary may not approve waivers that would use SCHIP funds to cover childless adults (excluding caretaker relatives).

Medicaid's Federal Medical Assistance Percentage (FMAP). The federal share of the cost of Medicaid items and services (excluding administrative expenses) is established by a formula set in statute. Determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita income). FMAP must not fall below 50% and may not exceed 83%. FMAP for the territories is statutorily set at 50%. In the territories, Medicaid is also subject to spending caps. Thus, the federal government pays 50% of the cost of Medicaid items and services up to those spending caps.

While the underlying FMAP formula for all states has not been changed, Congress has modified FMAP in certain situations. In BBA-97, the FMAP for the District of Columbia was permanently raised to 70%. It also increased Alaska's

FMAP to 59.8% for FY1998 through FY2000. Under BIPA-2000, the formula for calculating the state percentage and thus the federal share for Alaska for FY2001 through FY2005 was changed. The state percentage for Alaska is calculated using an adjusted per capita income calculation instead of the statewide average per capita income generally used. The adjusted per capita income for Alaska is calculated as the 3-year average per capita income for the state divided by 1.05.

As with the DSH provisions, the Senate bill responds to states' concerns that recent fiscal pressure may result in Medicaid cuts. To ease states' burden, S. 3018 would temporarily increase FMAPs for FY2003. Spending caps for the territories would be increased. Only states and territories that maintain Medicaid eligibility levels as of January 1, 2002 (or reinstate eligibility levels as of that date) would be eligible for the FMAP increase. This bill would also appropriate $1 billion in additional temporary grants under the Social Services Block Grant (Title XX of the Social Security Act). The grant allotments for each state and territory are specified, and these funds may be used for services directed at the goals set forth in Title XX.

The following side-by-side comparison provides a brief description of current law and the changes made to Medicaid, SCHIP and other health programs under H.R. 4954 and S. 3018. These provisions can be found in Title IX of H.R. 4954, and Titles VII and VIII of S. 3018. The other titles of both bills are devoted to major changes to the Medicare program (not described here). In addition, Medicare provisions in Title VIII of S. 3018 are not described here.

CRS has published three reports on the non-Medicare provisions of BBA-97, BBRA-99, and BIPA-2000. These are: CRS Report 98-132 EPW, *Medicaid: 105th Congress*, CRS Report RL30400, *Medicaid and the State Children's Health Insurance Program (SCHIP): Provisions in the Consolidated Appropriations Act for FY2000*, and CRS Report RL30718, *Medicaid, SCHIP and Other Health Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000*.

Medicaid and SCHIP Provisions

Provisions	Current Law	H.R. 4954	S. 3018
National Bipartisan Commission on the Future of Medicaid	No provision.	**Section 901**. The provisions would establish a 17-member, National Bipartisan Commission on the Future of Medicaid to analyze and recommend changes regarding the financial condition of the Medicaid program. An authorization of $1.5 million would support the Commission.	No provision.
Disproportionate share hospital (DSH) payments	The federal share of Medicaid disproportionate share hospital (DSH) payments is capped at specified amounts for each state for FY1998 through FY2002. A state's allotment for years after 2002 will be equal to its specified allotment for the previous year increased by the percentage change in the CPI-U for the previous year subject to a limit of no more than 12% of spending for medical assistance for that year. BIPA-2000 (P.L. 106-554) raised allotments for FY2001 and FY2002, but allotments for FY2003 and thereafter revert to the amounts calculated as specified above.	**Section 902.** DSH allotments for FY2003 would be increased by setting those amounts equal to FY2001 allotments (as specified in BBA-97), increased by the percentage change in the CPI-U for FY2001. Allotments for FY2004 and thereafter would be equal to the allotment for the previous year, increased by 1.7% unless the Secretary determines that the allotment under this provision would equal (or no longer exceed) the allotment for that state that would have been in effect under prior law. For these states, beginning in the first fiscal year that their allotment would equal or no longer exceed the prior law levels, their allotment would be equal to the allotment for the previous year increased by the percentage change in the CPI-U for the previous year.	**Section 701.** Would extend BIPA-2000's special rule for three additional years, raising DSH allotments, subject to the current law limit of 12% of medical assistance spending, for fiscal years 2003, 2004, and 2005. Allotments for 2003 would be calculated to be equal to FY2002 allotments under BIPA-2000 increased by the percentage change in the CPI-U for FY2002; for 2004 would be equal to FY2003 allotments increased by the percentage change in the CPI-U for FY2003; for 2005 would be equal to FY2004 allotments increased by the percentage change in the CPI-U for FY2004. For FY2006, allotments would be based on the amounts specified in BBA-97 for FY2002 increased by the percentage change in the CPI-U for fiscal years 2002 through 2005. For FY2007 and thereafter, allotments would be calculated based on the previous years' amount increased by the percentage change in the CPI-U for the previous fiscal year.
Disproportionate share payments for the District of Columbia	BBA-97 specified DSH allotments for the District of Columbia are $23 million for each of fiscal years 1998 through 2002. BBRA-99 increased	No provision.	**Section 701.** Subject to the current law limit of 12% of spending for medical assistance, DSH allotments for FY2003 for the District of Columbia would be

Provisions	Current Law	H.R. 4954	S. 3018
	DSH allotments for the District of Columbia to $32 million for each of fiscal years 2000 through 2002. DSH allotments for each year after 2002 will be equal to its specified allotment for the previous year increased by the percentage change in the CPI-U for the previous year subject to a limit of no more than 12% of spending for medical assistance for that year.		calculated by increasing $49 million by the percentage change in the CPI-U for fiscal years 2000, 2001 and 2002. For FY2004, the allotment would be equal to the FY2003 allotment as calculated above, increased by the percentage change in the CPI-U for FY2003. For FY2005, the allotment would be equal to the FY2004 allotment increased by the percentage change in the CPI-U for FY2004. For FY2006 and thereafter, the allotment would calculated in the manner specified for all other states.
Increase in floor for extremely low DSH states	For extremely low DSH states, i.e., states whose FY1999 federal and state DSH expenditures (as reported to CMS on August 31, 2000) are greater than zero but less than 1% of the state's total medical assistance expenditures during that fiscal year, the DSH allotments for FY2001 would be equal to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states would be equal to their allotment for the previous year, increased by the percentage change in the CPI-U for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.	No provision.	**Section 702.** Would create a temporary increase in the allotments for certain extremely low DSH states for FY2003 through FY2005. For states with DSH expenditures for FY2001 (as reported to CMS as of August 31, 2002) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year, the bill would raise the DSH allotments for FY2003 to 3% of the state's total amount of expenditures for such assistance during that fiscal year. For FY2004, allotments would be calculated by increasing FY2003 amounts by the percentage change in the CPI-U for FY2003; and for FY2005, by increasing FY2004 amounts by the percentage change in the CPI-U for FY2004.
Medicaid Pharmacy Assistance Program	No provision.	**Section 903.** States with approved Medicaid state plan amendments could receive grants to assist pharmacies in implementing the new prescription drug benefit proposed under Part D of Title XVIII. For each of fiscal years 2004 through 2007, the provision would authorize $150	No provision.

Provisions	Current Law	H.R. 4954	S. 3018
		million to be allotted among the states for such programs. The Secretary would be required to develop a method for the allocation of those funds among states, taking into account the distribution among states of priority pharmacies; small pharmacies and those serving in rural or underserved areas.	
5-Year extension of the Medicare qualified individual (QI-1) program under Medicaid	Federal law specifies several Medicare subgroups that are entitled to limited Medicaid protection. One group of qualified individuals (QI-1s) includes Medicare beneficiaries entitled to Part A coverage with income between 120-135% of the federal poverty level or FPL, (and who also meet certain resource standards) who are not otherwise eligible for Medicaid. For this group, Medicaid pays the monthly Part B premium. Expenditures for the QI-1 program are paid 100% by the federal government up to the state's allocation based on a distributional formula set in law. Total federal allocations are $200 million for FY1998, $250 million in FY1999, $300 million in FY2000, $350 million in FY2001, and $400 million in FY2002. The QI-1 temporary grant program ends as of December 31, 2002.	No provision.	**Section 703.** Extends the QI-1 program until December 2007. Each state's allocation is equal to the ratio of twice all its QI-1 individuals to the sum of these counts across all states. New annual federal allocations for FY2003 through FY2007 would be set at $400 million for each year.

Provisions	Current Law	H.R. 4954	S. 3018
Inpatient drug prices and certain public hospitals	Medicaid drug rebates are calculated based on the difference between the Average Manufacturer's Price and the manufacturer's "best price". In determining the "best price" for a drug sold by a manufacturer, certain discounted prices and fee schedules are excluded. The special discounted prices for *outpatient* drugs negotiated by the Office of Pharmacy Affairs (of HHS) with drug manufacturers on behalf of certain clinics and safety net providers are one example of prices excluded from Medicaid's best price determination. Because of this exclusion from Medicaid's best price definition, the discounts available to safety net providers have no bearing on the calculation of drug rebates under the Medicaid program allowing those providers to negotiate better rates with manufacturers – since Medicaid rebates will not change with the size of their negotiated discounts. Discounted prices for *inpatient* drugs for many safety net providers, however, are included in the Medicaid best price.	No provision.	**Section 704.** The provision would modify the definition of "best price" for the purpose of calculating Medicaid drug rebates, to also exclude the discounted inpatient drug prices charged to certain Medicare disproportionate share hospitals.

Provisions	Current Law	H.R. 4954	S. 3018
SCHIP allotments: *Changes to Rules for Redistribution and Extended Availability of Fiscal Year 2000 and Subsequent Fiscal Year Allotments*	Funds for the SCHIP Program are authorized and appropriated for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount as determined by a formula set in law. Funds not drawn from a state's allotment by the end of each fiscal year continue to be available to that state for 2 additional fiscal years. For FY2000 forward, allotments not used at the end of 3 years will be redistributed by the Secretary of Heath and Human Services (HHS) to states that have fully spent their original allotments for that year. BIPA-2000 created a special rule for the redistribution and availability of unused FY1998 and FY1999 SCHIP allotments. This special rule decreased the amount available for redistribution to states that had used all of their original allotments for these two years and allowed states that had not spent all of their allotments to retain some of their unspent funds.	No provision.	**Section 705(a).** Establishes a method for redistributing unspent allotments for FY2000 forward. For jurisdictions that exhausted their original allotment, for each of FY2000 through FY2003, each would receive an amount equal to their spending in excess of their original exhausted allotment, subject to caps on available unspent funds. Funds available for redistribution to these jurisdictions would be capped at specified percentages– 60% of unspent allotments for FY2000 and FY2001, 70% for FY2002, and 80% for FY2003. Territories would receive an amount equal to 1.05% of the total amount available for redistribution multiplied by each territory's proportion of the original allotment available for all territories. For FY2004 and subsequent fiscal years, the redistribution for those states and territories would be the same as under BIPA-2000. For states that did not use all their original SCHIP allotments, for each of FY2000 through FY2003, total amounts available for retention (after the reduction of amounts for states and territories as described above) would be subject to a floor– 40% for FY2000 and FY2001, 30% for FY2002, and 20% for FY2003. Of that amount, each state would receive a ratio of its contribution to the total pool of unspent funds to the remaining available funds. For FY2004 and subsequent fiscal years, amounts available for retention by such states, is the same as under BIPA-2000.

Provisions	Current Law	H.R. 4954	S. 3018
SCHIP allotments: *Length of the availability of reallocated funds*	The original enactment of SCHIP specifies that redistributed funds not used by the end of the fiscal year in which they are reallocated officially expire. Redistributed and retained funds from FY1998 and FY1999 are available through the end of FY2002.	No provision.	**Section 705(a).** Extends availability of the FY1998 and FY1999 redistributed funds through the end of FY2003. For FY2000 and beyond, reallocated funds would be available for 1 fiscal year.
SCHIP allotments: *Establishment of a caseload stabilization pool*	No provision.	No provision.	**Section 705(b).** For FY2004 and subsequent fiscal years, establishes a caseload stabilization pool to provide certain states with additional SCHIP funding. Any remaining unused redistributed dollars beginning with the FY1998 appropriation not spent by the applicable deadlines would become a part of this pool. In addition, unspent money in the pool would remain in the pool. For a given fiscal year, states eligible for these funds are those whose total cumulative spending through the end of the previous fiscal year exceeded their cumulative original allotments for the same time period. For this purpose cumulative spending means all SCHIP expenditures since the beginning of the program. These states would receive an amount from the caseload stabilization pool equal to the ratio of such state's original allotment (for the previous fiscal year) to the total original allotments of all eligible states (for the same prior fiscal year), multiplied by the total dollars available in this pool.

Provisions	Current Law	H.R. 4954	S. 3018
SCHIP allotments: *Authority for qualifying states to use a portion of SCHIP funds for Medicaid expenditures*	No provision.	No provision.	**Section 705(c).** For FY2003 and beyond, allows "qualifying states" to use up to 20% of their original SCHIP allotment (for that fiscal year) for certain Medicaid medical assistance payments. Qualifying states would be eligible to use, from their SCHIP allotment, an amount equal to the difference between spending at the enhanced SCHIP matching rate and the FMAP for children up to age 19 with family incomes greater than 150% of the FPL. For a given fiscal year, "qualifying states" would include those who: (1) as of March 31, 1997, had a Medicaid income eligibility standard for at least one category of children (excluding infants) of at least 185% FPL; (2) as of January 1, 2001, had a SCHIP eligibility standard of at least 200% FPL; (3) did not impose waiting lists or enrollment caps for children whose family income is at least 200% FPL; (4) provide statewide SCHIP coverage to all children who meet such state's eligibility requirements; and (5) have implemented at least four additional specified procedures for establishing children's eligibility for their Medicaid and SCHIP programs.

Provisions	Current Law	H.R. 4954	S. 3018
SCHIP allotments: *GAO study and report regarding expenditure of SCHIP allotments*	No provision.	No provision.	**Section 705(d).** Requires the General Accounting Office (GAO) to conduct a study on the expenditure of state SCHIP allotments and to submit to Congress an interim report no later than October 1, 2004 with the final report due no later than October 1, 2005. The study would examine why certain states did *not* use all their SCHIP allotments (for each of fiscal years 1998, 1999, and 2000) by the applicable 3-year deadline. GAO would be required to evaluate the methods applied to reallocate unused original allotments, the caseload stabilization pool, the adequacy of SCHIP funding and resources, and potential benefits and problems associated with the new redistribution method established by the caseload stabilization pool. In addition, the report would include recommendations for changes in legislative action regarding expenditure of SCHIP allotments and methods for reallocation of unused original allotments.

Provisions	Current Law	H.R. 4954	S. 3018
Improvement of the process for the development and implementation of Medicaid and SCHIP Waivers	Section 1115 of the Social Security Act provides the Secretary of HHS with broad authority to conduct research and demonstration projects under six programs, including Medicaid and SCHIP. The Secretary may waive provisions in Section 1902 of Medicaid statute (usually freedom of provider choice, comparability of benefits, and statewideness). The costs of such waivers are allowable expenditures under the applicable program. For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP. BBA-97 provided a mechanism for a 3-year extension of Medicaid statewide comprehensive 1115 waiver projects. Under BIPA-2000, a process was defined for receiving extensions of Medicaid 1115 waivers for those projects receiving the initial 3-year extension. Regulations describe HHS procedures for review and approval of Section 1115 waivers and requirements for states with respect to public notification and involvement during the development phase of proposed waiver projects. Those requirements were elaborated and amended in a letter to state Medicaid directors issued May 3, 2002.	No provision.	**Section 706.** Places on both states and the Secretary certain public notice and hearing requirements, and requirements regarding receipt and consideration of public comments in the waiver development, review and approval process. The Secretary must determine that a waiver proposal is based on a sound hypothesis and an appropriate method for evaluation. Any requirement under Medicaid or SCHIP, or any related regulation that is not explicitly waived and publicly identified by the Secretary when a proposal is approved would not be waived; similarly, waiver costs not explicitly identified as allowable must not be paid under Medicaid or SCHIP. Clarifies that: (1) the waiver of a specific section under a given title must promote the objectives of that title, (2) the Secretary may not waive requirements under Medicaid's early and periodic screening, diagnostic and treatment program, and (3) the Secretary may not approve any proposal that would use SCHIP funds for health benefits for childless adults (excluding caretaker relatives). Effective as of the date of enactment of this Act, and applies to new proposals and amendments to approved projects, that are approved or extended on or after the date of enactment.
Temporary State Fiscal Relief	The federal share of the cost of Medicaid items and services is equal to the federal medical assistance percentage (FMAP) multiplied by those	No provision.	**Section 707**. FMAPs for the states and territories would be temporarily increased for FY2003. First, states and territories whose FY2003 FMAP is

Provisions	Current Law	H.R. 4954	S. 3018
	costs. Determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). FMAPs for the states must not fall below 50% and may not exceed 83%. FMAPs for the territories are statutorily set at 50%. In the territories, Medicaid programs are also subject to spending caps and therefore the federal government pays 50% of the cost of Medicaid items and services up to the spending caps. Authorized under Title XX of the Social Security Act, the Social Services Block Grant (SSBG) is a flexible source of funds that states may use to support a wide variety of social services activities. Payments to states from SSBG funds for any fiscal year must be expended by the state in such fiscal year or in the succeeding fiscal year. The FY2003 Labor-HHS appropriation bill (H.R. 5320; introduced but not yet reported) includes $1.7 billion for the SSBG in FY2003.		lower than their FY2002 FMAP would retain the FY2002 FMAP (the higher rate) for FY2003. Then, the FMAP for each state and territory would be increased by 1.3 percentage points for FY2003. The spending caps for the territories would also be increased by 2.6%. The increases in the FMAP would not apply to disproportionate share hospital payments or for payments for programs under Title IV or Title XXI (SCHIP) of the Social Security Act. Only states and territories that maintain Medicaid eligibility levels as of January 1, 2002 (or reinstate eligibility levels as of January 1, 2002) are eligible for the FMAP increase. Appropriates $1 billion in additional temporary grants under SSBG. The grant allotments for each state and territory are specified and these funds may be used for services directed at the goals set forth in the SSBG program. These additional SSBG funds would be available for obligation through June 30, 2003 and for expenditure through September 30, 2003.

Other Provisions

Provisions	Current Law	H.R. 4954	S. 3018
Increase in appropriations for special diabetes programs for type I diabetes and Indians	BBA-97 amended Title III of the Public Health Service Act to create two diabetes grant programs; one targets diabetes research and the other supports diabetes prevention and treatment services for Indians. Each program received $30 million for each of FY1998 through FY2002, transferred from SCHIP (Title XXI of the Social Security Act). Under BIPA-2000, for each grant program, total funding was increased to $100 million per year for FY2001 through FY2003. For FY2001 and FY2002, the additional $70 million was drawn from the Treasury. For FY2003, the entire $100 million is to come from the Treasury. Also, the due date on the final evaluation report for these two grant programs was extended from January 1, 2002 to January 1, 2003.	No provision.	**Section 801.** Funds each grant program at $125 million per year for FY2004 and FY2005. In addition, the due date on the final evaluation report for both programs would be extended to January 1, 2005.
Disregard of certain payments under the Emergency Supplemental Act 2000, in the administration of federal programs and federally assisted programs	Federal programs such as the west coast groundfish fishery provide payments to individuals to buy out their vessels (i.e., boats, fishing licenses) thereby eliminating their capacity to harvest fish. The goal of these payments is to reduce the overall burden on the fishing industry to ensure the economic stability of remaining vessels.	No provision.	**Section 802.** Specifies that payments made to an individual with respect to west coast groundfish fishery would not be counted as income or resources for purposes of determining the eligibility or the amount or extent of benefits or assistance under any federal program.

Provisions	Current Law	H.R. 4954	S. 3018
Safety Net Organizations and Patient Advisory Committee	No provision.	No provision.	**Section 803.** Would establish a Safety Net Organization and Patient Advisory Commission to review the nation's health care safety net programs by: documenting and analyzing the impact of program and federal law changes on the capacity of the safety net; monitoring and linking existing data sources to track changes; supporting the development of new data systems and studying safety net failures; monitoring and providing oversight for transitions of individuals receiving SSI, Medicaid or SCHIP who enroll with managed care entities; and identifying and disseminating best practices. Identifies composition and the methods for appointing members, as well as operating and reporting requirements.
Publication guidance regarding discrimination by national origin	In August, 2000, the Office of Civil Rights in the Department of Health and Human Services (HHS) issued policy guidance that clarified the prohibition against national origin discrimination as it effects persons with limited English proficiency. Providers were instructed in methods, programs, and requirements that would avoid discrimination and would insure that patients with limited English skills receive necessary language assistance that would permit meaningful access to health services, free of charge. Although public comments were solicited, the guidance was effective immediately.	**Section 624.** The Secretary would be required to issue final written guidance by January 1, 2003 concerning the application of the prohibition against discrimination on the basis of national origin established by the Civil Rights Act of 1964. The guidance would pertain to requirements to insure access to Medicare covered health services for persons with limited proficiency in English.	**Section 804.** Same as H.R. 4954 except in addition to Medicare, the guidance would pertain to requirements to insure access to covered health services under Medicaid and SCHIP for persons with limited proficiency in English.

Provisions	Current Law	H.R. 4954	S. 3018
Federal reimbursement of emergency health services furnished to undocumented aliens	State Medicaid programs are required to cover emergency services furnished to undocumented aliens who otherwise meet Medicaid eligibility standards. Some states, especially border states, say they bear a disproportionate burden for this type of cost. To help defray the costs of emergency services to undocumented aliens, BBA-97 made $25 million available for grants to the 12 states with the highest number of undocumented aliens for each of FY1998-FY2001. (No such provision was made for FY 2002.) For each year, the Secretary would compute allotments based on a state's share of undocumented aliens relative to the undocumented aliens in all states. Numbers of undocumented aliens would be based on estimates prepared by the Statistics Division of the Immigration and Naturalization Services as of October 1992.	No provision.	**Section 805.** Would provide an appropriation for the emergency health services grant program of $48 million per year for FY2003 and FY2004. For each fiscal year, $32 million of the total appropriation will be distributed to the 17 states with the highest number of undocumented aliens. For each year, the Secretary would compute allotments and calculate counts of undocumented aliens in the same manner as defined under current law. For each fiscal year, $16 million of the total appropriation will be distributed to the six states with the highest number of undocumented alien apprehensions for such fiscal year. For each year, the Secretary would compute allotments for such states based on a state's share of undocumented alien apprehensions relative to the undocumented alien apprehensions in all such states. Numbers of undocumented alien apprehensions would be based on the four most recent quarterly apprehension rates for undocumented aliens as reported by the Immigration and Naturalization Service. Grants will be available to states for payment to local governments, hospitals, or other providers for 2 fiscal years.