The American Recovery and Reinvestment Act of 2009 and Medicaid
Compiled by the National Health Law Program, March 27, 2009

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5. ARRA is a nearly $790 billion spending and tax cut package aimed at stimulating the sagging economy. This paper discusses the provisions of ARRA that affect:

- Public and private insurance extensions for the unemployed (ARRA, Division B § 2002 and § 3001);
- Medicaid/Children's Health Insurance Program (ARRA, Division B, §§ 5000 – 5008); and
- Health information technology (ARRA, Division B, § 4201 and Division A, §§ 13101 - 13424).

The full text of the bill is available at: http://www.recovery.gov. Legislative history is available at http://appropriations.house.gov (Joint Explanatory Statement of the Committee of Conference). Text and history are also available at http://thomas.loc.gov.

Public and Private Insurance Extensions for the Unemployed

Emergency Unemployment Compensation Benefits, Medicaid Disregard—Section 2002.

Previous law enacted in 2008 extended unemployment insurance benefits through March 31, 2009 in recognition of the current economic climate and the difficulty that many job seekers are having in finding employment. Section 2002 of ARRA extends these "emergency" unemployment insurance benefits through December 31, 2009. The federal government assumes the cost of the extension. Beneficiaries will receive extended benefits at their current rates plus an additional $25 per week.

ARRA clarifies that the unemployment compensation paid under this section shall be *disregarded* when determining Medicaid or CHIP income eligibility. *See* ARRA, § 2002(h).

Premium Assistance for COBRA Benefits—Section 3001.

Most individuals who leave the workplace are eligible for "COBRA" coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended portions of the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code, and the Public Health Service Act to allow a person to continue employment-based group health insurance at his own expense after leaving employment for reasons other than gross misconduct. When the employee leaves the employment or when certain other "qualifying events" occur, the employer is required to provide the employee with notice of the right to continued health

coverage under the employer's plan. The former employee generally has 60 days to elect COBRA coverage. Both the former employee's own insurance and that of certain dependents can be continued for at least 18 months.

For most people leaving employment without new employment, exercising COBRA coverage has been a financial impossibility. The continued coverage is premised upon the individual paying the entire health insurance premium, plus an allowable two percent administrative fee. This is simply not financially feasible for many people. Many will not qualify for Medicaid coverage and, thus, are uninsured. If they remain uninsured for more than 63 days, the next employer's group health insurance may apply a pre-existing condition clause and deny coverage for medical expenses related to a pre-existing condition.

ARRA seeks to ameliorate the situation in this current economic crisis by providing an opportunity for individuals and families to continue group health insurance coverage after an insured worker loses his job. Group health coverage includes coverage provided by a former employer, a union or a multiemployer trust. *See* ARRA, § 3001(a)(1)(B).

Under the premium assistance provisions of ARRA, a person who is an "assistance eligible individual" need only pay 35 percent of the premium, which she would otherwise need to pay to obtain COBRA coverage. *Id.* at § 3001(a)(1)(A). Employers receive the other 65 percent of the premium in the form of a credit or refund of payroll taxes. *Id.* (adding 26 U.S.C. § 6432(c)(1)). The reduced premium payment applies to premiums for a period of coverage beginning on or after February 17, 2009, the date of ARRA's enactment. While ARRA discusses notice requirements, it does not require that a person receive notice before exercising her right to pay the reduced premium. Under the plain wording of ARRA, an eligible person could simply pay 35 percent of the premium amount on March 1 for the March health insurance premium, and she would be deemed to have paid the entire premium amount for the month. Alternatively, another person, other than the employer, may pay this amount on the COBRA beneficiary's behalf. *Id.* Note that the 35 percent amount pertains to the total amount of the premium. ARRA does not discuss payment of the two percent administrative fee that the employer may charge the individual. Presumably, this fee would need to be paid by the individual in addition to the 35 percent of the normal premium amount.

Premium assistance is available for up to nine months of extended coverage. *See* ARRA, § 3001(a)(2)(A)(ii). Premium assistance ends sooner if a person becomes eligible for other group coverage or if the individual's coverage reaches the time limits under COBRA. *Id.* Since the period of coverage, according to ARRA, must begin on or after the date of enactment, the subsidy could not be applied retroactively or to a premium, which covers a period of time prior to February 17, 2009 and extends beyond that date.

An "assistance eligible individual" is a person who was involuntarily terminated from her employment between September 1, 2008 and December 31, 2009, and who is eligible for and elects COBRA continuation coverage. ARRA, § 3001(a)(3). The continuation coverage is not available to an individual who has voluntarily left employment or became eligible through a qualifying event other than involuntary termination. If the individual did not elect COBRA

coverage when it was first offered and the election period has run out, she can still take advantage of a new COBRA election period. *See* ARRA, § 3001(a)(4)(A). This new election period begins on February 17, 2009 and runs until 60 days after the individual receives notice of the new election period. *Id.* However, if the individual exercises COBRA coverage under this new election period, she can only get coverage beginning on or after February 17, 2009, and the COBRA coverage will last only as long as it would have had she elected COBRA coverage when she first became eligible. *Id.*

The new election period will require a new COBRA notice, and the Secretary of Labor is directed to prescribe a model notice by March 19, 2009. ARRA, § 3001(a)(7). Any COBRA notice issued between September 1, 2008 and December 31, 2009 that does not explain the availability of the premium reduction and the option to enroll in different coverage (if the employer permits this), is considered inadequate notice. The revised or additional notice must include forms for establishing eligibility for premium assistance, contact information for the plan administrator or other person regarding the premium assistance, a description of the extended election period, the beneficiary's obligation to notify the administrator of the beneficiary's eligibility for new group health coverage or Medicare, and any description of the option to enroll in another plan offered by the employer. *Id.*

For people who were entitled to elect COBRA prior to enactment, group health plan administrators must provide notice of the new election period within 60 days of enactment. *Id.* If the notice is not issued in a timely manner, the individual's right to elect the coverage begins with enactment of the legislation and ends 60 days after receiving the notice; thus, a late notice lengthens, rather than shortens, the individual's election period. ARRA, § 3001(a)(4)(A), (a)(7)(C). However, if an individual has not enrolled in COBRA coverage to which he was entitled prior to February 17, 2009, under ARRA he can only begin his COBRA coverage with the first period of coverage after enactment, and the continuation coverage can continue only as long as the COBRA coverage would have continued had he elected the continuation coverage when it became available before enactment. *Id.* at § 3001(a)(4)(B).

COBRA premium assistance is available to people of all income levels. For low-income people who may be receiving public benefits, ARRA specifically excludes the premium assistance from consideration as income or a resource under any federal, state, or local program. ARRA, § 3001(a)(6). Thus, the subsidy is completely exempt from consideration for Medicaid eligibility and should have no effect on the amount of TANF or other benefits that an individual or family is entitled to receive. For Medicaid beneficiaries, there should be no need to report the amount of the subsidy, since it has no bearing on eligibility; however, if a beneficiary elects COBRA coverage, as with any other private insurance, she must report the additional coverage to the state Medicaid agency because Medicaid is a secondary payer to other insurance. *See* 42 U.S.C. § 1396a(a)(25). For individuals with income above $125,000, or $250,000 if filing jointly, premium assistance is also available, but the premium subsidies will be recouped from these individuals through their federal income taxes. ARRA, § 3001 (adding 26 U.S.C. § 139C(b)(1)).

Moreover, if the employer offers health insurance options other than the one in which the assistance eligible individual was enrolled and the premium costs the same or less, the employer can agree to allow the individual to enroll in the other health plan. Individuals would need to elect this option, if available, within 90 days of receiving the new COBRA notice. *See* ARRA, § 3001(a)(1)(B). However, the other plan option cannot be a flexible spending arrangement, coverage at an on-site medical facility maintained by the employer, or coverage that only covers dental, vision, counseling, or referral services (or any combination of those services). *Id.* This provision could be beneficial to individuals who had more expensive coverage while employed, but in order to stay insured at a more reasonable price, choose to switch to less expensive, yet still useful and comprehensive health coverage.

Individuals who use the COBRA premium assistance subsidy also receive additional protection from application of pre-existing condition exclusions. ARRA, § 3001(a)(4)(C). Currently, an individual who loses group health insurance and obtains new group health insurance within 63 days is protected from application of pre-existing condition exclusions in the new group health insurance policy. ARRA essentially adds the time from the qualifying event, i.e. the involuntary termination, until the end of the coverage allowed under ARRA to the 63-day period. Thus, even if an individual did not elect COBRA coverage when it first became available but does elect COBRA coverage under ARRA, at the end of his coverage period, he would have a new 63-day period in which to obtain new insurance without the application of a pre-existing condition exclusion.

Finally, if a group health plan denies an individual's request to be treated as eligible for the COBRA premium assistance made available through ARRA, the individual is entitled to an expedited review of the denial. ARRA, § 3001(a)(5). The appeal is made to the Secretary of Labor, or in the case of non-ERISA plans, to the Secretary of Health and Human Services. The appropriate Secretary must make a *de novo* determination within 15 business days of receipt of the request for review. That determination may be appealed, though the court must grant deference to the Secretary's determination. *Id.*

Medicaid State Fiscal Relief

Title V of ARRA concerns Medicaid. Besides providing "fiscal relief to States in a period of economic downturn[,]" the Medicaid funding authorized by ARRA should serve to "protect and maintain State Medicaid programs …, 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." ARRA, § 5000.

While there are a number of Medicaid provisions in ARRA, the House of Representatives included a couple of provisions in its bill, H.R. 1, that were not included in the final bill: (1) a temporary option allowing states to extend Medicaid coverage to certain unemployed and uninsured adults and their dependents, with a 100 percent federal match; and (2) an option

allowing states to extend Medicaid coverage of family planning services to women who would otherwise not qualify.

Temporary Increase in Medicaid FMAP and Maintenance of Effort—Section 5001.

Medicaid FMAP Increases

The Federal Medical Assistance Percentage (FMAP) is a federal payment to the state for Medicaid services covered by the state. The amount of the state's FMAP is adjusted annually and depends on the per capita income of the state. States with lower per capita incomes receive a higher FMAP, which can range from 50 percent to 83 percent. *See* 42 U..S.C. § 1396b(a).

ARRA augments states' FMAPs for a "recession adjustment period" from October 1, 2008 through December 31, 2010. ARRA, § 5001. The increased FMAP only applies to Medicaid-covered items and services furnished through calendar year 2010. *Id.* at § 5001(i). States must report to the Secretary of the Department of Health and Human Services (DHHS) on how the increased FMAP funds were expended by the end of September 2011. *Id.* at § 5001(g)(1).

The FMAP increases will be determined by a complicated, three-tiered analysis. Importantly, this formula is tied to the unemployment rates in the states. States with the highest unemployment rates should see the most significant boosts in FMAP during the recession adjustment period.

Basically, the first step is a "hold harmless" provision that maintains the base FMAP rates at levels no lower than the state's 2008 rates. For fiscal year 2009 and each subsequent fiscal year through December 2010, the base FMAP rate can be no lower than previous years' FMAP rate. ARRA, § 5001(a). Thus, if the state's FMAP was scheduled to decrease in fiscal year 2009, that state will receive its 2008 rate. If the state's FMAP for fiscal year 2010 would be less than the FMAP as determined for FY 2008 or 2009, they will receive the highest FMAP determined for the three-year period.

In the second step, each state receives a general 6.2 percent FMAP increase on top of the base rate calculated during step one. *Id.* at § 5001(b)(1). Thus, if after application of the first step, the state's FMAP is 60 percent, that state will receive a 63.72 percent FMAP rate (60% x .062=63.72%). Territories, whose FMAP is normally set at 50 percent, may chose to take this increase plus an additional 15 percent or a flat 30 percent increase with certain conditions. Territories are not eligible for the third tier of FMAP increases. *Id.* at §§ 5001(b)(2),(c)(2)(d).

In the third step, states experiencing severe economic downturns are eligible for additional FMAP—5.5 percent, 8.5 percent or 11.5 percent, depending on the extent to which the unemployment rate increases during a quarter. If a state's unemployment rate increases at a lower rate than in a previous quarter, the state nevertheless remains eligible for the higher FMAP increase rate through June 2010. *Id. at* § 5001(c). And while the FMAP increases are cumulative, together they cannot exceed 100 percent. *Id.* at § 5001(b)(1), (c)(1), (f)(5).

The increased FMAP does not apply to Medicaid payments attributable to:

- Disproportionate share hospital (DSH) payments;
- TANF payments, except to Title IV-E foster care and adoption assistance payments;
- Enhanced FMAP payments for CHIP;
- Services for beneficiaries eligible for Medicaid under the breast and cervical cancer treatment option, *See* 42 U.S.C. §§ 1397ee(b), 1396d(b);
- Expenditures for individuals made eligible through income eligibility expansions after July 1, 2008, including such expenditures when made under a state plan, any waiver under Title XIX, or under Section 1115 of the Social Security Act. This includes higher eligibility standards under a state law that was enacted but not effective as of July 1, 2008 or a state plan amendment or Title XIX waiver request pending approval on July 1, 2008.

ARRA, § 5001(e)

States will not receive the enhanced FMAP if they do not pay providers promptly as current Medicaid law requires. Under Medicaid, states must ensure that 90 percent of completed claims are paid within 30 days of receipt; 99 percent, within 90 days of receipt. *See* 42 U.S.C. § 1396a(a)(37)(A). To be eligible for the increased FMAP, a state must be in compliance with this law for claims made for most covered services after February 17, 2009. However, for purposes of the increased FMAP, states have until June 1, 2009 to have prompt payments in place for nursing facility and hospital claims. *See* ARRA, § 5001(f)(2). This requirement is the only prerequisite to obtaining the increased FMAP, which the Secretary may waive, and then only in exigent circumstances.

States may not shift the cost of Medicaid expenditures onto cities and counties and still claim the increased FMAP. If a state requires cities or counties to contribute toward the non-federal portion of Medicaid expenditures, the state is not entitled to the increased FMAP if it has increased the cities' or counties' share after September 30, 2008. ARRA, § 5001(g)(2).

ARRA's clear intent is to assist states with maintaining their Medicaid programs as those programs were in effect on July 1, 2008. This is further emphasized by a provision that denies increased FMAP if any amounts attributable, directly or indirectly, to the increased FMAP are deposited or credited into any reserve or rainy day fund of the state. ARRA, § 5001(f)(3). Please contact NHeLP if you learn of any abuses of this provision or of instances where your state is using the enhanced FMAP for non-Medicaid purposes, such as highway, prison or other infrastructure projects.

State Maintenance of Effort Requirements

The enhanced FMAP period runs from October 1, 2008 through December 31, 2010. However, to qualify for any enhanced FMAP, states and territories must maintain the "eligibility standards, methodologies, and procedures" in effect on July 1, 2008. ARRA, § 5001(f)(1)(A). The Secretary of DHHS cannot waive this provision. *Id.* at § 5001(f)(4).

ARRA provides a grace period for states that have recently enacted restrictive provisions. If a state has implemented more restrictive eligibility standards, methodologies or procedures after July 1, 2008 but before February 17, 2009 (the date of ARRA's enactment), it has until July 1, 2009 to return to the July 1, 2008 standards. If it makes this change, the state can obtain the full increased FMAP for expenditures back to October 1, 2008. *Id.* at § 5001(f)(1)(C). If a state otherwise reinstates eligibility standards as they were on July 1, 2008, the state becomes eligible for the full increased FMAP beginning in the quarter in which the state has reinstated eligibility. *Id.* at § 5001(f)(1)(B).

States have an incentive to reinstate coverage as soon as possible in order to obtain the increased FMAP payments at the earliest possible date. Indeed, four states initially cited by DHHS as not qualifying for the enhanced FMAP due to post July 2008 restrictions (NC, SC, MS, VA) have already taken the steps needed to reinstate coverage. Department of Health & Human Services, *American Recovery and Reinvestment Act (PL 111-5) Sec. 5001 Grant Award Summary*, at http://hhs.gov/recovery/statefunds.html (accessed March 8, 2009).

Application to Medicaid. The maintenance of effort requirement applies to Medicaid standards, methodologies and procedures, including under any waiver under Title XIX or under Section 1115 of the Social Security Act. *Id.* Thus, the requirement applies to managed care and home and community-based services waivers approved under Section 1915 of the Social Security Act (42 U.S.C. §§ 1396n) and to all demonstration projects operating pursuant to any authority under Section 1115 of the Social Security Act (42 U.S.C. § 1315).

The "in effect" requirement. The requirement applies to eligibility standards, methodologies, or procedures "in effect" on July 1, 2008. Thus, ARRA is worded to include requirements contained in state statute; Medicaid agency regulation, written policy or practice; and binding court orders or consent/settlement agreements.

Eligibility standards, methodologies and procedures. Finally, the requirement applies to "eligibility standards, methodologies, and procedures" in effect on July 1, 2008. The outer parameters of this phrase await clarification from DHHS. Meanwhile, the provision must be read in conjunction with the purpose of ARRA. That purpose is 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*." ARRA, § 5000 (emphasis added). When assessing state cutbacks against the maintenance of effort provision, the following are examples eligibility standards, methodologies, and procedures:

- Categorically and/or medically needy options selected by the state, for example non-institutionalized disabled children (Katie Beckett), women with breast and cervical cancer, medically needy;
- Income eligibility cut offs, such as the percentages of the federal poverty level at which the state covers children, pregnant women, and/or the aged, blind and disabled;
- Medically needy income levels;

- State definitions of disability;
- Countable income and income disregards when determining financial eligibility;
- Countable resources and resource disregards when determining financial eligibility;
- Exemptions of property for estate recovery purposes,
- Medically needy spend down periods;
- Look back periods for purposes of assessing transfers of assets;
- Income and resource protections used to determine eligibility of an institutionalized spouse (spousal impoverishment provisions);
- The number of waiver slots in a Medicaid home and community based care waiver;
- Individual verses aggregate cost neutrality caps in home and community based waivers under Title XIX;
- Premiums and other cost sharing levels;
- Continuous eligibility periods, such as 12-months' continuous eligibility for children regardless of changes in income;.
- Mail-in and/or face-to-face interviews;
- Outstationing locations for accepting and processing applications;
- Timeframes for making eligibility determinations and redeterminations;
- Qualifying entities for purposes of making presumptive eligibility determinations.

A pressing question involves changes in the amount, duration and scope of covered services that also affect eligibility. For example, some states use assessment tools to determine individuals' limitations in activities of daily living, and the scoring of those assessment tools, in turn, determines their level of care needs and Medicaid coverage. By altering the scoring methodology, a state can make fewer people eligible for institutional care and/or home and community based waivers. Such changes would presumably violate the maintenance of effort requirement.

If your state is considering implementing a Medicaid policy that is more restrictive than its July 1, 2008 rules, please contact us. In particular, we understand that members of Congress are monitoring the extent to which states are proposing service cutbacks. Please contact us if service cutbacks are being proposed or implemented. We are also interested in hearing from advocates in states that may obtain enhanced FMAP but use it for non-Medicaid purposes, i.e. on highways or other infrastructure projects. Close monitoring by advocates will help ensure accurate reporting by states, which must report to the Secretary of the Department of Health and Human Services on how the increased FMAP funds were expended by the end of September 2011. *See* ARRA, § 5001(g)(1).

Temporary Increase in DSH Allotments—Section 5002.

The Medicaid Act requires states to make Medicaid payment adjustments for hospitals that serve a disproportionate number of low-income patients with special needs. This is called the disproportionate share hospital (DSH) payment. *See* 42 U.S.C. § 1396a(a)(13)(A)(iv). The Act also includes state-specific limits on annual federal DSH allotments and hospital-specific limits on DSH payments. *See* 42 U.S.C. § 1396r-4. DSH allotments that most states receive

from the federal government will not exceed the greater of the DSH allotment for the previous year or 12 percent of the total amount of expenditures under the state Medicaid plan during the fiscal year. *See* 42 U.S.C. § 1396r-4(f)(3). State Medicaid agencies allocate the DSH allotment to qualifying hospitals.

ARRA temporarily increases DSH allotments to states for fiscal years 2009 and 2010. *See* ARRA, § 5002. For fiscal year 2009, states will get 102 percent of their DSH allotment. *Id.* (adding/amending 42 U.S.C. § 1396r-4(f)(3)(E)(i)(I)). For fiscal year 2010, states will receive 102 percent of what they received in 2009. *Id. See* Children's Health Insurance Program Reauthorization Act of 2009, § 616 (discussing DSH allotments for Hawaii and Tennessee).

Extension of Moratoria on Certain Medicaid Final Regulations—Section 5003.

During its last two years, the Bush administration issued a number of controversial Medicaid regulations that would reduce federal Medicaid spending and shift these costs to states, health care providers, or individuals. These rules affected a range of Medicaid services, particularly outpatient and ambulatory services. These regulations were controversial. Prior to the enactment of ARRA, Congress had imposed moratoria that would expire on April 1, 2009.

ARRA extends until July 1, 2009 the moratoria on three regulations that the previous administration had attempted to finalize, regarding: (1) optional case management services, 72 Fed. Reg. 68,077 (Dec. 4, 2007) (interim final rule with comment period); (2) allowable provider taxes, 73 Fed. Reg.9685 (Feb. 22, 2008) (final rule); and (3) cost claiming and transportation for school-based services, 72 Fed. Reg.73,635 (Dec. 28, 2007) (final rule).

ARRA establishes a new moratorium, until June 30, 2009, prohibiting the Secretary of DHHS from taking any action to implement a regulation relating to the definition of outpatient hospital facility services, 73 Fed. Reg. 66,187 (Nov. 7, 2008) (final rule).

ARRA includes a "sense of Congress" statement that the Secretary of DHHS should withdraw proposed regulations affecting: (1) rehabilitative services, 72 Fed. Reg. 45,201 (Aug. 13, 2007); (2) payments for graduate medical education, 72 Fed. Reg. 28,930 (May 23, 2007); and (3) cost limits for public providers, *See* 72 Fed. Reg. 2,236 (Jan. 18, 2007) (proposed) and 72 Fed. Reg. 29748 (May 29, 2007) (purported final rule with comment period); *but See Alameda Co. Med. Ctr. v. Leavitt*, 559 F. Supp. 2d 1 (D.D.C. 2008) (holding Secretary of DHHS violated moratorium and improperly promulgated May 29 regulation).

Extension of Transitional Medical Assistance—Section 5004.

Transitional medical assistance (TMA) provides extended Medicaid coverage for families that would otherwise lose coverage because of changes in income. *See* 42 U.S.C. § 1396a(e) (added by the Child Support Amendments of 1984 and made permanent by the Omnibus Budget Reconciliation Act of 1989 and requiring four-month extended benefits for families losing Medicaid because of increased child or spousal support or employment), 1396r-6 (added by the Family Support Act of 1988 and providing for extended work-related TMA). When Congress

enacted § 1396r-6, with its more generous transition benefit, it included a sunset provision. As a result, Congress did not repeal § 1396a(e) but rather suspended its operation for as long as § 1396r-6 remains in effect. The original sunset date for § 1396r-6 has long since passed, but Congress has continued to reauthorize its operation for varying lengths of time. In ARRA, Congress has extended the TMA provisions through December 31, 2010. *See* ARRA, § 5004(a) (effective July 1, 2009) (amending 42 U.S.C. § 1396r-6(f)).

Congress has also included important new options to make administration of TMA under § 1396r-6 easier for the states. Currently, states must extend Medicaid for families who were receiving welfare and Medicaid in at least three of the six months immediately preceding the month in which the family became ineligible because of increased hours of, or income from, employment. *Id.* at § 1396r-6(a); *see Kai v. Ross*, 336 F.3d 650 (8th Cir. 2003). States must also notify families and offer the option of six additional months of Medicaid coverage (for a total of up to 12 months) to families who received TMA during the entire initial six-month period. *Id.* at § 1396r-6(b). These families must make periodic earnings reports and may have to pay premiums. States can also exclude coverage of many non-acute benefits. *Id.* States must send periodic notices to families during the extended coverage period that explain earnings reporting requirements and premium payments. *Id.*

ARRA allows States to treat any reference in § 1396r-6(a) to the six-month period as a reference to a 12-month period. ARRA, § 5004(b) (effective July 1, 2009) (to be enacted as 42 U.S.C. § 1396r-6(a)(5)). In states selecting this option, subsection (b) will not apply. States are also given a new option to extend TMA to families who received public assistance for fewer than three months during the six immediately preceding months. *See* ARRA, § 5004(c) (amending 42 U.S.C. § 1396r-6(a)).

Finally, ARRA adds a new reporting provision that requires each state to collect and report to the Secretary of DHHS information on average TMA enrollment and participation rates for adults and children, including information on those who become ineligible for TMA whose Medicaid coverage is continued under another eligibility category or who are enrolled in CHIP. The Secretary must use this information in annual reports to Congress concerning enrollment and participation. *See* ARRA, § 5004(d) (effective July 1, 2009) (adding 42 U.S.C. § 1396r-6(g)).

Extension of the Qualifying Individual (QI) Program—Section 5005.

ARRA Section 5005 authorizes states to provide an additional year of Medicaid coverage for Qualifying Individuals (QIs) and appropriates more funds than were allocated for this purpose in 2009.

States are required to provide Medicaid coverage to certain Medicare beneficiaries to pay for their Medicare premiums, deductibles, and co-payments. These Medicare beneficiaries have resources that do not exceed twice the SSI resource eligibility standard and family incomes below a certain level. Qualified Medicare Beneficiaries (QMBs) have incomes at or below 100 percent of the federal poverty level (FPL) and Specified Low Income Beneficiaries (SLMBs) have incomes under 120 percent of FPL. *See* 42 U.S.C. §§ 1396a(a)(10)(E)(i), (iii), 1396d(p)(1)-

(4). Congress has also established an additional category known as Qualifying Individuals (QIs), consisting of beneficiaries who would otherwise be considered QMBs but have higher incomes. 42 U.S.C. § 1396a(a)(10)(E)(iv). States must cover the Medicare Part B premiums for QIs with family incomes of at least 120 but less than 135 percent of FPL. Unlike QMBs and SLMBs, however, states are allocated a capped amount of funding for QIs for the fiscal year. *See* 42 U.S.C. § 1396a(a)(10)(E)(iv). QIs are selected on a first-come, first-served basis. *Id.* at § 1396u-3(b)(2). Current law allocated funding to cover QIs only through December 31, 2009.

ARRA allocates funding to provide coverage for QIs through December 31, 2010. ARRA, § 5005(b). The new legislation allocates $412.5 million (rather than the original allocation of $350 million) for the period of January 1, 2010 through September 30, 2010, and $150 million for October 1, 2010 through December 31, 2010. *Id.*

Protections for Indians under Medicaid and CHIP—Section 5006.

ARRA establishes protections for Indians who receive Medicaid and CHIP services, including limitations on cost sharing, exemption of certain property for eligibility and estate recovery purposes, and imposition of safeguards related to managed care and provider choice. ARRA, § 5006 (effective July 1, 2009). While ARRA does not define the term "Indian," it is likely that definition will be the same as that applicable to Indian health care, which defines an Indian as a member of an Indian tribe. *See* 25 U.S.C. § 1603.

Premium and Cost Sharing Protection Under Medicaid

Current law specifies the requirements states must meet when they want to impose cost sharing on Medicaid beneficiaries. *See* 42 U.S.C. §§ 1396o, 1396o-1. For example, states may impose "nominal" copayments on many services, although some groups and services have been excluded, including emergency, family planning and hospice services. The Deficit Reduction Act of 2005 (DRA) expanded the states' Medicaid cost sharing options. *Id.* at § 1396o-1.[1]

ARRA prohibits states from imposing any cost sharing, such as premiums or copayments, on Indians who receive services directly through Indian health programs or contract health services.[2] Indian health programs are the Indian Health Service (IHS), Indian Tribes, Tribal Organizations, or Urban Indian Organizations. *See* ARRA, § 5600(a)(1). ARRA adds Indians to the list of individuals exempt from paying certain cost sharing under the DRA option. However, ARRA does not affect any other limitations on premiums or cost sharing that may otherwise apply under Medicaid. ARRA, § 5600(a)(2) (to be codified at 42 U.S.C. § 1396o-1(b)(3)).

Treatment of Certain Property from Resources for Medicaid and SCHIP Eligibility

[1] For in-depth discussion of the DRA, *see* National Health Law Program, *Health Advocate* (Spring 2006), available from NHeLP's Los Angeles office, and www.healthlaw.org.

[2] ARRA does not define "contract health services," but it is likely that the term is consistently with the current regulations governing Indian health services. *See, e.g.*, 42 C.F.R. § 136.21(e). Contract health services are provided by non-Indian health programs but paid for by IHS.

Currently, Medicaid applicants are entitled to at least the resource exemptions and disregards that apply to the cash assistance category to which they are most closely linked. For example, for individuals eligible for Medicaid in disability-related categories, states must have resource-counting rules that are at least as generous as those applicable under SSI. *See* 42 U.S.C. § 1396a(a)(17)(B). States may also have less restrictive methods of counting resources that result in more expansive eligibility. *Id.* at § 1396a(r)(2).

ARRA requires state Medicaid and CHIP programs to disregard certain kinds of property when determining eligibility of Indians. This includes: (1) real property and improvements located on a reservation, former reservation or near a reservation as designated by the Bureau of Indian affairs; (2) ownership interests in rents, leases, royalties, or usage rights related to natural resources that result from the exercise of federally-protected rights; and (3) ownership interests or usage rights in items that have religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle. ARRA § 5600(b)(to be codified at 42 U.S.C. § 1396a(ff) (Medicaid); *Id.* (to be codified at 42 U.S.C. § 1397gg(e)(1) (CHIP)).

Continuation of Current Protections of Certain Property from Estate Recovery

The Medicaid Act requires states to recover costs of providing Medicaid services from the estates of deceased beneficiaries. States, at a minimum, must seek recovery for nursing home and intermediate care facility services, and Medicare cost-sharing amounts. *See* 42 U.S.C. § 1396p(b). States must grant exemptions in cases of hardship. *Id.* On April 1, 2003, HHS issued instructions requiring states exempt certain property held by Indians from estate recovery, including ownership interest in: (1) real property located on or near a reservation; (2) royalties or usage rates related to natural resources resulting from federally protected rights; and (3) items of religious, cultural or spiritual significance. *See* CMS, *State Medicaid Manual*, § 3810(7). ARRA codifies these requirements. *See* ARRA, § 5600(c)(2) (to be codified at 42 U.S.C. § 1396p(b)(3)).

Application of Medicaid/CHIP Managed Care Rules

Current law allows states to provide Medicaid services through managed care entities (MCEs) as part of their regular state plan, subject to compliance with numerous requirements, including protections for Medicaid beneficiaries. *See* 42 U.S.C. § 1396u-2. Indians cannot be required to enroll in MCEs unless the MCE is the IHS or certain types of Indian Health Provider. *Id.* at § 1396u-2(2)(C).

ARRA imposes new requirements specifically applicable to Indian enrollees and providers. It includes the following definitions: (1) Indian health care provider means an Indian Health Program or Urban Indian Organization; (2) Indian managed care entity **(**Indian MCE**)** means an MCE that is controlled by the Indian Health Service, Tribe, Tribal Organization, Urban Indian Organization, or consortium of tribes or organizations; (3) Non-Indian managed care entity **(**non-Indian MCE**)** means any MCE that is not an Indian MCE. ARRA, § 5600(d)(1) (to be codified at 42 U.S.C. § 1396u-2(h)(4)(A)-(C)).

Non-Indian MCEs in which Indian health care providers are participating as primary care providers must require that any Indian enrolled with the entity be allowed to choose an Indian health care provider for his or her primary care. *Id.* at § 5600(d)(1) (to be codified at 42 U.S.C. § 1396u-2(h)). In addition, all contracts with MCEs must require them to demonstrate that the number of Indian health care providers is sufficient to ensure Indian enrollees timely access to covered services. Contracts must also obligate payment to Indian health care providers of negotiated rates or rates equal to the amount the MCE would make to non-Indian health care providers. Contracts must also require prompt payment to Indian health care providers. *Id.*

Some Indian health providers are federally qualified health care centers (FQHCs). FQHCs are generally paid prospective, per visit rates by Medicaid. Current law requires that, when an FQHC is a participating provider in an MCE, states must reimburse FQHCs for any difference between the MCE rate and the rate determined by the prospective payment system. *See* 42 U.S.C. § 1396a(bb)(5). ARRA adds a requirement regarding non-participating Indian health care FQHCs. When such FQHCs provide covered services to Indians enrolled in MCEs, the MCEs must pay the same rates to these entities that they would pay to a participating non-Indian FQHC. ARRA, § 5600(d)(1) (to be codified at 42 U.S.C. § 1396u-2(h)(2)(C)). Moreover, when an MCE makes payments for services provided to an Indian to either participating or non-participating FQHCs, if that rate is less than the state reimbursement rate for those services, the state must supplement those payments to make up the difference. *Id.* This also applies to non-FQHC providers. *Id.* ARRA specifically provides that states must still comply with the Medicaid requirement that states use payment standards that will ensure that reimbursement rates are sufficient to ensure efficiency, economy, and quality of care. *Id.* at § 5600(d)(1) (to be codified at 42 U.S.C. § 1396u-2(h)(2)(D)); *See also* 42 U.S.C. § 1396a(a)(30)(A).

Finally, ARRA requires that Indian Medicaid and CHIP managed care entities may restrict enrollment to Indians in the same manner that Indian health programs may restrict delivery of services to Indians. ARRA, § 5600(d)(1) (to be codified at 42 U.S.C. § 1396u-2(h)(3) (Medicaid); *Id.* at § 5600(d)(2) (to be codified at 42 U.S.C. § 1397gg(1)(J) (CHIP).

Consultation Regarding Medicaid, CHIP and Other Programs

ARRA requires the Secretary of DHHS to maintain a Tribal Technical Advisory Group (TTAG) within CMS. This group must include a representative of IHS and a national urban Indian health organization. *See* ARRA, § 5600(e)(1).

In addition, Medicaid and CHIP programs in states that have at least one IHS program or Urban Indian Organization furnishing health care services must seek advice from designees from those programs on an ongoing basis. This includes soliciting advice prior to submission of plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, and may include appointment of an advisory committee and a designee of an Indian Health Program to the medical care advisory committee. *Id.*, § 5600(e)(2)(A) (to be

codified at 42 U.S.C. § 1396a(a)(73) (Medicaid); *Id.* § 5600(e)(2)(B) (to be codified at 42 U.S.C. § 1397gg(1)(C)(CHIP).

Funding for Government Oversight—Section 5007.

Section 5007 of ARRA appropriates $31.25 million for FY 2009 to the DHHS Office of Inspector General (OIG) to oversee and ensure the proper expenditure of federal Medicaid funds. It also provides $5 million for FY 2009 to the Secretary of DHHS to implement the temporary enhanced FMAP under Section 5001. ARRA, § 5007.

GAO Study and Report Regarding State Needs During Periods of National Economic Downturn—Section 5008.

ARRA Section 5008 requires the Government Accountability Office (GAO) to evaluate the effectiveness of the enhanced FMAP during national economic recessions (countercyclical FMAP). By April 1, 2011, the Comptroller General must submit a report to Congress, which includes:

1. Recommendations for improving the national economic downturn assistance formula for temporarily adjusting FMAP under Medicaid, including:

    - What improvements are needed to identify factors to begin and end the application of countercyclical FMAP;
    - How to adjust the amount of countercyclical FMAP to account for state and regional economic variations during downturns; and
    - How countercyclical FMAP could be adjusted to better account for actual Medicaid costs incurred by states during economic recessions.

2. An analysis of the impact of economic downturns in states, including:

    - Declines in private health insurance coverage;
    - Declines in state revenues;
    - Changes in caseloads under Medicaid, CHIP, and other publicly programs that provide health benefits for state residents.

3. Identification of, and recommendations for addressing, the effects on states of any other specific economic indicators that the Comptroller General deems appropriate.

Additional Accountability Measures.

The oversight requirements in Sections 5007 and 5008 should be read in conjunction with other newly implemented accountability and transparency requirements. The Conference Agreement for H.R. 1 noted that ARRA "provides unprecedented oversight, accountability, and

transparency to ensure that taxpayer dollars are invested effectively, efficiently, and as quickly as possible." H.R. 1, 111th Congress (Conf. Rep.), Chairman Dave Obey, Chairman, Committee on Appropriations, *Detailed Summary* at 2, *available at:* http://appropriations.house.gov/.

The general public will have the ability to see how recovery funds are spent on a new website, http://www.recovery.gov. Office of Management and Budget (OMB), Executive Office of the President, *Memorandum for the Heads of Departments and Agencies Re: Initial Implementing Guidance for the American Recovery and Reinvestment Act of 2009* at 1 (Feb. 18, 2009) (OMB ARRA Guidance). And while the OMB is not requiring federal agencies to develop new websites dedicated to ARRA, it has called on agencies to dedicate a page of their primary website to recovery activities, along with a prominent link to "recovery.gov." *Id*. at 58-59.

Moreover, there will be strict oversight with independent review, including the creation of a Recovery Accountability and Transparency Board (RATB) drawn from the cabinet departments that are central to the recovery. The RATB will be advised by an outside panel, report regularly to Congress, and publish action alerts about urgent issues. *See* ARRA, § 1521. The RATB will also prevent fraud, waste, and abuse by conducting audits and reviews with inspectors general of relevant agencies. *Id.* at §§ 1521-24.

Also, in response to ARRA, the OMB issued a guidance that: (1) provides specific action steps that federal agencies, including the DHHS, must take immediately to meet the accountability and transparency objectives of ARRA; (2) directs all federal agencies to provide spending and performance data on the recovery.gov website; and (3) requires all federal agencies to implement mechanisms that will accurately track, monitor and report on taxpayer funds. OMB ARRA Guidance at 1; *See also* ARRA, § 1512(g). The reporting and transparency requirements were effective immediately, and will include weekly and monthly financial reporting throughout the implementation period. OMB ARRA Guidance at 3-9.

The accountability measures contained in ARRA and used by the Obama administration should provide consumer advocates with unprecedented access to DHHS information and an increased ability to ensure appropriate spending on behalf of program beneficiaries.

Health Information Technology

ARRA provides authority and funding to develop and implement interoperable computer systems capable of handling electronic health records (EHR) in both the private (ARRA, Division A, Title XIII) and public (ARRA, Division B, Title IV) sectors. This is a new undertaking and does not amend or replace previous law, except to strengthen certain provisions of the Health Insurance Portability and Accountability Act (HIPAA) regulations discussed below.

Provisions Specific to Medicaid—Section 4201.

Section 4201 of ARRA amends 42 U.S.C. § 1396b to set forth the funding rules and guidelines for helping "Medicaid providers" establish an EHR system. It adds a new § 1396b(t) that authorizes a total of $300 million to be used for the set up and operation of EHR systems by Medicaid providers, and describes how those funds are to be distributed by a state's Medicaid agency. The amount allocated will provide $40 million annually between 2009 and 2015, and $20 million for 2016. ARRA, § 4201 (adding 42 U.S.C. § 1396b(t)(10)).

A "Medicaid provider" that is not a hospital can get up to 85 percent of its net average allowable cost (as defined in § 1396b(t)(3)(C)), but not to exceed $25,000 for implementing EHR, and can get up to $10,000 per year for up to five years as an operating subsidy for the EHR system. An exception to this general rule is that pediatricians can only get two-thirds of these amounts, for reasons that have to do with the definition of "Medicaid provider," discussed below. *Id.* (adding § 1396b(t)(1), (4)). Medicaid providers that are hospitals are compensated pursuant to a much more complicated formula that is set forth in § 1396b(t)(5). To qualify for payments under this section, the Medicaid provider must demonstrate to the satisfaction of the state and the Secretary of DHHS that it is making "meaningful use" of the EHR technology. § 1396b(t)(6).

A "Medicaid provider" is defined in § 1396b(t)(2) as any children's hospital or an acute care hospital whose patient volume is at least 10 percent Medicaid recipients. It also includes a physician, dentist, certified nurse midwife, or nurse practitioner who is not hospital-based and (1) whose professional patient volume is made up of at least 30 percent Medicaid recipients, or (2) a pediatrician whose professional patient volume is made up of at least 20 percent Medicaid recipients (which accounts for pediatricians only being eligible for two-thirds of the reimbursement of other physicians), or (3) who practices predominantly in a federally qualified or rural health clinic, and whose professional patient volume is made up of at least 30 percent "needy individuals." A physician's assistant in such rural or federally qualified health centers can also qualify as a "Medicaid provider" if the clinic is headed by a physician's assistant. A "needy individual" is any Medicaid or CHIP recipient, or a person who receives uncompensated or reduced-price care from the clinic. *Id.* (adding § 1396b(t)(3)(F)).

ARRA also amends 42 U.S.C. § 1395w-4 by adding a new subsection (o), which provides payments, similar to those described above, to Medicare providers to implement and operate EHR systems. However, a Medicaid provider who would also be eligible for the Medicare payments must waive its right to those payments in order to qualify for payments under § 1396b(t). States must have systems in place to make certain that the same provider does not receive payments under both provisions. *See* new 42 U.S.C. § 1396b(t)(2), (3) and (7).

All of the Medicaid payments discussed above made by a state Medicaid agency are eligible for enhanced federal match. ARRA, § 4201 (amending 42 U.S.C. § 1396b(a)(3)(F)). This provision authorizes 100 percent federal match for funds that a state expends to help Medicaid providers implement EHR systems and a 90 percent match for the administrative expenses a state incurs in helping to establish a functioning EHR system. *Id*. However, to receive this increased federal match, a state must demonstrate to the Secretary that it is using the money only to further the implementation of EHR technology, and that it is conducting adequate

oversight, including tracking whether "meaningful use" is being made of the technology by Medicaid providers. ARRA, § 4201 (adding new § 1396b(t)(9)).

General Provisions That Apply to the Medicaid Program.

Title XIII of ARRA contains the Health Information Technology for Economic and Clinical Health Act, or the HITECH Act. This Act creates an elaborate mechanism for establishing EHR policies and standards, provides grants and loans for implementing an EHR system, and strengthens some privacy protections that people have with regard to their personal health information. The privacy protections are augmented by expanding the reach of some of the current HIPAA regulations, predominantly those found in 45 C.F.R. §§ 164.300 et seq. *See* ARRA §§ 13401, 13404, and 13405.

With regard to the privacy of a person's health information, the HITECH Act makes some significant improvements to the current state of affairs. First, it requires that "covered entities," as that term is defined for purposes of HIPAA, must notify people when their unencrypted personal health information has been improperly released through a breach of security. The required method of notification varies depending upon how many people have been affected by the breach. ARRA, § 13402. Because Medicaid (and CHIP) agencies are "health plans" for purposes of HIPAA, and because "health plans" are in turn "covered entities," these new protections apply to Medicaid programs. *Id.*

ARRA also provides that its protections, and the reporting requirements and financial penalties that attach for violations of the protections, apply with equal force to "covered entities" and their "business associates." *See* ARRA, §§ 13401 and 13404. This represents a change in the law, as under HIPAA it was at best unclear whether business associates could be held responsible for breaches of HIPAA. It is unclear what the implications of this provision are for Medicaid and CHIP program. Managed care organizations that contract with state agencies to provide care to Medicaid and CHIP beneficiaries are "business associates" of the state agency, but they are also "health plans" under HIPAA and thus independently subject to its provisions. But to the extent that Medicaid and CHIP agencies contract for services with entities not otherwise covered by HIPAA, as might be the case for example when they privatize administration of the program(s), advocates should be alert to any instances of personal health information being improperly released or otherwise misused, as that conduct by the private entity is now clearly covered, and prohibited, by the HITECH provisions of ARRA.