

**Description of the Chairman's Mark**  
**American Recovery and Reinvestment Act of 2009**

Scheduled for Markup  
By the Senate Committee on Finance  
On January 27, 2009

***TITLE I—REVENUE PROVISIONS (SEE SEPARATE DOCUMENT)***

**TITLE II—ASSISTANCE FOR UNEMPLOYED WORKERS AND STRUGGLING FAMILIES**

**SUBTITLE A—UNEMPLOYMENT INSURANCE**

**SUBTITLE B—ASSISTANCE FOR VULNERABLE INDIVIDUALS**

**TITLE III—HEALTH INSURANCE ASSISTANCE**

**SUBTITLE A—PREMIUM SUBSIDIES FOR COBRA CONTINUATION COVERAGE FOR UNEMPLOYED WORKERS**

**SUBTITLE B—TRANSITIONAL MEDICAL ASSISTANCE (TMA)**

**SUBTITLE C—EXTENSION OF QUALIFIED INDIVIDUAL PROGRAM**

**SUBTITLE D—OTHER PROVISIONS**

**TITLE IV—HEALTH INFORMATION TECHNOLOGY**

**TITLE V—STATE FISCAL RELIEF**

## **TITLE II—ASSISTANCE FOR UNEMPLOYED WORKERS AND STRUGGLING FAMILIES**

### **SUBTITLE A—UNEMPLOYMENT INSURANCE**

#### **Extension of Emergency Unemployment Compensation Program**

##### *Current Law*

Title IV, Emergency Unemployment Compensation, of the Supplemental Appropriations Act, 2008 (Public Law 110-252; 26 U.S.C.3304 note) as amended by the Unemployment Compensation Act of 2008 (Public Law 110-449) created a temporary emergency unemployment compensation program (EUC08).

This temporary unemployment insurance program provides up to an additional 20 weeks of unemployment benefits to certain workers who have exhausted their rights to regular unemployment compensation (UC) benefits. A second tier of benefits exists in States with a three-month seasonally adjusted average unemployment rate of at least 6 percent and provides up to an additional 13 weeks of EUC08 benefits (for a total of 33 weeks of EUC08 benefits).

Section 4007 of Title IV, as amended, terminates the program on the week ending on or before March 31, 2009. No compensation under the program is payable for any week beginning after August 27, 2009.

Section 4004 of Title IV, as amended, establishes that funds in the extended unemployment compensation account (EUCA) of the unemployment trust fund (UTF) shall be used for financing EUC08 payments. Funds to the States for administering the EUC08 program shall be from the employment security administration account (ESAA). Compensation for EUC08 payments to former employees of non-profits and governmental are from the general fund of the Treasury.

##### *Chairman's Mark*

The Chairman's Mark would amend Section 4007 of Title IV, Emergency Unemployment Compensation, of the Supplemental Appropriations Act, 2008 (Public Law 110-252; 26 U.S.C. 3304 note) as amended by the Unemployment Compensation Act of 2008 (Public Law 110-449) by extending the duration of the temporary EUC08 program. The proposal would terminate the EUC08 program on the week ending on or before December 31, 2009. Under this proposal no compensation under the program would be payable for any week beginning after May 31, 2010.

The Mark would also alter the funding of all EUC08 benefits covered under Section 4004 of Title IV as well as all State administration costs of the EUC08 benefit. The benefits and administration costs, without fiscal year limitation, would be funded through the general fund of the Treasury rather than the EUCA and ESAA accounts within the UTF. The funds used from the general fund would not be required to be repaid.

## **Increase in Unemployment Compensation Benefits**

### *Current Law*

**Federal-State Agreements.** The joint federal-State Unemployment Compensation (UC) program may provide income support through the payment of UC benefits to unemployed individuals. The program's two main objectives are to provide temporary and partial wage replacement to involuntarily unemployed workers and to stabilize the economy during recessions. The Federal Unemployment Tax Act (FUTA) of 1939 (Public Law 76-379) and titles III, IX, and XII of the Social Security Act of 1935 (Public Law 74-271) form the framework of the UC system. UC benefits are financed through employer taxes. The federal taxes on employers are under the authority of the Federal Unemployment Tax Act (FUTA), and the State taxes are under the authority given by the State Unemployment Tax Acts (SUTA). The federal unemployment tax on employers, among other uses, pays the federal share (50 percent) of the extended benefit (EB) program and 100 percent of federal and State administrative costs. State unemployment taxes on employers pay for 100 percent of the regular UC benefit and 50 percent of the EB benefit.

Federal law does not provide formulas, floors, or ceilings on the calculation of regular weekly State unemployment benefit amounts. In general, the States set weekly benefit amounts as a fraction of the individual's average weekly wage up to some State-determined maximum. Some States include dependents' allowances in addition to the underlying benefit.

The Extended Benefit (EB) program, established by the Federal-State Unemployment Compensation Act, Public Law 91-373 (26 U.S.C. 3304 note), may extend UC benefits at the State level if certain economic situations within the State exist.

Section 202(a)(2) of the Federal-State Unemployment Compensation Act sets the extended benefit (EB) amount to be equivalent to the regular UC benefit.

Section 4001(d)(1) of Title IV, Emergency Unemployment Compensation, of the Supplemental Appropriations Act, 2008 (Public Law 110-252; 26 U.S.C.3304 note) as amended, also requires that the EUC08 benefit be equivalent to the regular UC benefit.

**Fraud and Overpayments.** All State laws provide for recovering UC benefits paid to workers who later are found not to be entitled to them. In addition to direct repayment, States use several tools to recoup these funds. States may, at the discretion of the agency, recover overpayments by deducting from future benefits payable (benefit offset). They also may offset overpayments with State tax refunds due to the worker. They also can compel repayment by pursuing civil action in State court. Finally, some States may assess interest on outstanding overpayment balances. Some States provide that if the overpayment is not the fault of the individual, the individual is not liable to repay the amount overpaid.

Section 4005 of Title IV, Emergency Unemployment Compensation requires that if an individual knowingly has falsely received an amount of EUC08 compensation the individual is ineligible for further EUC08 compensation and shall be subject to prosecution under section 1100 of title 18 of the United States Code (Chapter 47 --- Fraud and False Statements). If an individual wrongly received amounts of EUC08 benefits to which they were not entitled, the

State requires such an individual to repay the amounts of EUC08 benefits to the State agency except that the State agency may waive such repayment if the individual was without fault and such repayment would be contrary to equity and good conscience. States are required to recover erroneous payments through deductions from any EUC08 benefits payable to such individual or from any State or federal unemployment benefit with respect to any week of unemployment, during the three-year period after the date such individual received the erroneous emergency UC benefit payment. No single deduction may exceed 50 percent of the weekly benefit amount from which such deduction is made. In addition to regular UC and EB benefits, the Trade Readjustment Allowance and the Federal Disaster Unemployment Assistance benefit (among other similar benefits) also qualify to have such a deduction. No repayment shall be required until a determination has been made and an opportunity for a fair hearing has been given to the individual and the determination has become final.

### *Chairman's Mark*

**Federal-State Agreements.** The Chairman's Mark would create an additional, federally funded, \$25 weekly benefit that would be available to all individuals receiving regular UC, EB, or EUC08 benefits. These \$25 additional weekly benefits would be available in States that enter into an agreement with the Labor Secretary. States would have the option to terminate such an agreement after providing 30 days' written notice.

**Provisions of Agreement.** The Mark specifies that agreements between the Labor Secretary and the States would require that States not take the additional compensation (the \$25 additional benefit) into consideration while determining regular UC benefit (including any dependents' allowances). The \$25 additional benefit would be payable either at the same time and in the same manner as any regular compensation payable for the week involved, or at the option of the State, the payments may be separate from but on the same weekly basis as any regular compensation otherwise payable.

**Nonreduction Rule.** The Mark requires that the agreement would not apply or would cease to apply if the Labor Secretary determines a State had altered the method governing the computation of regular compensation under the State law in such a manner that the weekly benefit amount would be less than the benefit amount that would have been payable during such a period under the State law as of December 31, 2008.

**Payment to States.** The Mark would require that States be paid 100 percent of the additional benefit cost as well as any additional administrative expenses incurred by the State by reason of such agreement as determined by the Labor Secretary. The Federal payments to the States would be made on a monthly basis, payable in advance or by way of reimbursement.

The Federal payments to the States for the \$25 additional benefit and associated administrative expenses would be appropriated from the general fund of the Treasury, without fiscal year limitation. These funds would not be required to be repaid.

**Applicability.** This Mark would begin the additional benefits for weeks of unemployment beginning after the date of enactment. The additional benefit would terminate for weeks of unemployment ending before January 1, 2010.

After such termination, in the case of individuals who have not exhausted the right to regular unemployment benefits and have been receiving the \$25 additional benefit, the \$25 additional benefit would continue to be payable until regular unemployment compensation exhaustion. That is, there would be a “grandfathering” of the additional benefit for individuals who were already receiving the \$25 additional benefit. No \$25 additional benefit would be payable for any week of unemployment beginning after June 30, 2010.

**Fraud and Overpayments.** The Mark would apply Section 4005 (Fraud and Overpayments) of the Supplemental Appropriations Act 2008, with respect to additional compensation to the same extent and in the same manner as in the case of EUC08 benefits.

**Application to Other Unemployment Benefits.** The Mark would also apply all the provisions of the proposal to all unemployment benefits (EB, and EUC08 benefits) to the same extent and in the same manner as if those benefits were regular unemployment compensation. Additionally, eligibility and termination rules shall be applied in the same manner.

For example, if an individual were receiving a tier I EUC08 benefit (and the \$25 additional benefit) in the week ending before January 1, 2010, the additional benefit would be continue to be payable while an individual continued to receive the tier I EUC08 until the exhaustion of the tier I EUC08 benefit. However, that individual would not receive the \$25 additional benefit if the individual then began to receive the EB benefit. No \$25 additional benefit would be payable for any week of unemployment beginning after June 30, 2010.

The proposal also requires that states disregard the \$25 in additional benefits for purposes of determining eligibility for Medicaid and CHIP.

## **Unemployment Compensation Modernization**

### *Current Law*

Section 903 of the Social Security Act (SSA) describes the set of conditions under which funds are transferred to eligible State unemployment accounts from the federal accounts in the Unemployment Trust Fund (UTF) when those federal account balances exceed certain levels. Transfers of excess funds in the UTF to State accounts are called Reed Act distributions.<sup>1</sup>

Section 903(a)(2)(B) of the SSA describes the manner in which the distribution of Reed Act funds occurs. Funds are distributed to the State UTF accounts based on the State’s share of estimated federal unemployment taxes (excluding reduced credit payments) made by the State’s employers.

---

<sup>1</sup> Legislatively, the most recent Reed Act distribution was a special transfer in 2002 through the Job Creation and Worker Assistance Act of 2002, P.L. 107-147. This provided for a one-time special Reed Act distribution of up to \$8 billion to State accounts. It required that the transferred funds first be used to pay outstanding State loans from the UTF. The remaining funds could be used for unemployment compensation (UC) benefits. States were also able to use the funds for UC and Employment Service (ES) administration; these required a State appropriation.

While federal laws and regulations provide broad guidelines on UC coverage, eligibility, and benefit determination, the specifics of regular UC benefits are determined by each State through State laws and regulations.

**Description of State Base Period Determination.** The monetary requirement for eligibility for UC benefits is determined by insured wages earned by claimants while they were employed during a specified period of time — referred to as the base period (BP). The BP spans four continuous calendar quarters. In most States the BP is the first four of the last five completed calendar quarters immediately preceding the filing of a claim. Many unemployed workers do not meet the requirements for monetary eligibility because their BP earnings are not sufficient in terms of either quarters worked or level of earnings earned in the “high” quarter. Some of these unemployed workers might qualify for UC benefits if their State allows workers to use more recent wage credits based on an Alternative Base Period (ABP). Depending on the State, the ABP allows wage credits earned during the last completed calendar quarter (lag quarter) or the quarter in which the claim is filed (current quarter) to help determine UC eligibility and benefit amounts. Unemployment Insurance Policy Letter 44-97 (which interpreted section 5401 of P.L. 105-33, the Balanced Budget Act of 1997) allows States to not offer an alternative base period (ABP) in determining eligibility for UC benefits.

**Description of State Treatments of Part-time Work.** In most States’ UC systems, workers who have had their hours reduced or who are working short-term in part-time jobs while looking for a permanent full-time job may receive some (although generally greatly offset) UC benefits. To encourage workers to remain in the labor force, all States disregard some earnings as an inducement to take part-time work. The worker’s UC benefit will generally equal the difference between the weekly benefit amount and earnings plus a small disregard. However, if the worker restricts his or her job search to only positions that are part-time in hours, some States may rule that the worker is ineligible for UC benefits. Some States allow workers to restrict job searches to part-time only positions if the worker has a history of part-time work or if the worker has a disability.

**Description of State Non-Monetary Requirements: “Quitting For Good Cause.”** Along with monetary requirements, each State’s UC law requires workers to meet non-monetary requirements. Federal law mandates some of these requirements. Generally, workers must have lost their jobs through no fault of their own and must be able, available, and actively seeking work. Since the UC program is designed to compensate wage loss due to lack of work, voluntarily leaving work without good cause is an obvious reason for disqualification from benefits. All States have such provisions.

There is often a distinction between issues that result in disqualification and issues that result in weeks of ineligibility. A *disqualified* worker has no right to benefits until the worker requalifies, usually by obtaining new work or by waiting out a set disqualification period. In some disqualifying cases, benefits and wage credits may be reduced for a period. In comparison, an *ineligible* worker does not receive benefits only as long as the condition that causes ineligibility exists.

A worker who leaves work for good cause may not be disqualified but is not necessarily eligible to receive benefits. For example, if the worker left because of illness or to take care of

illness in the family, the worker may not be able to work or be available for work. This ineligibility would generally last until the individual was ready and able to work.

Among many different considerations, some States consider quitting a job to be leaving for “good cause” if the quit may be attributed to:

- escaping domestic violence,
- caring for a disabled family member, and/or
- following a spouse whose job has been relocated.

**Description of State Determination of Benefit Duration.** When States compute a worker’s monetary eligibility for benefits, in addition to calculating the weekly benefit amount, they determine the duration of benefits—how long benefits can be collected. There are no federal standards for the duration of regular benefits. The duration is usually measured as a number of weeks of total unemployment. Maximum weeks of benefits vary from 26 to 30 weeks, most frequently 26 weeks. A few States’ laws establish uniform durations of 26 weeks for all workers who meet the qualifying-wage requirements, whereas the rest of the States have variable durations.

**Description of State Benefits: Dependents’ Allowances.** Although the primary factor in determining the weekly UC benefit a claimant receives each week is wages earned during the base period, some States’ laws provide for dependents’ allowances above and beyond the basic benefit amount payable. The definition of dependent varies from State to State as does the allowance granted. In general, a dependent must be wholly or mainly supported by the worker or living with or receiving regular support from the worker. All States with dependents’ allowances include children under a specified age. The intent is to include all children whom the worker is morally obligated to support. In most of these States, allowances may be paid on behalf of older children who are unable to work because of physical or mental disability. In some States, children are not the only dependents recognized - spouses, parents, or siblings are also included in the definition. As with the definition of dependents, there is much variation among States concerning the amount of weekly dependents’ allowances payable. However, there are some commonalities. For example, the allowance is ordinarily a fixed sum. In addition, all States have a limit on the total amount of the dependents’ allowances payable in any week: in terms of dollar amount, number of dependents, percentage of basic benefits, or of high-quarter wages or of average weekly wage.

**Definitions.** Section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304, note) provides definitions for the Extended Benefit (EB) program. Included among the definitions are the following:

- The term “benefit year” means the benefit year as defined in the applicable State law.
- The term “base period” means the base period as determined under applicable State law for the benefit year.
- The term “week” means a week as defined in the applicable State law.

#### *Chairman’s mark*

The Chairman’s Mark would amend section 903 of the Social Security Act to include two new subsections, Special Transfers for Unemployment Compensation Modernization and Special



Transfers in Fiscal Year 2009 for Administration. Detailed descriptions of both subsections are provided below.

The Mark would allow the Labor Secretary to prescribe any regulations, operating instructions, or other guidance necessary to carry out the provisions contained in the Mark.

**Special Transfers for Unemployment Compensation Modernization.** The Mark provides for a special transfer of UTF funds from the federal unemployment account (FUA) of up to \$7 billion to the State accounts within the UTF as “incentive payments” for changing certain State UC laws. The maximum incentive payment allowable for a State would be calculated using the methods required by the Reed Act if a distribution were to have occurred on October 1, 2008, as detailed in section 903(a)(2) [of the Social Security Act]. That is, funds would be distributed to the State UTF accounts based on the State’s share of estimated federal unemployment taxes (excluding reduced credit payments) made by the State’s employers.

One-third of the maximum payment would be contingent on State law calculating the base period by either:

- (A) allowing use of a base period that includes the most recently completed calendar quarter before the start of the benefit year for the purpose of determining UC eligibility; or
- (B) providing that, in the case of an individual who would not otherwise be UC-eligible under State law, eligibility shall be determined using a base period that includes the most recently completed calendar quarter.

The remaining 2/3 of the incentive payment would be contingent on State law containing at least two of the following four provisions<sup>2</sup> described in the proposal<sup>3</sup>:

- (A) No denial of UC under State law provisions relating to availability for work, active search for work, or refusal to accept work solely because the individual is seeking only part-time work. States may exclude an individual if the majority of the weeks of work in the individual’s base period do not include part-time work.
- (B) No UC disqualification for separation from employment if it is for compelling family reasons. These reasons must include (i) domestic violence, (ii) illness or disability of an immediate family member, and (iii) the need to accompany a spouse to a place from where it is impractical to commute and due to a change in location of the spouse’s employment.
- (C) Weekly UC continues for individuals who have exhausted all rights to regular and extended benefits but are enrolled and making satisfactory progress in a State-approved training program or in a job training program authorized under the Workforce Investment Act of 1998. The benefit must be for at least an additional 26 weeks and be equivalent to the previously calculated UC benefit (including dependents’ allowances) for the most recent benefit year. The training program must prepare the individual for entry into a “high-demand” occupation.

---

<sup>2</sup> Through regulation and program letters, the States currently have the option of electing or declining each of the “modernization” options listed in the proposal.

<sup>3</sup> Proposed subsection 903(f)(4), described later, limits these distributions only to States that have qualified for the ABP distribution as described in proposed subsection 903(f)(1)(C)(i).

- (D) UC Dependent's allowances are provided to all individuals with a dependent (as defined by State law) at a level equal to at least \$15 per dependent per week. The aggregate limit on dependent's allowances must be not less than the lesser of \$50 or 50 percent of the weekly benefit amount for the benefit year.

The Mark would require States to submit proof of compliance with the requirements for UC modernization (including information as to how the State intends to use the incentive payment to improve or strengthen the State's UC program). The Labor Secretary, within 60 days after the date of enactment, may prescribe (by regulation or otherwise) information required in relation to the compliance of the modernization requirements. The Secretary of Labor would have 30 days after receiving a complete application to determine if modernization incentives are payable to the State.

The Secretary of Labor, while determining if State law meets the requirements for an incentive payment, would be required to disregard any State law provisions that are not currently effective as permanent law or are subject to a discontinuation under certain circumstances. Once the Labor Secretary notifies the Treasury Secretary of the certification of the incentive payment, the appropriate transfer to the State account would occur within seven days. State law provisions which are to take effect within 12 months after the date of their certification would be considered to be in effect for the purposes of certification.

The Mark would further require that:

- (i) States must be eligible for certification under section 303 [of the Social Security Act] and under section 3304 of the Federal Unemployment Tax Act (FUTA) [section 3304 of the Internal Revenue Code of 1986];
- (ii) No State may receive the 2/3 share without also having a certified alternative base period; and
- (iii) Applications submitted before enactment or after the latest date necessary (as determined by the Labor Secretary) will not be considered in order to ensure that all incentive payments are made before October 1, 2010 (October 1, 2011, in the case of a State in which the first day of the first regularly scheduled session of the State legislature beginning after the date of enactment of the subsection begins after December 31, 2010).

States would be required to use the incentive payments only for the payment of UC benefits and dependents' allowances. An exception is made for those funds subject to conditions set forth in subsection (c)(2) [of section 903 of the Social Security Act], excluding the conditions in subparagraph (B) of section 903 [of the Social Security Act]. That is, the States would have to appropriate the funds for administrative expenses. Funds that satisfy this exception may be used for the administration of UC law and for public employment offices.

The Secretary of the Treasury would be required to reserve \$7 billion for incentive payments in the Federal Unemployment Account (FUA) of the UTF. These reserved funds should not be taken into account for purposes of any determination under sections 902, 910, or 1203 [of the Social Security Act] of the amount in the FUA as of any given time. Any amount so reserved for which the Secretary of the Treasury has not received a certification under the proposed paragraph (4)(B) of the bill by the deadline determined by the Secretary of Labor

shall become unrestricted regarding its use as part of the FUA upon the close of fiscal year 2011.

“Benefit year,” “base period,” and “week” are all defined to have the same meanings as found in section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

**Special Transfers in Fiscal Year 2009 for Administration.** The Mark proposes to transfer a total of \$500 million from the federal employment security administration account (ESAA) to the State’s accounts in the UTF within 30 days of enactment.

The Mark proposes to distribute the \$500 million to the State accounts in the UTF based upon ratios calculated by methods detailed herein. That is, funds would be distributed to the State UTF accounts based on the State’s share of estimated federal unemployment taxes (excluding reduced credit payments) made by the State’s employers. Any advances made to the State account would first be credited against, and operate to reduce, any additional amount transferred to the State account as part of the transfer. These distributions would be made regardless of whether the State qualified for any incentive payments.

The Chairman’s Mark would require that any amount transferred to a State account as a result of this \$500 million transfer would be used by the State agency of such State only in (A) payment of expenses incurred through carrying out of the purposes in State law required to receive the incentive payments, (B) improved outreach to individuals who might be eligible for regular UC by virtue of the changes in State law, (C) improvement of unemployment benefit and unemployment tax operations, including responding to increased demand for unemployment compensation, and (D) staff-assisted reemployment services for UC claimants.

### **Temporary Assistance for States with Advances**

#### *Current Law*

In budget terms, UC benefits are an entitlement (although the program is financed by a dedicated tax imposed on employers and not by general revenues). Thus, even if a State’s trust account is depleted, the State remains legally required to continue paying UC benefits. To do so, the State will be forced to borrow money from the dedicated loan account, the Federal Unemployment Account (FUA), within the Unemployment Trust Fund (UTF) or from outside sources. If the State chooses to borrow funds from the FUA, not only will the State be required to continue paying UC benefits, it will also be required to repay the funds (plus any interest due) it has borrowed from the FUA. To repay these loans, such States may raise taxes on their employers and/or reduce UC benefit levels. Interest on the loans may not be paid by collected State unemployment taxes but must come from outside the State unemployment taxation system.

Section 1202(b) of the Social Security Act (42 U.S.C. 1322(b)) requires that States are charged interest on new loans that are not repaid by the end of the fiscal year in which they were obtained. The interest rate on the loans is the same rate as that paid by the Federal government on state reserves in the UTF for the quarter ending December 31 of the preceding

year, but not higher than 10 percent per annum. States may not pay the interest directly or indirectly from funds in their state account with the UTF.

Section 1202(b)(2) allows a State to borrow funds without interest from the FUA during the year if the States repays the loans by September 30 of the calendar year in which the advances were made. No loans may be made in October, November, or December of the calendar year of such an interest-free loan. Otherwise, the “interest-free” loan will accrue interest charges.

#### *Chairman’s Mark*

The Mark would temporarily waive interest payments and the accrual of interest on advances to State unemployment funds.

Further, the Mark would require that (i) the interest payments due from the time of enactment of the proposal until December 31, 2010 be deemed to have been made by the State and (ii) no interest accrue during such period. That is, the interest due would be waived and no interest would accrue during such period.

### **SUBTITLE B—ASSISTANCE FOR VULNERABLE INDIVIDUALS**

#### **TANF Emergency Contingency Fund**

##### *Current Law*

**TANF Recession Funds.** The 1996 welfare reform established a contingency fund under the Temporary Assistance for Needy Families (TANF) block grant. It appropriated \$2 billion to the fund for capped matching grants. (As of the beginning of FY2009, about \$1.3 billion remained in the fund.) The maximum contingency fund grant a state could receive in a fiscal year equals 20 percent of its basic TANF block grant.

To qualify for contingency dollars, states must spend under the TANF program a sum of their own dollars equal to their pre-TANF FY1994 spending and meet a test of economic need based. Economic need is established by either: (1) increased participation in the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) for the most recent three months for which data are available of at least 10 percent compared with the corresponding three-month period in either FY1994 or FY1995; or (2) a three-month average unemployment rate of at least 6.5 percent and at least 110 percent of the unemployment rate in the corresponding three month period in either the previous two years. Eligible expenditures above the pre-TANF level are matched at the Medicaid (Federal Medical Assistance Percentage or FMAP) rate.

Contingency fund grants are available to the 50 states and the District of Columbia. Neither the Commonwealth of Puerto Rico, the territories of Guam and the Virgin Islands, nor tribes that run their own TANF programs are eligible for contingency funds.

**TANF Caseload Reduction Credit.** TANF established federal work participation standards, which are numerical performance standards that states must meet or be subject to a financial penalty. A state must meet two standards – the all family standard of 50 percent and the two-

parent standard of 90 percent. These standards may be met either by engaging participants in creditable activities or through reductions in the cash welfare caseload. States are given a caseload reduction credit toward the standards of one percentage point for each percent decline in the caseload from Fiscal Year 2005 to the preceding fiscal year. Under current law, the caseload reduction credit toward the Fiscal Year 2009 standard is based on caseload change from Fiscal Year 2005 to Fiscal Year 2008; the credit toward the Fiscal Year 2010 standard will be based on caseload change from Fiscal Year 2005 to Fiscal Year 2009; and the credit toward the Fiscal Year 2011 standard will be based on caseload change from Fiscal Year 2005 to Fiscal Year 2010.

### *Chairman's Mark*

The Chairman's Mark retains the current TANF contingency fund and creates a new, temporary emergency contingency fund for FY2009 and FY2010. States with increased cash welfare caseloads under TANF or separate state programs funded with TANF state maintenance of effort dollars are eligible for capped grants from the fund. Also eligible are states with increased short-term non-recurrent benefit expenditures or increased subsidized employment expenditures under TANF and separate state programs. The fund reimburses states for 80 percent of the increased expenditures on basic assistance (cash welfare), short-term non-recurrent benefits, or subsidized employment in TANF and separate state programs, up to a cap. Increased caseloads and expenditures are measured on a quarterly basis, comparing each quarter in Fiscal Year 2009 and Fiscal year 2010 to the corresponding quarter in the base years of Fiscal Year 2007 and Fiscal Year 2008. The applicable base period for a state varies depending on whichever results in the greatest increase for each state for the cash assistance caseload and by expenditure category (basic assistance, short-term non-recurrent benefit, and subsidized employment). The Secretary of Health and Human Services is given the authority to make the necessary adjustments and collect caseload and expenditure data to implement the provisions of the emergency fund. Total combined state grants from the current law contingency fund and the proposed emergency contingency fund are limited to 25 percent of a state's basic block grant.

The Chairman's Mark appropriates \$3.0 billion for Fiscal Year 2009 to the emergency fund. These funds are available for obligation to the states through the end of Fiscal Year 2010.

Emergency contingency fund grants are available to the 50 states, the District of Columbia, the Commonwealth of Puerto Rico and territories of Guam and the Virgin Islands. Emergency contingency fund grants do not count against the overall cap on federal funding for public assistance for Puerto Rico, Guam, and the Virgin Islands.

**Hold-harmless for Caseload Increases for the Caseload Reduction Credit.** The Chairman's Mark gives states an optional measuring period for the caseload reduction credit that would apply to the Fiscal Year 2009, 2010 and 2011 standards. States would have the option to measure caseload reduction from Fiscal Year 2005 to either Fiscal Year 2007 or Fiscal Year 2008 when determining the caseload reduction credit toward the TANF work participation standards for those three years.

## **Extension of TANF Supplemental Grants**

### *Current Law*

TANF provides supplemental grants for 17 states with exceptionally high population growth in the early 1990s, historic (FY1994) welfare grants per poor person lower than 35 percent of the national average, or a combination of above average population growth and below average historic welfare grants per poor person. Grants were authorized at \$800 million over FY1998 through FY2001, and annual grants grew from \$79 million in FY1998 to \$319 million in FY2001. Congress froze supplemental grants at \$319 million annual level when it extended supplemental grants for FY2002 and subsequent years. The Deficit Reduction Act of 2005 (P.L. 109-171), which extended most TANF grants through FY2010, continued supplemental grants only through FY2008. P.L. 110-275 extended supplemental grants through FY2009.

### *Chairman's Mark*

The mark extends supplemental grants at the \$319 million annual level through FY2010. In FY2010, each of the 17 qualifying states will receive the same supplemental grant amount as it will for FY2009.

## **TANF Carryover Funds**

### *Current Law*

Currently States and tribes are permitted to reserve, without fiscal year limit, unused TANF grants. These reserves or "carry-over" funds can only be used for "cash welfare." The mark permits carry-over funds to be used for any TANF benefit or service.

### *Chairman's Mark*

The Chairman's Mark permits states and tribes to use TANF reserves ("carry-over" funds) for any TANF benefit or service.

## **Temporary Reinstatement of Authority to Provide Federal Match for Child Support Enforcement**

### *Current Law*

The Federal Government pays States an incentive payment to encourage them to operate effective programs. The incentive payment is based on several factors including the State's performance in five program areas. Federal law requires States to reinvest Child Support Enforcement (CSE) incentive payments back into the CSE program or related activities. The Deficit Reduction Act of 2005 (P.L. 109-171) prohibits Federal matching/reimbursement of CSE incentive payments that are reinvested in the CSE program.

## *Chairman's Mark*

The mark requires the Department of Health and Human Services (HHS) to temporarily provide federal matching funds on CSE incentive payments that States reinvest back into the CSE program. This means that CSE incentive payments that are/were received by States and reinvested in the CSE program can be used to draw down Federal funds for the period October 1, 2008 through December 31, 2010.

## **TITLE III—HEALTH INSURANCE ASSISTANCE**

### **SUBTITLE A—PREMIUM SUBSIDIES FOR COBRA CONTINUATION COVERAGE FOR UNEMPLOYED WORKERS**

#### **Premium Subsidies for COBRA Continuation Coverage for Unemployed Workers**

##### *Current Law*

The Internal Revenue Code (the “Code”) contains rules that require certain group health plans to offer certain individuals (“qualified beneficiaries”) the opportunity to continue to participate for a specified period of time in the group health plan (“continuation coverage”) after the occurrence of certain events that otherwise would have terminated such participation (“qualifying events”). These continuation coverage rules are often referred to as “COBRA continuation coverage” or “COBRA.”

A group health plan is defined as a plan of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, and others associated or formerly associated with the employer in a business relationship, or their families. A group health plan includes a self-insured plan. The term group health plan does not, however, include a plan under which substantially all of the coverage is for qualified long-term care services.

The following types of group health plans are not subject to the Code’s COBRA rules: (1) a plan established and maintained for its employees by a church or by a convention or association of churches which is exempt from tax under section 501 (a “church plan”); (2) a plan established and maintained for its employees by the Federal government, the government of any State or political subdivision thereof, or by any instrumentality of the foregoing (a “governmental plan”); and (3) a plan maintained by an employer that normally employed fewer than 20 employees on a typical business day during the preceding calendar year (a “small employer plan”).

**Qualifying Events and Qualified Beneficiaries.** A qualifying event that gives rise to COBRA continuation coverage includes the following events which would result in a loss of coverage of a qualified beneficiary under a group health plan (but for COBRA continuation coverage): (1) death of the covered employee; (2) the termination (other than by reason of such employee’s gross misconduct), or a reduction in hours, of the covered employee’s employment; (3) divorce or legal separation of the covered employee; (4) the covered employee becoming entitled to Medicare benefits under title XVIII of the Social Security Act;

(5) a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; and (6) a proceeding in a case under the U.S. Bankruptcy Code commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

A “covered employee” is an individual who is (or was) provided coverage under the group health plan on account of the performance of services by the individual for one or more persons maintaining the plan and includes a self-employed individual. A “qualified beneficiary” means, with respect to a covered employee, any individual who on the day before the qualifying event for the employee is a beneficiary under the group health plan as the spouse or dependent child of the employee. The term qualified beneficiary also includes the covered employee in the case of a qualifying event that is a termination of employment or reduction in hours.

**Continuation Coverage Requirements.** Continuation coverage that must be offered to qualified beneficiaries pursuant to COBRA must consist of coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated non-COBRA beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage under a plan is modified for any group of similarly situated non-COBRA beneficiaries, the coverage must also be modified in the same manner for qualified beneficiaries. Similarly situated non-COBRA beneficiaries means the group of covered employees, spouses of covered employees, or dependent children of covered employees who (i) are receiving coverage under the group health plan for a reason other than pursuant to COBRA, and (ii) are the most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event, based on all of the facts and circumstances.

The maximum required period of continuation coverage for a qualified beneficiary (i.e., the minimum period for which continuation coverage must be offered) depends upon a number of factors, including the specific qualifying event that gives rise to a qualified beneficiary’s right to elect continuation coverage. In the case of a qualifying event that is the termination, or reduction of hours, of a covered employee’s employment, the minimum period of coverage that must be offered to the qualified beneficiary is coverage for the period beginning with the loss of coverage on account of the qualifying event and ending on the date that is 18 months after the date of the qualifying event. If coverage under a plan is lost on account of a qualifying event but the loss of coverage actually occurs at a later date, the minimum coverage period may be extended by the plan so that it is measured from the date when coverage is actually lost.

The minimum coverage period for a qualified beneficiary generally ends upon the earliest to occur of the following events: (1) the date on which the employer ceases to provide any group health plan to any employee, (2) the date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required with respect to the qualified beneficiary, and (3) the date on which the qualified beneficiary first becomes (after the date of election of continuation coverage) either (i) covered under any other group health plan (as an employee or otherwise) which does not include any exclusion or limitation with respect to any preexisting condition of such beneficiary or (ii) entitled to Medicare benefits under title XVIII of the Social Security Act. Mere eligibility for another group health plan or Medicare benefits is not sufficient to terminate the minimum coverage period. Instead, the qualified beneficiary



must be actually covered by the other group health plan or enrolled in Medicare. Coverage under another group health plan or enrollment in Medicare does not terminate the minimum coverage period if such other coverage or Medicare enrollment begins on or before the date that continuation coverage is elected.

**Notice Requirements.** A group health plan is required to give a general notice of COBRA continuation coverage rights to employees and their spouses at the time of enrollment in the group health plan.

An employer is required to give notice to the plan administrator of certain qualifying events (including a loss of coverage on account of a termination of employment or reduction in hours) generally within 30 days of the qualifying event. A covered employee or qualified beneficiary is required to give notice to the plan administrator of certain qualifying events within 60 days after the event. The qualifying events giving rise to an employee or beneficiary notification requirement are the divorce or legal separation of the covered employee or a dependent child ceasing to be a dependent child under the terms of the plan. Upon receiving notice of a qualifying event from the employer, covered employee, or qualified beneficiary, the plan administrator is then required to give notice of COBRA continuation coverage rights within 14 days to all qualified beneficiaries with respect to the event.

**Election of Continuation Coverage.** The COBRA rules specify a minimum election period under which a qualified beneficiary is entitled to elect continuation coverage. The election period begins not later than the date on which coverage under the plan terminates on account of the qualifying event, and ends not earlier than the later of 60 days or 60 days after notice is given to the qualified beneficiary of the qualifying event and the beneficiary's election rights.

**Premiums.** A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the "applicable premium" for such period and the premium must be payable, at the election of the payor, in monthly installments.

The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee. The determination of any applicable premium is made for a period of 12 months (the "determination period") and is required to be made before the beginning of such 12 month period.

In the case of a self-insured plan, the applicable premium for any period of continuation coverage of qualified beneficiaries is equal to a reasonable estimate of the cost of providing coverage during such period for similarly situated non-COBRA beneficiaries which is determined on an actuarial basis and takes into account such factors as the Secretary of Treasury prescribes in regulations. A self-insured plan may elect to determine the applicable premium on the basis of an adjusted cost to the plan for similarly situated non-COBRA beneficiaries during the preceding determination period.

A plan may not require payment of any premium before the day which is 45 days after the date on which the qualified beneficiary made the initial election for continuation coverage. A

plan is required to treat any required premium payment as timely if it is made within 30 days after the date the premium is due or within such longer period as applies to, or under, the plan.

**Other Continuation Coverage Rules.** Continuation coverage rules which are parallel to the Code's continuation coverage rules apply to group health plans under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally permits the Secretary of Labor and plan participants to bring a civil action to obtain appropriate equitable relief to enforce the continuation coverage rules of ERISA, and in the case of a plan administrator who fails to give timely notice to a participant or beneficiary with respect to COBRA continuation coverage, a court may hold the plan administrator liable to the participant or beneficiary in the amount of up to \$100 a day from the date of such failure.

Although the Federal government and State and local governments are not subject to the Code and ERISA's continuation coverage rules, other laws impose similar continuation coverage requirements with respect to plans maintained by such governmental employers. In addition, many States have enacted laws or promulgated regulations that provide continuation coverage rights that are similar to COBRA continuation coverage rights in the case of a loss of group health coverage. Such State laws, for example, may apply in the case of a loss of coverage under a group health plan maintained by a small employer.

#### *Chairman's Mark*

**Reduced COBRA Premium.** The Chairman's Mark provides that, for a period not exceeding 9 months, an assistance-eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. For this purpose, payment by an assistance-eligible individual includes payment by another individual paying on behalf of the individual, such as a parent or guardian or a State agency or charity. Thus, the assistance-eligible individual is entitled to a subsidy for 65 percent of the premium. An assistance-eligible individual is any qualified beneficiary who elects COBRA continuation coverage and satisfies two additional requirements. First, the qualifying event with respect to the covered employee for that qualified beneficiary must be a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment. A termination of employment for gross misconduct does not qualify. Second the qualifying event must occur during the period beginning September 1, 2008 and ending with December 31, 2009 and the qualified beneficiary must be eligible for COBRA continuation coverage during that period and elect such coverage.

An assistance-eligible individual can be any qualified beneficiary associated with the relevant covered employee (e.g., a dependent of an employee who is covered immediately prior to a qualifying event), and such qualified beneficiary can independently elect COBRA (as provided under present law COBRA rules) and independently receive a subsidy. Thus, the subsidy for an assistance-eligible individual continues after an intervening death of the covered employee.

Under the Mark, any subsidy provided is excludible from the gross income of the covered employee and any assistance-eligible individuals. However, for purposes of determining the gross income of the employer and any welfare benefit plan of which the group health plan is a

part, the amount of the premium reduction is intended to be treated as an employee contribution to the group health plan.

Finally, notwithstanding any other provision of law, the subsidy is not permitted to be considered as income or resources in determining eligibility for, or the amount of assistance or benefits under, any public benefit provided under Federal or State law (including the law of any political subdivision).

**Eligible COBRA Continuation Coverage.** In addition to COBRA continuation coverage required to be offered under the Code's rules, the Chairman's Mark provides assistance for coverage required under State law that requires continuation coverage comparable to the continuation coverage required under the Code's COBRA rules for group health plans not subject to those rules (e.g., a small employer plan) and includes continuation coverage requirements that apply to health plans maintained by the Federal government or a State government. To be comparable, the right generally must be to continue substantially similar coverage as was provided under the group health plan (or substantially similar coverage as is provided to similarly situated beneficiaries) at a monthly cost that is based on a specified percentage of the group health plan's cost of providing such coverage.

The cost of coverage under any group health plan that is subject to the Code's COBRA rules (or comparable State requirements or continuation coverage requirement under health plans maintained by the Federal government or any State government) is eligible for the subsidy, except contributions to a health flexible spending account.

**Termination of Eligibility for Reduced Premiums.** The assistance-eligible individual's eligibility for the subsidy terminates with the first month beginning on or after the earlier of (1) the date which is 9 months after the first month for which the subsidy applies, (2) the end of the maximum required period of continuation coverage for the qualified beneficiary under the Code's COBRA rules or the relevant State or Federal law (or regulation), or (3) the date that the assistance-eligible individual becomes eligible for Medicare benefits under title XVIII of the Social Security Act or health coverage under another group health plan (including, for example, a group health plan maintained by the new employer of the individual or a plan maintained by the employer of the individual's spouse). Eligibility for coverage under another group health plan terminates the subsidy even if the other group health plan contains an exclusion or limitation affecting a preexisting condition of the assistance-eligible individual and even if the individual does not actually elect coverage under the other group health plan. Thus, a qualified beneficiary's eligibility for the reduced premium may terminate even though the beneficiary's right to the Code's COBRA continuation coverage (or relevant State or Federal continuation coverage) continues. However, eligibility for coverage under another group health plan does not terminate eligibility for the subsidy if the other group health plan provides only dental, vision, counseling, or referral services (or a combination of the foregoing), is a health flexible spending account or health reimbursement arrangement, or is coverage for treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

If a qualified beneficiary paying a reduced premium for COBRA continuation coverage under this provision becomes eligible for coverage under another group health plan or Medicare, the

provision requires the qualified beneficiary to notify, in writing, the group health plan providing the COBRA continuation coverage with the reduced premium of such eligibility under the other plan or Medicare. The notification by the assistance-eligible individual must be provided to the group health plan in the time and manner specified by the Secretary of Labor. If an assistance-eligible individual fails to provide this notification at the required time and in the required manner, and as a result the individual's COBRA continuation coverage continues to be subsidized after the termination of the individual's eligibility for such subsidy, a penalty is imposed on the individual equal to 110 percent of the subsidy provided after termination of eligibility.

This penalty only applies if the subsidy in the form of the premium reduction is actually provided to a qualified beneficiary for a month that the beneficiary is not eligible for the reduction. If a qualified beneficiary becomes eligible for coverage under another group health plan and stops paying the reduced COBRA continuation premium, for example, the penalty generally will not apply. The group health plan is reimbursed for the subsidy for a month (65 percent of the amount of the premium for the month) only after receipt of the qualified beneficiary's portion (35 percent of the premium amount). Thus, the penalty generally will only arise when the qualified beneficiary continues to pay the reduced premium and does not notify the group health plan providing COBRA continuation coverage of the beneficiary's eligibility under another group health plan.

**Special COBRA Election Opportunity.** The Chairman's Mark provides a special 60 day election period for a qualified beneficiary who is eligible for a reduced premium and who has not elected COBRA continuation coverage as of the date of enactment. The 60 day election period begins on the date that notice is provided to the qualified beneficiary of the special election period. However, this special election period does not extend the period of COBRA continuation coverage beyond the original maximum required period (generally 18 months after the qualifying event) and any COBRA continuation coverage elected pursuant to this special election period begins on the date of enactment and does not include any period prior to that date. Thus, for example, if a covered employee involuntarily terminated employment on September 10, 2008, but did not elect COBRA continuation coverage and was not eligible for coverage under another group health plan, the employee would have 60 days after notification of this new election right to elect the coverage and receive the subsidy. If the employee made the election, the coverage would begin with the date of enactment and would not include any period prior to that date. However, the coverage would not be required to last for 18 months. Instead the maximum required COBRA continuation coverage period would end not later than 18 months after September 10, 2008.

The special enrollment provision applies to a group health plan that is subject to the COBRA continuation coverage requirements of the Code, ERISA, title 5 of the United States Code (relating to plans maintained by the Federal government), or the Public Health Service Act ("PHSA"). With respect to an assistance-eligible individual who elects coverage pursuant to the special election period, the period beginning on the date of the qualifying event and ending with the day before the date of enactment is disregarded for purposes of the rules that limit the group health plan from imposing pre-existing condition limitations with respect to the individual's coverage.

**Reimbursement of Group Health Plans.** The Mark provides that the entity to which premiums are payable (determined under the applicable COBRA continuation coverage requirement) shall be reimbursed by the amount of the premium for COBRA continuation coverage that is not paid by an assistance-eligible individual on account of the premium reduction. An entity is not eligible for subsidy reimbursement, however, until the entity has received the reduced premium payment from the assistance-eligible individual. To the extent that such entity has liability for income tax withholding from wages or FICA taxes with respect to its employees, the entity is reimbursed by treating the amount that is reimbursable to the entity as a credit against its liability for these payroll taxes. To the extent that such amount exceeds the amount of the entity's liability for these payroll taxes, the Secretary of Treasury shall reimburse the entity for the excess directly. Any entity entitled to such reimbursement must submit such reports as the Secretary of Treasury may require, including an attestation of the involuntary termination of employment of each covered employee on the basis of whose termination entitlement to reimbursement of premiums is claimed, and a report of the amount of payroll taxes offset for a reporting period and the estimated offsets of such taxes for the next reporting period. This report is required to be provided at the same time as the deposits of the payroll taxes would have been required, absent the offset, or such times as the Secretary specifies.

**Notice Requirements.** The notice of COBRA continuation coverage that a plan administrator is required to provide to qualified beneficiaries with respect to a qualifying event under present law must contain additional information including, for example, information about the qualified beneficiary's right to the premium reduction (and subsidy) and the conditions on the subsidy, and a description of the obligation of the qualified beneficiary to notify the group health plan of eligibility under another group health plan or eligibility for Medicare benefits under title XVIII of the Social Security Act, and the penalty for failure to provide this notification. The Chairman's Mark also requires a new notice to be given to qualified beneficiaries entitled to a special election period after enactment. In the case of group health plans that are not subject to the COBRA continuation coverage requirements of the Code, ERISA, title 5 of the United States Code (relating to plans maintained by the Federal government), or PHSa, the Mark requires that notice be given to the relevant employees and beneficiaries as well, as specified by the Secretary of Labor. Within 30 days after enactment, the Secretary of Labor is directed to provide model language for the additional notification required under the provision. The Mark also provides an expedited 10-day review process by the Department of Labor, under which an individual may request review of a denial of treatment as an assistance-eligible individual by a group health plan.

**Regulatory Authority.** The Chairman's Mark provides authority to the Secretary of the Treasury to issue regulations or other guidance as may be necessary or appropriate to carry out the provision, including any reporting requirements or the establishment of other methods for verifying the correct amounts of payments and credits under the provision. For example, the Secretary of the Treasury might require verification on the return of an assistance-eligible beneficiary who is the covered employee that the individual's termination of employment was involuntary. The Secretary of the Treasury also may promulgate rules, procedures, regulations, and other guidance as is necessary and appropriate to prevent fraud and abuse in the subsidy program, including the employment tax offset mechanism.

The provision is effective for premiums for months of coverage beginning on or after the date of enactment.

## **SUBTITLE B—TRANSITIONAL MEDICAL ASSISTANCE (TMA)**

### **Transitional Medical Assistance (TMA)**

#### *Current law*

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. However, Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide at least six, and up to 12, months of coverage. Since 2001, these work-related TMA requirements have been funded by a series of short-term extensions, most recently through June 30, 2009.

To qualify for work-related TMA under Section 1925, a family must have received Medicaid in at least three of the six months preceding the month in which eligibility is lost and have a dependent child in the home. During the initial 6-month period of TMA, states must provide the same benefits the family was receiving, although this requirement may be met by paying a family's premiums, deductibles, coinsurance, and similar costs for employer-based health coverage. An additional 6-month extension of TMA (for a total of up to 12 months) is available for families who continue to have a dependent child in the home, who meet reporting requirements, and whose average gross monthly earnings (less work-related child care costs) are below 185 percent of the federal poverty line. States may impose a premium, limit the scope of benefits, and use an alternative service delivery system during the second six months of TMA.

#### *Chairman's Mark*

The provision would extend work-related TMA under Section 1925 through December 31, 2010. States could opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months) for purposes of the initial eligibility period for work-related TMA, in which case the additional 6-month extension would not apply. States could opt to waive the requirement that a family have received Medicaid in at least three of the last six months in order to qualify. They would be required to collect and submit to the Secretary of Health and Human Services (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in the State Children's Health Insurance Program. The Secretary would submit annual reports to Congress concerning these rates.

## **SUBTITLE C—EXTENSION OF QUALIFIED INDIVIDUAL PROGRAM**

### **Extension of Qualified Individual (QI) program**

#### *Current Law*

Certain low-income individuals who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, and who are eligible for Medicare are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QI-1s). QMBs have incomes no greater than 100 percent of the federal poverty level (FPL) and assets no greater than \$4,000 for an individual and \$6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100 percent of FPL but do not exceed 120 percent FPL.

QI-1s meet the QMB criteria, except that their income is between 120 percent and 135 percent of the federal poverty level. Further, they are not otherwise eligible for Medicaid. The QI-1 program is currently slated to terminate December 2009.

In general, Medicaid payments are shared between federal and state governments according to a matching formula. Unlike the QMB and SLMB programs, federal spending under the QI-1 program is subject to annual limits. Expenditures under the QI-1 program are paid 100 percent by the federal government (from the Part B Trust fund) up to a state's allocation level. States are required to cover only the number of people which would bring their annual spending on these population groups to their allocation levels.

For the period beginning on January 1, 2009 and ending on June 30, 2008, the total allocation amount was \$350 million. For the period that begins on October 1, 2009 and ends on December 31, 2009, the total allocation is \$150 million.

#### *Chairman's Mark*

The Chairman's Mark would extend the authorization of the QI-1 program through December 31, 2010. The Mark would provide \$562.5 million in funding for the QI-1 program from January 1, 2010 through December 31, 2010.

## **SUBTITLE D—OTHER PROVISIONS**

### **Premiums and Cost-Sharing Protections under Medicaid for Indians**

#### *Current Law*

Under Medicaid, premiums and enrollment fees are generally prohibited for most beneficiaries. Nominal premiums and enrollment fees specified in regulations may be imposed on selected groups (e.g., medically needy, certain families qualifying for transitional Medicaid, pregnant women and infants with income over 150 percent FPL). Premiums and enrollment fees can exceed these nominal amounts for other selected groups (e.g., certain

workers with disabilities and individuals covered under Section 1115 waivers). Service-related cost-sharing (e.g., deductibles, copayments, and co-insurance) is prohibited for selected groups (e.g., children under 18, pregnant women) and for selected benefits (e.g., hospice care, emergency services, family planning services and supplies). For most other groups and services, nominal cost-sharing amounts specified in regulations may be applied at state option. For other selected groups (e.g., workers with disabilities and individuals covered under Section 1115 waivers) cost-sharing can exceed nominal amounts. The Deficit Reduction Act of 2005 (P.L. 109-171) added a new Medicaid state option for alternative premiums and cost-sharing for certain subgroups. Applicable maximum amounts vary by income level (as a percent of the federal poverty level). Special rules apply to prescription drugs and to non-emergency services provided in hospital emergency rooms.

### *Chairman's Mark*

The provision would add a new subsection specifying that no enrollment fee, premium or similar charge, and no deduction, co-payment, cost-sharing, or similar charge shall be imposed against an Indian who receives Medicaid-coverable items or services directly from the Indian Health Service (IHS), an Indian Tribe (IT), Tribal Organization (TO), or Urban Indian Organization (UIO), or through referral under the contract health service. In addition, Medicaid payments due to the IHS, an IT, TO, or UIO, or to a health care provider through referral under the contract health service for providing services to a Medicaid-eligible Indian, could not be reduced by the amount of any enrollment fee, premium or similar charge, as well as any cost-sharing or similar charge that would otherwise be due from an Indian, if such charges were permitted. A rule of construction would specify that nothing in this provision could be construed as restricting the application of any other limitations on the imposition of premiums or cost-sharing that may apply to a Medicaid-enrolled Indian. This language would also add Indians receiving services through Indian entities to the list of individuals exempt from paying premiums or cost-sharing under the DRA option for alternative premiums and cost-sharing under Medicaid. The effective date of this provision would be April 1, 2009.

## **Eligibility Determinations under Medicaid and CHIP for Indians**

### *Current Law*

The federal Medicaid statute defines more than 50 eligibility pathways. For some pathways, states are required to apply an assets test. For other pathways, assets tests are a state option. When assets tests apply, some pathways give states flexibility to define specific assets that are to be counted and which can be disregarded. For other pathways, primarily for people qualifying on the basis of having a disability or who are elderly, assets tests are required. States generally follow asset guidelines specified for the Supplementary Security Income (SSI) program. Medicaid also defines the rules for the counting of certain assets. Under SSI law, several types of assets are excluded, including: (1) any land held in trust by the United States for a member of a federally-recognized tribe, or any land held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government; and (2) certain distributions (including land or an interest in land) received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation



pursuant to the Alaska Native Claims Settlement Act. Most other property is required to be counted. There is no similar provision in current CHIP law.

*Chairman's Mark*

The provision would prohibit consideration of four different classes of property from resources in determining Medicaid eligibility of an Indian. These classes include: (1) property, including real property and improvements, that is held in trust (subject to federal restrictions or otherwise under the supervision of the Secretary of the Interior), located on a reservation, including any federally recognized Indian Tribes reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act (ANCSA), and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs; (2) for any federally recognized Tribe not described in the first class, property located within the most recent boundaries of a prior federal reservation; (3) ownership interests in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights; and (4) ownership interest in or usage rights to items not covered in the previous classes that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom. The provision would also apply this new language to CHIP in the same manner in which it applies to Medicaid.

**Protection of Certain Indian Property from Medicaid Estate Recovery**

*Current Law*

The Omnibus Budget Reconciliation Act of 1993 requires all states to recover property and assets of deceased Medicaid beneficiaries for outstanding services provided by Medicaid. At a minimum, states must seek recovery for certain services provided, including nursing home care, services provided by an intermediate care facility for the mentally retarded or other similar medical institutions, and Medicaid payments to Medicare for cost-sharing related benefits. The state does have discretion to recover further assets to cover the costs for all Medicaid services provided to the beneficiary. The state also has the authority to grant an exemption if the recovery would place undue hardship against the estate. The Secretary specifies the standards for a state hardship waiver for Medicaid estate recovery purposes

*Chairman's Mark*

The provision would provide that certain income, resources, and property would remain exempt from Medicaid estate recovery if they were exempted under Section 1917(b)(3) of the Social Security Act (allowing the Secretary to specify standards for a state hardship waiver of asset criteria) under instructions regarding Indian tribes and Alaskan Native Villages as of April 1, 2003. The provision would not prohibit the Secretary from providing additional estate recovery exemptions for Indians under Medicaid.

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

### *Current Law*

There are no provisions in current Medicaid or CHIP statutes regarding a Tribal Technical Advisory Group (TAG) within the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare, Medicaid and CHIP programs.

### *Chairman's Mark*

The provision would require the Secretary to maintain within CMS a Tribal TAG, previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TAG include a representative of the Urban Indian Organizations (UIOs) and Indian Health Service (IHS). The UIO representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act for certain meetings with federal officials. The provision would also require certain states to establish a process for obtaining advice on a regular, on-going basis from designees of Indian Health Programs (IHPs) and UIOs regarding Medicaid law and its direct effects on those entities. Applicable states would include those in which one or more IHPs or UIOs provide health care services. This process must include seeking advice prior to submission of state Medicaid plan amendments, waiver requests or proposed demonstrations likely to directly affect Indians, IHPs, or UIOs. This process may include appointment of an advisory panel and of a designee of IHPs and UIOs to the Medicaid medical care advisory committee advising the state on its state Medicaid plan. The provision would also apply this new language to CHIP in the same manner in which it applies to Medicaid. Finally, the provision would prohibit construing these amendments as superseding existing advisory committees, working groups, guidance or other advisory procedures established by the Secretary or any state with respect to the provision of health care to Indians.

## **Rules Applicable Under Medicaid and CHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities**

### *Current Law*

Section 1903(m)(1) of Title XIX defines: (1) the term Medicaid managed care organization, (2) requirements regarding accessibility of services for Medicaid managed care organizations (MCO) beneficiaries vis-à-vis non-MCO Medicaid beneficiaries within the area served by the MCO; (3) solvency standards in general and specific to different types of organizations; and (4) the duties and functions of the Secretary with respect to the status of an organization as a Medicaid MCO.

Section 1905(t) of Title XIX defines another type of managed care arrangement called primary care case management (PCCM). Under such arrangements, states contract with primary care case managers who are responsible for locating, coordinating and monitoring

covered primary care (and other services stipulated in contracts) provided to all individuals enrolled in such PCCM programs.

Title XIX contains a number of additional provisions regarding managed care under Medicaid. Section 1932(a)(5) specifies rules regarding the provision of information about managed care to beneficiaries and potential enrollees. Such information must be in an easily understood form, and must address the following topics: (1) who providers are and where they are located, (2) enrollee rights and responsibilities, (3) grievance and appeal procedures, (4) covered items and services, (5) comparative information for available MCOs regarding benefits, cost-sharing, service area and quality and performance, and (6) information on benefits not covered under managed care arrangements. In addition, Section 1932(d)(2)(B) requires managed care entities to distribute marketing materials to their entire service areas.

Sections 1903(m) and 1932 provide cross-referencing definitions for the term “Medicaid managed care organization.”

Under Title XIX, Section 1932(a)(2)(C) stipulates the rules regarding Indian enrollment in Medicaid managed care. A state may not require an Indian (as defined in Section 4(c) of the IHCA) to enroll in a managed care entity unless the entity is one of the following (and only if such entity is participating under the plan): (1) the IHS, (2) an Indian Health Provider (IHP) operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or (3) an urban IHP operated by a Urban Indian Organization (UIO) pursuant to a grant or contract with the IHS pursuant to Title V of the IHCA.

In general, Federally Qualified Health Centers (FQHCs) are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services. When an FQHC is a participating provider with a Medicaid managed care entity (MCE), the state must make supplemental payments to the center in an amount equal to any difference between the rate paid by the MCE and the per visit amount determined under the prospective payment system.

#### *Chairman’s Mark*

The provision would add a new Section 1932(h) to the Medicaid statute. New Section 1932(h)(1) would require that Indians enrolled in a non-Indian Medicaid managed care entity (MCE) with an Indian Provider participating as a primary care provider within the MCE’s network be allowed to choose such an Indian Provider as their primary care provider when the Indian is otherwise eligible to receive services from such a provider and the Indian Provider has the capacity to provide primary care services to that Indian. Contracts between the state and such MCEs must reflect this requirement, and Medicaid payments to these entities are conditional on meeting this requirement.

New Section 1932(h)(2)(A) would stipulate that contracts with Medicaid MCEs must require those entities to meet certain requirements as a condition of receiving Medicaid payments. These conditions include: (1) such MCEs and PCCMs must demonstrate that the number of participating Indian health care providers is sufficient to ensure timely access to covered

Medicaid managed care services for those enrollees who are eligible to receive services from such providers; and (2) such entities must agree to pay Indian health care providers (excluding non-participating FQHCs) at a rate equal to the rate negotiated between such entity and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE would make for services rendered by a participating non-Indian health care provider.

In addition, new Section 1932(h)(2)(B) specifies that such MCEs must agree to make prompt payment (in accordance with Section 1932(f)) to participating Indian health care providers or, in the case of non-participating Indian health care providers or non-participating Indian FQHCs, in accordance with other applicable rules.

New Section 1932(h)(2)(C) would apply special payment provisions to certain Indian health care providers that are FQHCs. For non-participating Indian FQHCs that provide covered Medicaid managed care services to an Indian MCE enrollee, the MCE must pay a rate equal to the payment that would apply to a participating non-Indian FQHC. When payments to such participating and non-participating providers by an MCE for services rendered to an Indian enrollee with the MCE are less than the rate under the state plan, the state must pay such providers the difference between the rate and the MCE payment. Likewise, if the amount paid to a participating non-FQHC Indian provider is less than the rate that applies under the state plan, the state must pay the difference between the applicable rate and the amount paid by the MCE.

New Section 1932(h)(2)(D) would prohibit waiving requirements relating to assurance that payments are consistent with efficiency, economy and quality.

### **Application of Prompt Pay Requirement to Nursing Facilities**

#### *Current Law*

Under section 1902(a)(37)(A), a State has to have claims payment procedures that ensure 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of receipt of such claims. Claims submitted for services provided in or by skilled nursing facilities are not subject to these requirements.

#### *Chairman's Mark*

This provision would extend prompt payment requirements to skilled nursing facilities. This provision would take effect April 1, 2009 and sunset on December 31, 2010.

### **Period of Applications; Sunset**

#### *Current Law*

No Provision

### *Chairman's Mark*

The Chairman's Mark provides an effective date of April 1, 2009 for provisions related to Indian Health and sunset those provisions on December 31, 2010.

## **TITLE IV—HEALTH INFORMATION TECHNOLOGY**

### **SUBTITLE A—PROMOTION OF HEALTH INFORMATION TECHNOLOGY**

#### **ONCHIT; Standards Development and Adoption**

##### *Current Law*

There are no existing statutory provisions regarding the current Office of the National Coordinator for Health Information Technology (ONCHIT) within the Department of Health and Human Services (HHS). ONCHIT was created by Executive Order 13335, signed by the President on April 27, 2004. The National Coordinator was instructed to develop, maintain, and direct a strategic plan to guide the nationwide implementation of interoperable health information technology (HIT) in the public and private health care sectors. In 2005, the Secretary created the American Health Information Community (AHIC), a public-private advisory body, to make recommendations to the Secretary on how to accelerate the development and adoption of interoperable HIT using a market-driven approach. The AHIC charter required it to provide the Secretary with recommendations to create a successor entity based in the private sector. AHIC Successor, Inc. was established in July 2008 to transition AHIC's accomplishments into a new public-private partnership. That partnership, the National eHealth Collaborative (NeHC), was launched on January 8, 2009.

ONCHIT awarded a contract to the American National Standards Institute (ANSI) to establish a public-private collaborative, known as the Healthcare Information Technology Standards Panel (HITSP), to harmonize existing HIT standards and identify and establish standards to fill gaps. To date, the Secretary has recognized 52 harmonized standards, including many that need to be used for interoperable electronic health records (EHRs). To ensure that these standards are incorporated into products, a second contract was awarded to the Certification Commission for Healthcare Information Technology (CCHIT), a private, nonprofit organization created by HIT industry associations, which establishes criteria for certifying products that use recognized standards. CCHIT has certified over 150 ambulatory and inpatient EHR products.

##### *Chairman's Mark*

**Definitions.** The Chairman's Mark defines the following terms: certified EHR technology, enterprise integration, health care provider, health information, health information technology, health plan, HIT Policy Committee, HIT Standards Committee, individually identifiable health information, laboratory, National Coordinator, pharmacist, qualified electronic health record, and state.

**Office of the National Coordinator for Health Information Technology.** The Mark would establish within HHS the Office of the National Coordinator for Health Information Technology (ONCHIT). The National Coordinator would be appointed by the Secretary and report directly to the Secretary. The purpose of ONCHIT would be to promote the development of a national health information technology infrastructure that allows the electronic use and exchange of information, in order to improve health care quality, reduce health care costs, improve public health, and facilitate research, among other things. The National Coordinator would be charged with the following duties. First, the National Coordinator would be required to review and determine whether to endorse standards recommended by the HIT Standards Committee (described below). Second, the National Coordinator would be responsible for coordinating HIT policy and programs within HHS and with those of other Federal agencies and would be a leading member in the establishment of the HIT Policy Committee and the HIT Standards Committee and act as a liaison among these Committees and the Federal government. Third, the National Coordinator would be required to update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to the electronic exchange and use of health information, the utilization of an EHR for each person in the United States by 2014, and the incorporation of privacy and security protections for the electronic exchange of an individual's health information, among other things. The plan would include measurable outcome goals and the National Coordinator would be required to republish the plan, including all updates.

Fourth, the National Coordinator would maintain and update a website to post relevant information about the work related to efforts to promote a nationwide health information technology infrastructure. Fifth, the National Coordinator would be required, in consultation with the National Institute of Standards and Technology (NIST), to develop a program for the voluntary certification of HIT as being in compliance with applicable certification criteria adopted by the Secretary. Sixth, the National Coordinator would have to prepare several reports, including a report on any additional funding or authority needed to evaluate and develop standards for a nationwide health information technology infrastructure; a report on lessons learned from HIT implementation by major public and private health care systems; a report on the benefits and costs of the electronic use and exchange of health information; an assessment of the impact of HIT on communities with health disparities and in areas that serve uninsured, underinsured, and medically underserved individuals; and an estimate of the public and private resources needed annually to achieve utilization of an EHR for each person in the United States by 2014. Seventh, the National Coordinator would be required to establish a national governance mechanism for the national health information network. Finally, the National Coordinator would be permitted to accept or request Federal detailees and would be required, within 12 months of enactment, to appoint a Chief Privacy Officer of the Office of the National Coordinator to advise the National Coordinator on privacy, security, and data stewardship.

**HIT Policy Committee.** The Mark would establish an HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure. The duties of the HIT Policy Committee would include providing recommendations on a policy framework for the development and adoption of a nationwide health information technology infrastructure, recommending areas in which standards are needed for the electronic exchange and use of health information, and

recommending an order of priority for the development of such standards. The Committee would be required to provide recommendations in five areas: (1) technologies that protect the privacy and security of electronic health information; (2) a nationwide HIT infrastructure that enables electronic information exchange; (3) nationwide adoption of certified EHRs; (4) EHR technologies that allow for an accounting of disclosures; and (5) using EHRs to improve health care quality. The mark describes other areas that the committee might consider, including using HIT to reduce medical errors, and telemedicine. The membership of the HIT Policy Committee would reflect (at least) providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality and privacy and security. The National Coordinator must ensure that the Committee's recommendations are considered in the development of policies, and the Secretary would be required to publish all of the Committee's recommendations in the Federal Register and post them on a website. The provisions of the Federal Advisory Committee Act, other than section 14, would apply to the HIT Policy Committee.

**HIT Standards Committee.** The Mark would establish an HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange of health information. Duties of the HIT Standards Committee would include the development and pilot testing of standards, and serving as a forum for the participation of a broad range of stakeholders to provide input on the development, harmonization, and recognition of standards. Not later than 90 days after enactment, the HIT Standards Committee would outline a schedule for assessing the policy recommendations developed by the HIT Policy Committee, and this schedule would be published in the Federal Register. In addition, the Committee would be required to conduct open public meetings and develop a process to allow for public comment on this schedule. The membership of the HIT Standards Committee would reflect (at least) providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security. The National Coordinator would be required to ensure that the Committee's recommendations are considered in the development of policies; the Secretary would be authorized to provide financial assistance to Committee members that are non-profit or consumer advocacy groups in order to defray costs associated with participating in the Committee's activities, and the Committee would be required to publish all of its recommendations in the Federal Register and post them on a website. The provisions of the Federal Advisory Committee Act, other than section 14, would apply to the HIT Standards Committee.

**Process for Adoption of Endorsed Recommendations; Adoption of Initial Set of Standards, Implementation Specifications, and Certification Criteria.** The Mark would require the Secretary, within 90 days of receiving from the National Coordinator a recommendation for HIT standards, implementation specifications, or certification criteria, to determine in consultation with representatives of other relevant Federal agencies, whether or not to propose adoption of such standards, implementation specifications, or certification criteria. Adoption would be accomplished through regulation, whereas a decision by the Secretary not to adopt would have to be conveyed in writing to the National Coordinator and the HIT Standard Committee. The Secretary would be required to adopt, through rulemaking, an initial set of standards by December 31, 2009.

**Transitions.** The Mark would provide for the transfer of all functions, personnel, assets, liabilities, and administrative actions of the existing ONCHIT, created under Executive Order 13335, to the new ONCHIT established by this Act. Similarly, all functions, personnel, assets, liabilities applicable to AHIC Successor, Inc., now operating as the National eHealth Collaborative (NeHC), would be transferred to the HIT Policy Committee or the HIT Standards Committee, as appropriate. Nothing in the mark would require the creation of a new entity to the extent that the existing ONCHIT is consistent with the provision of Section 3001. Similarly, nothing in the mark would prohibit NeHC from modifying its charter, duties, membership, and other functions to be consistent with Sections 3002 and 3003 in a manner that would permit the Secretary to recognize it as the HIT Policy Committee or the HIT Standards Committee.

## **SUBTITLE B—INCENTIVES FOR THE USE OF HEALTH INFORMATION TECHNOLOGY**

### **Part I—Medicare Program**

#### **Incentives for Eligible Professionals**

##### *Current law*

There are several current legislative and administrative initiatives to promote HIT and EHRs in the Medicare program. The Medicare Modernization Act of 2003 (MMA; P.L. 108-173) established a timetable for the Centers for Medicare and Medicaid Services (CMS) to develop e-prescribing standards, which provide for the transmittal of such information as eligibility and benefits (including formulary drugs), information on the drug being prescribed and other drugs listed in the patient's medication history (including drug-drug interactions), and information on the availability of lower-cost, therapeutically appropriate alternative drugs. CMS issued a set of foundation standards in 2005, then piloted and tested additional standards in 2006, several of which were part of a 2008 final rule. The final Medicare e-prescribing standards, which become effective on April 1, 2009, apply to all Part D sponsors, as well as to prescribers and dispensers that electronically transmit prescriptions and prescription-related information about Part D drugs prescribed for Part D eligible individuals. The MMA did not require Part D drug prescribers and dispensers to e-prescribe. Under its provisions, only those who choose to e-prescribe must comply with the new standards. However, the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA; P.L. 110-275) included an e-prescribing mandate and authorized incentive bonus payments for e-prescribers between 2009 and 2013. Beginning in 2012, payments would be reduced for those who fail to e-prescribe.

CMS is administering a number of additional programs to promote EHR adoption. The MMA mandated a three-year pay-for-performance demonstration in four states (AR, CA, MA, and UT) to encourage physicians to adopt and use EHRs to improve care for chronically ill Medicare patients. Physicians participating in the Medicare Care Management Performance (MCMP) demonstration receive bonus payments for reporting clinical quality data and meeting clinical performance standards for treating patients with certain chronic conditions. They are eligible for an additional incentive payment for using a certified EHR and reporting the clinical performance data electronically.



CMS has developed a second demonstration to promote EHR adoption using its Medicare waiver authority. The five-year Medicare EHR demonstration is intended to build on the foundation created by the MCMP program. It will provide financial incentives to as many as 1,200 small- to medium-sized physician practices in 12 communities across the country for using certified EHRs to improve quality, as measured by their performance on specific clinical quality measures. Additional bonus payments will be made based on the number of EHR functionalities a physician group has incorporated into its practice.

The Tax Relief and Health Care Act of 2006 (P.L. 109-432) established a voluntary physician quality reporting system, including an incentive payment for Medicare providers who report data on quality measures. The Medicare Physician Quality Reporting Initiative (PQRI) was expanded by the Medicare, Medicaid, and CHIP Extension Act of 2007 (P.L. 110-173) and by MIPPA, which authorized the program indefinitely and increased the incentive that eligible physicians can receive for satisfactorily reporting quality measures. In 2009, eligible physicians may earn a bonus payment equivalent to 2.0 percent of their total allowed charges for covered Medicare physician fee schedule services. The PQRI quality measures include a structural measure that conveys whether a physician has and uses an EHR.

#### *Chairman's Mark*

The Chairman's Mark would amend Title XVIII of the Social Security Act to add an incentive payment to the Medicare Part B program for the adoption and meaningful use of a certified electronic health record system by an eligible Medicare professional. Eligible Medicare professionals who provide covered services during the designated period and who are "meaningful EHR users" would be eligible for an incentive payment. The incentive payment would come from the Federal Supplementary Medical Insurance Trust Fund (Medicare Part B Fund) and would be equal to 75 percent of the Secretary's estimate of the allowed Part B charges during the reporting period. The estimate would be based on claims submitted not later than 2 months after the end of the reporting period.

The amount of EHR incentive payments that providers could receive in a given year would be capped and the amount of the annual incentive payment cap would decrease over time. For the first year of participation the annual limit would be \$15,000. Over the next four calendar years, the amount would decrease to \$12,000, then to \$8,000, then \$4,000, and then \$2,000, respectively. For early adopters whose first payment year is 2011 or 2012, the limit in those years would be increased to \$18,000.

The phase down is different for eligible professionals first adopting EHR in 2014. For these eligible providers, the limit on the amount of the incentive payment would equal the limit for someone whose first payment year is 2013. For example, in 2014 the payment limit would equal \$12,000. If the first payment year is after 2014 then the limit on the incentive payments for that year and any subsequent year would be \$0. No bonus payments would be made for designated periods after 2015. For eligible professionals predominantly furnishing services in a rural health professional shortage area, the incentive payment amounts would be increased by 25 percent.

The EHR incentive payments would not be available to hospital-based eligible professionals, such as a pathologist, anesthesiologist or emergency room physician who furnishes

substantially all such services in a hospital setting (inpatient or outpatient) and through the use of the facilities and equipment, including computer equipment, of the hospital.

The payment(s) could be in the form of a single consolidated payment or in periodic installments, as determined by the Secretary. The Secretary would establish rules to coordinate the limits on the incentive payments for eligible professionals who provide covered professional services in more than one practice (as specified by the Secretary). The Secretary would seek to avoid duplicative requirements from Federal and state governments to demonstrate meaningful use of certified EHR technology under the Medicare and Medicaid programs. In doing so, the Secretary could deem that the satisfaction of state requirements under Medicaid would be sufficient to qualify the professional as a meaningful user under the Medicare incentive program and vice versa. The Secretary would be allowed to adjust the reporting periods in order to carry out this clause.

For purposes of the EHR incentive program, the payment year is defined as a year beginning with 2011. The term ‘first payment year’ means the first year for which an incentive payment is made for such services under this subsection. The terms ‘second payment year’, ‘third payment year’, ‘fourth payment year’, and ‘fifth payment year’ mean, with respect to an eligible professional, each successive year immediately following the first payment year for that professional.

For purposes of the EHR incentive payment, an eligible professional would be treated as a meaningful EHR user if the eligible professional meets the following three criteria: (1) the eligible professional demonstrates to the satisfaction of the Secretary that during the period the professional is using a certified EHR technology in a meaningful manner, which would include, at minimum, the use of electronic prescribing as determined to be appropriate by the Secretary; (2) the eligible professional demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; and (3) the eligible professional uses certified EHR technology to submit information for the period, in a form and manner specified by the Secretary, on clinical quality measures and other measures as selected by the Secretary.

The Secretary could provide for the use of alternative means for meeting the above requirements in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary).

The Secretary would select the clinical quality measures and other measures but must be consistent with the following: (1) the Secretary would provide preference to clinical quality measures that have been endorsed by the consensus-based entity regarding performance measurement with which the Secretary has a contract under section 1890(a) of the Social Security Act; and (2) prior to any measure being selected for the purposes of this provision, the Secretary would publish the measure in the Federal Register and provide for a period of public comment. The Secretary could not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically.

A professional could satisfy the demonstration of meaningful use requirement through means specified by the Secretary, which may include the following: (1) an attestation; (2) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology); (3) a survey response; (4) reporting the clinical quality and other measures mentioned above; and (5) other means specified by the Secretary. The Secretary would seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use within the categories specified in this paragraph. Notwithstanding some sections of the Social Security Act that place restrictions on the use of Part D data, the Secretary could use data regarding drug claims submitted for purposes of determining payment under Part D that are necessary for purposes of determining the EHR incentive payments described here.

There would be no administrative or judicial review of any EHR incentive payment, including the determination of a meaningful EHR user or the cap on EHR incentive payments as described above. The Secretary would post a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments in an easily understandable format on the Internet website of the Centers for Medicare & Medicaid Services.

For purposes of the EHR incentive payment, the following definitions would apply. The term ‘certified EHR technology’ would mean health information technology (as defined in section 3000 of the mark) that constitutes or supports a qualified electronic health record (as defined in section 3000) and that is certified pursuant to the standards adopted under section 3004 that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals). The term ‘covered professional services’ would have the meaning given such term under current law. The term ‘eligible professional’ would mean a physician, also as defined under current law. The term ‘reporting period’ would mean any period (or periods), with respect to a payment year, as specified by the Secretary.

For covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the eligible professional is not a meaningful EHR user for a prior reporting period, the fee schedule amount would be reduced to 99 percent in 2015 (or, in the case of an eligible professional who was subject to the application of the payment adjustment under the current electronic prescribing program for 2014, 98 percent), 98 percent in 2016, and 97 percent in 2017 and in each subsequent year.

For 2018 and each subsequent year, if the Secretary were to find that the proportion of eligible professionals who are meaningful EHR users is less than 75 percent, the applicable fee schedule amount would be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case would the applicable percent be less than 95 percent.

The Secretary could, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment above if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case would an eligible professional be

granted such an exemption for more than 5 years. This adjustment would not apply to hospital-based eligible professionals.

Beginning in 2011, the Chairman's Mark also establishes incentive payments and adjustments to encourage the adoption and meaningful use of certified EHR technology by eligible professionals who are affiliated with certain Medicare Advantage organizations. In general, with respect to eligible professionals in a qualifying MA organization who the organization attests are meaningful EHR users (see below) but who do not bill for services under Medicare Part B or do so on a limited basis, incentive payments would be available and payment adjustments applicable. Incentive payments and adjustments would 1) apply in a similar manner as they apply to eligible non-MA professionals and 2) be made to and apply to the qualifying MA organizations.

With respect to qualifying MA organizations, an eligible professional is one who: (1) is employed by the organization or is employed by or is a partner of an entity that through contract furnishes at least 80 percent of the entity's patient care services to enrollees of the organization; and furnishes at least 75 percent of their professional services to enrollees of the organization; and (2) furnishes, on average, at least 20 hours per week of patient care services. The Secretary may substitute an amount similar to the estimated amount that would be payable in the aggregate if the eligible professional's services furnished were payable under Medicare Part B instead of under Part C. To account for economies of scale within large MA organizations, incentive payments to qualifying MA organizations would be capped to reflect no more than 5,000 eligible professionals per organization.

The Secretary would be required to avoid duplicate payments to eligible professionals. If an eligible professional is both MA-affiliated and eligible for the maximum EHR incentive payment under Medicare Part B, then the incentive payment could only be made under the Part B program. For eligible professionals who are both MA-affiliated and qualify for the FFS EHR incentive program but do not reach the incentive payment limit, the Secretary would develop a process to ensure that duplicate payments are not made and collect data from MA organizations to ensure against duplicate payments. Qualifying MA organizations would be required to specify the first payment year (not earlier than 2011) for which it receives incentive payments for all eligible professionals.

Beginning in 2015, payments to qualifying MA organizations would be reduced if they have eligible professionals that have not adopted and meaningfully used EHRs in a prior reporting period. The payment adjustment would be equal to 100 percent minus the product of the applicable Part B fee schedule adjustment (1 percent in 2015, 2 percent in 2016, and 3 percent in 2017 and each subsequent year) and the Secretary's estimate of Medicare FFS physician expenditures as a proportion of total Medicare FFS expenditures for the year. If a qualifying MA organization attests that not all their eligible professionals are meaningful EHR users with respect to a year, the Secretary would apply the payment adjustment described here based on the proportion of such eligible professionals that are not meaningful EHR users for such year. The payment adjustment would be based on a maximum of 5,000 eligible professionals per MA organization.

The term 'qualifying MA organization' would mean a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the

Public Health Service Act). In addition, a qualifying MA organization would submit an attestation, in a form and manner specified by the Secretary as part of submission of the initial bid identifying (a) whether each MA-affiliated eligible professional described above is a meaningful EHR user, and (b) whether each MA-affiliated eligible hospital is a meaningful EHR user for an applicable period specified by the Secretary. The Secretary would post a list of the names, business addresses, and business phone numbers of the MA-qualifying organizations that have eligible professionals who are meaningful EHR users.

## **Incentives for Hospitals**

### *Current Law*

Medicare pays acute care hospitals using a prospectively determined payment for each discharge. These payment rates are increased annually by an update factor that is established, in part, by the projected increase in the hospital market basket (MB) index. Starting in FY2007, hospitals that do not submit required quality data under the Reporting Hospital Quality Data for Annual Payment Update (“RHAQDPU” program) will have the applicable MB percentage reduced by two percentage points. The reduction would apply for that year and would not be taken into account in subsequent years. Currently, Medicare's payments to acute care hospitals under the inpatient prospective payment system (IPPS) are not affected by the adoption of electronic health records (EHR).

Critical access hospitals (CAHs) are limited-service facilities in rural areas that are located more than 35 miles from another hospital (15 miles in certain circumstances) or have been designated by the state as a necessary provider of health care. CAHs offer 24-hour emergency care; have no more than 25 acute care inpatient beds; and have a 96-hour average length of stay. Generally, a rural hospital designated as a CAH receives 101 percent reasonable, cost-based reimbursement for inpatient care rendered to Medicare beneficiaries.

### *Chairman's Mark*

The Chairman's Mark would amend Title XVIII of the Social Security Act to establish payment incentives for eligible IPPS hospitals and CAHs that are meaningful EHR users beginning in FY2011. Starting in FY2015, eligible hospitals that are not meaningful EHR users would receive lower Medicare payments.

Regarding the payment incentives, starting in FY2011, eligible hospitals would receive additional payments from the Medicare Federal Hospital Insurance (Part A) trust fund. These incentive payments would be calculated based on a base amount, increased by payment add-ons for certain discharge levels. This total amount would be further adjusted by the hospital's overall Medicare share.

Specifically, incentive payments for qualified hospitals would be calculated as the sum of a base amount (\$2 million) added to its discharge related payment multiplied by its Medicare's share. Although the base amount is constant, a hospital's discharge related payment amount would change depending on the number of its total discharges (regardless of payer) up to its 23,000<sup>th</sup> discharge, according to the following. A qualified hospital would receive \$200 for each discharge starting with its 1,150<sup>th</sup> discharge through its 9,200<sup>th</sup> discharge, an additional

\$100 for each discharge from its 9,201<sup>st</sup> through its 13,800<sup>th</sup> discharge, and an additional \$60 for each discharge from its 13,801<sup>st</sup> to its 23,000<sup>th</sup> discharge. This total amount would be further adjusted by the Medicare share.

The Medicare share would be calculated according to a specified formula. The numerator would equal inpatient bed days attributable to individuals for whom Part A payment may be made, either under traditional fee-for-service Medicare or for those who are enrolled in Medicare Advantage (MA) organizations under Part C of Medicare. The denominator would equal the total number of inpatient bed days in the hospital adjusted by a hospital's share of charges attributed to charity care. If a hospital's charge data on charity care is not available, the Secretary would be required to use the hospital's uncompensated care data adjusted to eliminate bad debt. If hospital data to construct the charity care factor is unavailable, the fraction would be set at 1.0. If hospital data necessary to include MA days is not available, that component of the formula would be set at 0.0.

Eligible hospitals would receive four years of incentive payments based on this calculation, which would be phased down over four years according to the following: A hospital that demonstrates it is a meaningful EHR user starting in FY2011-FY2013 would receive the full amount of the incentive payment based on the above incentive payment formula in its first payment year; 75 percent of the amount in its second payment year; 50 percent of the amount in its third payment year; and 25 percent of the amount in its fourth payment year. A hospital that first qualifies for the incentive payments starting in FY2014, would receive three years of incentive payments, starting with 75 percent of the incentive payment amount in its first year; 50 percent in the second year; and 25 percent in the third year. A hospital that first qualifies for incentive payments in FY2015 would receive two years of incentive payments, receiving 50 percent of the amount in its first year and 25 percent of the amount in its second year. Hospitals that become meaningful EHR users starting in FY2016 would not qualify for incentive payments. The incentive payments may be made as a single consolidated payment or may be made as periodic payments, as determined by the Secretary. In no case would the total payments to any CAH in any payment year exceed \$1,000,000.

An eligible hospital would be treated as a meaningful EHR user if it demonstrates that it uses certified EHR technology in a meaningful manner and provides for the electronic exchange of health information (in accordance with applicable legal standards) to improve the quality of care. A hospital would satisfy the demonstration requirements through: an attestation; the submission of appropriately coded claims; a survey response; EHR reporting on certain measures; or other means specified by the Secretary. These EHR measures would include clinical quality measures and other measures selected by the Secretary. Prior to implementation, the measures would be published in the Federal Register and subject to public comment. The electronic reporting of the clinical quality measures would not be required unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. When establishing the measures, the Secretary would seek to avoid redundant measures or duplicative reporting. Notwithstanding restrictions placed on the use and disclosure of Medicare Part D information, the Secretary would be able to use data regarding drug claims.

There would be no administrative or judicial review of the determination of any incentive payment or payment adjustment (described subsequently), including: the determination of a

meaningful EHR user; the determination of the measures; or the determination of an exception to the payment adjustment.

The Secretary would post a listing of the eligible hospitals that are meaningful EHR users and other relevant data on the CMS website. Hospitals would have the opportunity to review the relevant data prior to the data being made publicly available.

Starting in FY2015, IPPS hospitals that do not submit the required quality data according to rules of the RHAQDPU program would be subject to a 25 percent reduction in their annual update. Those hospitals that are not meaningful EHR users in a prior reporting period would be subject to a further reduction in their annual MB update. This reduction would be phased-in over a three-year period. Specifically, in FY2015, 33.33 percent of the remainder of the MB update would be subject to the payment reduction and in FY2016, 66.66 percent of the remainder of the MB update would be subject to the payment reduction. In FY2017 and beyond, the full 75 percent adjustment to the MB update (i.e. the percentage not subject to RHAQDPU) would be subject to the payment reduction. These reductions would apply only to the fiscal year involved and would not be taken into account in subsequent fiscal years. Starting in FY2015, acute care hospitals being paid under a state's Medicare waiver would be subject to reductions in a manner that is comparable to the IPPS hospitals.

Starting in FY2015, Medicare payments for inpatient services provided by eligible CAHs that do not become meaningful EHR users in a prior reporting period would also be subject to a payment reduction. In FY2015, the inpatient services provided by these CAHs would be reimbursed at 100.66 percent of reasonable costs and in FY2016, the percentage would be 100.33 percent. In FY2017 and each subsequent year, 100 percent.

The Secretary would be allowed to exempt certain IPPS hospitals and CAHs from these payment reductions for a fiscal year if the Secretary determines that requiring a hospital to be a meaningful EHR user during that year would result in significant hardship, such as in the case of a facility that does not have adequate Internet access. Such determinations would be subject to annual renewal. In no case would a hospital be granted an exemption for more than five years.

Beginning in 2011, payment incentives and adjustments would be established for qualifying MA organizations to provide incentives for eligible hospitals to become meaningful EHR users. An eligible hospital would be one that is under common corporate governance with a qualifying MA organization and serves enrollees in an MA plan offered by the organization.

The Secretary would be required to determine incentive payment amounts similar to the estimated amount in the aggregate that would be paid if the hospital services had been payable under Part A as described above. If discharge data is not available, the Secretary would use appropriate alternative data and methodologies to estimate discharges. If data to determine the Medicare share are not available, the Secretary would be able to use alternative data and methodologies to estimate the share for the eligible hospital, such as inpatient bed days or discharges for individuals whose care is paid under Part A or Part C as a proportion of the total number of patient-bed-days or discharges.

The Secretary would be required to avoid duplicative EHR incentive payments to hospitals. If an eligible hospital under Medicare Part C was also eligible for EHR incentive payments under Part A, and for which at least 33 percent of hospital discharges (or bed days) were covered under Medicare Part A, the EHR incentive payment would only be made under Part A and not Part C. If fewer than 33 percent of discharges are covered under Part A, the Secretary would be required to develop a process to ensure that duplicative payments were not made and to collect data from MA organizations to ensure against duplicative payments.

Beginning in 2015, if one or more eligible hospitals under a common corporate governance with a qualifying MA organization are not meaningful EHR users, payment to the organization would be reduced by a specified percentage. The percentage is defined as 100 percent minus the product of the percentage point reduction to the hospital payment update for the period as described above and the Secretary's estimate of Medicare FFS hospital expenditure as a proportion of total Medicare FFS expenditures for the year. The Secretary would be required to apply the payment adjustment taking into account the proportion of eligible hospitals or discharges from eligible hospitals that are not meaningful EHR users for the period.

The calculation of the annual MA capitation rates, the national per capita MA growth percentage, and the payments from the Medicare trust funds would be held harmless, as the FFS incentive payments and payment adjustments described above (for physicians and hospitals) would not affect these MA calculations. The Secretary would post a list of the names, business addresses, and business phone numbers of the MA-qualifying organizations that have hospitals that are meaningful EHR users.

## **Premium Hold Harmless and Implementation Funding**

### *Current Law*

Physician and outpatient services provided under Medicare Part B are financed through a combination of beneficiary premiums, deductibles, and Federal general revenues. In general, Part B beneficiary premiums are set to equal 25 percent of estimated program costs for the aged, with Federal general revenues accounting for the remainder. The Part B premium has increased over the years along with total Part B expenditures and has more than doubled in recent years, increasing from \$45.50 in 2000 to \$96.40 in 2008 and 2009. Proposals that attempt to shield Medicare beneficiaries from premium increases by including hold-harmless provisions, without drawing on additional funding sources, would require that general revenues cover the expenses not offset by premiums.

### *Chairman's Mark*

The annual amount of Medicare physician expenditures used to calculate the Part B premium would not include the additional incentive payments to physicians for EHR as described above; beneficiaries would be held harmless from potential premium increases due to the increased Part B expenditures that result from this added payment. Further, the Chairman's Mark authorizes the transfer of funds from the Treasury to the Supplementary Medical Insurance (Part B) Trust Fund to cover the amount of payment incentives payable under the EHR incentive program.



To implement the provisions in and amendments made by this section, \$100 million for each of FY2009 through FY2015 and \$45 million for each succeeding fiscal year through FY2018 would be appropriated to the Secretary for the CMS Program Management Account. The amounts appropriated would be available until expended.

### **Study on Application of HIT Payment Incentives for Providers Not Receiving Other Incentive Payments**

#### *Current law*

No current law.

#### *Chairman's Mark*

This Chairman's Mark would amend Title XVIII of the Social Security Act to require the Secretary of Health and Human Services to conduct a study to determine whether payment incentives to implement and use qualified health information technology should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, from Medicare or Medicaid, or any other funding. These health care providers could include non-physician professionals, skilled nursing facilities, home health agencies, hospice programs, and laboratories.

The study would include an examination of the following: (A) the adoption rates of qualified health information technology by such health care providers; (B) the clinical utility of HIT by such health care providers; (C) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology; (D) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, Medicare or Medicaid, or otherwise; (E) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and (F) any other issues the Secretary deems to be appropriate. The Secretary would submit a report to Congress on the findings and conclusions of the study by June 30, 2010.

## **Part II—Medicaid Funding**

### **Medicaid Provider EHR Adoption and Operation Payments; Implementation Funding**

#### *Current Law*

The Federal government pays a share of every state's spending on Medicaid services and program administration. The Federal match for administrative expenditures does not vary by state and is generally 50 percent, but certain functions receive a higher amount. Section 1903(a)(3) of the Social Security Act authorizes a 90 percent match for expenditures attributable to the design, development, or installation of mechanized claims processing and information retrieval systems - referred to as Medicaid Management Information Systems (MMISs) - and a 75 percent match for the operation of MMISs that are approved by the Secretary of Health and Human Services (HHS). A 50 percent match is available for non-

approved MMISs under Section 1903(a)(7). In order to receive payments under Section 1903(a) for the use of automated data systems in the administration of their Medicaid programs, states are required under Section 1903(r) to have an MMIS that meets specified requirements and that the Secretary has found (among other things) is compatible with the claims processing and information retrieval systems used in the administration of the Medicare program.

### *Chairman's Mark*

The Chairman's Mark would amend Title XIX of the Social Security Act to authorize a 100 percent Federal match for a portion of payments attributable for certified electronic health records (EHR) technology (including support services and maintenance) to certain Medicaid providers who meet certain requirements. The state must provide assurances to the Secretary that all allowable costs are paid directly to the provider without any deduction or rebate; the provider is responsible for payment of the EHR technology costs not provided for; and, that for costs not associated with purchase and initial implementation, the provider certifies meaningful use of the EHR technology. Finally, the certified EHR technology should be compatible with state or Federal administrative management systems.

Eligible providers would include physicians, nurse mid-wives, and nurse practitioners who are not hospital-based and that have at least 30 percent of their patient volume made up of Medicaid patients. In order to qualify as a Medicaid provider, the professional would have to waive any right to Medicare EHR incentive payments for professionals detailed in Section 4311. This group of providers would be eligible for a payment equal to 85 percent of their net allowable technology costs. However, the allowable costs for the purchase and initial implementation of EHR technology cannot exceed \$25,000 or include costs over a period of more than 5 years. Annual allowable costs not associated with initial implementation or purchase of the EHR technology could not exceed \$10,000 per annum or be made over a period of more than 5 years. Aggregate allowable costs for these eligible professionals could not exceed \$75,000.

Eligible providers would also include acute care hospitals that have at least 10 percent of their patient volume attributable to Medicaid patients and children's hospitals. For these providers, incentive payment limitations would be calculated based on the Medicare incentive payment formula (described in Section 4312), with some modifications. These modifications include calculating the Medicaid share (in lieu of the Medicare share). To do so, the numerator in the Medicare share component of the incentive formula would equal Medicaid inpatient days. Incentive payments would be available for four years and would be made available to the state in year one to distribute to eligible professionals as the state deems appropriate. After the first payment year, the Secretary should assume that Medicaid discharges increase at an annual rate of growth reflective of the most recent three years for which discharge data are available. The calculations for acute care hospitals and children's hospitals should also take into account Medicaid managed care beneficiaries, as well as other Medicaid beneficiaries.

Rural health clinics and Federally-Qualified Health Centers that have at least 30 percent of their patient volume attributable to Medicaid patients would also be eligible for a payment equal to not less than 85 percent of their net allowable technology costs. Payments to these

eligible providers would be subject to aggregate or annual limitations established by the Secretary.

The Secretary shall ensure coordination of the different programs for health information technology between providers, as well as payments provided under Medicare or Medicaid to assure no duplication of funding. The Secretary should attempt to avoid duplicative requirements for Federal and state governments to demonstrate meaningful use of EHR technology under Medicaid or Medicare.

The Chairman's Mark would authorize a 90 percent Federal match for payment to the states for administrative expenses related to EHR technology payments. In order for a state to receive the match it must show that: it is using the funds provided for these purposes to administer these systems including tracking of meaningful use by providers; conducting adequate oversight of meaningful use of the systems; and pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the appropriate exchange of information. In determining meaningful use, including through the electronic reporting of clinical quality measure, states shall ensure that populations with unique needs, such as children, are appropriately addressed.

The Chairman's Mark would further require that the Secretary shall periodically submit reports to the House Committee on Energy and Commerce and the Senate Finance Committee on the status, progress and oversight of payments to Medicaid providers for EHR technology adoption and operation.

The Chairman's Mark would appropriate \$40 million for each of fiscal years 2009 through 2015 and \$20 million for each succeeding fiscal year through 2019 for these payments.

## **TITLE V—STATE FISCAL RELIEF**

### **Purposes**

#### *Current Law*

No current law.

#### *Chairman's Mark*

The Chairman's Mark states the purposes of this title are to provide fiscal relief to states in a period of economic downturn and to protect and maintain state Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.

## Temporary Federal Medical Assistance Percentages (FMAP) Increase

### *Current law*

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50 percent and maximum of 83 percent. Exceptions to the FMAP formula have been made for certain states and situations. For example, the District of Columbia's Medicaid FMAP is set in statute at 70 percent, and the territories have FMAPs set at 50 percent (they are also subject to federal spending caps). Under the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27), all states received a temporary increase in Medicaid FMAPs for the last two quarters of FY2003 and the first three quarters of FY2004 as part of a fiscal relief package. In addition to Medicaid, the FMAP is used in determining the federal share of certain other programs (e.g., foster care and adoption assistance under Title IV-E of the Social Security Act) and serves as the basis for calculating an enhanced FMAP that applies to the State Children's Health Insurance Program.

### *Chairman's Mark*

During a recession adjustment period that begins with the first quarter of FY2009 and runs through the first quarter of FY2011, the provision would hold all states harmless from any decline in their regular FMAPs, provide all states FMAP relief through an increase of 5.6 percentage points with a corresponding increase in spending caps of 11.2 percent for the territories, and provide eligible states with additional unemployment-related bonus.

States would be evaluated on a quarterly basis for the unemployment-related bonus, which would equal an additional percentage reduction in the state share. For example, after applying the 5.5 point increase provided to all states, a state with a FMAP of 50 percent (state share of 50 percent) would have an FMAP of 55.5 percent (state share of 44.5 percent). If the state share were further reduced by 10 percent because of the bonus, the state would receive an additional FMAP increase of 4.45 points ( $44.5 * 0.10 = 4.45$ ). The state's total FMAP increase would be 9.95 points ( $5.5 + 4.45 = 9.95$ ).

The unemployment-related bonus calculation would be based on a state's unemployment rate in the most recent 3-month period for which data are available compared to its lowest unemployment rate in any 3-month period beginning on or after January 1, 2006. The criteria would be as follows:

- unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 5 percent reduction in state share;
- unemployment rate increase of at least 2.5 but less than 3.5 percentage points = 10 percent reduction in state share;
- unemployment rate increase of at least 3.5 percentage points = 13 percent reduction in state share;

At the beginning of each quarter within the recession adjustment period, each state's unemployment rate is reevaluated to determine if it qualifies for a bonus reduction in state

share or for states already receiving a bonus, a bigger reduction in the state share. If a state qualifies for the additional 5 percent, 10 percent, or 13 percent reduction in state share and later has a *decrease* in its unemployment rate, its percentage reduction in state share would not decrease before July 1, 2010. After July 1, 2010, the state's bonus eligibility would be reevaluated for the remaining two quarters of the recession adjustment period. The Secretary of Health and Human Services would be required to notify a state at least three months prior to applying a lower percentage reduction in state share.

The temporary FMAP increase would only apply to Medicaid (excluding disproportionate share hospital payments) and Title IV-E foster care and adoption assistance. States would be required to maintain their Medicaid eligibility standards, methodologies, and procedures as in effect on July 1, 2008, in order to be eligible for the increase. Any reimbursement made for services provided to individuals eligible for medical assistance, who were not eligible for medical assistance under a state's income eligibility standards as of July 1, 2008, will not be made at the recession adjustment period increased FMAP rate. They would be prohibited from depositing or crediting the additional federal funds paid as a result of the temporary FMAP increase to any reserve or rainy day fund, and would be required to submit a report to the Secretary regarding how the funds were expended. States would also be required to ensure that local governments do not pay a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required on September 30, 2008.