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Summary

This report provides a list of selected health-related programs and activities under specified titles of the Social Security Act (SSA), including the Maternal and Child Health Services Block Grant (Title V), General Provisions, Peer Review, and Administrative Simplification (Title XI), Medicare (Title XVIII), Medicaid (Title XIX), and the State Children's Health Insurance Program (CHIP; Title XXI); the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); as well as selected provisions from the Public Health Service Act (PHSA) that are scheduled to terminate during the first session of the 114th Congress (i.e., by December 31, 2015). This report includes only those health care-related expiring provisions for which congressional action would be needed to extend the application of a provision once the expiration date is reached, and it does not include demonstration projects or pilot programs. Although the Congressional Research Service (CRS) has attempted to be comprehensive, CRS cannot guarantee that every relevant provision is included here.

The report defines what constitutes an expiring provision, clarifies which issues do not meet the definition of an expiring provision, lists the legislative history of each of the programs and policies that are due to expire before the end of the first session of the 114th Congress, and includes future deadlines, when applicable, for those programs and policies. The historical legislative actions that created, modified, or extended the expiring provisions covered in this report are also summarized.

Expiring provisions are organized by SSA section, ACA section, or PHSA title and section, as appropriate. The last part of the report includes provisions with expiration dates in 2013 that were not extended in any subsequent legislation. The main body of the text also includes a number of provisions that expired in 2014.

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Expiring Provision Defined

Some health care-related statutes in current law include provisions that (1) are time limited and (2) will expire absent further congressional action. Most expiring provisions provide temporary increases or decreases in funding or special protections that may result in greater funding.[2] For example, one Medicare provision provided increased payments for certain Medicare mental health services provided during a certain time period; when the provision was not extended, the bonus payments ended.[3] Examples of funding protections include those Medicare funding provisions that establish a floor (e.g., for a geographic adjustment index under the physician fee schedule) or a "hold harmless." Generally, the list covers provisions that have or will expire before the end of the first session of the 114th Congress (i.e., by December 31, 2015).

Exclusions That Do Not Meet the Definition

While Medicare payments are reviewed for modification and updates each year, not every provision that changes Medicare payments is considered an expiring provision. Services for which payments are automatically updated each year are not considered expiring provisions and are not included in this report. For example, the physician fee schedule update is not considered an expiring provision because the statute prescribes the update process (the sustainable growth

[1] The Congressional Research Service (CRS) does not determine committee jurisdiction. The programs included in this report are generally those that the Senate Finance Committee; the Senate Committee on Health, Education, Labor, and Pensions; the House Committee on Energy and Commerce; and the House Committee on Ways and Means typically have exercised jurisdiction over. However, there may be some programs for which jurisdiction has not been explicitly established.

[2] A less common type of expiring provision is one that temporarily delays the implementation of a regulation, requirement, or deadline. For example, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) delayed the implementation of the revised case-mix classification methodology for payments to skilled nursing facilities (Resource Utilization Group–Version Four; RUG-IV) until October 1, 2011. There are currently no health care–related provisions of this type expiring in 2015.

[3] The 5% bonus for certain Medicare mental health services was in place from July 1, 2008, to February 29, 2012.

rate, or SGR, system) that applies each year, even though Congress has regularly chosen to supersede those updates in almost all recent years.[4] Similarly, a recent change in Medicare payment policy included in the ACA requires the payment updates for many Medicare entities be adjusted by a productivity adjustment (similar to the payment adjustment for physicians).[5] In general, the ACA provisions specify that the adjustment may result in a negative payment update allowing the payment rate for a year to be less than the rate for the preceding year. Just as the Medicare physician payment update is not considered an expiring provision, negative payment updates resulting from the productivity adjustment would not be considered expiring provisions because the updates are not time limited and do not expire absent congressional action, though, as with physician payments, Congress may choose to modify those updates.[6]

This report includes only those health care-related expiring provisions for which congressional action would be needed to extend the application of a provision once the expiration date is reached. Demonstration projects and pilot programs are not included. Provisions that expired or were repealed in 2013 are collected in the last section of the report.

Report Organization and Legislative Acts

The expiring provisions are summarized below, organized by SSA or PHSA title and section, as appropriate. The last part of the report includes provisions with expiration dates in 2013 that were not extended in any subsequent legislation. Because these programs and provisions are diverse, the provisions identified herein are not perfectly consistent, including with regard to the style of citations. The legislative actions that created, modified, or extended the expiring provisions covered in this report are the following:

Table 1. Legislative Acts That Created, Modified, or Extended Current Health Care-Related Expiring Provisions

P.L. #	Acronym	Act Title
P.L. 104-193	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
P.L. 105-33	BBA97	Balanced Budget Act of 1997
P.L. 105-100	—	District of Columbia Appropriations Act, Fiscal Year 1998
P.L. 105-277	—	Omnibus Consolidated and Emergency Supplemental Appropriation Act of FY1999
P.L. 106-113	BBRA 99	Balanced Budget Refinement Act of 1999
P.L. 106-554	BIPA 2000	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
P.L. 108-40	WREA	Welfare Reform Extension Act of 2003
P.L. 108-74	—	State Children's Health Insurance Program Allotments Extension Act
P.L. 108-127	—	Technical Corrections with Respect to the Definition of Qualifying State
P.L. 108-173	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003[a]
P.L. 109-171	DRA	Deficit Reduction Act of 2005
P.L. 109-432	TRHCA	Tax Relief and Health Care Act of 2006

[4] CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*.

[5] CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

[6] CRS Report RL30526, *Medicare Payment Updates and Payment Rates*.

P.L. #	Acronym	Act Title
P.L. 109-482	—	National Institutes of Health Reform Act of 2006
P.L. 110-28	—	U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007
P.L. 110-48	—	An Act to Provide for the Extension of Transitional Medical Assistance, and Other Provisions
P.L. 110-92	—	Making Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes
P.L. 110-116	—	Department of Defense Appropriations Act of 2008
P.L. 110-137	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes.
P.L. 110-149	—	Making Further Continuing Appropriations for the Fiscal Year 2008, and for Other Purposes.
P.L. 110-173	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007[b]
P.L. 110-275	MIPPA	Medicare Improvements for Patients and Providers Act of 2008[c]
P.L. 111-3	CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009[d]
P.L. 111-5	ARRA	American Recovery and Reinvestment Act of 2009[e]
P.L. 111-148	ACA	Patient Protection and Affordable Care Act of 2010[f]
P.L. 111-152	HCERA	Health Care and Education Reconciliation Act of 2010[g]
P.L. 111-309	MMEA	Medicare and Medicaid Extenders Act of 2010
P.L. 111-225	IACTA	Improving Access to Clinical Trials Act of 2009
P.L. 112-78	TPTCCA	Temporary Payroll Tax Cut Continuation Act of 2011
P.L. 112-96	MCTRJCA	Middle Class Tax Relief and Job Creation Act of 2012
P.L. 112-240	ATRA	American Taxpayer Relief Act of 2012[h]
P.L. 113-67	—	Continuing Appropriations Resolution of 2014, which includes the Bipartisan Budget Act of 2013 and the Pathway for SGR Reform Act of 2013
P.L. 113-93	PAMA	Protecting Access to Medicare Act of 2014

Source: The Congressional Research Service (CRS).

a. See CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, and CRS Report RL32005, *Medicare Fee-for-Service Modifications and Medicaid Provisions of H.R. 1 as Enacted*.

b. See CRS Report RL34360, *P.L. 110-173: Provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007*.

c. See CRS Report RL34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008*.

d. See CRS Report R40226, *P.L. 111-3: The Children's Health Insurance Program Reauthorization Act of 2009*.

e. The Health Information Technology for Economic and Clinical Health Act was incorporated into ARRA. A description of the Medicare provisions in that bill can be found in CRS Report R40161, *The Health Information Technology for Economic and Clinical Health (HITECH) Act*.

f. See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, and CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

g. See CRS Report R41124, *Medicare: Changes Made by the Reconciliation Act of 2010 to the Patient Protection and Affordable Care Act (P.L. 111-148)*.

h. See CRS Report R42944, *Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012*.

Social Security Act Expiring Provisions

Title V: Maternal and Child Health Services Block Grant

Family-to-Family Health Information Centers (SSA Section 501(c))

DRA Section 6064 established the Family-to-Family Health Information Centers program in SSA Section 501(c). The program, administered by the Health Resources and Services Administration (HRSA), provides grants to family-staffed organizations that provide health care information and resources to families of children with special health care needs.

- *DRA (Section 6064)* appropriated $3 million for FY2007; $4 million for FY2008; and $5 million for FY2009.
- *ACA (Section 5507(b))* extended the $5 million appropriation through FY2012.
- *ATRA (Section 624)* extended the $5 million appropriation through FY2013.
- *PAMA (Section 207)* provided $2.5 million for the remainder of FY2014 (from April 1, 2014, to September 30, 2014) and provided $2.5 million for the first half of FY2015 (October 1, 2014, through March 31, 2015).

Current status: The funding designated for Family-to-Family Health Information Centers expires March 31, 2015.

Abstinence Education Grants (SSA Section 510)

PRWORA Section 912 authorized abstinence education formula grants in SSA Section 510.[7] To receive these formula grants, states must request funding when applying for Maternal and Child Health Block Grant funds[8] authorized in SSA Section 501. Funds provided must be used exclusively for teaching abstinence from sexual activity outside of marriage. PRWORA authorized and appropriated $250 million ($50 million for each of FY1998 through FY2002) for abstinence education. Subsequently, funding for this program was extended through June 30, 2009, by a series of legislation detailed below. ACA Section 2954 appropriated $50 million for each of FY2010 through FY2014 for this program. Most recently, PAMA extended funding for the program through FY2015. In addition, for FY2012 (P.L. 112-74) and FY2013 (P.L. 113-6), $5 million was added to this program to be used to award competitive grants. This program is administered by the Administration for Children and Families (ACF).

[7] For more information on abstinence education programs in Title V of the Social Security Act (SSA), see CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*.

[8] For more information on the Maternal and Child Health Block Grant, see CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*.

- *PRWORA (Section 912)* appropriated $50 million for each of FY1998 through FY2002.
- *WREA 2003 (Section 6)* extended the appropriation through FY2003.
- *P.L. 108-89 (Section 101*) extended the appropriation through March 31, 2004.
- *WREA 2004 (Section 2)* extended the appropriation through June 30, 2004.
- *P.L. 108-262 (Section 2)* extended the appropriation through September 30, 2004.
- *P.L. 108-308 (Section 2)* extended the appropriation through March 31, 2005.
- *WREA 2005 (Section 2)* extended the appropriation through June 30, 2005.
- *P.L. 109-19 (Section 2)* extended the appropriation through September 30, 2005.
- *P.L. 109-91 (Section 102)* extended the appropriation through December 31, 2005.
- *TRHCA (Section 401)* extended the appropriation through June 30, 2007.
- *P.L. 110-48 (Section 1)* extended the appropriation through September 30, 2007.
- *P.L. 110-90 (Section 2)* extended the appropriation through December 31, 2007.
- *MMSEA (Section 202)* extended the appropriation through June 30, 2008.
- *MIPPA (Section 201)* extended the appropriation through June 30, 2009.[9]
- *ACA (Section 2954)* appropriated $50 million for each of FY2010 through FY2014.[10]
- *PAMA (Section 205)* appropriated $50 million for FY2015.

Current status: The funding designated for abstinence education grants expires September 30, 2015.

Maternal, Infant, and Early Childhood Home Visiting Program (SSA Section 511)

ACA Section 2951 established the Maternal, Infant, and Early Childhood Home Visiting Program in SSA Section 511. This program provides grants to states, territories, and tribes for the support of evidence-based early childhood home visiting programs. These programs support in-home visits by health or social service professionals with at-risk families. The ACA appropriated a total of $1.5 billion for FY2010 through FY2014 for the home visitation grant program. PAMA extended this funding through March 31, 2015. Of the amount appropriated for this program, 3% annually is reserved for research and evaluation and 3% annually is reserved to make grants to tribal entities for home visitation services to Indian families. This program is administered collaboratively by the Maternal and Child Health Bureau at HRSA and ACF.

- *ACA (Section 2951)* appropriated $100 million for FY2010; $250 million for FY2011; $350 million for FY2012; $400 million for FY2013; and $400 million for FY2014.
- *PAMA (Section 209)* provided $400 million for the program for the first half of FY2015 (October 1, 2014, through March 31, 2015). It also reserved portions of

[9] Funding for the Abstinence Education Program was $37.5 million in FY2009 (i.e., rate of $50 million per year for three-quarters of the fiscal year).

[10] For FY2012, Division F, Title II of the Consolidated Appropriations Act, 2012 (P.L. 112-74) provided an additional $5 million for competitive abstinence education grants to supplement the formula grants under SSA §510.

this part-year funding for Indian tribal entities (3% of the appropriation) and research and evaluation (3% of the appropriation).

Current status: The funding designated for Maternal, Infant, and Early Childhood Home Visiting Program expires March 31, 2015.

Personal Responsibility Education Program (SSA Section 513)

ACA Section 2953 established the Personal Responsibility Education Program (PREP) in Section 513 of the SSA. PREP is a state formula grant program to support evidence-based programs designed to educate adolescents about abstinence, contraception, and adulthood. The ACA also required the Secretary of Health and Human Services (the Secretary) to award grants to implement innovative youth pregnancy prevention strategies and to target services to high-risk populations. The ACA appropriated a total of $375 million, with $75 million appropriated for each of FY2010 through FY2014. The ACA required that $10 million each year be reserved for the youth pregnancy prevention grants. PAMA extended funding for the program through FY2015. The funds are available until expended. The program is administered by ACF.

- *ACA (Section 2953)* appropriated a total of $375 million from FY2010 through FY2014.
- *PAMA (Section 206)* appropriated $75 million for FY2015.

Current status: The funding designated for PREP expires September 30, 2015. The funds are available until expended.

Title XI: General Provisions, Peer Review, and Administrative Simplification

Outreach and Assistance for Low-Income Programs (SSA Sections 1102 and 1871, PAMA Section 110)

See SSA Section 1871.

CHIPRA Children's Health Care Quality Measures (SSA Section 1139A(i))

- *CHIPRA (Section 104)* required the Secretary to identify and publish an initial core set of pediatric quality measures by no later than January 1, 2010. The Secretary, not later than January 1, 2011, and every three years thereafter, also is required to submit a report to Congress on, for example, the quality of children's health care under Medicaid and CHIP. A Pediatric Quality Measures Program (PQMP) was required to be established by January 1, 2011; this program is required to identify pediatric measure gaps and development priorities, award grants and contracts to develop measures, and revise and strengthen the core measure set, among other things. States are required to submit reports to the Secretary annually to include, for example, information about state-specific child health quality measures applied by the state. The Secretary is required to collect, analyze, and make publicly available the information reported by states not later than September 30, 2010, and annually thereafter. The Secretary was required, between FY2009 and FY2013, to award no more than 10 grants to states for demonstration projects to evaluate ideas to improve the quality of children's health care; in addition, the Secretary, not later than January 1, 2010, was

required to establish a program to encourage the development and dissemination of a model electronic health record for children. The Institute of Medicine (IOM) was required to develop a report on measurement of child health status and quality by no later than July 1, 2010. Funding for these activities was appropriated in the amount of $45 million for each of FY2009 through FY2013.

- *PAMA (Section 210)* extended funding for SSA Section 1139A(b) for FY2014 by requiring that $15 million of the $60 million appropriated under Section 1139B(e) be used to carry out Section 1139A(b).

Current status: The appropriation in Section 1139A(i) for funding to carry out SSA Section 1139A expired in FY2013; the funding designated to carry out SSA Section 1139A(b) expired in FY2014.

Adult Quality Measures (SSA Section 1139B(e))

- *ACA (Section 2701)* required the Secretary to publish a core set of Medicaid adult health quality measures by January 1, 2012. Also, no later than January 1, 2013, the Secretary was required to develop a standardized format for reporting information based on this initial core measurement set. The Secretary is required to submit a report to Congress by January 1, 2014, and every three years thereafter, that describes the Secretary's efforts to improve, for example, the quality of care of different services for adults under Medicaid. Within one year after the release of the recommended core set of adult health quality measures, the Secretary is required to establish a Medicaid Quality Measurement Program (MQMP). To this end, the Secretary is required to award grants and contracts for developing, testing, and validating emerging and innovative evidence-based measures applicable to Medicaid adults. Not later than two years after the establishment of the MQMP, and annually thereafter, the Secretary is required to publish recommended changes to the initial core set of adult health quality measures based on the results of testing, validation, and the consensus process for development of these measures. States are required to submit reports to the Secretary annually to include, for example, information about state-specific adult health quality measures applied by the state. The Secretary is required to collect, analyze, and make publicly available the information reported by states before September 30, 2014, and annually thereafter. Funding for these activities was appropriated in the amount of $60 million for each of FY2010 through FY2014.
- *PAMA (Section 210)* required that, of the funds appropriated for FY2014, $15 million be used to carry out SSA Section 1139A(b).

Current status: The appropriation in SSA Section 1139B(e) for funding to carry out SSA Section 1139B and SSA Section 1139A(b) expired in FY2014.

Title XVIII: Medicare

Therapy Services (SSA Section 1833(g))

- *BBA 97 (Section 4541)* established, beginning in CY1999, a $1,500 limit on outpatient physical therapy services (including speech language pathology services) provided by nonhospital providers and a separate $1,500 limit on outpatient occupational therapy services provided by nonhospital providers.

Provided that these limits would be updated by the Medicare Economic Index (MEI) beginning in CY2002.

- *BBRA 99 (Section 221)* suspended application of the limits for CY2000 and CY2001.
- *BIPA 2000 (Section 421)* suspended application of limits for CY2002.
- *MMA (Section 624)* suspended application of limits beginning December 8, 2003, through December 31, 2005.
- *DRA (Section 5107)* required the Secretary to implement an exceptions process for services meeting specified criteria for medically necessary services provided in 2006.
- *TRHCA (Section 201)* extended the exceptions process through CY2007.
- *MMSEA (Section 105)* extended the exceptions process through the first six months of 2008.
- *MIPAA (Section 141)* extended the exceptions process through CY2009.
- *ACA (Section 3103)* extended the exceptions process through CY2010.
- *MMEA (Section 104)* extended the exceptions process through CY2011.
- *TPTCCA (*Section *304)* extended the exceptions process through February 2012.
- *MCTRJCA (Section 3005)* extended the exceptions process through December 2012 and created several additional requirements.[11] The provision also set the annual threshold at $3,700 to be applied separately (1) for physical therapy services and speech language pathology services and (2) for occupational therapy services. However, this increased amount applies to therapy service received both in physicians' offices as well as hospital outpatient departments. The increased cap amount expires coincident with the expiration of the exceptions process.
- *ATRA (Section 603)* extended the exceptions process through December 31, 2013, extended the application of the cap and threshold to therapy services furnished in a hospital outpatient department, and counted outpatient therapy services furnished in a Critical Access Hospital (CAH) toward the cap and threshold. This change did not affect the payment method for outpatient therapy services provided by CAHs. ATRA also extended the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013, through December 31, 2013, for which an exception is requested when the

[11] MCTRJCA added the following requirements: (1) Any request for such an exception, for services furnished on or after October 1, 2012, would be subject to a manual medical review process "that is similar to the manual medical review process used for certain exceptions under this paragraph in 2006"; (2) claims are to include a modifier specifying that "the services are medically necessary as justified by appropriate documentation in the medical record involved"; (3) beginning October 1, 2012, the national provider identifier (NPI) of the physician who reviews the therapy plan be included in each request for payment, or bill submitted, for therapy services; (4) not later than June 15, 2013, the Medicare Payment Advisory Commission (MedPAC) is to submit a report making recommendations on how to improve the outpatient therapy benefit under Medicare Part B that is to include recommendations on how to reform the payment system for outpatient therapy services so that the benefit is better designed to reflect individual acuity, condition, and therapy needs of the patient, as well as an examination of private sector initiatives relating to outpatient therapy benefits; (5) to assist in reforming the Medicare payment system for outpatient therapy services, beginning on January 1, 2013, the Secretary is to collect claims-based data on patient function during the course of therapy services in order to better understand patient condition and outcomes; and (6) not later than May 1, 2013, the Comptroller General is to submit a report on the implementation of the manual medical review process that will include aggregate data on the number of individuals and claims affected, the number of reviews conducted, and the outcome of such reviews.

beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services.

- *PAMA (Section 103)* extended the therapy cap exceptions process through March 31, 2015.

Current Status: The Medicare therapy cap exceptions process and the associated mandated medical review expire March 31, 2015.

Assistance for Rural Ambulance Providers in Low Population Density Areas (SSA Section 1834(l)(12))

- *MMA (Section 414(c))* provided an increase in base payments for ground ambulance services furnished in low population density rural areas beginning July 1, 2004, and ending December 31, 2009. The Centers for Medicare & Medicaid Services (CMS) established this increase as 22.6%.
- *ACA (Section 3105)* extended increased base payments in low population density areas through CY2010 (super rural ambulance payments).
- *MMEA (Section 106)* extended the super rural ambulance payments through CY2011.
- *TPTCCA (Section 306)* extended the super rural ambulance payments until March 1, 2012.
- *MCTRJCA (Section 3007)* extended the super rural ambulance payments until January 1, 2013.
- *ATRA (Section 604)* extended the super rural ambulance payments until January 1, 2014.
- *P.L. 113-67 (Section 1104(b))* extended the MIPPA payment increases until March 31, 2014.
- *PAMA (Section 104(b))* extended the super rural ambulance payments until March 31, 2015.

Current Status: Increased Medicare ambulance payments in low population density areas apply through March 31, 2015.

Temporary Increase For Ground Ambulance Services (SSA Section 1834(l)(13)) and Grandfathered Rural Areas for Air Ambulance Services

- *MMA (Section 414(d))* provided that the rate otherwise established for the year would be increased an additional 2% for rural ambulance services and 1% for urban ambulance services beginning July 1, 2004, through December 31, 2006.
- *MIPPA (Section 146)* provided that the rate otherwise established for the year would be increased an additional 3% for rural ambulance services and 2% for other areas for the period July 1, 2008, through December 31, 2009.
- *ACA (Section 3105)* extended the MIPPA payment increases through CY2010.
- *MMEA (Section 106)* extended the MIPPA payment increases through CY2011.
- *TPTCCA (Section 306)* extended the MIPPA payment increases until March 1, 2012.
- *MCTRJCA (Section 3007)* extended the MIPPA payment increases until January 1, 2013. Required the Government Accountability Office (GAO) to update the

report GAO-07-383, *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly* by October 1, 2012. (See GAO 13-6, published October 1, 2012). It also required the Medicare Payment Advisory Commission (MedPAC) to study the appropriateness of ambulance add-on payments and submit a report to the congressional committees with jurisdiction over Medicare by June 15, 2013. In its November 1, 2012, meeting, MedPAC commissioners voted to recommend that the ambulance add-on payments not be extended. This recommendation (and others concerning Medicare's ambulance payments) was included in MedPAC's June 2013 *Report to Congress*.

- *ATRA (Section 604)* extended the 2% urban add-on payment and the 3% rural add-on payment until January 1, 2014. The Department of Health and Human Services (HHS) is required to conduct studies of various aspects of ambulance costs and consult with the industry on the design of such cost-collection efforts, explore the use of cost surveys and cost reports, examine the development of a standard cost reporting tool, and examine the ability of different types of ambulance providers to furnish the cost data. Two reports, each with legislative and administrative recommendations, were due to Congress no later than October 1, 2012, and July 1, 2014. CMS has not yet issued those reports.
- *P.L. 113-67 (Section 1104(a))* extended the MIPPA payment increases until March 31, 2014.
- *PAMA (Section 104(a))* extended the MIPPA payment increases through March 31, 2015.

Current Status: The MIPAA Medicare rural and urban add-on payments expire on March 31, 2015.

Physician Quality Reporting Payments (Section 1848(a)(8))

- *TRHCA (Section 101)* provided a 1.5% bonus payment for physicians voluntarily reporting certain quality measures for the period July 1, 2007-December 31, 2007.
- *MMSEA (Section 101)* extended and modified the Physician Quality Reporting Initiative (PQRI) for physicians and other health care professionals under Medicare for 2008 and 2009.[12]
- *MIPPA (Section 131)* made permanent the PQRI and extended bonus payments equal to 1.5% for 2008 and 2.0% for 2009 and 2010.
- *ACA (Section 3002 as modified by Section 10327)* extended the Physician Quality Reporting System (PQRS)[13] incentive payments through 2014. Eligible professionals who successfully reported in 2010 received a 1% bonus in 2011; those who successfully report in 2011, 2012, and 2013 received a 0.5% bonus in 2012, 2013, and 2014, respectively. The provisions also implemented an incentive (penalty) for providers who do not report quality measures beginning in 2015. Eligible professionals who fail to participate successfully in the program will face a 1.5% payment penalty in 2015 and a 2% payment penalty in 2016 and in subsequent years. There is no expiration for this penalty.

[12] Generally, Medicare physician fee schedule payment rates are established by rule on a calendar year basis.

[13] In 2011, CMS changed the name from the Physician Quality Reporting Initiative (PQRI) to the Physician Quality Reporting System (PQRS). See http://www.cms.gov/PQRS/.

In addition, the ACA added a 0.5% incentive payment available in years 2011 through 2014 for eligible professionals who also meet the requirements of a Maintenance of Certification Program (MOCP).

- *ATRA (Section 601)* required the Secretary to deem those eligible professionals who satisfactorily participate in a qualified clinical data registry as having met the quality reporting requirements for PQRS for 2014 and subsequent years. The provision also required the Secretary to establish requirements for a qualified clinical data registry and, in so doing, to consider, among other things, whether an entity has mechanisms in place to ensure transparency and to support quality improvement initiatives for participants.[14]

Current Status: The Medicare PQRS incentive payments expired on December 31, 2014, with a penalty imposed beginning in 2015 and in subsequent years for professionals who do not successfully report. There is no expiration for this penalty.

Floor on Geographic Adjustment for Physician Fee Schedule (SSA Section 1848(e)(1)(E))

- *MMA (Section 412)* provided for an increase in the work geographic index to 1.0 (floor) for any locality for which the work geographic index was less than 1.0 for services furnished from January 1, 2004, through December 31, 2006.
- *TRHCA (Section 102)* extended the floor through CY2007.
- *MMSEA (Section 103)* extended the floor through June 30, 2008.
- *MIPPA (Section 134)* extended the floor through December 2009. In addition, beginning January 1, 2009, and with no expiration, the work geographic index for Alaska was set to 1.5 if the index would otherwise be less than 1.5.
- *ACA (Section 3102)* extended the floor through December 2010.
- *MMEA (Section 103)* extended the floor through December 2011.
- *TPTCCA (Section 303)* extended the floor through February 2012.
- *MCTRJCA (Section 3004)* extended the floor through December 2012 and required a MedPAC to report on whether any work geographic adjustment to the physician fee schedule is appropriate, what that level of adjustment should be (if appropriate), and where the adjustment should be applied. The report also was required to assess the impact of such an adjustment, including how it affects access to care.
- *ATRA (Section 602)* extended the 1.0 floor for the physician work geographic index through December 31, 2013.
- *PAMA (Section 102)* extended the 1.00 floor for the physician work geographic index through March 31, 2015.

Current Status: The 1.0 floor for the Medicare physician fee schedule work geographic index will expire on March 31, 2015.

[14] For details, see CRS Report R42944, *Medicare, Medicaid, and Other Health Provisions in the American Taxpayer Relief Act of 2012*.

Electronic Health Record Incentive Payments for Physicians (SSA Section 1848(o))

- *ARRA (Title IV, Subtitle A, Section 4101)* authorized incentive payments through Medicare Part B for up to five years beginning as early as 2011 to physicians who are meaningful users of certified electronic health record (EHR) technology. Incentive payments were available for physicians who qualified as meaningful users in CY2011, CY2012, or CY2013. However, no payment incentives will be provided after December 31, 2016, regardless of what year the physician first receives an incentive payment.

Current Status: No Medicare EHR payment incentives will be provided after December 31, 2016, regardless of what year the physician first receives an incentive payment.

Restriction on Enrollment for Medicare Advantage Plans for Special Needs Individuals (SSA Subsection 1859)

- *MMA (Section 231)* created a new Medicare Advantage (MA) option—MA plans for special needs beneficiaries. Special Needs Plans (SNPs) are MA plans that can limit enrollment to the following subgroups of Medicare beneficiaries: (1) those dually eligible for Medicare and Medicaid; (2) those who are institutionalized; and (3) those with severe or disabling chronic conditions. SNPs are paid in the same way as other MA plans and are subject to the same regulations. Under MMA, authority for SNPs to limit enrollment to beneficiary subgroups expired December 31, 2008.
- *MMSEA (Section 108)* extended the time SNPs may restrict enrollment to one or more classes of special needs beneficiaries until January 1, 2010.
- *MIPPA (Section 164)* extended the time SNPs may restrict enrollment to one or more classes of special needs individuals until January 1, 2011.
- *ACA (Section 3205)* extended through December 31, 2013, the time SNPs may restrict enrollment to special needs individuals.
- *ATRA (Section 607)* extended through December 31, 2014, the time SNPs may restrict enrollment to special needs individuals.
- *PSRA (Section 1107)* extended through December 31, 2015, the time SNPs may restrict enrollment to special needs individuals.
- *PAMA (Section 107)* extended through December 31, 2016, the time SNPs may restrict enrollment to special needs individuals.

Current Status: Enrollment in SNPs will no longer be limited to special needs individuals after December 31, 2016.

Medicare Dependent Hospital (SSA Section 1886(d)(5)(G))

- *BBA 97 (Section 4204)* reinstated the Medicare Dependent Hospital (MDH) classification, starting on October 1, 1997, through October 1, 2001, for small rural hospitals that treat a relatively high proportion of Medicare patients, allowing these hospitals to continue to receive special Medicare payments.
- *BBRA 99 (Section 404)* extended the MDH program to October 1, 2006.

- *DRA (Section 5003)* extended the MDH program through discharges occurring before October 1, 2011. Starting for discharges on October 1, 2006, an MDH may elect payments based on 50% of its FY2002 hospital-specific costs if doing so resulted in higher Medicare payments. MDHs' payments are based on 75% of their adjusted hospital-specific costs starting for discharges on October 1, 2006. MDHs that qualify for a disproportionate share hospital (DSH) adjustment do not have the adjustment capped at 12%.
- *ACA (Section 3124)* extended the MDH program until September 30, 2012.
- *ATRA (Section 606)* extended the MDH program until September 30, 2013.
- *P.L. 113-67 (Section 1106)* extended the MDH program until March 31, 2014.
- *PAMA (Section 106)* extended the MDH program until March 31, 2015.

Current Status: MDH special payment status expires for discharges starting April 1, 2015.

Low-Volume Adjustment (SSA 1866(d)(12))

- *ACA (Section. 3125 as modified by Section 10314)* eased the distance and volume requirements for hospitals to qualify for the low-volume adjustment and receive increased Medicare Inpatient Prospective Payment System (IPPS) payments for FY2011 and FY2012. Under the enhanced adjustment, hospitals must have fewer than 1,600 Medicare discharges and be at least 15 miles from the nearest like hospital.
- *ATRA (Section 605)* extended the enhanced low-volume adjustment for FY2013.
- *P.L. 113-67 (Section 1105)* extended the enhanced low-volume adjustment through March 31, 2014.
- *PAMA (Section 105)* extended the enhanced low-volume adjustment though March 31, 2015.

Current status: The low-volume adjustment will revert to original standards starting for discharges on April 1, 2015. These standards are set in statute at more than 25 road miles and less than 800 discharges. As directed, CMS examined the empirical cost relationship and set the standards at fewer than 200 total discharges established at Title 42, Section 412.101, of the *Code of Federal Regulations*.

Outreach and Assistance for Low-Income Programs (SSA Sections 1102 and 1871, PAMA Section 110)

- *MIPPA (Section 119)* provided $25 million for FY2008 and FY2009 for low-income Medicare beneficiary outreach and education through State Health Insurance Counseling and Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging (AoA).
- *ACA (Section 3306)* temporarily extended MIPPA Section 119 and provided an additional $45 million for outreach and education related to Medicare low income assistance programs. Funds were available for obligation through 2012.
- *ATRA (Section 610)* extended MIPPA Section 119 authority through FY2013 and appropriated the following amounts for low-income Medicare beneficiary outreach and assistance programs: SHIPs, $7.5 million; AAAs, $7.5 million;

ADRCs, $5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, $5 million.

- *PSRA (Section 1110)* extended MIPPA Section 119 authority through March 31, 2014, and appropriated the following amounts for low-income Medicare beneficiary outreach and assistance programs: SHIPs, $3.75 million; AAAs, $3.75 million; ADRCs, $2.5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, $2.5 million.
- *PAMA (Section 110)* further extended MIPPA Section 119 authority through September 31, 2014, and appropriated the following amounts for low-income Medicare beneficiary outreach and assistance programs: SHIPs, $7.5 million; AAAs, $7.5 million; ADRCs, $5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, $5 million. In addition, PAMA Section 110 extended MIPPA Section 119 authority through March 31, 2015, and appropriated the following amounts for low-income Medicare beneficiary outreach and assistance programs: SHIPs, $3.75 million; AAAs, $3.75 million; ADRCs, $2.5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, $2.5 million.

Current Status: Funding for low-income Medicare beneficiary outreach and education is available for obligation through March 31, 2015.

Extension of Medicare Cost Contracts (SSA Section 1876(h)(5)(C)(ii))

- *BBA 97 (Section 4002)* established transition from Medicare Risk Contract program to Medicare + Choice program.
- *BBRA 99 (Section 503*) extended Medicare cost contracts through CY2004.
- *BIPA 2000 (Section 634*) allowed service-area expansion for certain Medicare cost contracts.
- *MMA (Section 234)* transitioned from Medicare + Choice to MA program and allowed cost contracts to be extended or renewed indefinitely. Beginning in 2008, these contracts could not be extended or renewed for a service area that during the entire previous year had two or more MA regional plans or two or more MA local plans.
- *MMSEA (Section 109)* extended by one year—from January 1, 2008, to January 1, 2009—the length of time a cost plan contract could continue for a cost plan in an area served by two or more local or two or more regional plans.
- *MIPPA (Section 167)* extended by one year—from January 1, 2009, to January 1, 2010—the length of time a cost plan contract could continue for a cost plan in an area served by two or more local or two or more regional plans. To prohibit a cost plan from participating after January 1, 2010, the two or more plans in a service area were required to be offered by different organizations and had to meet minimum enrollment requirements.
- *ACA (Section 3206)* extended by three years—from January 1, 2010, to January 1, 2013—the length of time a cost plan contract could continue for a cost plan in an area served by two or more local or two or more regional plans that meet minimum enrollment requirements.
- *ATRA (Section 608)* extended by one year—from January 1, 2013, to January 1, 2014—the length of time a cost plan contract could continue for a cost plan in an

area served by two or more local or two or more regional plans that meet minimum enrollment requirements.

- *P.L. 113-67 (Section 1108)* extended by one year—from January 1, 2014, to January 1, 2015—the length of time a cost plan contract could continue for a cost plan in an area served by two or more local or two or more regional plans that meet minimum enrollment requirements.
- *PAMA (Section108)* extended by one year—from January 1, 2015, to January 1, 2016—the length of time a cost plan contract could continue for a cost plan in an area served by two or more local or two or more regional plans that meet minimum enrollment requirements.

Current Status: Medicare cost contracts can be extended or renewed indefinitely, except that beginning on or after January 1, 2016, these contracts may not be extended or renewed in areas that during the entire previous year had two or more MA regional plans or two or more MA local plans offered by different organizations, with a minimum enrollment. This means that such plans will not be renewed at the end of 2016, based on minimum enrollment data for the 2015 contract year, and will cease to operate at the end of 2016.

Electronic Health Record Incentive Payments for Hospitals (SSA Section 1886(n))

- *ARRA (Title IV, Subtitle A, Section 4102)* authorized incentive payments to eligible acute care hospitals and critical access hospitals that are meaningful users of certified EHR technology. Payments were authorized over a four-year period, from FY2011 to FY2014.

Current Status: Incentive payments to hospitals for the meaningful use of EHRs were authorized from FY2011 through FY2014.

Quality Measure Selection (SSA Section 1890A(a)-(d))

- *ACA (Section 3014(b) and (c))* required the Secretary to establish a pre-rulemaking process to include a series of six steps to select quality measures for use in the Medicare program. These steps included requirements that the consensus-based entity with a contract gather multi-stakeholder input and annually transmit that input to the Secretary. The provision also required the Secretary to make measures under consideration available to the public and to publish in the *Federal Register* the rationale for the use of any quality measure that has not been endorsed by the consensus-based entity, among other things. In addition, it required the Secretary to establish a process for disseminating those quality measures that are being used and to periodically review and determine whether to maintain or to phase out these quality measures. The ACA also provided for the transfer of a total of $20 million from the Medicare Part A and Part B Trust Funds for each of FY2010 through FY2014 to carry out the amendments made in ACA Section 3014(b) (and in ACA Section 3014(a), see below).
- *PAMA (Section 109)* required the transfer of $5 million for FY2014 and $15 million for the first six months of FY2015 to carry out both SSA Section 1890 and SSA Section 1890A(a)-(d); funds are required to remain available until expended.

Current Status: Funding to carry out the quality measure selection activities under SSA Section 1890A(a)-(d) will expire on March 31, 2015. The funding will remain available until expended.

Contract with a Consensus-Based Entity Regarding Performance Measurement (SSA Section 1890(d))

- *MIPPA (Section 183)* required the Secretary to have a contract with a consensus-based entity (e.g., National Quality Forum, or NQF) to carry out specified duties related to performance improvement and measurement. These duties included, among others, priority setting; measure endorsement; measure maintenance; convening multi-stakeholder groups to provide input on the selection of quality measures and national priorities; and annual reporting to Congress. MIPPA also provided for the transfer, from the Medicare Part A and Part B Trust Funds, of a total of $10 million for each of FY2009 through FY2012.
- *ACA (Section 3014(a))* added to the annual reporting requirements and also added a requirement that the consensus-based entity convene multi-stakeholder groups to provide input on the selection of quality measures for use in the Medicare program and on national priorities for improvement in population health and health care delivery.
- *ATRA (Section 609(a))* extended funding through FY2013 and modified the duties of the consensus-based entity.
- *PSRA (Section 1109)* required that transferred funding remain available until expended.
- *PAMA (Section 109)* required the transfer of $5 million for FY2014 and $15 million for the first six months of FY2015 to carry out both SSA Section 1890 and SSA Section 1890A(a)-(d).

Current Status: Funding for the contract with the consensus-based entity (NQF) will expire on March 31, 2015. Funds transferred will remain available until expended.

Home Health Prospective Payment System Rural Add-On (SSA Section 1895)

- *BIPA (Section 508)* provided a 10% increase in Medicare's Home Health (HH) Prospective Payment System (PPS) for services provided to beneficiaries in rural areas beginning April 1, 2001, through March 31, 2003.
- *MMA (Section 421)* provided a 5% increase to Medicare's HH PPS for services provided to beneficiaries in rural areas beginning April 1, 2004, through March 31, 2005.
- *DRA (Section 5201)* reestablished the Medicare HH PPS rural add-on in MMA as a 5% increase beginning January 1, 2006, through December 31, 2006.
- *ACA (Section 3131)* reestablished the Medicare HH PPS rural add-on in MMA as a 3% increase beginning April 1, 2010, through December 31, 2015.

Current Status: The Medicare HH PPS rural add-on will expire on December 31, 2015.

Title XIX: Medicaid

Qualifying Individual Program (SSA Section 1902(a)(10)(E)(iv) and Funding (SSA Section 1933(g))

- *MMEA (Section 110)* authorized and appropriated $280 million in funding for the Medicaid Qualifying Individual (QI) program for the first quarter of FY2012.
- *TPTCA (Section 310)* reauthorized and funded the QI program from January 1, 2012, through February 29, 2012 (increasing FY2012 funding through February 29, 2012, to $430 million).
- *MCTRJCA (Section 3101)* reauthorized and funded the QI program through September 30, 2012, increasing total FY2012 funds available to $730 million, as well as authorizing and appropriating $280 million to extend the QI program through the first quarter of 2013 (October 1, 2012-December 31, 2012).
- *ATRA (Section 621)* reauthorized and funded the QI program through December 31, 2013. For the period between January 1, 2013, and September 30, 2013, the total allocation amount for the QI program was $485 million, and for the period between October 1, 2013, and December 31, 2013, the total allocation amount was $300 million.
- *PSRA (Section 1201)* reauthorized and funded the QI program through March 31, 2014. For the period between January 1, 2014, and March 31, 2014, $200 million was appropriated for the QI program.
- *PAMA (Section 201)* reauthorized and funded the QI program through March 31, 2015. The following amounts are appropriated for the QI program: for the period between April 1, 2014, and September 30, 2014, $485 million; for the period between October 1, 2014, and December 31, 2014, $300 million; and for the period between January 1, 2015, and March 31, 2015, $250 million.

Current Status: The QI program authorization expires on March 31, 2015, and $1.035 billion has been appropriated through the second quarter of FY2015 (March 31, 2015).

Medicaid Payments to Primary Care Providers (SSA Sections 1902(a)(13)(C), 1902(jj), 1905(dd)), and 1932(f))

Under Medicaid, for the most part, states establish their own payment rates for Medicaid providers. Federal statute requires that these rates be sufficient to enlist enough providers so that covered benefits will be available to Medicaid enrollees at least to the same extent they are available to the general population in the same geographic area.

- *HCERA (Section 1202)* added the required increase to the Medicaid primary care rates. Specifically, for CY2013 and CY2014, Medicaid payment rates for certain primary care services furnished by physicians with certain subspecialties (i.e., family medicine, general internal medicine, and pediatrics) are required to be the same as what Medicare pays for these services. The federal government is picking up the entire cost of that increase in primary care rates (i.e., the difference between states' Medicaid payment rates as of July 1, 2009, and Medicare payment rates) for those two years.

Current Status: The requirement for states to provide Medicaid primary care payments at parity with Medicare and the full federal financing of the increased primary care rates expired December 31, 2014.

Transitional Medical Assistance (SSA Sections 1902(e)(1)(B) and Section 1925(f))

Under federal law, states are required to continue Medicaid benefits for certain low-income families that would otherwise lose coverage because of changes in their income. This continuation, called transitional medical assistance (TMA), requires four months of TMA for families that lose Medicaid eligibility due to increased spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Section 303(a)(1) of the Family Support Act of 1988 (P.L. 100-485) expanded work-related TMA and requires states to provide at least 6, and up to 12, months of coverage. Since 1996, these work-related TMA requirements have been funded by short-term extensions.

- *PRWORA (Section 114(c))* extended TMA from September 30, 1998, to September 30, 2001.
- *BIPA 2000 (Section 707(a))* extended TMA through September 30, 2002.
- *WREA (Section 5)* extended TMA through September 30, 2003.
- *ARRA (Section 5004(a)(1))* extended TMA through December 31, 2010.
- *MMSEA (Section 202)* extended TMA through December 31, 2011.
- *TPTCCA (Section 311)* extended TMA through February 29, 2012.
- *MCTRJCA (Section 3102)* extended TMA through December 31, 2012.
- *ATRA (Section 622)* extended TMA through December 31, 2013.
- *P.L. 113-67 (Section 1202)* extended TMA through March 31, 2014.
- *PAMA (Section 202)* extended TMA through March 31, 2015.

Current status: Medicaid work-related TMA will expire after March 31, 2015.

Medicaid and CHIP Express Lane Option (SSA Sections 1902(e)(13)(A)(i) and 1902(e)(13)(I))

CHIPRA created a state plan option for "Express Lane" eligibility, through September 30, 2013, whereby states are permitted to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) for (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility, (2) eligibility redeterminations, or (3) renewal of eligibility for medical assistance under Medicaid or CHIP.

- *ATRA (Section 623)* permitted states to rely on "Express Lane" eligibility determinations through September 30, 2014.
- *P.L. 113-93 (Section 203)* permitted states to rely on "Express Lane" eligibility determinations through September 30, 2015.

Current status: Authority for "Express Lane" eligibility determinations will expire after September 30, 2015.

Improving Access to Clinical Trials (SSA Section 1902(e)(14) and Section (3)(e) of the IACTA)

- *IACTA (Sections 3(c)(1) and 3(e))* permitted individuals (who have attained 19 years of age) to exclude the first $2,000 received as compensation for participation in a clinical trial for the testing of treatments for a rare disease or condition when determining Medicaid income eligibility for such individual. Section 3(e) repeals the amendments made by this act five years after the date of enactment (or October 5, 2015).

Current Status: Authority for individuals to exclude certain earnings from participation in a clinical trial for rare diseases or conditions when determining Medicaid income eligibility will expire five years after the date of enactment (i.e., October 5, 2015).

Additional FMAP Increase for Certain "Expansion States" (SSA Section 1905(z)(1))

Medicaid is jointly financed by the federal government and the states. The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP), which varies by state and is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services.

- *ACA (Sections 2001 and 10201) and HCERA (Section 1201)* added the additional FMAP increase for certain "expansion states," which provides an FMAP rate increase of 2.2 percentage points during 2014 and 2015 to expansion states (i.e., states that had provided health benefits coverage meeting certain criteria statewide to parents with dependent children and adults without dependent children up to at least 100% of the federal poverty level [FPL] as of March 23, 2010) that (1) the Secretary of HHS determines would not receive any FMAP rate increase for "newly eligible" individuals under the ACA Medicaid expansion and (2) had not been approved to use Medicaid disproportionate share hospital (DSH) funds to pay for the cost of health coverage under a waiver in effect as of July 2009. The 2.2 percentage point increase is applied to the state's regular FMAP rate and used for Medicaid expenditures for enrollees who are not newly eligible individuals. Vermont is the only state that has been confirmed as meeting the criteria for the additional FMAP increase for certain expansion states.

Current Status: The additional Medicaid FMAP increase for certain expansion states expires on December 31, 2015.

Balancing Incentive Payments Program (ACA Section 10202)

The Balancing Incentive Payments (BIP) Program authorizes CMS to provide incentive payment grants to qualifying state Medicaid programs for increasing their share of long-term services and supports (LTSS) spending on home and community-based services while reducing their share of spending on institutional long-term care. To be eligible to receive incentive payments, states must have spent less than 50% of total Medicaid medical assistance spending on non-institutionally based LTSS for FY2009, among other requirements. Participating states will receive an FMAP rate increase for eligible medical assistance payments.

- *ACA (Section 10202)* authorized CMS to provide incentive payments to states, which are not to exceed $3 billion from October 1, 2011, to September 30, 2015.

Current status: Authority for Medicaid BIP Program payments to states will expire after September 30, 2015.

Title XX: Block Grants to States for Social Services and Elder Justice

Health Professions Opportunity Grants for Low-Income Individuals (SSA Section 2008)

ACA Section 5507(a) required the Secretary to establish a demonstration project in SSA Section 2008 that awarded funds to states, Indian tribes, institutions of higher education, and local workforce investment boards for health profession opportunity grants (HPOG). These grants were used to help low-income individuals—including individuals receiving assistance from the State Temporary Assistance for Needy Families (TANF) program—to obtain education and training in health care jobs that pay well and are in high demand. Funds also were used to provide financial aid and other supportive services. The section appropriated $85 million for each of FY2010 through FY2014 ($425 million total) but reserved a total of $15 million for a demonstration project for personal and home care aides from FY2010 through FY2012. PAMA extended funding for the HPOG program through FY2015. This program is administered jointly by HRSA and ACF.

- *ACA (Section 5507(a))* appropriated a total of $425 million from FY2010 to FY2014.
- *PAMA (Section 208)* appropriated $85 million for FY2015.

Current status: Health Professions Opportunity Grants are funded through September 30, 2015.

Title XXI: Children's Health Insurance Program

CHIP Appropriations (SSA Section 2104(a) and CHIPRA Section 108 as amended by the ACA)

Federal funding for CHIP is provided through FY2015 with appropriation amounts in statute that are the overall annual ceiling on federal CHIP spending to the states, the District of Columbia, and the territories. CHIP was established as part of the Balanced Budget Act of 1997 (P.L. 105-33). Since that time, other federal laws have provided additional years of appropriation amounts.

- *BBA97 (Section 4901)* provided appropriations amounts for FY1998 through FY2007.
- *Continuing Resolutions (P.L. 110-92, Section 106; P.L. 110-116, Section 101; P.L. 110-137; and P.L. 110-149)* provided an FY2008 CHIP appropriation amount of $5.04 billion, the same amount used in FY2007, through specified termination dates (respectively, November 16, December 14, December 21, and December 31, 2007).
- *MMSEA (Section 201)* made the appropriation amount for FY2008 available through March 31, 2009. It also appropriated $5.04 billion for FY2009 allotments, available through March 31, 2009.

- *CHIPRA (Sections 101 and 108)* provided appropriations for FY2009 through FY2013.
- *ACA (Section 2101 as modified by Section 10203(d))* provided annual national appropriation amounts for an additional two years. For FY2014 and FY2015, the annual appropriation amounts are $19.1 billion and $21.1 billion, respectively. The FY2015 appropriation is the combination of semiannual appropriations of $2.85 billion from Section 2104(a) of SSA plus a one-time appropriation in the amount of $15.36 billion from Section 108 of CHIPRA.

Current Status: FY2015 is the last year for which a CHIP appropriation amount is provided.

CHIP Allotments (SSA Section 2104(m))

State allotments are the federal funds allocated to each state for the federal share of their CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. There are two formulas for determining state allotments: an even year formula and an odd year formula. In even years, such as FY2014, state CHIP allotments are each state's previous year *allotment* plus any Child Enrollment Contingency Fund (described below) payments from the previous year adjusted for health care inflation and child population growth in the state. For even years, the allotment amount can be adjusted to reflect CHIP eligibility or benefit expansions. In odd years, state CHIP allotments are each state's previous year *spending* (including federal CHIP payments from the state CHIP allotment, Child Enrollment Contingency Funds, and redistribution funds) adjusted using the same growth factor as the even year formula (i.e., health care inflation and child population growth in the state). Since the odd year formula is based on states' actual use of CHIP funds, it is called the "re-basing year" because a state's CHIP allotment can either increase or decrease depending on each state's CHIP expenditures in the previous year.

- *BBA97 (Section 4901)* authorized allotments for FY1998 through FY2007.
- *DRA (Section 6101)* provided additional allotments to eliminate FY2006 funding shortfalls.
- *U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Section 7001)* allotted funds to eliminate the remainder of CHIP funding shortfalls.
- *Continuing Resolutions (P.L. 110-92, Section 106; P.L. 110-116, Section 101; P.L. 110-137; and P.L. 110-149)* authorized FY2008 CHIP allotments through the specified termination dates (respectively, November 16, December 14, December 21, and December 31, 2007).
- *MMSEA (Section 201)* made the FY2008 allotments available through March 31, 2009, and it also authorized FY2009 allotments through March 31, 2009.
- *CHIPRA (Section 102)* authorized CHIP allotments for FY2009 through FY2013.
- *ACA (Section 2101 as modified by Section 10203(d))* extended the authorization for CHIP allotments through FY2015.

Current Status: CHIP allotments are authorized through FY2015.

CHIP Child Enrollment Contingency Funds (SSA Section 2104(n))

If a state's CHIP allotment for the current year, in addition to any allotment funds carried over from the prior year, is insufficient to cover the projected CHIP expenditures for the current year, a

few different shortfall funding sources are potentially available. These include Child Enrollment Contingency Fund payments, redistribution funds, and Medicaid funds. For FY2009 through FY2015, Child Enrollment Contingency Fund payments have been available to states with both a funding shortfall (i.e., current year CHIP allotment plus any unused CHIP allotment funds from the previous year are insufficient to cover the federal share of the state's CHIP program) and CHIP enrollment for children exceeding a target level. As a result, not all states with funding shortfalls are eligible for Child Enrollment Contingency Fund payments. The contingency fund payments are based on a state's growth in CHIP enrollment and per capita spending. This means that a state may receive a payment from the fund that does not equal its actual shortfall in CHIP funding.

- *CHIPRA (Section 103)* established the Child Enrollment Contingency Fund.
- *ACA (Section 2101 as modified by Section 10203(d))* extended the authority for the Child Enrollment Contingency Fund through FY2015.

Current Status: CHIP Child Enrollment Contingency Fund payments are authorized through September 30, 2015.

CHIP Qualifying State Option (SSA Section 2105 (g)(4))

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, certain states significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997. These states are allowed to use their CHIP allotment funds to fund the difference between the Medicaid and CHIP matching rates (i.e., federal medical assistance percentage [FMAP] and enhanced federal medical assistance percentage [E-FMAP] rates, respectively) to finance the cost for children in Medicaid above 133% FPL. The following 11 states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. This is referred to as the "qualifying state" option, and FY2015 is the last year the qualifying state option is authorized.

- *State Children's Health Insurance Program Allotments Extension Act (Section 1(b))* added the authority for qualifying states to use certain funds for Medicaid expenditures.
- *Technical Corrections with Respect to the Definition of Qualifying State* changed the income standard and applicable dates for the "qualifying state" option.
- *DRA (Section 6103)* continued authority for qualifying states to use available FY2001, FY2004, and FY2005 CHIP funds for certain Medicaid expenditures.
- *National Institutes of Health Reform Act of 2006 (Section 201(b))* continued authority for qualifying states to use any available FY2006 and FY2007 CHIP funds for certain Medicaid expenditures.
- *Continuing Resolutions (P.L. 110-92, Section 106; P.L. 110-116, Section 101; P.L. 110-137; and P.L. 110-149)* permitted the use of FY2008 allotments for expenditures allowed for qualifying states under Section 2105(g), through the specified termination dates.
- *MMSEA (Section 201)* made permanent to use qualifying states' FY2008 allotments for expenditures under Section 2105(g), as initially permitted under the continuing resolutions. Qualifying states' ability to use FY2009 allotments under Section 2105(g) was permitted through March 31, 2009.
- *CHIPRA (Section 107)* allowed qualifying states to use CHIP allotments for FY2009 through FY2013 for certain Medicaid expenditures.

- *ACA (Section 2101 as modified by Section 10203(d))* extended the authorization for the qualifying state option through FY2015.

Current Status: The qualifying state option is authorized through September 30, 2015.

CHIP Outreach and Enrollment Grants (SSA Sections 2113(a)(1) and 2113(g))

CHIPRA authorized $100 million in outreach and enrollment grants in addition to the regular CHIP allotments for fiscal years 2009 through 2013. Ten percent of the allocation is directed to a national enrollment campaign, and 10% is targeted to outreach for Native American children. The remaining 80% is distributed among state and local governments and to community-based organizations for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds are also targeted to proposals that address cultural and linguistic barriers to enrollment.

- ACA (§10203(d)(2)(E)) appropriated $140 million for the period of FY2009 through FY2015 for CHIP outreach and enrollment grants.

Current status: Authority for CHIP outreach and enrollment grants will expire after September 30, 2015.

CHIPRA Children's Health Care Quality Measures (SSA Section 1139A(i))

See "Adult Quality Measures (SSA Section 1139B(e))" and "CHIPRA Children's Health Care Quality Measures (SSA Section 1139A(i))," above.

Public Health Service Act Expiring Provisions

Community Health Center Fund (PHSA Section 330)

The ACA created the Community Health Center Fund (CHCF) that provided mandatory funding for federal health centers authorized in PHSA Section 330.[15] These centers are located in medically underserved areas and provide primary care, dental care, and other health and supportive services to individuals regardless of their ability to pay.

- *ACA (Section 10503 as amended by HCERA 2303)* appropriated a total of $9.5 billion from FY2011 through FY2015 annually as follows: $1 billion for FY2011; $1.2 billion for FY2012; $1.5 billion for FY2013; $2.2 billion for FY2014; and $3.6 billion for FY2015. Funds are to remain available until expended. ACA also appropriates $1.5 billion for health center construction and renovation for the period FY2011 through FY2015, to remain available until expended.

Current Status: Funding for the Community Health Center Fund is appropriated through FY2015. Funds transferred will remain available until expended.

[15] For more information on health centers, see CRS Report R42433, *Federal Health Centers*.

Special Diabetes Programs (PHSA Sections 330B and 330C)

The BBA97 authorized two diabetes-related programs within the PHSA. The first, authorized in Section 330B, provides funding for the National Institutes of Health[16] to award grants for research into the prevention and cure of Type I diabetes. The second, authorized in Section 330C, provided funding for the Indian Health Service (IHS)[17] to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities.[18]

- *BBA97* (*Sections 4921 and 4922*) transferred $30 million from CHIP funds to each of these programs from FY1998 through FY2002.
- *BIPPA* (*Section 931*) increased each program's annual appropriation to $70 million for FY2001 through FY2002 and appropriated $100 million for FY2003.
- *P.L. 107-360 (Section 1*) increased each program's annual appropriation to $150 million and appropriated funds from FY2004 through FY2008.
- *MMSEA* (*Section 302*) extended each program's annual appropriation of $150 million through FY2009.
- *MIPPA (Section 302)* extended each program's annual appropriation of $150 million through FY2011.
- *MMEA* (*Section 112*) extended each program's annual appropriation of $150 million through FY2013.
- *ATRA* (*Section 625*) extended each program's annual appropriation of $150 million through FY2014.
- *PAMA (Section 204)* extended each program's annual appropriation of $150 million through FY2015.

Current Status: Funding for the two PHSA diabetes-related programs will expire on September 30, 2015.

National Health Service Corps Appropriations (PHSA Section 338H)

The ACA created the Community Health Center Fund that provided mandatory funding for the National Health Service Corps (NHSC), authorized in Title III of the PHSA, which provides scholarships and loan repayments to certain health professionals in exchange for providing care in a health professional shortage area for a period of time that varies based on the length of the scholarship or the number of years of loan repayment received.

- *ACA (Section 10503 as amended by HCERA 2303)* appropriated $1.50 billion to support the National Health Service Corps from FY2011 through FY2015 annually as follows: $290 million for FY2011; $295 million for FY2012; $300 million for FY2013; $305 million for FY2014; and $310 million for FY2015. Funds are to remain available until expended.

[16] For more information on the National Institutes of Health, see CRS Report R41705, *The National Institutes of Health (NIH): Background and Congressional Issues*.

[17] For more information on the Indian Health Service, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[18] IHS-funded facilities refer to facilities operated directly by the IHS, by an Indian Tribe, a Tribal Organization, or an Urban Indian Organization as these terms are defined in §4 of the Indian Health Care Improvement Act (25 U.S.C. §1604).

Current Status: Funding for the National Health Service Corp is appropriated through FY2015. Funds transferred will remain available until expended.

Teaching Health Centers (PHSA Section 340H)

The ACA Section 5508(c) created PHSA Section 340H, which required the Secretary to make direct and indirect Graduate Medical Education payments to qualified teaching health centers.

- ACA *(Section 5508(a))* appropriated $230 million in direct and indirect Graduate Medical Education payments for the period of FY2011 through FY2015.

Current Status: Funding for direct and indirect Graduate Medical Education payments to teaching health centers has been provided through September 30, 2015.

Private Health Insurance Expiring Provisions

Federal Grants for Health Insurance Exchanges (ACA Section 1311(a))

The ACA authorizes grants to states for the planning and establishment of health insurance exchanges. Exchanges are marketplaces where individuals and small businesses can "shop" for health insurance sold by private insurance companies. The ACA provides an indefinite appropriation for the exchange grants. For each fiscal year, the HHS Secretary is to determine the total amount that will be made available to each state for exchange grants.

Current status: Authority for the exchange grants terminated after December 31, 2014. However, states may continue to use the grant funding they previously received for exchange design and implementation in 2015 and beyond.

Expired Provisions

The following provisions have expiration dates on or before December 31, 2013, and were not addressed in any subsequent legislation.

Maintenance of Effort for Adults (SSA Section 1902(gg)(1))

The ACA included maintenance of effort (MOE) provisions under which states were required to maintain their Medicaid programs for adults with no more restrictive eligibility standards, methodologies, and procedures until the exchanges were operational (i.e., through December 31, 2013), and for Medicaid-eligible children up to the age of 19 until September 30, 2019. Failure to comply with the ACA MOE requirements means a state loses all of its federal Medicaid matching funds.

Current Status: The ACA adult MOE requirement expired December 31, 2013.

Medicaid Disproportionate Share Hospital Allotment for Tennessee (SSA Section 1923(f)(6)(A)(v)(II))

The Medicaid statute requires that states make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. While most federal Medicaid funding is provided on an open-ended basis, federal DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds a state is permitted to claim for Medicaid DSH payments. States' Medicaid DSH allotments are based on each state's

prior year DSH allotment, but Hawaii and Tennessee have special statutory arrangements for the determination of their respective DSH allotments provided through multiple laws. Most recently, the ACA provided Hawaii a Medicaid DSH allotment for FY2012 and subsequent years, and the Tennessee provision provided an allotment for FY2012 and FY2013.

- *TRHCA (Section 404)* established a Medicaid DSH allotment for FY2007 for Tennessee.
- *MMSEA (Section 204)* extended the Medicaid DSH allotment for Tennessee through June 30, 2008.
- *MIPPA (Section 202)* extended the Medicaid DSH allotment for Tennessee through the end of FY2008, FY2009, and for the first calendar quarter of FY2010.
- *CHIPRA (Section 616)* extended the Medicaid DSH allotment for Tennessee through the end of FY2010, FY2011, and for the first calendar quarter of FY2012.
- *ACA (Section 2551 as modified by Section 10201(e) and Section 1203 of HCERA)* extended the Medicaid DSH allotment for Tennessee set Tennessee's Medicaid DSH allotment through the end of FY2012 and FY2013.

Current Status: For FY2014 and subsequent years, Tennessee is the only state without a Medicaid DSH allotment.

CHIPRA Performance Bonus Payments (SSA Section 2105(a)(3))

CHIPRA established performance bonus payments for states that increase their Medicaid (not CHIP) enrollment among low-income children above a defined baseline. From FY2009 through FY2013, performance bonus payments were available to states. To qualify for bonus payments, states had to have (1) implemented five out of eight specified enrollment and retention provisions and (2) achieved state-specific targets for increasing Medicaid enrollment among children. There were two tiers of bonus payments depending on how much the state's enrollment exceeded the baseline. From FY2009 through FY2013, 27 states received CHIPRA performance bonus payments totaling $1.1 billion over the five years. Some states received payments in more than one year.

- *CHIPRA (Section 104)* established performance bonus payments for FY2009 through FY2013.

Current Status: CHIPRA performance bonus payments were authorized through FY2013.

CHIP Federal Matching Funds for Parent Coverage Waivers (SSA Section 2111(b)(2)(A))

In the early years of the CHIP program, states were permitted and encouraged to extend CHIP coverage to uninsured pregnant women, parents, and childless adults aged 19 and older generally through the use of the Section 1115 waiver authority. However, Congress acted to largely limit this practice through a series of laws. The DRA prohibited the use of CHIP funds from coverage of non-pregnant childless adults in any *new* waivers approved after February 8, 2006. CHIPRA terminated CHIP coverage of non-pregnant childless adults by the end of calendar year 2009, prohibited *new* states from obtaining waivers to extend CHIP coverage to uninsured parents, and phased out coverage of parents altogether by FY2014.

Current Status: The authority for states to use CHIP federal matching funds for parent coverage waivers expired September 30, 2013.

School-Based Health Center Funding (ACA 4101(a))

ACA directly appropriated funding to support construction and renovation of school-based health centers. The ACA appropriated $50 million for each of FY2010 through FY2013 for a total of $200 million.

Current status: No funding was appropriated in FY2014 or in F2015 as of the publication date of this report.

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