

Graham-Cassidy Section by Section

Title I

Section 101: Recapture of Excess Advance Premiums Tax Credits

- Would not apply IRC Section 36B(f)(2)(B), relating to limits on the excess amounts to be repaid with respect to the ACA premium tax credits, to taxable years ending after December 31, 2017.
- Any individual who was overpaid in premium tax credits would have to repay the entire excess amount, regardless of income, beginning in taxable year 2018.

Section 102: Modification and Repeal of Premium Tax Credits

- Excludes from the definition of QHP a plan that provides coverage for abortions (except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest), beginning tax year 2018.
- Repeals the ACA premium tax credits as of January 1, 2020

Section 103: Modification and Repeal of Small Business Tax Credits

- Starting in 2018, amends IRC Section 45R to indicate that the term “qualified health plan” does not include any health plan that includes coverage for abortions, except abortions necessary to save the life of a mother or abortions for pregnancies that are a result of rape or incest.
- Repeals the small business health insurance tax credit beginning as of January 1, 2020.

Section 104: Repeal of the Individual Mandate

- Strikes the individual mandate penalty and makes it \$0, retroactive to calendar year 2016.

Section 105: Repeal of the Employer Mandate

- Strikes the employer mandate penalty and makes it \$0, retroactive to calendar year 2016.

Section 106: Short Term Assistance for States and Market-Based Health Care Grant Program

- This section would add two new subsections (h) and (i) to Section 2105 of the Social Security Act (SSA). The new subsection (h)(1) would appropriate \$10 billion for CY2019, and \$15 billion for CY2020 to the Administrator of the Centers for Medicare & Medicaid Services (CMS).
- The CMS Administrator would be required to use the monies to fund arrangements with health insurance issuers to “assist in the purchase of health benefits coverage by addressing coverage and access disruption and responding to urgent health care needs within states.” Appropriated funds would remain available until expended.
- The new subsection (h)(2) would direct the CMS Administrator to issue guidance to health insurance issuers regarding how to submit notice of intent to participate in the program established no later than 30 days after enactment. To be eligible to receive funding under the program, issuers would have to submit the notice in a manner specified by the CMS Administrator. The notice would have to certify that the issuer would use the

funds in accordance with specified requirements, and provide other information as required by the CMS Administrator.

- The new subsection (h)(3) would direct the CMS Administrator to determine a procedure for providing and distributing the funds.
- New subsection (i) would create the market-based grant program, which would make funding available to the 50 states and the District of Columbia from CY2020 through CY2026. Under the program, a state would be required to submit an application to the CMS Administrator to receive federal funding to carry-out specified activities in the state.
- States would be able to use payments allocated from the program for one or more of the following allowed activities:
 - To establish or maintain a program or mechanism to help high-risk individuals purchase health benefits coverage, including by reducing premiums for such individuals, who have or are projected to have high health care utilization (as measured by cost) and who do not have access to employer-sponsored insurance;
 - To establish or maintain a program to enter into arrangements with health insurance issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting market participation and plan choice in the individual market;
 - To provide payments for health care providers for the provision of services specified by the CMS Administrator;
 - To provide health insurance coverage by funding assistance to reduce out-of-pocket costs (such as copayments, coinsurance, and deductibles) for individuals with individual health insurance coverage;
 - To establish or maintain a program or mechanism to help individuals purchase health benefits coverage, including by reducing premium costs for plans offered in the individual market (within the meaning of section 5000A(f)(1)(C) of the Internal Revenue Code of 1986) for individuals who do not have access to health insurance coverage offered through an employer.
 - Up to 20% of the funds can be used to provide health insurance coverage for individuals who are eligible for medical assistance under a State plan under title XIX by establishing or maintaining relationships with health insurance issuers to provide such coverage.
- A state must submit an application in a form and manner as specified by the CMS Administrator. The application would be required to include a description of how funds would be used for allowed activities; a certification that the state would, with non-Federal funds, make required contributions for allowed activities; a certification that funds would only be used for allowed activities; a certification that none of the funds would be used for prohibited activities; how a state will regulate plans utilizing the dollars within the block grant, including how it will maintain access to adequate and affordable coverage for individuals with pre-existing conditions; and any other information as required by the CMS Administrator.
- A state would only need to apply once to be treated as providing applications for subsequent years. Applications must be submitted no later than March 31, 2019.
- The amount appropriated each year would be equal to the following:
 - 2020= \$136 billion

- 2021= \$146 billion
- 2022= \$157 billion
- 2023= \$168 billion
- 2024= \$179 billion
- 2025= \$190 billion
- 2026= \$200 billion
- There is a reserve fund of \$10 billion dollars for 2020. Should a state experience a shortfall in federal dollars in 2020 because their experience is different than projected, a state may get an advancement of up to 5% of their 2026 allotment in 2020 through the reserve fund. Any funds accessed would be subtracted from the states allotment in 2026. Any leftover funds would go to states that did not draw money from this fund in 2026.
- Each year states will receive their allotted amount based on a formula. Amounts allotted would remain available for use by the state through the end of the second succeeding year.
- In 2020, funds will be allotted using the following base rate:
 - Each state picks 4 consecutive quarters from the beginning of fiscal year 2014 through the end of fiscal year 2017.
 - The federal spending spent on residents in each state during those consecutive quarters for all Group VIII Medicaid expansion enrollees, tax credits, cost-sharing reduction subsidies, and Basic Health Program will be summed to provide a base period for 2017.
 - The Medicaid expansion expenditures will be grown by MACPAC's inflation rate for the Medicaid expansion expenditure, while the rest of the expenditures will be grown by CPI-M from 2018-2020 to give the state's 2020 baseline.
 - The total amount allotted in 2020 for the start of the block grant will be \$136 billion, which is equivalent to the total expenditures described above.
- A state's allocation is determined using the following formula:
 - $\{(Previous\ year's\ allotment) + [(2026\ amount) - (2020\ baseline)]/6\}$.
- The 2026 amount is determined by looking at the total number of eligible beneficiaries between 50 and 138% of Federal Poverty Level (FPL) for the United States. Then, the percent of those in this FPL range that live in each state are calculated for each state. This is defined as the "State's percent of beneficiaries".
- The total amount of Federal money 2026 is then multiplied by the state's percent of beneficiaries to determine what their 2026 amount would be. This percentage amount is recalculated annually to account for changes in population in the FPL range.
- Starting in 2024, a state's allotment starts to shift from being based on its percent of eligible individuals to instead be based on its percent of eligible individuals enrolled in credible coverage in the previous year. This is defined as "State's enrolled population" and is compared to the total eligible individuals enrolled in credible coverage.
- Credible coverage is defined as having an actuarial value that fulfills the lowest level CHIP actuarial value allowed in a state.
- If a state chooses to provide coverage with policies of actuarial value less than the CHIP standard, the amount of money the state receives is adjusted for this. This is done by multiplying the amount of money that the state would receive by the ratio of the average AV of what is provided divided by the AV of the CHIP standard.

- State's Adjusted 2024 Amount = {(Average AV value of coverage of enrolled population)/(State's lowest CHIP policy AV) * (State's Unadjusted 2024 amount)}
- The enrollment formula is blended with the eligible population as it is being phased in using the following percentages:
 - 2024 – enrollment factor accounts for 25%
 - 2025 – enrollment factor accounts for 50%
 - 2026 – enrollment factor accounts for 75%
- By 2026, the formula ensures that every state receives the same base amount of money on a per person basis.
- To account for differences between states, starting in 2021, a risk adjustment formula begins to phase in to account for certain population characteristics.
- The Secretary would develop a specific population case mix index for eligible individuals reflected of clinical risk categories that reflect severity of illness and state specific population adjustment factors, such as demographics, wage rates, income levels, and other factors determined by the Secretary.
- This risk adjustment overlay will be applied in a budget neutral manner and ensure that every state remains within ten percent of the mean per beneficiary amount in 2026. This risk adjustment formula will be phased in in the following manner:
 - 2020 – 0%
 - 2021 – 25%
 - 2022 – 50%
 - 2023 – 75%
 - 2024 – 100%
 - 2025 – 100%
 - 2026 – 100%
- There are prohibitions on using funds for health insurance coverage of abortion; using federal funds for required state contributions; and paying for abortion. There are also requirements related to citizenship documentation.

Section 107: HHS Implementation Fund

- Establishes a Better Care Reconciliation Implementation Fund within HHS to provide for administrative expenses to carry out the bill. Appropriates \$2 billion to the fund.

Section 108: Repeal of the Tax on Over-the-Counter Medications

- Repeals the language in IRC Sections 106, 220, and 223 that stipulates that a medicine or drug must be a prescribed drug or insulin to be considered a qualified expense in terms of spending from a tax-advantaged health account. The provision would be effective beginning tax year 2017.

Section 109: Repeal of the Tax on Health Savings Accounts

- Amends IRC Sections 220 and 223 to reduce the applicable rate for non-qualified expense to 15% and 10% for Archer MSAs and HSAs, respectively. The lower rates would apply to distributions made after December 31, 2016.

Section 110: Repeal of the Medical Device Tax

- Amend IRC Section 4191 to provide that the medical device excise tax does not apply to sales after December 31, 2017.

Section 111: Repeal of the Elimination of the Deduction for Expenses Allocable to a Medicare Part D Subsidy

- Amends IRC Section 139A to reinstate prior law so that business-expense deductions for retiree prescription drug costs would be allowable without reduction by the amount of any federal subsidy.
- The change would be effective for taxable years beginning after December 31, 2016.

Section 112: Purchase of Insurance from a Health Savings Account

- Amends IRC Section 223(d)(2)(A) to add that qualified medical expenses may include amounts paid for an account holder's children who are under the age of 27.
- Amend subparagraphs (B) and (C) of IRC Section 223(d)(2) to provide that HSA funds may be used to pay premiums for a high deductible health plan (HDHP) for which no deduction is allowed under IRC Section 162(l), that is not an employer-sponsored plan to which the exclusion under IRC Section 106 applies, and only for amounts that exceed any tax credit amounts allowed under IRC 36B.
- The amendments under this section would become effective in 2018.

Section 113: Primary Care Enhancement Act

- Amends the Internal Revenue Code to:
 - (1) Permit an individual to pay primary care service arrangement costs from a health savings account; and
 - (2) Allow an eligible taxpayer enrolled in a high-deductible health plan to take a tax deduction for cash paid into a health savings account, even if the taxpayer is simultaneously enrolled in a primary care service arrangement.
- Under a "primary care service arrangement," an individual is provided coverage restricted to primary care services in exchange for a fixed periodic fee or payment for such services.
- Amends the definition of a qualified medical expense to include periodic provider fees paid to a primary care physician for a defined set of medical services provided on an as-needed basis.

Section 114: Increase in the Maximum Contribution Limit for Health Savings Accounts

- Increases the HSA annual contribution limits for self-only and family coverage to match the out-of-pocket limits for HSA-qualified HDHPs for self-only and family coverage.
- The change would go into effect beginning in tax year 2018.

Section 115: Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account

- Amends IRC Section 223(b)(5) to provide that, with respect to the contribution limit to an HSA, married persons do not have to take into account whether their spouse is also covered by an HSA-qualified HDHP.
- In other words, spouses' aggregate contributions to their respective HSAs could be more than the annual contribution limit for family coverage. Their annual contribution limit

would be reduced by any amount paid to Archer MSAs of either spouse for the taxable year, and then the remaining contribution amount would be divided equally between the spouses unless they agreed on a different division.

- Both spouses are eligible to make catch-up contributions before the close of the taxable year, then each spouse's catch-up contribution is included when dividing up the contribution amounts between the spouses.
- This provision would effectively allow both spouses to make catch-up contributions to one HSA and would apply to taxable years beginning in 2018.

Section 116: Special Rule for Medical Expenses Incurred Before the Establishment of a Health Savings Account

- Amends IRC Section 223(d)(2) to provide a circumstance under which HSA withdrawals could be used to pay qualified medical expenses incurred before the HSA was established.
- If an HSA were established within 60 days of when an individual's coverage under an HSA-qualified plan begins, then the HSA would be treated as having been established on the date the coverage begins for purposes of determining whether an HSA withdrawal is used for a qualified medical expense.
- This would apply to coverage beginning after December 31, 2017.

Section 117: Exclusion from Health Savings Accounts of High Deductible Health Plans Including Coverage for Abortion

- Amends IRC Section 223(d)(2)(C) to not allow HSA funds to be used to pay for an HDHP that provides coverage for abortions (except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest), beginning in 2018.

Section 118: Federal Payments to States

- Prohibits federal funds made available to a state through direct spending from being provided to a prohibited entity (as defined), either directly or through a managed care organization, for a one-year period beginning upon enactment of the draft bill.
- The provision specifies that this prohibition would be implemented notwithstanding certain programmatic rules (e.g., the Medicaid freedom of choice of provider requirement that requires enrollees to be able to receive services from any willing Medicaid participating provider, and states cannot exclude providers solely on the basis of the range of services they provide).
- The section defines a "prohibited entity," as an entity that meets the following criteria at enactment:
 - (1) it is designated as a not-for-profit by the IRS;
 - (2) it is described as an essential community provider that is primarily engaged in family planning services, reproductive health, and related medical care;
 - (3) it is an abortion provider that provides abortion in cases that do not meet the Hyde amendment exception for federal payment; and
 - (4) it received more than \$1 million in Medicaid expenditures (both federal and state) in FY2014.

Section 119: Medicaid

- Specifies the end date of the ACA Medicaid expansion as December 31, 2019.
- Specifies the date after which no state can expand as September 1, 2017.
- States that expanded Pre-ACA would get a match rate of 90% in 2018 and 2019, at which point the match rate would go down to 0%.

Section 120: Reducing State Medicaid Costs

- Limits the effective date for retroactive coverage of Medicaid benefits provided in or after the second month prior to the month in which the applicant (or individual acting on behalf of a deceased individual) applied, with certain specified exceptions. Specifically, the provision would continue to require states to provide for retroactive Medicaid coverage for services provided in or after the third month before the month of application for (1) recipients who are 65 years of age or older, and (2) individuals who are eligible for medical assistance on the basis of being blind or disabled at the time the application is made. This provision would apply to Medicaid applications made (or deemed to be made) on or after October 1, 2017.

Section 121: Eligibility Redeterminations

- Permits states to redetermine Medicaid eligibility every six months (or more frequently) for individuals eligible for Medicaid through (1) the ACA Medicaid expansion or (2) the state option for coverage for individuals with income that exceeds 133% of FPL.
- Increases the federal match for the administrative activities attributable to the option under Section 129(a) of redetermining Medicaid eligibility every six months (or more frequently) by five percentage points. This increased federal match would be available from October 1, 2017, through December 31, 2019.
- Grandfathers in Native Americans and Alaska Natives who are currently enrolled in Medicaid expansion as of December 31, 2019 to allow them to continue to be eligible for Medicaid.

Section 122: Optional Work Requirements for Non-Disabled, Non-Elderly, Non-Pregnant Individuals

- Permits states, effective October 1, 2017, to require nondisabled, non-elderly, non-pregnant individuals to satisfy a work requirement as a condition for receipt of Medicaid medical assistance.
- The provision would define work requirements as an individual's participation in work activities for a specified period of time as administered by the state.
- The provision would incorporate the definition of work activities as they appear in SSA Section 407(d) under Part A of Title IV (Block Grants to States for TANF)
- Participating states would be required to exempt the following groups from participation in the work requirement:
 - (1) pregnant women (for the duration of the pregnancy and through the end of the month in which the 60-day postpartum period ends);
 - (2) individuals under 19 years of age;
 - (3) an individual who is the sole parent or caretaker relative in the family of (a) a child who is under the age of 6 or (b) a child with disabilities;

- (4) an individual who is less than 20 years of age, who is married or a head of household and who (a) maintains satisfactory attendance at secondary school or the equivalent or (b) participates in education directly related to employment
- (5) a regular participant in an inpatient or intensive outpatient drug addiction or alcoholic treatment and rehabilitation program
- (6) an individual who is a full-time student at an institution of higher education
- Increases the federal match for administrative activities to implement the work requirement by five percentage points.

Section 123: Provider Taxes

- Phases down the Medicaid provider tax threshold from the current level of 6% to 5.6% in FY2021, 5.2% in FY2022, 4.8% in FY2023, 4.4% in FY2024, and 4.0% in FY2025 and subsequent fiscal years.

Section 124: Per Capita Allotment for Medical Assistance

- Reforms federal Medicaid financing to a per capita cap model (i.e., per enrollee limits on federal payments to states) starting in FY2020. Specifically, each state's spending during the state-selected base period would be the base to set targeted spending for each enrollee category in FY2019 and subsequent years for that state.
- Each state's targeted spending amounts would increase annually by the applicable annual inflation factor, which varies by enrollee category. For the elderly and the disabled, the inflation factor will be CPI-M+1 through 2024, and CPI-M after 2024. For children and non-elderly, non-disabled adults, the inflation factor will be CPI-M through 2024 and CPI-U after 2024.
- Starting in FY2020, any state with spending higher than its specified targeted aggregate amount would receive reductions to its Medicaid funding for the following fiscal year.
- One provision would reduce the target amount for New York if certain local government contributions to the state share are required.
- Section (a). Application of Per Capita Cap on Payments for Medical Assistance Expenditures
 - Under Section (a) of the new SSA Section 1903A, beginning in FY2020, if a state has excess aggregate medical assistance expenditures for a fiscal year, the state's quarterly Medicaid payments from the federal government for the following fiscal year would be reduced by one-quarter of the excess aggregate medical assistance payments for the previous fiscal year. This section would be applicable to the 50 states and the District of Columbia.
 - Excess aggregate medical assistance expenditures for the state and fiscal year would be the amount by which the adjusted total medical assistance expenditures (defined under Section (b) of the new SSA Section 1903A) exceeds the amount of target total medical assistance expenditures (defined under Section (c) of the new SSA Section 1903A).
 - Excess aggregate medical assistance payments would be the product of the excess aggregate medical assistance expenditures and the federal average medical assistance matching percentage.
 - The federal average medical assistance matching percentage for each state and fiscal year would be the ratio of (1) the amount of federal payments made to the

state under SSA Section 1903(a)(1) for medical assistance expenditures in the fiscal year prior to any potential reduction applied under this section to (2) the amount of the state's total medical assistance expenditures for the fiscal year (including both federal and state expenditures).

- The per capita base period for each state would be a period of eight consecutive fiscal quarters selected by the state no later than January 1, 2018. The state would need to select a period (1) for which all the data necessary to make the determinations for the per capita base period as determined by the HHS Secretary is available and (2) that begins as early as the first quarter of FY2014 and ends no later than the third quarter of FY2017.
- The HHS Secretary would be able to make adjustments to a state's data if the state took action to diminish the quality of the data (including making retroactive adjustments to supplemental payments) for the per capita base period after the date of enactment of this section.
- Section (b). Adjusted Total Medical Assistance Expenditures
 - Under Section (b), there would be two formulas for adjusted total medical assistance expenditures: one formula for the per capita base period and another formula for FY2019 and subsequent years. Both formulas for adjusted total medical assistance expenditures would exclude expenditures for Medicaid DSH payments under SSA Section 1923, Medicare cost-sharing payments under SSA Section 1905(p)(3), and expenditures for public health emergencies for calendar years 2020 through 2024.
 - The per capita base period formula for adjusted total medical assistance expenditures would be the product of (1) the amount of medical assistance expenditures for a state reduced by the amount of any excluded expenditures in the base period and (2) the 1903A base period population percentage, which is the HHS Secretary's calculation of the percentage of actual medical assistance expenditures attributable to 1903A enrollees in a state in the base period (discussed below, under Section (e)). The base period medical assistance expenditures and excluded expenditures would be the total amount of expenditures divided by two.
 - The FY2019 or subsequent fiscal years formula for adjusted total medical assistance expenditures for a state and fiscal year would be the amount of medical assistance expenditures attributable to 1903A enrollees reduced by any excluded expenditures.
 - Medical assistance expenditures would be defined as medical assistance payments as reported under the medical services category on the Form CMS-64 quarterly expense report (or successor to such form) for which payment is made pursuant to SSA Section 1903(a)(1).
 - The language specifies that the medical assistance expenditures for FY2019 and subsequent years would include non-DSH supplemental payments (including certain waiver expenditures for delivery system reform incentive pools, uncompensated care pools, and designated state health programs).
 - The medical assistance expenditures for FY2019 and subsequent years would not include expenditures for the Vaccines for Children program.

- The excluded expenditures for public health emergencies from January 1, 2020 through December 31, 2024 would be medical assistance expenditures during the period of a public health emergency declared by the HHS Secretary pursuant to the Public Health Service Act (PHSA) Section 319 that the HHS Secretary determines would be appropriate to exclude from the Medicaid per capita caps.
- The maximum amount of excluded expenditures for public health emergencies in a given fiscal year would be equal to the amount by which (1) medical assistance expenditures for 1903A enrollees in areas of the state subject to public health emergency declarations during the period of such declarations exceeds (2) the medical assistance expenditures for such enrollees in such area during the most recent fiscal year or portion of a fiscal year of equal length before the public health emergency was declared.
- If a state has funds excluded from the per capita caps due to a public health emergency, then the HHS Secretary would be required to audit the impacted medical assistance expenditures no later than six months after the public health emergency declaration.
- The aggregate limit for excluded expenditures for public health emergencies under the per capita caps and additional federal funds under the block grant option would be \$5 billion for the period of January 1, 2020 through December 31, 2024.
- Section (c). Target Total Medical Assistance Expenditures
 - Under Section (c) of the new SSA Section 1903A, target total medical assistance expenditures for a state and fiscal year would be the sum of the following formula for each 1903A enrollee category (defined under Section (e) of the new SSA Section 1903A): (1) target per capita medical assistance expenditures for the enrollee category times (2) the number of 1903A enrollees for such 1903A enrollee category.
 - For FY2020, the target per capita medical assistance expenditures for each 1903A enrollee category would be the provisional FY2019 target per capita amount (defined in Section (d) of the new SSA Section 1903A) for such enrollee category for the state increased by the applicable annual inflation factor.
 - For subsequent years, the target per capita medical assistance expenditures for each 1903A enrollee category would be the target per capita medical assistance expenditures for the previous year for such enrollee category for the state increased by the applicable annual inflation factor.
 - The applicable inflation factor for the children and other non-elderly, nondisabled, adult categories would be the percentage increase in the medical care component of the CPI-U from September of the previous fiscal year to September of the fiscal year involved. For the elderly and disabled categories, the applicable inflation factor would be the percentage increase in the medical care component of the CPI-U from September of the previous fiscal year to September of the fiscal year involved plus one percentage point.
 - Beginning in FY2020, a state's target per capita medical assistance expenditures for each 1903A enrollee category would be adjusted if the state's per capita categorical medical assistance expenditures for the preceding fiscal year exceeds or is less than the mean per capita categorical medical assistance expenditures for the enrollee category in all states by 25.0%. The adjustment would be a decrease

for expenditures that exceed 25.0% of the mean and an increase for expenditures that are less than 25.0% of the mean that would not be less than 0.5% or greater than 3.0%.

- The HHS Secretary would determine the amount of the increase or decrease, and the adjustments would be required to be budget neutral (i.e., would not result in a net increase of federal payments under the per capita caps for the fiscal year).
- The adjustments would not apply to low-density states (i.e., any state with population density of less than 15 individuals per square mile).
- The adjustments would be disregarded when determining the target medical assistance expenditures for the succeeding fiscal year. For FY2020 and FY2021, the HHS Secretary would apply the adjustment by deeming all enrollee categories to be a single category.
- For each state and fiscal year, per capita categorical medical assistance expenditures would be the categorical medical assistance expenditures (i.e., medical assistance expenditures for an enrollee category minus the excluded expenditures) divided by the number of 1903A enrollees in the enrollee category.
- Section (d). Calculation of FY2019 Provisional Target Amount for Each 1903A Enrollee Category
 - The HHS Secretary would calculate for each state the provisional FY2019 per capita target amounts for each 1903A enrollee category.
 - The formula for the provisional FY2019 per capita target amounts would be the average per capita medical assistance expenditures for the state for FY2019 for such enrollee category multiplied by the ratio of (1) the product of the FY2019 average per capita amount for the state and the number of 1903A enrollees for the state in FY2019 to (2) the amount of FY2019 adjusted total medical assistance expenditures for the state.
 - The average per capita medical assistance expenditures for FY2019 for each 1903A enrollee category would be the FY2019 adjusted total medical assistance expenditures for the state divided by the number of 1903A enrollees for the state in FY2019.
 - The FY2019 adjusted total medical assistance expenditures would exclude non-DSH supplemental expenditures (including certain waiver expenditures for delivery system reform incentive pools, uncompensated care pools, and designated state health programs) for FY2019 and would be increased by the non-DSH supplemental payment percentage for the base period, which is the ratio of the total amount of non-DSH supplemental payments for the base period divided by two to adjusted total medical assistance expenditures for the base period.
 - For each state, the FY2019 average per capita amount would be the base period average per capita medical assistance expenditures increased by the percentage increase in the medical care component of the CPI-U from the last month of the base period to September of FY2019. The base period average per capita medical assistance expenditures would be the amount of the base period adjusted total medical assistance expenditures (discussed in Section (b)) divided by the number of 1903A enrollees for the state in the base period.
- Section (e). 1903A Enrollee; 1903A Enrollee Category

- This section would define 1903A enrollees as Medicaid enrollees (i.e., individuals eligible for medical assistance under Medicaid and enrolled under the Medicaid state plan or waiver) for the month in a state that is not covered under the block grant option and does not fall into one of the following categories:
 - individuals covered under a CHIP Medicaid expansion program (SSA Section 2101(a)(2)),
 - individuals who receive medical assistance through an Indian Health Service facility (the third sentence under SSA Section 1905(b)),
 - individuals eligible for medical assistance coverage of breast and cervical cancer treatment due to screening under the Breast and Cervical Cancer Early Detection Program (SSA Section 1902(a)(10)(A)(ii)(XVIII)),
 - blind and disabled children under the age of 19, or
 - the following partial-benefit enrollees:
 - unauthorized (illegally present) aliens eligible for Medicaid emergency medical care (SSA Section 1903(v)(2)),
 - individuals eligible for Medicaid family planning options (SSA Section 1902(a)(10)(A)(ii)(XXI)),
 - individuals infected with tuberculosis (SSA Section 1902(a)(10)(A)(ii)(XII)),
 - dual-eligible individuals eligible for coverage of Medicare cost sharing (SSA Section 1905(p)(3)(A)(i) or (ii)), or
 - individuals eligible for premium assistance (SSA Section 1906 or 1906A).
- The enrollment count would be based on the average monthly amount reported through the Form CMS-64 as required under Section (h).
- The 1903A enrollee categories would be (1) elderly; (2) blind and disabled adults; (3) children; and (4) other non-elderly, nondisabled, non-expansion adults.
- Section (f). Special Payment Rules
 - Section (f) of the new SSA Section 1903A would provide special payment rules for (1) payments made under Section 1115 waivers or Section 1915 waivers, (2) states that did not have the ACA Medicaid expansion as of July 1, 2016 and later implement the expansion, and (3) states that fail to satisfactorily submit data in accordance with Section (h)(1) of the new SSA Section 1903A.
- Section (g). Recalculation of Certain Amounts for Data Errors
 - Section (g) of the new SSA Section 1903A would allow for the recalculation of certain amounts for data errors.
 - Any adjustment under this section would not result in an increase of the target total medical assistance expenditures exceeding 2%.
- Section (h). Required Reporting and Auditing; Transitional Increase in Federal Matching Percentage for Certain Administrative Expenses
 - In addition to the required reporting for ACA Medicaid expansion on the Form CMS-64 report as of January 1, 2017, Section (h) of the new SSA Section 1903A would impose additional reporting requirements on states starting October 1, 2018.
 - The additional reporting requirements would include data on medical assistance expenditures within categories of services and categories of enrollees (including

each 1903A enrollee category and the enrollment categories excluded from the definition of 1903A enrollees).

- In addition, Section (h) would require reporting of the number of enrollees within each enrollee category. The HHS Secretary would determine the specific reporting requirements.
- States would also be required to report medical assistance expenditures for qualified inpatient psychiatric hospital services on the Form CMS-64. The HHS Secretary would modify the Form CMS-64 no later than 60 days after the date of enactment.
- The HHS Secretary would also modify the Form CMS-64 no later than January 1, 2020 to require states to report data about children with complex medical conditions.
- Specifically, states would be required to report information about individuals enrolled in Medicaid or CHIP who are under the age of 21 and have a chronic medical condition that either (1) requires intensive healthcare interventions or (2) meets the criteria for medical complexity.
- The HHS Secretary would conduct audits of each state's enrollment and expenditures reported on the Form CMS-64 for the base period, FY2019, and subsequent years. These audits may be conducted on a representative sample, as determined by the HHS Secretary. The HHS Inspector General also would audit each state's spending under the per capita caps at least every three years.
- For states that select the most recent eight consecutive fiscal quarter period for its base period, this section would provide a temporary increase to the federal matching percentage for the administrative activities related to improving data reporting systems. The temporary increases would impact expenditures on or after October 1, 2017, and before October 1, 2019.
- Section 124(b). Ensuring Access to Home and Community-Based Services
 - Section 124(b) would establish a new SSA Section 1915(l) to require the HHS Secretary to establish a four-year demonstration project under which eligible states may make HCBS payment adjustments for the purpose of continuing to provide and improving the quality of HCBS under a Section 1915(c) or (d) waiver or the Section 1915(i) HCBS state plan option.
 - Participating states would be selected on a competitive basis with priority given to any one of the 15 states with the lowest population density, as determined by the HHS Secretary based on data from the U.S. Census Bureau.
 - The demonstration project would begin on January 1, 2020 and end on December 31, 2023. Under the demonstration, each state would receive an amount allotted for each year with the aggregate amount allotted to eligible states for all years not to exceed \$8 billion.
 - The HCBS payment adjustment would be an adjustment made by an eligible state to the amount of payment otherwise provided for HCBS under a Section 1915(c) or (d) waiver or the Section 1915(i) HCBS state plan option provided to a 1903A enrollee who is in either the elderly or blind and disabled enrollee category.
 - For each year of the demonstration project, expenditures by eligible states would receive a 100% federal matching rate (i.e., fully federal funded) for the HCBS payment adjustments, subject to certain limitations for: (1) payments to individual

providers; and (2) annual state allotment amounts. Each eligible state would be required to collect and report information, as determined by the HHS Secretary

- Delays implementation for the per capita cap in the instance of low-density states that the Secretary determines are receiving a block grant under the Market-Based Grant Program that is insufficient after taking into consideration the unique circumstances of such state to provide comprehensive and adequate assistance to its citizens or are receiving less in the block grant than their 2020 amount grown by CPI-M in the individual year. If the state does not meet the criteria in a year after 2020, then the per capita cap would go into effect.

Section 125: Flexible Block-Grant for States

- Section 125 would give states the option to participate in the Medicaid Flexibility Program beginning with FY2020. Under the Medicaid Flexibility Program, states would receive block grant funding (i.e., a predetermined fixed amount of federal funding) instead of per capita cap funding for non-elderly, nondisabled, non-expansion adults. Some statutory requirements would not apply under the block grant option, and states would elect this option for a five-year period.
- Section 125 would add a new SSA Section 1903B. The following provides a description of what would be the new SSA Section 1903B.
- Section (a). In General
 - Beginning in FY2020, states (defined as the 50 states and the District of Columbia) would have the option to have a Medicaid Flexibility Program, which is a state program for providing targeted health assistance to program enrollees funded by a block grant.
 - The applicable program enrollee category with respect to a state's Medicaid Flexibility Program for a program period would be specified by the state, and the applicable program enrollee category would include non-elderly, nondisabled, non-expansion adults
 - Targeted health assistance would be defined as assistance for healthcare-related items and medical services for program enrollees. This definition is from Section (e).
 - Program enrollee would be defined as an individual who is included in the applicable program enrollee category specified by the state. This definition is from Section (e).
 - The program period for a state's Medicaid Flexibility Program would be defined as a period of five consecutive fiscal years that begin with either (1) the first fiscal year in which the state has the program or (2) the next fiscal year in which the state has such a program that begins after the end of a previous program period. This definition is from Section (e).
- Section (b). State Application
 - States would need to submit an application to be eligible to participate in the Medicaid Flexibility Program. The application would need to include the following list of items:
 - A description of the proposed Medicaid Flexibility Program and how the states would satisfy the program requirements.
 - The proposed conditions of eligibility of program enrollees.

- The applicable program enrollee category.
 - A description of the types, amount, duration, and scope of services covered.
 - A description of how the state would notify current Medicaid enrollees of the transition to the Medicaid Flexibility Program.
 - Statements certifying that the state report the required data and information, including enrollment data; T-MSIS data; adult quality health measures; additional information as determined by the HHS Secretary; and annual program evaluation.
 - An information technology systems plan.
 - A statement of goals for the proposed program with a plan for monitoring and evaluating the goals are met and plan for remedial action if goals are not met.
- Before submitting the application, states would need to make the application publicly available for a 30-day notice and comment period. During the notice and comment period, the state would provide opportunities for meaningful public input. The HHS Secretary would not approve the application for the program without the notice and comment period.
- Each year beginning with 2019, the HHS Secretary would specify a deadline for a state to submit an application to have a Medicaid Flexibility Program that would begin in the next fiscal year. The deadline would be no earlier than 60 days after the date the HHS Secretary publishes states' amount of block grant funds for the next fiscal year.
- Section (c). Financing
 - For each year a state has a Medicaid Flexibility Program, the state would receive block grant funds rather than per capita cap funding for the program enrollees. The block grant amounts would be equal to the sum of the amounts calculated for each 1903A enrollee category within the applicable program enrollee category.
 - For the first fiscal year a state includes an enrollee category in their Medicaid Flexibility Program, the amount calculated for the enrollee category would be equal to the federal average medical assistance matching percentage for the state and year multiplied by the product of (1) the target per capita medical assistance expenditures for the enrollee category and (2) the number of enrollees in the category for the second fiscal year preceding such first fiscal year increased by the percentage increase in the state population from such second preceding fiscal year to the first fiscal year based on estimates from the Bureau of Census.
 - In calculating each state's amounts for the first fiscal year in which each enrollee category is included in the Medicaid Flexibility Program, the total number of enrollees for the fiscal year and category would not exceed the adjusted number of base period enrollees. The adjusted number of base year enrollees for each state would be the number of enrollees for the state's per capita base period increased by the percentage increase (if any) in total state population from the last April in the state's per capita base period to the April of the fiscal year preceding the fiscal year involved plus three percentage points.
 - For subsequent years, states' amounts for each enrollment category would be the amount from the previous fiscal year increased by the percentage increase in the

- CPI-U from April of the second fiscal year proceeding the fiscal year involved to April of the fiscal year proceeding the fiscal year involved.
- States could receive federal funds in addition to the block grant amount if a state has medical assistance expenditures excluded from the Medicaid per capita caps for public health emergencies from January 1, 2020 through December 31, 2024. If a state has uncompensated targeted health assistance, the HHS Secretary would be able to make additional payments to the state equal to the federal average medical assistance matching percentage of the uncompensated targeted health assistance during the period of the public health declaration.
 - The uncompensated targeted health assistance would be the amount by which (1) total expenditures for targeted health assistance during the period of the declaration exceeds (2) the block grant amount divided by the federal average medical assistance matching percentage.
 - The maximum federal payment a state could receive would be the amount by which (1) state expenditures for the targeted health assistance in the area of the state subject to the public health emergency declaration during the period of the declaration exceeds (2) the state expenditures for targeted health assistance for such enrollees in such area during the most recent fiscal year or portion of a fiscal year of equal length before the public health emergency was declared.
 - If a state receives this additional federal payment, then the HHS Secretary would be required to audit the impacted targeted health assistance expenditures no later than six months after the public health emergency declaration.
 - If the block grant amount for a state exceeds the federal payments to a state for a fiscal year, the excess block grant funds would be available to the states for the succeeding fiscal year if the state satisfies the maintenance of effort requirement and has the Medicaid Flexibility Program in the succeeding fiscal year. These rollover funds would be used for states' Medicaid state plan or the Medicaid Flexibility Program.
 - Each state would be paid quarterly from their annual block grant amount an amount equal to the federal average medical assistance percentage of the total amount expended for the Medicaid Flexibility Program during such quarter. The state would be responsible for funding the rest of the program.
 - The state maintenance of effort expenditures under the Medicaid Flexibility Program would require states to have expenditures for each year under the program equal to the product of (1) each state's block grant amount for the fiscal year and (2) E-FMAP rate used for CHIP.
 - States that fail to meet the maintenance of effort requirement for a fiscal year would receive a reduction to their block grant amount for the succeeding fiscal year. The reduction would be the amount by which the state expenditures were less than the required amount, and this reduction would be disregarded for determining the block grant amount in the year after the reduction is applied. For states that terminate the Medicaid Flexibility Program and the termination is effective with the end of a fiscal year in which the state doesn't meet the maintenance of effort requirement, the reduction amount would be treated as a Medicaid overpayment.

- The HHS Secretary would be able to withhold payment, reduce payment, or recover previous payment under the Medicaid Flexibility Program for states that are not in compliance with the program requirements.
- Beginning in 2019 and each year thereafter, the HHS Secretary would be required to determine the block grant amount for all states for the upcoming fiscal year. The amounts would be published no later than June 1 of each year.
- Section (d). Program Requirements
 - No payment would be made to a state under the Medicaid Flexibility Program unless the state's program meets all of the Medicaid Flexibility Program requirements.
 - States would have the Medicaid Flexibility Program for not less than one program period (i.e., five consecutive fiscal years). States would have the option to continue the Medicaid Flexibility Program for succeeding program periods without resubmitting an application provided that (1) the state provides notice to the HHS Secretary and (2) no significant changes are made to the program.
 - The Medicaid Flexibility Program would be subject to termination only by the state. In order to elect to terminate the program, a state would be required to have an appropriate transition plan approved by the HHS Secretary. A state's termination would be effective the first day after the end of the program period, and after the termination of the program, the state would receive per capita cap funding as if the state had never had the Medicaid Flexibility Program.
 - States would be able to provide targeted health assistance coverage to the program enrollees that could be different from the medical assistance provided to other Medicaid enrollees not under the Medicaid Flexibility Program. States would be able to establish the conditions of eligibility that could be different from the conditions of eligibility for the rest of Medicaid, but states would be required to provide coverage to program enrollees that are currently required to be covered by Medicaid programs under SSA Section 1902(a)(10)(A)(i). States would be required to use the MAGI counting rules to establish eligibility for program enrollees.
 - For program enrollees whom the state is currently required to provide Medicaid coverage under SSA Section 1902(a)(10)(A)(i), states would be required to provide targeted health assistance and the Medicaid Flexibility Program that includes the following types of services: inpatient and outpatient hospital services; laboratory and x-ray services; nursing facility services for individuals aged 21 and over; physician services; home health care services; rural health clinic services; federally-qualified health centers; family planning services and supplies; nurse midwife services; certified pediatric and family nurse practitioner services; freestanding birth center services; emergency medical transportation; non-cosmetic dental services; and pregnancy services.
 - States would also be able to provide coverage of optional benefits not listed as a required service under the Medicaid Flexibility Program.
 - The targeted health assistance provided to any group of program enrollees would be required to have (1) an aggregate actuarial value equal to at least 95% of the aggregate actuarial value of the benchmark coverage from SSA Section 1937(b)(1) that was in effect prior to the enactment of the ACA or (2) benchmark-

equivalent coverage from SSA Section 1937(b)(2) that was in effect prior to the enactment of the ACA.

- States would be able to determine the amount, duration, and scope of the targeted health assistance provided to all program enrollees except for as otherwise specified.
- The targeted health assistance would be required to provide mental health and substance use disorder coverage that complies with federal mental health parity requirements. Also, if a state provides coverage of prescription drug to program enrollees, then the prescription drugs would be subject to a rebate agreement that complies with the requirements of SSA Section 1927.
- Under the Medicaid Flexibility Program, states would be able to impose premiums, deductibles, cost-sharing, or other similar charges as long as the total annual aggregate amount of all such charges does not exceed 5% of the family's annual income.
- States would be required to designate a single agency to administer the Medicaid Flexibility Program. States with Medicaid Flexibility Programs would be required (1) to provide for simplified enrollment processes and coordination with state health insurance exchanges and (2) establish a fair process for individuals to appeal adverse eligibility determinations.

Section 126: Medicaid and CHIP Quality Performance Bonus Payments

- Establishes Medicaid and CHIP quality performance bonus payments for FY2023 through FY2026. To be eligible for the Medicaid and CHIP quality performance bonus payments, a state (defined as the 50 states and the District of Columbia) would:
 - (1) have lower than expected aggregate medical assistance expenditures excluding expenditures for other non-elderly, nondisabled, non-expansion adults for that fiscal year; and
 - (2) have to submit the required information to the HHS Secretary.
- For the Medicaid and CHIP quality performance bonus payments, lower than expected aggregate medical assistance expenditures would be the amounts (if any) by which the adjusted total medical assistance expenditures (i.e., actual medical assistance expenditures minus the excluded expenditures and the excluded populations) are less than the target total medical assistance expenditures as (i.e., the targeted medical assistance expenditures under the per capita allotment).
- To be eligible for the bonus payments, states would be required to submit to the following information:
 - (1) quality measures for each category of Medicaid eligible individuals; and
 - (2) a plan for spending a portion of the bonus payment funds on quality improvement. The quality measures states would be required to submit for the bonus payments would be determined by the HHS Secretary and may include, among other measures, those identified under SSA Sections 1139A and 1139B.
- The bonus payment allotments for states would be determined according to a formula established by the HHS Secretary. The formula would be based on performance, including improvement, with respect to the quality measures (as determined by the HHS Secretary) for Medicaid and CHIP over the performance period (as determined by the HHS Secretary) for such fiscal year.

- The quality bonus payment allotments for all states would total \$8 billion for FY2023 through FY2026.
- The quality bonus payment allotment funds would be used to increase the Medicaid federal matching rate of 50% for administrative services by such percentage (as determined by the HHS Secretary) so that the increase does not exceed each state's quality bonus payment allotment.

Section 127: Optional Assistance for Certain Inpatient Psychiatric Services

- Provides states with the option of providing Medicaid coverage of qualified inpatient psychiatric hospital services to individuals over the age of 21 and under the age of 65.
- For this provision, qualified inpatient psychiatric hospital services would be services furnished at a psychiatric hospital (i.e., an institution that is primarily engaged in providing for the diagnosis and treatment of mentally ill persons) for a Medicaid enrollee who has a stay that does not exceed (1) 30 consecutive days in a month and (2) 90 days in any calendar year.
- As a condition of providing this coverage, states would be required to maintain the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the state on the date of enactment of this provision unless the numbers of beds increases between the date of enactment and when the state applies to provide this coverage. In that case, the state would be required to maintain the number of beds as of the date of application.
- As another condition of providing this coverage, states would be required to maintain the level of annual state spending for (1) inpatient services at a psychiatric hospital and (2) active psychiatric care and treatment provided on an outpatient basis as of the date of enactment of this provision unless the state spending on these services increases between the date of enactment and when the state applies to provide this coverage. In that case, the state would be required to maintain the annual state spending on inpatient and outpatient psychiatric care as of the date of application.
- States would receive a 50% federal matching rate for providing coverage of qualified inpatient psychiatric hospital services to Medicaid enrollees over the age of 21 and under the age of 65, unless the state already has a waiver in place to receive a higher match.
- This provision would be effective on or after October 1, 2018.

Section 128: Enhance FMAP for Medical Assistance to Eligible Indians

- Provides for a 100% FMAP rate for amounts expended as medical assistance for services provided by any provider under a Medicaid state plan to an individual who is a member of an Indian tribe and eligible for assistance under a Medicaid state plan.

Section 129: Non-Application of DSH Cuts for States with Low Market-Based Health Care Grant Allotments

- In any year after 2020 that a state's allotment amount under the Market-Based Grant Program is less than its 2020 base amount grown by CPI-M to the comparison year in the block grant, then the state is eligible to pull down its DSH dollars for that same year that are currently scheduled to be cut under the ACA.

- The amount received from DSH would still be subject to a state match and, when added to the state's allotment total, cannot exceed the amount the state would have received in that year had the state's 2020 base rate been grown by CPI-M to the comparison year.

Title II

Section 201: The Prevention and Public Health Fund

- Repeals the ACA's Prevention and Public Health Fund

Section 202: Community Health Center Program

- Provides an additional \$422 million for FY2017 to the Community Health Center Fund.

Section 203: Allowing All Individuals Purchasing Health Insurance in the Individual Market the Option to Purchase a Lower Premium Catastrophic Plan

- Amend ACA Section 1302(e) to allow any individual to enroll in a catastrophic plan, effective plan years beginning on or after January 1, 2019.
- ACA Section 1312(c) to include enrollees in catastrophic plans as part of the individual market and small-group market's single risk pools for plan years beginning on or after January 1, 2019.
- Allows an individual who is eligible for the tax credit, as modified under Section 102, to apply that credit towards the purchase of a catastrophic plan.

Section 204: Application of Enforcement Penalties

- Amends Section 2723 of the PHSa to establish a penalty for violations of the ACA's abortion funding segregation requirements.
- A plan issuer that fails to comply with these requirements would be liable for a penalty of up to \$100 for each day for each individual with respect to whom such a failure occurs. In determining the actual amount of a penalty, the HHS Secretary would consider a plan issuer's previous record of compliance and the gravity of the violation.
- This section also would provide that a state's receipt of an ACA Section 1332 waiver shall not affect the HHS Secretary's authority to impose penalties under PHSa Section 2723.

Section 205: Repeal of the Cost-Sharing Subsidy Program

- Repeals the Cost-Sharing Reduction Subsidy Program as of December 31, 2019.