A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 (P.L. 105-33) with Prior Law

Prepared by

Sara Rosenbaum
Julie Darnell
Center for Health Policy Research
The George Washington University Medical Center

for the
Kaiser Commission on the Future of Medicaid

October 1997

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INTRODUCTION

A. Overview

The following table compares prior Medicaid law with the Medicaid provisions contained in the Balanced Budget Act of 1997 (P.L. 105-33), signed into law by President Clinton on August 5, 1997.[1] The legislation makes significant changes in the structure of the Medicaid program in the areas of eligibility, provider qualification and reimbursement, long-term care, and managed care. In many respects, the legislation reflects many of the changes in law and program structure which have taken place under statewide Medicaid managed care demonstrations authorized under Sections 1915 and 1115 of the Social Security Act.[2] The Congressional Budget Office has estimated federal savings of $13 billion over five years from reductions in Medicaid spending under the Balanced Budget Act.

Eligibility. The Balanced Budget Act adds new state eligibility options for children and disabled persons; expands premium assistance for low-income Medicare beneficiaries; and restores Medicaid coverage to children and immigrants who lost SSI benefits as a result of the 1996 welfare reform legislation.

Benefits. The legislation retains Medicaid as a program that covers a defined set of benefits. It adds a new primary care case management benefit option and liberalizes eligibility requirements for Medicaid assistance under home- and community-based care waivers.

Premiums and Cost Sharing. The new law permits states to impose cost sharing on beneficiaries enrolled in managed care organizations to the same extent as is permitted in the fee-for-service program.

Provider Participation and Reimbursement. The new law makes major changes in payment rules for hospitals, nursing homes, intermediate care facilities, home health agencies, federally qualified health centers (FQHCs), and rural health clinics (RHCs). In fact, most of the reductions in federal Medicaid spending are achieved through reductions in provider payments, the most significant of which are targeted to disproportionate share hospitals. The new law also repeals the Boren Amendment and phases out cost-based reimbursement for FQHCs and RHCs. The legislation also allows states to pay Medicare providers the Medicaid reimbursement rate for services provided to Qualified Medicare Beneficiaries and dual eligibles.

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[1]For an additional analysis detailing the new legislation and the financial assumptions on which it is based see Andy Schneider, *Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33* (Center on Budget and Policy Priorities, Washington D.C., August, 1997).

[2]For a review of Section 1115 demonstrations and their implications for Medicaid reform see Sara Rosenbaum and Julie Darnell, *Statewide Medicaid Managed Care Demonstrations under Section 1115 of the Social Security Act: A Review of the Waiver Applications, Letters of Approval and Terms and Conditions*, (Washington, D.C.: Kaiser Commission on the Future of Medicaid), 1997.

Managed Care. The Balanced Budget Act eliminates many of the provisions of prior law for which states frequently requested waivers under Section 1915 and Section 1115 of the Social Security Act. Most significantly, the new law permits states to require most Medicaid beneficiaries to enroll in a managed care organization without first obtaining waiver approval from HCFA. Furthermore, the new law permits the establishment of Medicaid-only plans without Secretarial approval by eliminating the pre-existing 75/25 Medicare - Medicaid/private coverage composition requirement and increases to $1 million the threshold for prior federal approval of managed care contracts. Finally, the law establishes certain new managed care consumer protections, but exempts Section 1915 and Section 1115 waiver states from its new requirements.

Long-Term Care. The new law establishes an optional program, Program of All Inclusive Care for the Elderly (PACE), for Medicare entitled Medicaid beneficiaries who are 55 years of age or older, require nursing facility-level care, reside in the PACE program service area, and meet other applicable conditions of eligibility permitted under the program.

Federal Financial Assistance. The Balanced Budget Act makes changes in the amount of federal payments to the states and the territories and to specific providers. The new law increases federal payments to D.C., Alaska, and the territories. Furthermore, it entitles 12 states with the highest number of undocumented persons to additional funding for FY 1998 through FY 2001 for emergency services furnished to otherwise eligible undocumented persons. The law places additional caps on state DSH allotments, beginning FY 1998, with the specific amount established per state until FY 2002; thereafter, the allotment is increased by the CPI.

B. Eligibility

The legislation makes the following changes in Medicaid eligibility:

- **Restores Medicaid (and Supplemental Security Income (SSI)) to elderly and disabled legal residents who lived in the U.S. and received assistance as of August 22, 1996**, the date on which the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which terminated such coverage, was signed into law. Additionally, the legislation permits legal residents who were in the U.S. as of August 22, 1996, to receive SSI and Medicaid if they become disabled in the future.

- **Restores Medicaid to children who were receiving SSI and Medicaid as of August 22, 1996 who lose their SSI coverage as a result of changes enacted in the welfare reform legislation**, and who continue to meet the previously applicable SSI disability criteria (which included coverage of children with functional disabilities) as well as SSI financial eligibility rules and other conditions of eligibility.

- **Creates a new state option to provide 12 months of continuous eligibility to children up to age 19.** States also have new authority to grant presumptive (i.e., temporary) Medicaid eligibility to children under 19 while their applications for Medicaid or the state's children's insurance program are pending.

- **Permits states to guarantee 6 months of Medicaid coverage to managed care enrollees.**

- **Establishes a new capped Medicare Part B block grant** ($1.5 billion between FY 1998 and FY 2002) which entitles states (but not individuals) to financial assistance for the cost of paying Medicare Part B premiums for low-income persons on a first-come, first-served basis. Eligibility for full premium assistance is limited to individuals with incomes between 120% and 135% of the federal poverty level, with partial premium assistance for individuals with incomes between 135% and 175% of the federal poverty level.

- **Creates a new state option to permit disabled SSI beneficiaries with incomes up to 250% of the federal poverty level who are not otherwise eligible for benefits to buy into Medicaid** on a sliding scale premium basis.

Companion provisions in the Act provide states with $20.3 billion over a five-year time period beginning in FY 1998 to extend insurance coverage to children. The new State Children's Health Insurance Program (Title XXI of the Social Security Act) gives states the option of using their new funds to either extend Medicaid coverage to additional children or establish alternative insurance programs for these children. The legislation also permits states to accelerate coverage of poverty-level children under age 19 regardless of their date of birth (prior law limited mandatory coverage to children born after September 30, 1983).

C. Benefits

The law retains the existing defined set of benefits but restricts assistance for Medicare beneficiaries who also qualify for Medicaid. The new law:

- **Eliminates state requirement to pay the 20 percent Medicare coinsurance for qualified Medicare beneficiaries and dual enrollees** if such payments exceed the state Medicaid program's payment schedule for similar services. Medicare providers would be prohibited from balance billing beneficiaries for the unpaid coinsurance amount.

- **Requires the Department of Health and Human Services to conduct a study and report to Congress on the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit**. The report is due one year following enactment.

D. Premiums and Cost Sharing

The new law modifies the rules on cost-sharing for enrollees in managed care organizations.

- **The legislation retains most prior rules on cost sharing,** but permits states to impose cost sharing on managed care organization enrollees to the same extent that it is permitted in the fee-for-service system.

E. Provider Participation and Reimbursement

The legislation includes major changes in payment rules for hospitals, nursing homes, intermediate care facilities and home health agencies. The law also revises the payment system for federally qualified health centers (FQHCs) and rural health clinics (RHCs) that participate in managed care. In addition, the law alters the payment methodology for disproportionate share hospitals and sets new rules for payment to hospitals that participate in managed care arrangements. The legislation:

- **Repeals the Boren Amendment and related cost reimbursement provisions** relating to nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR) and home health agencies.

- **Revises the existing disproportionate share hospital (DSH) payment requirements and reduces DSH payments by $10.4 billion over 5 years.** It requires states to develop a system for identification of DSH facilities and for making payment adjustments to these facilities. The law also limits DSH payments to Institutions for Mental Diseases[3] (IMD) and requires direct supplemental DSH payments in certain instances to qualifying disproportionate share hospitals that participate in managed care arrangements.

- **Phases out cost-based reimbursement over a 6 year period while establishing new state payment obligations to FQHCs and RHCs that contract with managed care organizations.**

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[4]The law provides a phase-down method for payments to IMDs. Early analysis suggests that the IMD payment formula will need to be revised because it was erroneously drafted and results in federal payment reductions that are significantly below the agreed-upon level.

F. *Managed Care*

The legislation makes far-reaching changes and establishes new consumer protections under Medicaid managed care. States with Section 1115 and Section 1915 managed care demonstrations are exempted from new consumer and managed care organization provider protections (unless also required as a condition of their demonstration approval).[4] The law:

- **Permits states to condition Medicaid coverage for nearly all enrollees on mandatory enrollment in a qualified managed care entity.** This new Section 1932 option does not require federal waiver approval but operates instead through the more simple state plan amendment process. Exempted from the new state option process are children with special health care needs (including SSI children, certain institutionalized children, children receiving foster care and adoption subsidies, and children recognized as "special needs" children under state Maternal and Child Health Block Grant programs) as well as Medicaid beneficiaries also enrolled in Medicare (e.g., as dual enrollees, qualified Medicare beneficiaries (QMBs) or specified low income Medicare beneficiaries (SLMBs)). States may seek permission under Section 1915 or Section 1115 to mandate enrollment of these populations. States may also continue to use Section 1915 and Section 1115 for other populations.

- **Permits states to continue their managed care demonstration programs and exempts them from new consumer and managed care organization (MCO) protections.** States would be permitted to extend their Section 1115 demonstrations through an expedited process for up to 3 years. They could also continue to use the Section 1915 waiver statute both for the special needs children and low income Medicare beneficiaries who are exempt from the new state managed care option, as well as for other populations covered by the new option. States that continue to operate their managed care programs as demonstrations would be exempt from the new consumer and MCO protection requirements.

- **Creates two basic statutory categories of "managed care entities": primary care case managers and managed care organizations.** These entities may participate in the program if they meet applicable conditions of participation set forth in the statute and in their provider contracts. Certain federal requirements are applicable to both types of entities, while others apply only to larger "managed care organizations" which are distinguished by the fact that they are at financial risk for three or more contract services. Primary care case managers (PCCMs) (first authorized under Section 1915 enacted in 1981) may participate if they enter into either fee-for-service or risk-based "primary care case management" contracts with a state. Managed care organizations include traditional federally qualified or state licensed HMOs as well as other organizations (including Medicare Provider Sponsored Networks and other entities participating in the new Medicare+Choice program).

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[4]The Secretary could alter her demonstration standards to require compliance with these new requirements as a condition of approval of new or continuing waivers. At this point no action has been taken.

- **Establishes minimum federal conditions of participation for PCCMs and revises the conditions of participation for HMOs and other managed care organizations.** The law repeals certain HMO standards (most notably, the prohibition against participation by plans with 75% or greater Medicare/Medicaid enrollment) and revises and, in some cases, expands other requirements. The law establishes new consumer protections in the areas of emergency care (requiring coverage in accordance with a "prudent layperson" standard), hospital stays for mothers and newborns, and mental health parity. The legislation also establishes new standards governing prohibitions on physician communication, managed care organization solvency, information and disclosure, and access to care.[5] Most standards applicable to managed care organizations do not apply to PCCMs.

- **Gives auto-enrolled managed care enrollees a 90-day period to switch plans.**

- **Creates certain requirements for states that elect to mandate managed care enrollment**, including choice of plan for non-rural beneficiaries, information and disclosure to beneficiaries, use of certain intermediate sanctions in the case of plans which are substantially out of compliance with conditions of participation, anti-fraud and abuse measures, requirements applicable to contracts with managed care entities, and prior approval of all contracts valued at $1 million or more by HCFA.

- **Creates a new right of managed care entities to notice and a hearing prior to the termination of a contract with a state Medicaid agency.** States may, but are not required to, notify enrollees that a termination proceeding is under way and offer them the choice of disenrollment.

- **Retains the right of most managed care enrollees to select the family planning provider of their choice.** The right is retained for enrollees of comprehensive service managed care organizations regardless of whether they are enrolled through Section 1915 or Section 1932 or waived as part of a Section 1115 demonstration. PCCM enrollees in Section 1915 demonstrations continue to have a free-choice-of-provider right, but the right does not appear to extend to PCCM enrollees in the Section 1932 state option arrangements that do not require Secretarial waiver approval.

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[5]House provisions which would have guaranteed beneficiaries direct access to obstetrical and gynecological care as well as set forth more detailed grievance requirements for managed care organizations were dropped in conference.

G. Long-Term Care

The legislation creates a new long-term care option, building on the experience of the On Lok and PACE demonstration programs, which are terminated.

- **The legislation creates a new state option to extend the Medicare PACE program** (Programs of All-Inclusive Care for the Elderly) to Medicare entitled Medicaid beneficiaries who are 55 years of age or older, who require nursing facility-level care, and who meet other applicable conditions of eligibility permitted under the program. PACE providers would be required to furnish eligible persons with 24 hour-per-day access to all medically necessary services covered under Medicare and Medicaid without any limitation or condition on amount, duration and scope and without application of deductibles, coinsurance or other cost sharing that would otherwise be applicable under Medicaid. States have the authority to limit enrollment under PACE.

H. Federal Financial Assistance

The new law makes no change to prior payment structure but reduces federal DSH payments by $10.4 billion over five years, with upward adjustments for inflation in subsequent years. It also includes a 4-year $100 million emergency care fund ($25 million a year) for 12 states with high numbers of undocumented aliens. The law:

- **Reduces disproportionate share hospital (DSH) payments to states**, establishing specific annual payment levels for each state in the statute. After 2002, each state's DSH payment would be permitted to rise with the medical component of the CPI, subject to an upper limit of 12 percent of total state Medicaid expenditures.

- **Increases federal payments to the District of Columbia and the trusts and territories.** The law increases the federal medical assistance percentage (FMAP) to the District of Columbia from 50 percent to 70 percent. Federal payments to the trusts and territories are increased but continue to be subject to statutory limits.

- **Authorizes a new state entitlement grant program of $100 million over 4 years (FY 1998 through FY 2001) for emergency services to each of the 12 States with the highest number of undocumented aliens.** Each state's allotment of total funds would be based on its share of the total undocumented aliens in the 12 eligible states. Estimates of the number of undocumented aliens would be prepared by the Immigration and Naturalization Service (INS).

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
A. OVERVIEW		
1. Summary	**Eligibility.** Entitles individuals who meet eligibility conditions to coverage for a range of required and optional acute and long-term care services.	Retains Medicaid as an individual entitlement with open-ended federal financing. Adds new eligibility options for children and persons with disabilities, expands coverage of low-income Medicare beneficiaries, and restores coverage for certain disabled children and elderly and disabled legal residents.
	Benefits. Entitles individuals to coverage for a defined set of benefits.	Retains the existing defined benefit package while adding new benefit options for primary care case management, and liberalizing eligibility requirements for assistance under home and community-based care.
	Premiums and Cost Sharing. Permits copayments for Medicaid beneficiaries in limited circumstances.	Expands state options to require cost sharing for members of managed care organizations to the same extent that it is permitted in the fee-for-service system.
	Provider Participation and Reimbursement. Entitles certain providers, including hospitals, nursing homes, home health agencies, federally qualified health centers (FQHCs), and rural health clinics (RHCs), to reimbursements in accordance with cost principles under a provision commonly known as the Boren Amendment. Providers serving Medicaid beneficiaries with Medicare receive the Medicare payment rate.	Repeals Boren Amendment cost payment requirements for hospitals, nursing facilities and home health agencies. Phases out cost reimbursement for FQHCs and RHCs. Eliminates entitlement to payment at the Medicare rate for Medicaid beneficiaries who also are enrolled in Medicare.
	Managed Care. Permits states to offer voluntary managed care enrollment. Permits states to mandate enrollment via federal waivers of the freedom of choice provisions (Section 1915 or Section 1115). Permits states to implement research and demonstration programs for up to 5 years.	Permits states to mandate managed care enrollment for all Medicaid beneficiaries except special needs children and Medicaid beneficiaries who receive Medicare. Allows states to continue their Section 1115 and 1915 demonstrations and to continue using the demonstration authority in lieu of the new state option.
	Long-Term Care. Mandates coverage of nursing facility, home health benefits and hospital services for all beneficiaries and gives states the option to cover other benefits.	Creates a new state option to extend the Medicare PACE program.
	Federal Financial Assistance. States are entitled to open-ended federal contributions toward program costs, with upper limits on disproportionate share hospital payments. Prohibits non-emergency Medicaid coverage of otherwise-eligible undocumented aliens.	Makes no change to prior payment structure but reduces federal DSH payments by $10.4 billion over five years, with upward adjustments for inflation in subsequent years. Includes a 4-year $100 million emergency care fund for 12 states with high numbers of undocumented aliens.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
B. ELIGIBILITY		
1. General approach to eligibility	Entitles eligible persons to coverage for defined benefits, with eligibility conditioned on a series of financial, categorical and general conditions of eligibility. Entitles individuals who meet eligibility requirements to coverage for medical assistance items and services covered under a State's Medicaid plan when furnished by participating providers.	Retains the individual entitlement to coverage for eligible individuals with open-ended financing. Adds new eligibility options for children and persons with disabilities, expands coverage of low-income Medicare beneficiaries, and restores coverage for certain disabled children and elderly and disabled legal residents. Permits states to condition coverage for most beneficiaries on mandatory enrollment in a managed care entity. Exempts Medicaid beneficiaries who receive Medicare and special needs children (those who receive SSI, are in foster care or adoption placements, are recognized as "special needs" children under Title V, and certain institutionalized children) from mandatory managed care enrollment.
2. Poverty-level children	Mandates coverage of all poverty level children up to age 19 who meet financial conditions of eligibility and who were born after September 20, 1983, thereby phasing in coverage for children under 19 to the year 2002. States can expand coverage to children under 1902(r)(2) or Section 1115 waivers.	Clarifies state option to immediately extend coverage to all poverty level children under age 19. Accompanying provisions under the State Children's Health Insurance Program provide additional federal financial participation (FFP) to states that elect to extend Medicaid eligibility to additional groups of children.
3. Disabled children	Disabled children who receive SSI automatically receive Medicaid in most states. Children's disability criteria was restricted under the 1996 welfare reform law to remove functionally disabled and certain mentally ill children. Approximately 95,000 children receiving SSI (out of 170,000 cases reviewed) have had their benefits terminated.	Requires states to restore Medicaid to children who lose SSI as a result of welfare reform and who would continue to qualify for SSI under pre-welfare reform SSI standards.
4. Continuous coverage of children	Terminates eligibility for children who no longer meet conditions of eligibility.	Permits states to guarantee 12 months continuous eligibility following a determination of eligibility up to an age specified by the state, but not exceeding 19 years of age.
5. Presumptive eligibility for children	Provides states with the option to extend a period of presumptive (i.e., temporary) eligibility for prenatal care in the case of pregnant women who have applied for Medicaid and who, based on preliminary information, appear to be eligible for coverage.	Adds a state option to provide presumptive Medicaid eligibility for children under age 19 and identifies the following organizations as potentially qualified to make presumptive eligibility determinations: Head Start agencies, child care providers and WIC programs. Presumptive eligibility costs are offset against payments to states under the new State Children's Health Insurance Program.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
B. ELIGIBILITY		
6. Legal Immigrants	The 1996 welfare reform law terminated SSI for legal aliens and authorized, but did not require, states to continue Medicaid. As of Spring 1997, seven states had elected not to extend Medicaid to some or all former SSI recipients who were qualified aliens. Imposes 5-year limit on Medicaid coverage for non-emergency care only for otherwise eligible "qualified" aliens who enter the U.S. on or after August 22, 1996.	Restores SSI and Medicaid benefits to all elderly and disabled qualified aliens who received SSI and Medicaid as of August 22, 1996. Additionally permits legal residents in the U.S. as of August 22, 1996, to receive SSI if they subsequently become disabled and qualify for coverage. Extends from 5 to 7 years the time period for which eligible refugees may receive SSI and emergency Medicaid coverage. Adds Cuban and Haitian entrants to the group of legal immigrants covered by the exemptions for refugees. Exempts legal immigrants who are members of an Indian tribe from the restrictions on SSI and Medicaid eligibility.
7.Undocumented aliens	Prohibits medical assistance other than emergency coverage to undocumented aliens who would otherwise meet the eligibility requirements for the state's Medicaid program.	Authorizes a new capped state entitlement grant program of $100 million ($25 million per year for FY 1998 through FY 2001) for emergency services for undocumented aliens to each of the 12 States with the highest estimated number of undocumented aliens. Each state's allotment of total funds would be based on its share of the total undocumented aliens in the 12 eligible states. Estimates of the number of undocumented aliens would be prepared by the Immigration and Naturalization Service.
8. Low-income Medicare beneficiaries	Requires states to pay for the premiums, deductibles and coinsurance to Qualified Medicare Beneficiaries (QMBs) with resources at or below twice the SSI resource-eligibility standard and with incomes at or below 100% of the FPL. Requires states to pay Medicare premiums for Specified Low Income Medicare Beneficiaries (SLMBs) with family incomes at or below 120% of the FPL and resources at or below twice the SSI resource-eligibility standard. Federal contributions to the QMB and SLMB program are at the state's federal medical assistance percentage rate (between 50% and 79% of total state outlays).	Creates a new $1.5 billion, 100% federally-financed state entitlement, payable out of Medicare Part B, to provide premium assistance to low-income elderly and disabled beneficiaries. Specifies that individuals are not entitled to coverage. Funds are allocated to states based on the proportion of low-income elderly persons residing in the state. Funds would be used to assist states to increase coverage of SLMBs from 120% to 135% of the Federal Poverty Level (FPL) and to provide partial assistance to beneficiaries with incomes up to 175% of the FPL to offset the Part B premium rise as a result of Medicare home health coverage changes. Coverage of eligible persons would be on a first-come, first-served basis until funding runs out. Program ends in December 2002.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
B. ELIGIBILITY		
9. Disabled workers	Mandates coverage of persons "who previously received SSI if they continue to have a disabling physical or mental impairment, continue to meet all SSI requirements other than income from earnings, do not have enough earned income to disqualify them from special SSI coverage, and would be seriously inhibited from continuing to work in the absence of Medicaid and do not have enough earnings to provide a reasonable equivalent to Medicaid."	Authorizes states to offer buy-in coverage (with the premium based on a sliding scale) to otherwise ineligible disabled workers with incomes up to 250% of the FPL who, but for excess income, would receive SSI.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
C. BENEFITS		
1. General approach to benefits	Medicaid beneficiaries are entitled to coverage for a defined set of benefits. Certain benefits are required while others are included at state option. Coverage must be sufficient in amount, duration and scope to reasonably achieve the purpose of the benefit and states may not arbitrarily discriminate in coverage based on a condition or diagnosis.	Retains the existing defined benefit structure while adding new benefit options for primary care case management, and liberalizing eligibility requirements for assistance under home- and community-based care waivers.
2. Early and Periodic Screening Diagnosis and Treatment (EPSDT)	Mandates coverage for beneficiaries under 21 years of periodic and as-needed health exams, vision, dental and hearing care, and all federally recognized medically necessary treatment regardless of coverage for adults. Coverage levels exceed usual benefits offered by most commercial insurance plans.	Directs the Secretary to contract a study of the actuarial value of the EPSDT benefit, including the medically necessary treatment requirement. The report is due to Congress one year following enactment.
3. Primary care case management services	Primary care case management services are not an explicitly recognized Medicaid benefit. States may cover case management services at their option (case management services are required for children if medically necessary). Case management is defined as a service which assists beneficiaries to obtain necessary medical, educational, health or social services.	Adds a new primary care case management (PCCM) coverage option; PCCM benefits are defined as "case management-related services (including coordinating and monitoring of health services) provided by a primary care case manager under a PCCM managed care contract. Primary care means services customarily provided by primary care practitioners (including medical, health and lab services).
4. Home- and community-based care	Limits coverage of habilitation services under Section 1915(c) home- and community-based demonstrations to individuals who otherwise require nursing home or other forms of institutional care.	Eliminates the prior institutionalization requirement for habilitation services in the case of individuals participating in home- and community-based care demonstration programs.

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ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
D. PREMIUMS AND COST SHARING		
1. General approach to premiums and cost sharing	Authorizes the use of copayments in the case of certain beneficiaries but prohibits cost-sharing for children, pregnant women (other than premiums for pregnant women with incomes > 150% of the FPL), nursing facility residents and HMO enrollees.	Modifies rules on cost-sharing for MCO enrollees.
2. HMO copayments	Prohibits the use of copayments and cost sharing in the case of HMO enrollees.	Allows cost sharing for managed care enrollees to the same extent as in the fee-for-service program.
3. Co-insurance requirements for dual eligibles and Qualified Medicare Beneficiaries (QMBs)	State Medicaid programs are required to pay Medicare cost sharing charges (20% coinsurance) for dual eligibles and Qualified Medicare Beneficiaries (QMBs).	Eliminates state requirement to pay 20% coinsurance for Medicare beneficiaries if payment for services under Medicare exceeds that of Medicaid.
4. Payment of Medicare premiums for Specified Low-Income Medicare Beneficiaries (SLMBs)	Entitles Specified Low-Income Medicare Beneficiaries (SLMBs) with income at or below 120% of the FPL and resources at or less than twice the SSI resource-eligibility standard to coverage of Medicare premiums only. Federal contributions to the SLMB program are at the state's federal medical assistance percentage rate(between 50% and 79% of total state outlays).	Establishes a total state entitlement to $1.5 billion under Medicare Part B between January 1998 and December 2002. Funds must be used to pay Part B premiums for low-income beneficiaries with family incomes between 120% and 135% of the FPL, with partial premium assistance for persons with incomes between 135% and 175% of the FPL to offset Part B premium increases resulting from Medicare home health changes. (The Part B premium is set at 25% of the program's cost; home health was transferred from Part A to Part B, thereby requiring an increase in the premium). Assistance would be on a first-come, first-served basis for a five-year period, with no entitlement to any individual. Federal contributions to state programs would be 100% FFP level.
5. Private health insurance premiums	Requires states to pay private health insurance premiums in the case of beneficiaries with access to private health coverage to the extent that such payments are determined to be cost effective. Individuals are required to enroll in cost effective arrangements as a condition of coverage.	Revises the provision to make the purchase of private health insurance at state option along with enrollment in cost effective arrangements as a condition of coverage.

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E. PROVIDER PARTICIPATION AND REIMBURSEMENT		
1. General approach to provider reimbursement	Statute establishes certain rules on provider reimbursement with minimum payment standards for certain providers.	Eliminates minimum payment standards for most classes of providers. Repeals Boren Amendment cost payment requirements for hospitals, nursing facilities, and home health agencies. Revises cost reimbursement system for federally qualified health centers (FQHCs) and rural health clinics (RHCs). Eliminates entitlement to payment at the Medicare rate for Medicare providers furnishing services to Medicaid beneficiaries also enrolled in Medicare.
2. Hospitals	State payment to hospitals must be reasonable and adequate to meet the cost of efficiently provided care as required under the Boren Amendment, subject to Medicare upper payment limits. Provisions do not apply to institutions that are participating providers in risk contracts with managed care plans.	Repeals the Boren Amendment.[6] Establishes a public rate-setting process under which proposed rates, methodologies underlying the rates, and justifications for such rates, are published and subject to public review and comment. Requires Secretary of HHS to study the effects of state rate-setting methods on access and quality. Retains Medicare upper payment limit provisions.
3. Disproportionate Share Hospitals (DSH hospitals)	Requires states to make additional payments to hospitals (known as disproportionate share hospitals (DSH hospitals)) that serve a disproportionate number of low-income and Medicaid patients. States must make DSH payments to DSH hospitals that have Medicaid utilization rates more than one standard deviation above the average Medicaid utilization rate for participating hospitals in the state or a low-income utilization rate greater than 25 percent. States may also treat as a DSH hospital any hospital with Medicaid in-patient utilization greater than 1% (including state mental hospitals).	Reduces federal DSH payments to states by $10.4 billion from FY 1998 to 2002, with actual payment amounts per state set forth in statute for each fiscal year between FY 1998 and FY 2002. After 2002, DSH payments for each state would rise by an amount equal to the medical care component of the Consumer Price Index (CPI) for urban consumers, with aggregate DSH payments capped at 12% of a state's total Medicaid expenditures. Prohibits states from folding DSH payments into HMO payments and requires separate and direct payment to DSH facilities. Exempts current payment arrangements.
4. Nursing facilities	State payment to nursing facilities must be reasonable and adequate to meet the cost of efficiently provided care as required under the Boren Amendment. Medicare upper payment limits apply. Provisions do not apply under HCFA regulations to institutions that are participating providers in risk-based managed care plans.	Repeals the Boren Amendment. Establishes a public rate-setting process under which proposed rates, methodologies underlying the rates, and justifications for such rates are published and subject to public review and comment. Requires Secretary of HHS to study the effects of state rate-setting methods on access and quality.

[6]The statute is unclear regarding whether the repeal of the Boren requirements is retroactive.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
E. PROVIDER PARTICIPATION AND REIMBURSEMENT		
5. Managed care entities	Requires that Medicaid payment to a contractor under a risk contract for a defined scope of services be actuarially sound. Payment may not exceed the cost to the agency of providing similar services on a fee-for-service basis (known as upper payment limits).	No change to prior law. No change to prior law.
6. Federally qualified health centers (FQHCs) and rural health clinics (RHCs)	Federally qualified health center (FQHC) and rural health clinic (RHC) services are mandatory. FQHCs and RHCs receive cost-based reimbursement. Special rules apply to FQHCs and RHCs that participate in risk-based managed care systems that permit them to elect cost-based reimbursement.	Phases out reasonable cost payment as follows: 100% in FY 1998 and 1999; 95% in FY 2000; 90% in FY 2001; 85% in FY 2002; and 70% in FY 2003. Repeals requirement on October 1, 2003. Additionally, limits the definition of FQHCs and RHCs to exclude entities that are provider-owned. Prohibits managed care organizations from discriminating against clinics in establishment of payments. Establishes new payment system for FQHCs and RHCs that contract with managed care organizations that requires state agencies to pay FQHCs and RHCs the difference between the amount received from managed care organizations and the amount they are owed under applicable cost principles.
7. Obstetric and pediatric providers	Requires states to submit data on obstetric and pediatric payment levels to demonstrate that payments are sufficient to enlist adequate numbers of providers.	Eliminates obstetric and pediatric payment rate requirements.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
1. General approach to managed care	Authorizes states to offer enrollment as a beneficiary option in qualified managed care entities. Entities that meet the requirements of Section 1903(m) (HMOs and HIOs) are the only entities formally recognized in statute. Additionally the Secretary permits states to mandate enrollment through Section 1915 or Section 1115 freedom-of-choice waivers. States may offer enrollment in HMOs and HIOs or with primary care case managers (PCCMs) who may be paid on a fee-for-service or risk basis. As of 1996 virtually all states mandated managed care enrollment for at least some Medicaid beneficiaries; one third of all beneficiaries were enrolled in managed care. Federal statute establishes conditions of participation for HMOs and HIOs covered by Section 1903(m). States may seek waiver of these conditions under Section 1115 demonstrations.	Permits states to mandate managed care enrollment as a condition of coverage and without either Section 1915 or 1115 waivers for all Medicaid beneficiaries except beneficiaries who also receive Medicare, Indians and children with special health care needs (i.e., children on SSI, children with special health care needs under the Title V MCH block grant, or certain institutionalized children). Indians may be required to enroll under certain circumstances. Creates two new groups of "managed care entities" under the statute: "managed care organizations," which are managed care companies at risk for both hospital and physician care and which must meet the conditions under Section 1903(m); and primary care case managers, which do not offer comprehensive care and which may be paid on a fee-for-service or risk basis. States may continue to seek Section 1915 and Section 1115 waivers in order to mandate enrollment for special needs children and Medicare/Medicaid beneficiaries. States may also seek Section 1115 waivers for other aspects of their managed care programs (e.g., waiver of new conditions of participation) Expands categories of managed care organizations covered by Section 1903(m). Relaxes certain existing conditions of participation for managed care organizations covered by Section 1903(m) while adding other conditions of participation in the areas of access, solvency, fraud and abuse, quality assurance, protections against patient billing, information and disclosure and marketing.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
2. Continuation of Section 1915 and 1115 waivers	Under authority granted by Section 1115 of the Social Security Act, the Secretary may allow states to implement research and demonstration programs for a period of up to five years. In the case of Arizona, however, the waiver has been renewed several times since its implementation in 1983. As of September 1997, 26 states had requested, been approved to operate, or actually were operating statewide mandatory Medicaid managed care demonstrations under Section 1115. Under the authority granted under Section 1915 states may waive the freedom of choice provision in order to require enrollment in managed care arrangements. States may implement Section 1915 waivers for up to 2 years, with renewals available thereafter. As of 1997, 40 states were operating 1915(b) waivers.	Allows states to continue their Section 1115 and 1915 demonstrations and to continue using the demonstration authority in lieu of the new state option. States operating under Section 1915 or 1115 are exempt from the new consumer and managed care organization protections unless the protections are included as waiver conditions. Establishes an expedited Section 1115 renewal process, with 3-year renewals available. Allows states to continue to mandate managed care enrollment as part of a Section 1915 demonstration as opposed to the new state option, which is subject to new federal requirements.
3. Mandatory enrollment as a condition of coverage	States have the option to offer managed care enrollment to any group of beneficiaries on a voluntary basis. Enrollment may be mandatory only if states receive federal waivers and the federal government approves in advance the design of the managed care program with respect to access and quality.	Creates a new state option to mandate managed care enrollment as a condition of eligibility for medical assistance for all beneficiaries except individuals eligible for Medicare, Indians, and special needs children. State mandates would be implemented as state plan amendments and without advance federal approval except for contracts valued at $1 million or more, adjusted for inflation.
4. Enrollment composition of Medicaid-qualified managed care organizations	Managed care organizations operating on a full-risk basis (i.e., at risk for three or more services) may have a public (i.e., Medicaid/Medicare) enrollment of no more than 75% of total enrollees, commonly referred to as the "75/25" rule. (This provision is frequently waived under Section 1115 demonstration programs.)	Eliminates the "75/25" rule.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
5. Default enrollment	Mandatory managed care demonstrations all include provisions to "default enroll" into a plan individuals who do not select a plan. HCFA conditions of participation set certain maximum standards for the size of the default population. States with large default rates must permit beneficiaries additional time to choose a plan.	Requires state default enrollment systems to consider maintaining existing provider-individual relationships or relationships with traditional Medicaid providers. If maintaining such relationships is not possible, states must provide for the equitable distribution of default enrollees among qualified managed care entities, consistent with their enrollment capacity.
6. Guaranteed enrollment	States may guarantee 6 month enrollment in federally qualified HMOs without waivers. States conducting Section 1115 demonstrations may elect to guarantee enrollment for a minimum period of time for enrollees with any managed care entity.	Permits states to guarantee 6 months enrollment in any qualified managed care entity, not just federally qualified HMOs.
7. Disenrollment	Permits beneficiaries to disenroll without cause in the case of voluntary HMO enrollment after 30 days membership. This provision is commonly waived in Section 1115 demonstration programs, with no cause disenrollment rights restricted.	Provides states the option to restrict no-cause disenrollment to the first 90 days in an enrollment period which may last up to 12 months. Permits disenrollment for cause at any time (cause is not defined).

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
8. Conditions of participation for PCCMs	The statute establishes no conditions of participation for partial risk plans or primary care case management (PCCM) providers. HCFA regulations and guidelines establish general access conditions.	Adds a limited set of conditions of participation for primary care case management. (Entities that are not governed by broader Section 1903(m) standards are subject to those applicable to comprehensive MCOs.) PCCM contracts must: • Provide for reasonable and adequate hours of operation including 24-hour availability of "information, referral and treatment" with respect to medical emergencies. • Limit enrollment to individuals living sufficiently near the PCCM delivery site(s) to be able to reach the site within a reasonable time "using available and affordable modes of transportation." • Provide for arrangements with sufficient physicians and other health professionals "to ensure that services under the contract can be furnished to enrollees promptly and without compromise to [sic] quality of care." • Prohibit discrimination on the basis of health status in enrollment, disenrollment and re-enrollment. • Provide for compliance with a "prudent layperson" emergency care coverage standard and the post stabilization standard. Compliance with a "prudent layperson" emergency care coverage standard requires PCCMs to provide coverage for emergency services "without regard to prior authorization or the emergency care provider's contractual relationship with the MCO or the PCCM." Defines emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily function or serious dysfunction of any bodily organ or part." Compliance includes compliance with post-stabilization requirements applicable to managed care organizations participating in Medicare+Choice. • Specify which benefits the PCCM is responsible for under the contract and which remain the direct responsibility of the state. • Prohibit use of marketing materials that contain false or materially misleading information. Obtain prior approval of marketing materials from the state. Prohibit direct, door-to-door and cold call marketing, selective service area marketing, and tie-ins. • Require the provision of information on request, including information on participating providers, enrollee rights and responsibilities, covered services, grievance and appeals procedures, and comparative information showing benefits and cost sharing, service area, and quality and performance to the extent available.

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
9. Conditions of participation for MCOs	Federal law establishes a series of conditions of participation for full risk managed care organizations participating in Medicaid.	Adds amendments to the conditions of participation for managed care organizations. Entities that are not governed by broader Section 1903(m) standards are subject to those applicable to comprehensive MCOs. Requires managed care organizations to: • Comply with a "prudent layperson" emergency care coverage standard which requires MCOs and PCCMs to provide coverage for emergency services "without regard to prior authorization or the emergency care provider's contractual relationship with the MCO or the PCCM." Defines emergency medical condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily function or serious dysfunction of any bodily organ or part." Compliance includes compliance with post-stabilization requirements applicable to managed care organizations participating in Medicare+Choice. • Specify all managed care benefits in the contract for which the MCO is responsible and which remain the direct responsibility of the state. • Not discriminate against individual providers based on their licensure or certification under law. • Comply with the Mothers and Newborns Protection Act (the 48-hour hospital stay rule) and the Mental Health Parity Act. • Agree to external review of all contract obligations by an independent entity unless the plan is accredited or (at state election) participates in the Medicare+Choice. • Include increased solvency protections to (in order to be licensed) require licensure by the state as an HMO or lawful risk bearing entity unless the managed care organization has solvency guaranteed by the state, is a public entity, or is not at risk for hospital care. • Prohibit use of marketing materials that contain false or materially misleading information. Obtain prior approval of marketing materials to obtain prior approval from the state. Prohibit direct, door-to-door and cold call marketing, selective service area marketing, and tie-ins. • Not place restrictions on provider/patient communications. • Maintain an internal grievance procedure for enrollees and providers to challenge the denial of coverage or payment. Retain fair hearing requirements. • Protect enrollees against liability for payment in the event of an MCO's insolvency.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
9. Conditions of participation for MCOs *(continued)*		• Provide information on request regarding participating providers, enrollee rights and responsibilities, information on covered services, grievance and appeals procedures, and comparative information showing benefits and cost sharing, service area, and quality and performance to the extent available. • Demonstrate that the managed care organization "has the capacity to serve the expected enrollment in the service area" including assurances that the organization "offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area and maintains a sufficient number, mix, and geographic distribution of providers of services." • Apply balance billing limitation requirements to any entity subcontracting with the MCO.
10. Prior approval of contracts with managed care organizations	HCFA must pre-approve MCO contracts valued at $100,000 or greater.	Raises pre-approval threshold from $100,000 to $1 million, indexed for inflation.
11. Plan protections	States impose a variety of sanctions against managed care entities under their contracts ranging from financial penalties and freezing enrollment to contract termination.	Requires states to build into their managed care organization contracts intermediate sanctions for certain types of misconduct. Sanctions include financial penalties, beneficiary disenrollment options, receivership, freezing enrollment and withholding payments. Sanctionable offenses include "substantial" failure to provide medically necessary items and services, charging excess amounts for care, and discrimination on the basis of health status or need for health services. Prohibits states from terminating contracts with managed care entities without notice and hearing that meets due process standards. At their option states may, but need not, notify beneficiaries and permit them to disenroll from an entity that is in contract termination proceedings.
12. Payments to Disproportionate Share Hospitals	Prior law is silent about how DSH hospitals should be paid when they treat managed care patients.	Prohibits folding DSH payments into HMO premiums. Requires that a DSH payment adjustment for services furnished by a hospital for individuals entitled to benefits and enrolled in a managed care plan or PCCM be made directly to the hospital and not as part of the capitation amount.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
F. MANAGED CARE		
13. Quality assurance	Federal statute requires that HMOs maintain internal quality assurance processes and requires an independent external review of contractor performance. There are no similar provisions for PCCMs and partial risk plans. Requires states to have quality assurance systems for Section 1903(m) entities.	Permits waiver of external review procedures in the case of Section 1903(m) managed care organizations that participate in Medicare+Choice. Does not require external quality assurance reviews of PCCMs. Requires states to develop and implement a quality assessment and improvement strategy (consistent with standards established by the Secretary and in consultation with the states) that includes (1) "[s]tandards for access to care so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity," (2) examination of other quality of care measures, and (3) procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees, including submitting quality assurance data meeting requirements for entities with Medicare contracts or other requirements approved by the Secretary, and periodic assessment of quality assurance measures.
14. Enrollment of Indians	No special rules in the statute regarding treatment of Medicaid-eligible Native Americans. HCFA may condition approvals of state waiver requests on compliance with certain provisions regarding access to health services by Indians.	Requires Indians to enroll with a managed care entity only if it is one of the following (and is participating under a state's managed care program): the Indian Health Service; an Indian health program operated by an Indian tribe or tribal organization; an urban Indian health program operated by an urban Indian organization.
15. Treatment of family planning services	Patients have free choice of family planning providers for covered family planning services even if enrolled in managed care. States may obtain waivers of the family planning freedom-of-choice provisions under Section 1115.	Retains free choice of provider rule except for persons enrolled in new Section 1932 state option PCCM program. Enrollees in MCOs retain freedom-of-choice unless waived as part of a Section 1115 demonstration.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
G. LONG-TERM CARE		
1. Long-term care services	Mandates coverage of nursing facility, home health benefits and hospital services for all beneficiaries (including frail elderly), and gives states the option to cover a broad range of other long-term care benefits. Authorizes the Secretary to waive otherwise applicable limitations on benefits, statewideness and eligibility in order to permit states to cover home- and community-based services for individuals at risk for nursing home care.	Establishes a new optional "Program of All Inclusive Care For the Elderly (PACE)" authorizing coverage of integrated acute and long-term care services: PACE program benefit consists of all items and services covered under Medicare and Medicaid without limitation or condition related to amount, duration and scope (within PACE specified protocol for benefits) and without copayment and coinsurance. Enrollment is voluntary; states may limit number of enrollees. Services furnished through certified PACE program providers who are paid on a prospective, capitated basis, who comply with a PACE protocol, and meet conditions of participation. PACE program-eligible persons are individuals ages 55 years and older, who require nursing facility-level care, reside in the PACE program service area, meet other applicable eligibility conditions, and whose health status meets PACE protocols. Health status eligibility must be re-evaluated annually unless there is no reasonable expectation of improvement. Secretary may waive aspects of PACE protocols to permit adaptation of PACE to needs of particular organizations. Secretary is required to carry out for-profit PACE provider demonstrations. [Note: Corresponding provisions also added to Medicare]

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
H. FEDERAL FINANCIAL ASSISTANCE		
1. General Approach	States are entitled to open-ended federal contributions toward program costs, with upper limits on disproportionate share hospital payments. Prohibits non-emergency Medicaid coverage of otherwise-eligible undocumented aliens.	No change to prior payment structure but reduces federal DSH payments by $10.4 billion over five years, with upward adjustments for inflation in subsequent years. Includes a 4-year $100 million emergency care fund for states with high numbers of undocumented aliens.
2. Disproportionate share hospital (DSH) payments	Federal payments toward states' disproportionate share hospital program are capped at an aggregate level per state as well as at a facility level. For FY 1994, the total federal DSH allocation was $18.5 billion.	Reduces the federal DSH allocation by $10.4 billion over 5 years. State DSH allocations are specified by statute from FY 98 through 2002, with upward adjustment beginning in FY 2003 by the percentage increase in the medical care component of the consumer price index for urban consumers, up to an aggregate ceiling of 12 percent of total state Medicaid program outlays.
3. Disproportionate share hospital payments for institutions for mental diseases (IMDs)	States may cover Medicaid services furnished in an institution for mental diseases (IMD) only in rare circumstances. An IMD is a hospital, nursing facility, or other institution of more than 16 beds which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. IMDs include state and private psychiatric hospitals and large board-and-care homes. Services in IMDs are covered only for beneficiaries under age 21 and ages 65 and older, effectively excluding coverage for persons between the ages of 21 and 64 (except for those residing in an IMD with 16 or fewer beds). DSH payment rules do not prohibit DSH payments to IMDs or establish upper limits. A number of states made high DSH payments to state mental institutions to support their activities.	Curbs use of DSH for children in mental institutions. Freezes federal DSH payments to IMDs and other mental health facilities at the DSH spending level for 1995. No state will receive more than the 1995 level. Furthermore, beginning in FY 2001, phases down the payment amount as follows: 50% in FY 2001, 40% in FY 2002, and 33% in FY 2003 and each succeeding fiscal year.
4. Federal Medicaid assistance percentage (FMAP)	The Federal government contributes between 50% and 80% of every state dollar spent on medical assistance for eligible persons; this amount is known as the federal medical assistance percentage (FMAP) and is based on a state's per capita income relative to the national average. Federal financial assistance for the District of Columbia is 50% Federal payments to the territories is 50%, subject to statutory limits.	Increases the FMAP for the District of Columbia from 50 percent to 70 percent, beginning FY 1998, and for Alaska from 50 percent to 59.8 percent for FY 1998, FY 1999, and FY 2000. Increases federal payments to Puerto Rico, Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for FY 1998. In subsequent years the rate will reflect the percentage increase in the medical care component of the CPI.

A Comparison of the Medicaid Provisions in the Balanced Budget Act of 1997 with Prior Law

ISSUE	PRIOR LAW	BALANCED BUDGET ACT OF 1997 (P.L. 105-33)
H. FEDERAL FINANCIAL ASSISTANCE		
5. Federal financial assistance for care of aliens	Federal financial participation is available for Medicaid coverage for emergency services only for undocumented persons who otherwise would meet the eligibility requirements for the state Medicaid program.	Authorizes a new state entitlement grant program of $100 million ($25 million per year) for FY 1998 through FY 2001 for emergency services to each of the 12 states with the highest number of undocumented aliens. Each state's allotment of total funds would be based on its share of the total undocumented aliens in the 12 eligible states. Estimates of the number of undocumented aliens would be prepared by the Immigration and Naturalization Service.