



A Comprehensive Outline

To amend titles XIX and XXI of the SSA act and to reform payment to States under the Medicaid program

Section 1: Medicaid Accountability and Care Act of 2012

Section 2: Medicaid Payment Reform

(a) Reform inserted after section 1903 Title XIX of the Social Security Act

Section 1903A: Reformed Payment to States

(a) “Reformed Payment System

(1) For quarters beginning July 1, 2014, payments to states will be equal to the sum of the following:

- (A) Adjusted Total Capitated Amount- The amount specified by the per capita amount that is then risk adjusted
- (B) Chronic Care Quality Bonus- The amount of bonus the State receives for meeting quality care measures

(2) Requirement of State Share

(A) A State must spend an amount equal to its State share for a quarter on expenditures for which Federal funds would have been payable under Medicaid

(B) Non Payment for Failure to Pay State Share-

- (i) If a State fails to spend the required money; it will be reduced by the product of—
 - (I) The Federal-to-State ratio described below and
 - (II) The amount by which the State payment is less than the State share
- (ii) Grace Period- A state will not be considered to have failed its state requirement if the aggregate State payment toward the required share for the 4-quarter period beginning with such quarter exceeds the required State share for the 4-quarter period

- (C) State Share- the State share is equal to the product of
 - (i) The aggregate capitated amount specified below for the quarter and the State and
 - (ii) The State-to-Federal ratio described below
- (D) Uniform Federal and State Percentages
 - (i) Uniform Federal percentage- The highest Federal Medical Assistance Percentage without regard to 2009 Stimulus
 - (ii) Uniform State Percentage- is 100% minus Uniform Federal Percentage
 - (iii) Federal-to-State Ratio
 - (I) Federal percentage as defined above to
 - (II) State percentage as defined above
 - (iv) State-to-federal ratio
 - (I) State percentage as defined above to
 - (II) Federal percentage as defined above
- (E) Rules for crediting toward State Share- A payment will not be counted unless
 - (i) A Federal payment would be made under Medicaid
 - (ii) State follows limitations:
 - (I) no abortion dollars
 - (II) no intergovernmental transfers
 - (III) no provider taxes
 - (IV) no certified public expenditures
 - (iii) Fraud and Abuse- any recovery shall be fully counted towards State share
- (F) Construction- A state can spend in excess of the required state share
- (G) Claims data will continue on a 2 years reconciliation basis
- (3) Use of Federal Payments-
 - (A) Application of Medicaid Limitations- Federal funds may only be used for such expenditures that have previously been eligible for federal funds
 - (B) Limitation for Certain Eligibles
 - (i) In General- A state may not use Federal payments for individuals that exceed 100% Federal poverty limit
 - (ii) Determination of Income
 - (I) Application of spend down
 - (II) Modified Adjusted Gross Income (MAGI-relating to 5% reduction) shall not apply
 - (iii) Exceptions- shall not apply to these individuals

- (I) pregnant women
- (II) Children under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose
- (III) Enrolled in Medicaid at the date of enactment
- (IV) Certain Duals
- (iv) Clarification related to community spouse- Long term care and nursing home recipients

(4) Exceptions to new system-

- (A) The following shall not apply
 - (i) Payments to territories
 - (ii) Medicare Cost sharing
 - (iii) Pediatric Vaccines
 - (iv) Emergency Services for certain individuals
 - (v) Indian Health Care facilities
 - (vi) Employment sponsored Insurance
 - (vii) Other populations with limited benefit coverage: population would not include any inpatient, nursing facility, or long term care service
- (B) Certain Expenses- these amounts will continue to be payable
 - (i) Administration of Medicare Prescription Drug benefit
 - (ii) HIT Bonus Payments
 - (iii) Payments for MMIS

(5) Payments of Amounts-

- (A) Prior to the beginning of each quarter, the Secretary will estimate the amount to which a State is entitled, then must pay in such installments the amount estimated, reduced, or increased to the extent of under or overpayment
- (B) Information and Forms
 - (i) A state is required to fill out forms as developed by the Secretary as a condition for receiving payment
 - (ii) The Secretary shall develop such forms as may be needed to assure uniform reporting
- (C) Requirement of Transparent reporting of medical loss ratios for managed care

(b) Aggregate Capitated Amount

- (1) The total amount for a State for a quarter is equal to the sum of the products for each category of Medicaid beneficiaries for each quarter
 - (A) Per Capita Quarterly Amount
 - (B) Number of Individuals in Category

(2) Categories

- (A) Elderly- Individuals over 65 years
- (B) Blind or Disabled
- (C) Children
- (D) Other Adults

(c) Computation of Per Capita, Per Category Quarterly Amount

(1) For a State, for each category of beneficiary for a quarter

(A) Fiscal Year 2014- the per capita quarterly amount is equal to $\frac{1}{4}$ of the base average per capita for each category that is adjusted by a factor that reflects the sum of

(i) Historical Medical CPI percentage increase from 2012 to 2013 and

(ii) Projected Medical CPI percentage increase 2013 to 2014

(B) Fiscal Years 2015 and 2016- The per capita quarterly amount for a State for a category is equal to the amount under this paragraph for such State and category for the previous fiscal year increased by the per capita percentage increase

(C) Fiscal Years 2017 through 2024- The per capita quarterly amount for a state is

(i) In the case of a State that is over 110% of the national mean, the amount determined below

(ii) In the case of a State that is less than 90% of the national mean, the amount determined below

(D) Fiscal Year 2025 and Subsequent Fiscal Years- The per capita quarterly amount for a State for a category for quarters beginning with FY 2025 is equal to the per capita quarterly amount under this paragraph for the previous fiscal year increased by the per capita percentage increase for such category and fiscal year

(E) Annual Percentage Increase beginning with FY 2015- For purposes of this subsection, the term 'per capita percentage increase' means for a fiscal year the sum of

(i) The projected percentage change in nominal GDP from the midpoint of the previous fiscal year to the midpoint of the fiscal year for which the increase is being applied and

(ii) One percentage point

(2) Base Per Capita, Per Category Amount for Each State

(A) Average per Category

(i) The Secretary will determine a base per capita per category amount for each of the 50 states and DC equal to the average amount, per Medicaid beneficiary, of Federal payments,

including payments to DSH hospitals, for each category of beneficiaries for the base fiscal year

(ii) Best available data- Secretary will use best available data

(iii) Updates- updated yearly on best data

(B) Exclusion of Pass-Through Payments- In calculating base per capita per category amounts the Secretary should exclude all exception payments described in subsection (a)(4)

(C) Standardization

(i) In General- In computing each amount, the Secretary will risk adjust for the following factors

(I) Risk Factors- Age, Health and Disability Status, Gender, Institutional Status, and others determined by the Secretary to ensure actuarial equivalence

(II) Geographic- variations in costs on a count-by-county basis

(ii) Application of Medicare Methodology

(I) Method for Risk Standardization- The Secretary may apply the hierarchical condition category methodology used in Medicare advantage programs, if used it must be adjusted to take into account the differences in services provided under Medicaid

(II) Method for Geographic Standardization- The Secretary shall apply the standardization above in a manner similar to that applied under MA

(iii) Application on a national, budget neutral basis- The standardization under clause (i) shall be designed and implemented on a uniform national basis and shall be budget neutral

(iv) Response to New Risk- The Secretary may adjust the standardization under the above clause to respond promptly to new instances of communicable diseases and other public health hazards

(D) Adjustment for Temporary FMAP Increases- In computing amounts, the Secretary will disregard portions of payments that are attributable to temporary increases such as

(i) PPACA Disaster FMAP

(ii) ARRA

(iii) Extraordinary Employer Pension Contribution

(3) Allocation of Non-Medical Assistance Payments- The Secretary will establish rules for the allocation of payments

- (A) Among different categories of beneficiaries and
 - (B) Between payments included under this section
- (4) Transition to a corridor around the national average-
- (A) Determination of National Average Base per Capita per Category Amount- The Secretary shall determine a national average base per capita, per category amount equal to the base per capita per category amounts of the 50 states and DC that is weighted by the average number of beneficiaries in each such category and State as determined by the Secretary
 - (B) Transition Adjustment-
 - (i) High Per Capita States- In the case of a state with higher than 110% of the per capita, per category spending to the national mean, the per capita quarterly amount for such State and category is equal to the sum of-
 - (I) The product of the State- specific factor for such fiscal year and the per capita quarterly amount that would otherwise be determined under paragraph (1) for such state and category if this paragraph did not apply, and
 - (II) The product of 1 minus the State-specific factor for such fiscal year and the per capita quarterly amount that would otherwise be determined under paragraph (1) for a State and category if the base per capita, per category amount determined under paragraph (2) for the State and category were equal to 110 percent of the national average base per capita, per category
 - (ii) Low per capita states- In the case of a state with lower than 90% of the per capita, per category spending to the national mean, the per capita amount for the State and category is equal to the sum of-
 - (I) The product of the State- specific factor for such fiscal year and the per capita quarterly amount that would otherwise be determined under paragraph (1) for such state and category if this paragraph did not apply, and
 - (II) The product of 1 minus the State-specific factor for such fiscal year and the per capita quarterly amount that would otherwise be determined under paragraph (1) for a State and category if the base per capita, per category amount determined under paragraph (2) for the State and category were equal to 90 percent of the national average base per capita, per category

- (iii) High and low per capita states defined
 - (I) High per capita state means with respect to a category, a State for which the base per capita, per category amount is greater than 110 percent of the national average per capita per category
 - (II) Low per capita state means with respect to a category, a State for which the base per capita, per category amount is less than 90 percent of the national average per capita per category
- (iv) State- Specific Factor-
 - (I) Fiscal year 2017 is $\frac{7}{8}$; and
 - (II) A subsequent fiscal year is the State-specific factor under this clause for the previous fiscal year minus $\frac{1}{8}$
- (C) No additional expenditures-
 - (i) The Secretary shall determine whether the application of this paragraph
 - (I) To the category for the fiscal year will result in an aggregate increase in the aggregate Federal expenditures under this section; and
 - (II) To all the categories for the fiscal year will result in a net aggregate increase in the aggregate Federal expenditures under this section that the application of this paragraph for a fiscal year will result in an aggregate increase in the aggregate Federal expenditures under this section, the Secretary shall adjust the national average base per capita, per category amount for each category to such a level to ensure no aggregate increase
 - (ii) Adjustment- If the Secretary determines that the application will result in a net aggregate increase in the aggregate Federal expenditures under this section, the Secretary shall reduce the national average base per capita, per category amount for each of the categories determined for which there will be an increase in Federal expenditures by a uniform percentage that will ensure no Federal expenditure increase

(5) Reports on Per Capita Rates; Appeals

- (A) Report to States- Not later than 8 months after the date of the enactment of this section, the Secretary shall submit to each State the initial determination of
 - (i) the base per capita per category amounts

- (ii) National average base per capita, per category
- (B) Opportunity to Appeal- Not later than 3 months after the date the State receives notice of the initial determination, the State may file an appeal
- (C) Determination of Appeal- Not later than 3 months after receiving the appeal, the Secretary shall make a final determination
- (6) Base Fiscal Year Defined- latest fiscal year before enactment
- (d) Not Counting Individuals to Account for Excluded Payments-** Under rules specified by the Secretary, individuals will not be counted as Medicaid beneficiaries for purposes of exceptions outlined in (b)(1)(b) and (c)(2)(a)
- (e) Risk Adjustment**
 - (1) In General- The amount the State shall receive will be adjusted in an appropriate manner specified by the Secretary and consistent with paragraph (2) to take into account
 - (A) The risk adjusted factors described above within a category of beneficiaries and
 - (B) Variations in costs on a county-by-county basis
 - (2) Method of adjustment- The above adjustment shall be made in a similar manner to adjustments under (c)(2)(c)
- (f) Chronic Care Quality Bonus Payments**
 - (1) Determination of Bonus Payments- based on the reports under (5), with respect to categories of chronic disease for which chronic care performance targets had been established under paragraph (3) for each category and that such targets have been met by a state so the Secretary will make additional payment to such state in a manner specified by the Secretary
 - (2) Identification of Categories of Chronic Disease- The Secretary will determine the categories of chronic disease for which bonus payments may be available
 - (3) Adoption of Quality Measurement System and Identification of Performance Targets-
 - (A) System and Data- the Secretary will adopt a quality measurement system that uses data described in paragraph (4) and is similar to the Five Star Quality Rating System used to indicate the performance of Medicare Advantage
 - (B) Targets- The Secretary shall establish the chronic care performance targets for purposes of the payments. They will be established in consultation with States, associations representing individuals with chronic illnesses, entities providing treatment to such individuals for such chronic illnesses and other stakeholders
 - (4) Data to be Used- The data to be used under the above paragraph shall include
 - (A) Data collected through methods such as

- (i) HEDIS measures
- (ii) Consumer Assessment of Healthcare Providers and Systems- CAHPS or an appropriate successor performance measurement tool
- (iii) Health Outcomes Survey
- (B) Other data collected by the State

(5) Reports

- (A) In General- Each State shall collect, analyze and report to the Secretary, the data that permits the Secretary to monitor the State's performance relative to the chronic care performance targets
- (B) Review and Verification- The Secretary will verify the reports

(6) Amount of Bonus Payments-

- (A) In General- To each category, if it is determined if the case performs
 - (i) In the top 5 of states in a category, the bonus amount will be 10 percent of the payment paid to the state within such category
 - (ii) In the next 5 states the amount will be 5 percent of the payment
 - (iii) In the next 5 states the amount will be 3 percent of the payment
 - (iv) In the next 5 states the amount will be 2 percent
 - (v) In the next 5 states the amount will be 1 percent
- (B) Aggregate Annual Limit for each Category of Medicaid Beneficiaries-
 - (i) In General- In no case may the aggregate amount of bonuses under this subsection exceed the limit specified in the next clause for a fiscal year
 - (ii) Limit- The limit specified in this clause
 - (I) For 2015 is \$250,000,000
 - (II) For subsequent fiscal year is equal to the limit specified in this clause for the previous fiscal year plus GDP plus 1

(C) Limitation and Proration of Bonuses Based on Application of Aggregate Limit-

- (i) No Bonus for third or subsequent tiers unless aggregate limit not reached on first two tiers-No bonus shall be payable unless the amount of bonuses is less than the limit for the year
- (ii) Proration for first two tiers- If the aggregate amount of bonuses of the first 2 years exceeds the limit, the amount of each bonus shall be prorated in a manner so the aggregate amount is equal to the limit

- (iii) Proration for next three tiers- If the bonus is less for categories 1 and 2 than the limit for bonuses, but the sum for categories (i) through (v) exceeds the limit for bonuses, (iii) through (v) will be pro-rated in a manner so the sum of all bonuses equal to the limit

(g) State Option for Receiving Medicare Payments for Full-Benefit Dual Eligible Individuals

- (1) In General- A State may elect for a fiscal year
 - (A) Full duals will continue to be paid as stipulated in title XVIII, the SS Health Insurance for the Aged and Disabled and
 - (B) To received continued payments from the Secretary
- (2) Payment Requirement
 - (A) In General- A state must provide payment to providers for items and services at a rate not less than the rate at which payments would be made to providers under Medicare
 - (B) Flexibility in Payment Methods- Nothing in subparagraph (A) shall be construed as preventing a State from using alternative payment methods such as bundled payments or the use of ACOs for purposes of making payments to health care providers for items and services provided to duals
- (3) Responsibilities of the Secretary- If the State elects option (A), the Secretary shall pay to a State the amount that the Secretary would otherwise pay under Medicare for items and services provided to full-benefit duals
- (4) Full Benefit Dual Eligible Individual Defined- The term “full benefit dual eligible individual” means an individual who meets the requirements already in statute

(h) Audits- The Secretary shall conduct such audits on the number and classification of Medicaid beneficiaries as deemed necessary to ensure appropriate payments

(i) Treatment of Waivers-

- (1) No Impact on Current Waivers
- (2) Application of Budget Neutrality to Subsequent Waivers and Renewals

(j) Report to Congress- Not later than January 1 2016, the Secretary shall submit to Congress a report on the implementation of this section.” *End of insertion to 1903A*

(b) Conforming Amendments

- (1) Continued application of clawback provisions- MMA Part D provision
 - (A) Continued application of clawback
 - (B) Technical Amendment- to new dual section
- (2) Payment Rules under Section 1903
- (3) Conforming Waiver Authority

- (4) Report on Additional Conforming Amendments- 6 months have enactment
Secretary shall report to Congress