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Consolidated Appropriations Act, 2024 (P.L. 118-42): Medicaid and Medicare Provisions

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The Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42), enacted on March 9, 2024, provides appropriations to federal agencies for the remainder of FY2024 and extends several expiring programs and authorities, including various public health programs.

The CAA 2024 includes numerous provisions related to Medicaid and the State Children’s Health Insurance Program (CHIP) under Division G, Title I, Subtitle B. The law also includes a number of Medicare provisions under Division G, Title I, Subtitle C.

With regard to Medicaid and CHIP, the CAA 2024 includes numerous provisions related to mental health (MH) and substance use disorder (SUD). The law permanently requires state Medicaid programs to cover medication-assisted treatment (MAT) for opioid use disorders. The CAA 2024 requires the Secretary of the Department of Health and Human Services (HHS) to link, analyze, and publish annually data relating to MH and SUD services provided to Medicaid and CHIP enrollees diagnosed with MH and/or SUD conditions. It also expands state requirements to monitor and manage antipsychotic drug utilization for Medicaid enrollees over the age of 18 housed in institutional care settings. In addition, the CAA 2024 provisions make permanent a state plan option to provide Medicaid coverage of certain individuals who are patients in eligible institutions for mental diseases (IMDs) and add certified community behavioral health clinic services to the list of Medicaid optional service categories under traditional Medicaid. The provisions also require the HHS Secretary to issue guidance on (1) opportunities to increase access to MH and SUD Medicaid and CHIP participating providers and (2) opportunities to promote the integration of MH or SUD services with primary care.

With respect to incarcerated individuals, the CAA 2024 expands the population for whom states are prohibited from terminating Medicaid eligibility to include all incarcerated individuals, as well as “eligible juveniles” during the period in which they are detained pending disposition of charges. The law expands the population for whom states are prohibited from terminating CHIP eligibility to include targeted low-income pregnant women enrollees who are inmates of a public institution. Finally, the provisions require the HHS Secretary to award grants to states to develop operational capabilities and continuity of care for Medicaid and CHIP enrollees upon release.

The CAA 2024 eliminates the Medicaid disproportionate share hospital (DSH) reductions for FY2024 and applies the reductions for FY2025 to the period beginning January 1, 2025, and ending September 30, 2025. It also removes the end date for the temporary provision lowering the federal share of medical loss ratio (MLR) remittances specific to the Medicaid expansion from 90% to each state’s regular federal medical assistance percentage (FMAP) rate. In addition, the law changes the amounts available in the Medicaid Improvement Fund (MIF).

With regard to Medicare, the CAA 2024 extends funding for quality measure endorsement, input, and selection for Medicare quality programs and for outreach and assistance to low-income beneficiaries. The law extends certain Medicare payment adjustments, including geographic adjustments under the physician fee schedule, incentive payments for qualified participants in alternative payment models (APMs), and payment adjustments for hospice agencies. It also extends certain payment adjustments and eligibility criteria for low-volume hospitals (LVHs) and extends the Medicare-Dependent Hospital (MDH) program in its entirety. In addition, the CAA 2024 eliminates the funds available in the Medicare MIF.

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Introduction

The Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42), enacted on March 9, 2024, provides appropriations to federal agencies for the remainder of FY2024 and extends several expiring programs and authorities, including various public health programs.

The CAA 2024 includes numerous Medicaid and State Children’s Health Insurance Program (CHIP) provisions under Division G, Title I, Subtitle B. Several provisions modify mental health (MH) and substance use disorder (SUD) treatment services under Medicaid. Others address Medicaid and CHIP data collection and state-level monitoring associated with such treatment. The law also requires the Secretary of the Department of Health and Human Services (HHS) to issue guidance to improve the Medicaid and CHIP MH provider workforce and to integrate behavioral health services with primary care.

The Medicaid and CHIP provisions in the CAA 2024 also modify eligibility requirements for incarcerated individuals and establish state grants to promote continuity of care upon release. The law includes provisions to eliminate certain Medicaid disproportionate share hospital (DSH) reductions and makes permanent a provision that requires Medicaid expansion states to return a smaller portion of their medical loss ratio (MLR) remittances to the federal government by lowering the federal share of MLR remittances. The law also changes the amounts available in the Medicaid Improvement Fund (MIF).

In addition, the law includes several Medicare provisions under Division G, Title I, Subtitle C. Specifically, the CAA 2024 provides funding for quality measure endorsement, input, and selection for certain Medicare quality programs. It also provides additional funding for outreach and assistance to low-income Medicare beneficiaries and extends certain Medicare payment adjustments.

This report provides information on the Medicaid-, CHIP-, and Medicare-related provisions in the CAA 2024 as enacted. It will not be updated to reflect any future amendments or changes to affected programs or provisions.

The report begins with short descriptions of the Medicaid, CHIP, and Medicare programs. These descriptions are followed by summaries of the provisions in the CAA 2024 impacting Medicaid, CHIP, and Medicare. These summaries are under the following headings: Subtitle B—Medicaid and Subtitle C—Medicare.

Table A-1 provides abbreviated summaries for each of the provisions in the CAA 2024 that impacts Medicaid, CHIP, and Medicare. **Table B-1** lists abbreviations used in this report.

Descriptions of Medicaid, CHIP, and Medicare

Medicaid and CHIP are similar in that both programs are federal-state partnerships that provide coverage of health care services to low-income individuals. However, the income eligibility thresholds for CHIP are higher than those for Medicaid in each state.¹ Both programs are designed and administered by states, and both are jointly financed by the federal government and states.

¹ The Medicaid and CHIP Payment and Access Commission (MACPAC), “Exhibit 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State,” MACStats, July 2023.

Medicaid²

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports, to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older. In FY2022, Medicaid covered health care services for an estimated 92 million individuals at an estimated cost of \$824 billion, with the federal government paying \$585 billion of that total.³

Participation in Medicaid is voluntary for states; all 50 states plus the District of Columbia (DC) and the five territories choose to participate.⁴ The federal government requires participating states to cover certain mandatory populations and benefits but allows states to cover other optional populations and benefits. Due to this flexibility, there is substantial state variation in factors such as Medicaid eligibility, covered benefits, and provider payment rates. In addition, several waiver and demonstration authorities in statute allow states to operate their Medicaid programs outside of certain federal rules.

CHIP

CHIP is a federal-state program that provides health coverage to certain uninsured, low-income children and pregnant women in families that have annual income above Medicaid eligibility thresholds but do not have health insurance. CHIP is jointly financed by the federal government and the states and administered by the states.⁵ In FY2022, CHIP covered health care services for an estimated 7 million individuals at an estimated cost of \$22 billion, with the federal government paying \$17 billion of that total.⁶

Participation in CHIP is voluntary, and all states, DC, and the five territories participate. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own versions of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs.

States may design their CHIP programs in one of three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach in which the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. CHIP benefit coverage and cost-sharing rules depend on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits and cost sharing. For separate CHIP programs, the benefits are permitted to look more like private health insurance and states may impose cost sharing, such as

² For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

³ This enrollment figure is the average monthly enrollment from the Congressional Budget Office (CBO), "Medicaid Baseline Projections," May 2023, <https://www.cbo.gov/system/files/2023-05/51301-2023-05-medicaid.pdf>. The expenditures figures are from Centers for Medicare & Medicaid Services (CMS), "Form CMS-64 Data as Reported by States to the Medicaid Budget and Expenditure System, as of August 11, 2023," <https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html>.

⁴ The five territories are American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

⁵ For more information about the federal financing of the State Children's Health Insurance Program (CHIP), see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*.

⁶ This enrollment figure is the average monthly enrollment from CBO, "CHIP Baseline Projections," May 2023, <https://www.cbo.gov/system/files/2023-05/51296-2023-05-chip.pdf>. The expenditures figures are from CMS, "Form CMS-64 Data as Reported by States to the Medicaid Budget and Expenditure System, as of August 11, 2023," <https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html>.

premiums or enrollment fees, with a maximum allowable amount that is tied to annual family income.

Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act (SSA; as amended by P.L. 89-97) to provide health insurance to individuals aged 65 and older, and it was expanded in 1972 to include permanently disabled individuals under the age of 65. In CY2023, Medicare covered health care services for an estimated 66.4 million individuals and, in FY2022, had an estimated cost of \$773 billion.⁷

Medicare consists of four distinct parts. Medicare Parts A, B, and D each cover different services. Together, Parts A and B of Medicare comprise *original* or *fee-for-service* Medicare. Part A covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. Part B covers a range of medical services and supplies, including physician-administered drugs and durable medical equipment. Although enrollment in Part B is optional, most beneficiaries with Part A also enroll in Part B. Part C offers a private plan alternative for Parts A and B, and Part D is an optional outpatient prescription drug benefit.⁸

Summaries of Provisions

The following are summaries of the provisions in the CAA 2024 that impact Medicaid, CHIP, and Medicare. For each provision, there is background and a summary of the provision as enacted by the CAA 2024. These summaries are under the following headings: Subtitle B—Medicaid and Subtitle C—Medicare.

Subtitle B—Medicaid

Section 201: Requirement for State Medicaid Plans to Provide Coverage for Medication-Assisted Treatment

Background

Under federal law, state Medicaid programs have the option to cover outpatient prescription drugs. If a program elects to cover drugs, it is obligated to cover most drugs offered by drug manufacturers that participate in the Medicaid drug rebate program. Federal law defines *covered outpatient drugs* as outpatient drugs that are available only by prescription but are not paid for as part of bundled service, such as part of hospital treatment.⁹

Although there are different approaches to treating SUD that vary depending on the individual seeking treatment and the substance being abused, medication-assisted treatment (MAT) can help reduce an individual's addiction. All state Medicaid programs cover MAT drugs, although states

⁷ Medicare enrollment estimates are from CMS, Office of Enterprise Data and Analytics, "CMS Fast Facts," March 2024, https://data.cms.gov/sites/default/files/2024-03/CMSFastFactsMar2024_508.pdf. The Medicare expenditure estimates are CRS calculations based on CMS, *Financial Report 2022: Consolidated Statement of New Cost*, November 2022, p. 27, <https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2022.pdf>.

⁸ For more information about the Medicare program, see CRS Report R40425, *Medicare Primer*.

⁹ Social Security Act (SSA) §1927(k)(3), "Limiting Definition."

may not consider all MAT drugs preferred drugs; consequently, these drugs might be available only if a provider completes a prior authorization request.

Section 1006(b) of the SUPPORT for Patients and Communities Act (SUPPORT Act; P.L. 115-271) requires state Medicaid programs to cover MAT for Medicaid beneficiaries, including those enrolled through state plan waivers for FY2021-FY2025 (October 1, 2020, through September 30, 2025). SUPPORT Act Section 1006 also defined MAT to include all drugs approved by the Food and Drug Administration to treat opioid use disorders, including methadone and biologic products, as well as counseling services and behavioral therapy. States that require legislation to approve Medicaid state plan amendments, and when those state legislatures meet less frequently, may request additional time to meet the Section 1006 MAT coverage requirement.

State Medicaid programs may be exempt from the MAT coverage requirement if they certified to the HHS Secretary's satisfaction before October 1, 2020, that implementation of the MAT coverage requirement was infeasible because there were insufficient qualified MAT providers or facilities within the state that were enrolled as providers in the state's Medicaid program.

Provision

Section 201 of the CAA 2024 amends SSA Section 1905 (42 U.S.C. §1396d) by removing the September 30, 2025, expiration date for the state Medicaid program requirement to cover all forms of MAT drugs. In addition, if a state has certified that implementing MAT coverage would be infeasible due to a MAT provider or participating facility shortage, Section 201 requires state Medicaid programs to recertify at least every five years to the satisfaction of the HHS Secretary that they are unable to meet the MAT coverage requirements for those reasons.

Section 202: Collection and Reporting of Comprehensive Data for Specified Populations Enrolled in Medicaid and CHIP

Background

SSA Section 1903(r) requires states to operate Medicaid mechanized claims information retrieval systems that allow for the efficient and effective administration of Medicaid state plans. The Balanced Budget Act of 1997 (BBA 1997; P.L. 105-33) required states to submit electronic claims data, enrollee encounter data, and other supporting information consistent with the Medicaid Statistical Information System (MSIS). Section 6504 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) expanded the state Medicaid data reporting requirements to include data elements that the HHS Secretary determines necessary for program integrity, program oversight, and administration. These additional data reporting requirements resulted in the Centers for Medicare & Medicaid Services' (CMS's) transition from MSIS to the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS expands the data states are required to submit to CMS to include information on providers, third-party payers, and managed care plans.

Section 1015 of the SUPPORT Act required the HHS Secretary to publish a report on the prevalence of SUDs and the SUD treatment services provided to Medicaid enrollees based on federally required state submissions of T-MSIS data. CMS is required to issue annual updates that include certain specified information no later than January 1 for each calendar year through 2024. Similar reporting requirements do not exist for CHIP.

When federal agencies have records with individually identifying information (i.e., a system of records), federal agencies are required to publish a notice in the *Federal Register* for each system

of records that is called a *system of records notice* (SORN).¹⁰ The SORN associated with the MSIS is SORN 09-70-0541, which has been modified over time to reflect changes to the system of records, including the data-sharing activities that allow for researchers and states to analyze the prevalence of SUDs and SUD treatment services by service type and by treatment setting for Medicaid enrollees in the 50 states, DC, and the five territories.

Provision

Section 202 of the CAA 2024 adds a new SSA Section 1948 to SSA Title XIX (42 U.S.C. §§1396 et seq.) to require the HHS Secretary to annually link, analyze, and publish data from T-MSIS (or a successor system) relating to MH and/or SUD services provided to Medicaid and CHIP enrollees who have been diagnosed with an MH condition and/or an SUD. This information is to be published on a publicly available website. For Medicaid or CHIP enrollees who have received an SUD and/or MH condition diagnosis, the analysis must include data that are disaggregated by age, adhere to HHS privacy standards, and are aggregated to protect the privacy of enrollees, as necessary.

The analysis should include data from the 50 states and (to the extent available) from DC and the five territories. The provision specifies the data for HHS to analyze. For example, the analysis is to include the following:

- The number and percentage of Medicaid and CHIP enrollees, by enrollment category, diagnosed with an MH condition and/or an SUD;
- A list of the SUD and MH treatment services for Medicaid and CHIP enrollees with an MH and/or SUD diagnosis;
- The number and percentage of Medicaid and CHIP enrollees with an MH and/or SUD diagnosis who have received services for that diagnosis;
- A list of adult and pediatric treatment services provided to Medicaid and CHIP enrollees with an MH and/or SUD diagnosis, by service type;
- The number and percentage of Medicaid and CHIP enrollees with an MH and/or SUD diagnosis who received services for that diagnosis by service type, setting type, and service delivery system;
- The number of services provided to Medicaid and CHIP enrollees with an MH and/or SUD diagnosis who have received services for that diagnosis, by service type;
- The number and percentage of Medicaid and CHIP enrollees with an MH and/or SUD diagnosis who received MH or SUD services in an outpatient or home- or community-based setting after receiving such services in an inpatient or residential setting, and the count of such services provided to such individuals;

¹⁰ The Privacy Act of 1974 (Privacy Act; 5 U.S.C. Section 552a) prescribes how federal agency records with individually identifying information are to be stored, who may access such information, and when the government may use or disclose it. For purposes of the Privacy Act, an agency may control a group of records where information is retrievable by an individual's name or other unique identifier. This group of records is referred to as a *system of records*. When an agency seeks to establish a new system of records or make significant changes to an existing system of records, the act requires the agency to submit a proposal to the Office of Management and Budget (OMB) and Congress. After review and potential comments from OMB, the agency publishes a system of records notice in the *Federal Register*. For more information about the Privacy Act, see CRS Report R47863, *The Privacy Act of 1974: Overview and Issues for Congress*.

- The number and percentage of inpatient admissions during which MH or SUD treatment services were provided to a Medicaid or CHIP enrollee within 30 days after discharge from a stay at a hospital or residential facility during which MH or SUD services were provided (this data must be disaggregated by diagnosis and facility type);
- The number of emergency department visits by Medicaid and CHIP enrollees with an MH and/or SUD diagnosis that occurred within seven days of the enrollee's discharge from an inpatient stay during which MH or SUD services were provided (this data must be disaggregated by diagnosis and facility type);
- The number and percentage of Medicaid or CHIP enrollees who received an assessment for an MH condition or an SUD, and the number of MH or SUD services such individuals received in the 30 days post assessment; and
- A list of Prescription National Drug Code codes, fill dates, and number of days' supply of any outpatient drug used to treat an MH condition or SUD in the period between a Medicaid or CHIP enrollee's discharge and admission for MH or SUD treatment services in the scenarios described above.

The HHS Secretary must make the first MH and SUD data analysis publicly available no later than 18 months after the date of enactment of this section (i.e., no later than September 9, 2025), and no later than January 1 each calendar year thereafter.¹¹

This analysis is required to rely on T-MSIS data and definitions that are no more than 12 months old as of the analysis publication date. As appropriate, the analysis is required to include information with respect to each state on data quality and completeness, including caveats on data limitations to inform the appropriate uses for the information. No later than three years after the date of enactment of this section (i.e., no later than February 9, 2027), the HHS Secretary is to publish revised analysis requirements developed in consultation with stakeholders that take into account the usability of the data contained in the publication and allow for a research-ready, publicly accessible publication.

The provision also requires the HHS Secretary to publish a SORN in the *Federal Register* for the specified data to outline the policies and procedures to protect the security and privacy of the data that, at a minimum, meet the MSIS system privacy and security policies in SORN 09-70-0541. The data specified in the SORN is to be made available to researchers and states, and the data should be sufficient for researchers and states to analyze the prevalence of MH conditions and/or SUDs in the Medicaid and CHIP populations and the treatment of such conditions by service type and by treatment setting for Medicaid enrollees in the 50 states, DC, and the five territories. The HHS Secretary is required to initiate the SUD data-sharing activities outlined in the SORN no later than January 1, 2025.

The HHS Secretary will not be required to publish a new SORN for the specified data in the *Federal Register* if the HHS Secretary determines before January 1, 2025, that the SORN published by the HHS Secretary in the *Federal Register* on February 6, 2019,¹² satisfies the specified requirements described above.

¹¹ The Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42), §208, appropriates out of any funds in the Treasury not otherwise appropriated to the Secretary of the Department of Health and Human Services (HHS) \$10 million for the recurring collection, analysis, and publication of health care data under SSA §1948, as added by the CAA 2024 §202.

¹² HHS, "Privacy Act of 1974; System of Records; Notice of a Modified System of Records," 84 *Federal Register* 2230-2233, February 6, 2019.

Section 203: Monitoring Prescribing of Antipsychotic Medications

Background

To receive federal financial participation for prescription drugs, state Medicaid programs are required to monitor and report on prescription drug utilization review (DUR).¹³ Under DUR, state Medicaid programs are required to conduct prospective and retrospective drug review.

Prospective DUR is performed at the point of sale by pharmacies prior to dispensing prescription drugs to patients. Under prospective DUR, Medicaid beneficiaries' prescription drug claims are monitored electronically through computer edits to prevent errors such as duplicative prescriptions, adverse drug interactions, incorrect dosages and misuse or abuse.

In retrospective DUR, states, vendor companies, or academic institutions examine Medicaid drug claims data after prescriptions are dispensed to Medicaid beneficiaries to identify patterns of fraud, abusive utilization, overuse, medically unnecessary care, and the outcome of corrective action(s). To conduct retrospective DUR, state Medicaid programs use evidence-based literature, clinical data, and existing guidelines to identify concerning patterns.

To receive federal financial participation for prescription drugs, state Medicaid programs are required to operate a program, designed and implemented by the state, to monitor and manage appropriate use of antipsychotic medications by children enrolled in Medicaid (or through a waiver) and submit an annual report to the HHS Secretary on the program. The antipsychotic medication monitoring program covers children up to the age of 18 generally and foster care children specifically.

State Medicaid programs are required to respond to an annual CMS survey on the operation of their DUR programs. The survey includes a summary of the interventions used in retrospective DUR, an assessment of the education programs deployed by the Medicaid program, an overall assessment of the DUR program's effect on quality of care, and identification of the DUR program's cost savings. All state Medicaid programs have DUR activities to manage and/or monitor appropriate antipsychotic drug use in children, including children in foster care.¹⁴

Provision

Section 203 of the CAA 2024 amends SSA Section 1902(o)(1)(B) (42 U.S.C. §1396a(o)(1)(B)) to require state Medicaid programs to expand the program to monitor antipsychotic medication utilization. In addition to children generally and foster care children specifically, state Medicaid programs are required to monitor antipsychotic medication utilization dispensed to individuals over the age of 18 who reside in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings). Section 203 requires state Medicaid programs to include in the children's antipsychotic drug utilization annual report to the HHS Secretary information on each category and individuals over the age of 18. Section 203 is effective 24 months after the enactment date (i.e., March 9, 2026).

¹³ SSA §1927(g)(3)(D), "Drug Use Review."

¹⁴ CMS, *National Medicaid Fee-For-Service (FFS) FFY 2022 Drug Utilization Review (DUR) Annual Report*, <https://www.medicaid.gov/media/171456>.

Section 204: Extension of State Option to Provide Medical Assistance for Certain Individuals in Institutions for Mental Diseases

Background

Medicaid's institutions for mental diseases (IMD) exclusion limits the circumstances under which federal Medicaid funding to states is available for inpatient behavioral health care.¹⁵ Section 5052 of the SUPPORT Act added a new Section 1915(l) of the SSA for a new state option to provide Medicaid coverage of eligible individuals who are patients in an eligible IMD for up to 30 days (whether or not consecutive) within a 12-month period. The state plan option began on October 1, 2019, and expired on September 30, 2023.

As a condition of the state plan option, states have a maintenance-of-effort (MOE) requirement to maintain the annual level of state and local expenditures for items and services provided to Medicaid enrollees aged 21 through 64 with at least one SUD in both eligible IMDs and outpatient and community-based settings. The MOE is based on state and local expenditures outside of the Medicaid program from FY2018 or, if higher, the level of spending in the most recent federal fiscal year as of the day the state submits the state plan amendment.

Also, states adopting this option are required to ensure a continuum of services is available by (1) notifying the HHS Secretary, prior to the approval of the state plan amendment, of how individuals will receive evidence-based clinical screening before receiving services in an eligible IMD; (2) providing coverage of certain outpatient, inpatient, and residential services; and (3) ensuring appropriate transition from an eligible IMD to receiving care at a lower level of clinical intensity. Two states (South Dakota and Tennessee) were participating in this state option when it expired.

Provision

Section 204 of the CAA 2024 amends SSA Section 1915(l)(1) (42 U.S.C. §1396n(l)(1)) by removing the September 30, 2023, expiration date of the state option to make the state option permanent.

The provision also amends the MOE requirement, changing it to apply to state and local expenditures within the Medicaid program instead of outside of the Medicaid program. Furthermore, the provision removes the MOE on expenditures to eligible IMDs. The provision also amends the MOE requirement by giving states the option to set the MOE base year as either FY2018 or the most recently ended fiscal year as of the date the state submits the state plan amendment to the HHS Secretary.

With the amendments in the provision, instead of notifying the HHS Secretary of how individuals will receive evidence-based clinical screening before the individuals receive services in an eligible IMD, states must establish criteria to ensure placement of eligible individuals in appropriate levels of care. The provision also adds a requirement that states have a process in place to review the compliance of eligible IMDs with nationally recognized program standards. In addition, the provision adds a requirement that states commence a one-time assessment of (1) the availability of treatment at each level of care for Medicaid enrollees and (2) the availability of

¹⁵See CRS In Focus IF10222, *Medicaid's Institution for Mental Diseases (IMD) Exclusion*, for more information about the IMD exclusion.

MAT and medically supervised withdrawal management services. The list of required services states must provide to enrollees to ensure a continuum of services is amended to no longer refer to specific dimensions of care defined by the American Society of Addiction Medicine.

States that had adopted the state plan option as of September 30, 2023, are able to request to renew their state plan amendment with an effective date of October 1, 2023, if the request is submitted no later than 60 days after the date of enactment.

Section 205: Prohibition on Termination of Enrollment Due to Incarceration

Background

Medicaid

Individuals who are held involuntarily in a public institution may be eligible for and enrolled in Medicaid. However, the federal Medicaid statute generally prohibits the use of federal Medicaid funds to pay for the health care of an “inmate of a public institution,” except when the individual is a “patient in a medical institution” that is organized for the primary purpose of providing medical care (hereinafter referred to as the *inmate payment exclusion*). CMS guidance permits states to suspend, rather than terminate, Medicaid eligibility for individuals who are incarcerated, thereby maintaining enrollment for Medicaid-eligible individuals while still complying with Medicaid’s inmate payment exclusion.

The SUPPORT Act added a new requirement at SSA Section 1902(a)(84) (42 U.S.C. § 1396a) that prohibits states from terminating Medicaid eligibility for “eligible juveniles,” as defined, among other requirements. Instead, the law allows states to suspend Medicaid eligibility. The SUPPORT Act did not change the inmate payment exclusion; Medicaid coverage for eligible juveniles is still limited to inpatient services. The law generally applies to eligible juveniles who became inmates of public institutions on or after October 24, 2019.¹⁶ Under the Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), beginning January 1, 2025, states are permitted to receive federal payment for allowable medical assistance services provided to “eligible juveniles” while detained pending disposition of charges. The CAA 2023 directs states to establish a plan within 30 days of the date that an “eligible juvenile” is scheduled to be released that provides for specified screenings and referrals for treatment.

Although the SUPPORT Act did not change the inmate payment exclusion, Medicaid coverage for eligible juveniles is still generally limited to inpatient services; the CAA 2023 provision specifies that services provided under such plans are not subject to Medicaid’s inmate payment exclusion.

CHIP

At the time of enactment of BBA 1997, SSA Section 2110(b)(2) (42 U.S.C. § 1397bb) explicitly excluded children who were inmates of a public institution or patients in an IMD from being eligible to enroll in child health coverage under CHIP.

Starting January 1, 2025, the CAA 2023 aligns CHIP with existing Medicaid rules for eligible juveniles regarding suspension of coverage while a child is an inmate of a public institution;

¹⁶ For more information, see CRS In Focus IF10285, *Medicaid and Inmates of Public Institutions*.

redeterminations of coverage upon release; and coverage of certain screening, diagnostic, and case management services prior to release.

The CAA 2023 also directs states to establish a plan within 30 days of the date on which the enrollee is scheduled to be released following adjudication. Such plans must provide for screenings, diagnostic services, referrals, and case management services, as permitted under CHIP. In addition, the CAA 2023 amended SSA Section 2110(b) (42 U.S.C. §1397jj(b)) to clarify that services provided under such plans during the 30 days prior to the enrollee’s release were not subject to CHIP’s inmate payment exclusion.

Provision

Medicaid

Section 205 of the CAA 2024 amends SSA Section 1902(a)(84)(A) (42 U.S.C. §1396a(a)(84)(A)) to expand the population for which states are prohibited from terminating Medicaid eligibility to include *all* individuals who are considered an “inmate of a public institution” (not just “eligible juveniles”). Instead, the law allows states to suspend Medicaid eligibility for all such individuals, beginning March 9, 2024.

For states that opt to receive federal payment for allowable medical assistance services provided to “eligible juveniles” while detained and pending disposition of charges, as permitted under CAA 2023, the CAA 2024 provision further specifies that states are prohibited from terminating (but may suspend) Medicaid eligibility for such “eligible juveniles” during such period. These changes are effective beginning January 1, 2026.

CHIP

Section 205 of the CAA 2024 amends SSA Section 2102(d)(1)(A) (42 U.S.C. §1397bb(d)(1)(A)) to expand the groups for which states are prohibited from terminating CHIP eligibility to include targeted low-income pregnant women enrollees who are inmates of a public institution. Instead, the CAA 2024 allows states to suspend coverage during the enrollee’s incarceration. These changes are effective beginning January 1, 2026.

Section 206: Addressing Operational Barriers to Promote Continuity of Care for Medicaid and CHIP Beneficiaries Following Incarceration

Background

See “Section 205: Prohibition on Termination of Enrollment Due to Incarceration.” Prior to the enactment of the CAA 2024, there were no requirements for continuity of care for Medicaid and CHIP enrollees following incarceration.

Provision

Section 206 of the CAA 2024 requires the HHS Secretary to award grants to states no later than 12 months after the date of enactment of this act (i.e., no later than March 9, 2025) for the purpose of developing operational capabilities and continuity of care for Medicaid and CHIP enrollees who are inmates of a public institution. The provision appropriates \$113.5 million to the HHS Secretary for FY2024, out of funds in the Treasury that are not otherwise appropriated, to remain available until expended for the purpose of awarding and administering these grants.

Use of Funds

States are permitted to use these grant funds for activities and expenses related to complying with (1) Medicaid program requirements that prohibit states from terminating eligibility for individuals who are considered an “inmate of a public institution” as well as for “eligible juveniles” while detained pending disposition of charges in states that adopt this state plan option; (2) CHIP program requirements that prohibit states from terminating eligibility for enrollees who are “inmates of a public institution”; or (3) other activities and expenses that promote the continuity of care for Medicaid and CHIP enrollees who are “inmates of a public institution,” including

- Collaborating with key institutions, agencies, managed care plans, health care providers, community-based organizations, and stakeholders to identify and address operational gaps related to state compliance with the requirement to maintain enrollment for Medicaid and CHIP for enrollees who are “inmates of a public institution”;
- Establishing standardized processes and automated systems for activities, such as
 - Determining an inmate’s Medicaid or CHIP enrollment status upon incarceration,
 - Permitting incarcerated individuals to enroll or renew eligibility for Medicaid or CHIP prior to release,
 - Facilitating the delivery of allowable Medicaid or CHIP services while enrollees are incarcerated, and
 - Restoring Medicaid or CHIP coverage for incarcerated individuals prior to release for those program enrollees whose eligibility was suspended while incarcerated;
- Investing in information technology (1) to promote the sharing of information between key institutions, agencies, and other entities (e.g., managed care plans, health care providers) to support care transitions and coordination of health care treatment after release and (2) to ensure the proper use of Medicaid and CHIP funds during a period of incarceration; and
- Establishing oversight processes to ensure public institutions and the entities with which they contract comply with Medicaid and CHIP program rules.

Limitations on the Use of Grant Funds

States are prohibited from using grant funds (1) to provide Medicaid or CHIP health care services or otherwise directly administer health care services to individuals, (2) to build carceral facilities of any kind, or (3) to pay for carceral facility improvements other than those improvements that are for the direct and primary purpose of meeting the health care needs of incarcerated Medicaid and CHIP enrollees.

Allocation of Grant Funds

The HHS Secretary will consider the following factors when determining the amount of grant funds that will be awarded to a given state that applies for the grant relative to all states that apply: (1) the number of individuals in the state who were inmates in nonfederal public institutions (e.g., state prisons, local and county jails, tribal jails, youth correctional or detention facilities) and who were eligible for Medicaid at any time during CY2022, (2) the number of nonfederal public institutions in the state, and (3) the state’s progress in developing, implementing and operating initiatives to promote continuity of care for Medicaid- or CHIP-eligible individuals who are “inmates of a public institution.”

Guidance to States

The HHS Secretary is required to issue state guidance no later than 18 months after enactment of this act (i.e., no later than September 9, 2025) regarding implementation and operational challenges that states face when ensuring access to allowable care for Medicaid- and CHIP-eligible individuals before, during, and after periods of incarceration. Guidance topics to be addressed include (1) compliance with requirements and (2) best practices and strategies.¹⁷

Section 207: Guidance Relating to Improving the Behavioral Health Workforce and Integration of Care Under Medicaid and CHIP

Background

In general, Medicaid state plans must allow program enrollees to obtain services from any willing and qualified provider that chooses to offer such services. States are generally responsible for determining which providers meet program qualification criteria, including licensed clinicians and unlicensed providers, such as peer support specialists. Providers who meet these federal and state requirements may enter into agreements with state Medicaid agencies to provide Medicaid-coverable services to individuals enrolled in the Medicaid program.

Section 1003 of the SUPPORT Act established a time-limited competitive demonstration project to increase the treatment capacity of Medicaid SUD providers and inform best practices through specified activities, including improved reimbursement, recruitment, training, and technical assistance.

CMS has issued guidance to encourage states to adopt strategies that promote the integration of physical and MH or SUD care delivery under existing Medicaid and CHIP authorities, payment methodologies, and integrated care models. This approach is being undertaken in an attempt to more effectively identify enrollee health care needs and connect enrollees with appropriate treatment.¹⁸

Provision

Section 207 of the CAA 2024 requires the HHS Secretary to release state guidance no later than 24 months after the date of enactment of this act (i.e., no later than March 9, 2026) on (1) behavioral health workforce guidance on opportunities to increase access to MH and SUD providers that participate in Medicaid and CHIP, which may include education, training, recruitment, and retention of MH and SUD providers under Medicaid and CHIP, with a focus on improving MH/SUD provider capacity in rural and underserved areas; and (2) opportunities to promote the integration of MH and SUD services with primary care services. See CAA 2024 “Section 208: Funding for Implementation and Operations.”

The behavioral health workforce guidance must include the following:

¹⁷ CAA 2024 §208 appropriates out of any funds in the Treasury not otherwise appropriated to the HHS Secretary \$5 million for FY2024 for the purpose of carrying out §§203 (and the amendments made by such section), 206, and 207, to remain available until expended.

¹⁸ CMS, Center for Medicaid & CHIP Services (CMCS), “CMCS Informational Bulletin. Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth,” August 18, 2022, <https://www.medicare.gov/sites/default/files/2022-08/bhccib08182022.pdf>.

- Best practices under SSA Titles XI, XIX, or XXI (including under SSA §1115 waivers) to improve the Medicaid and CHIP behavioral health workforce, including those pertinent to pediatric care;
- Opportunities for states to finance, support, and expand the availability of Medicaid and CHIP providers of community-based MH and SUD services across the continuum of care (e.g., through paraprofessionals with behavioral health expertise, including clinicians with baccalaureate degrees and peer support specialists);
- Examples of innovative policies states have adopted to expand access to behavioral health services (e.g., by establishing more expansive and diverse behavioral health workforce roles, such as certified wellness coaches); and
- Best practices related to financing, supporting, and expanding the education and training of providers of MH and SUD services to increase the Medicaid and CHIP behavioral health workforce across the continuum of care (e.g., innovative public-private partnerships).

The state guidance on opportunities to promote the integration of MH or SUD services with primary care services must include the following:

- State options to adopt and expand value-based payment arrangements and alternative payment models, including accountable care organization-like models and other shared savings programs;
- State opportunities to use and align existing authorities and resources to finance the integration of MH or SUD services with primary care services (e.g., the use of electronic health records);
- The use of nonclinical professionals and paraprofessionals, including peer support specialists; and
- Examples of specific strategies for differing age groups, including children and youth and individuals over the age of 65 (e.g., the collaborative care model or primary care behavioral health model for behavioral health integration).

The provision defines the “integration of MH or SUD services with primary care services” to mean any of the following:

- Delivering MH or SUD services in a setting that is physically located in the same practice or building as a primary care setting, or when at least one provider of MH or SUD services is available in a primary care setting via telehealth;
- Using behavioral health integration models primarily intended for pediatric populations with non-severe MH needs that are focused on prevention and early detection and intervention methods through a multidisciplinary collaborative behavioral health team approach comanaged with primary care, to include same-day access to family-focused MH treatment services;
- Having providers of MH or SUD services physically colocated in a primary care setting with same-day visit availability;
- Implementing or maintaining enhanced care coordination or targeted case management that includes regular interactions between and within care teams;
- Providing MH or SUD screening and follow-up assessments, interventions, or services within the same practice or facility as a primary care or physical service setting;

- Using assertive community treatment that is integrated with or facilitated by a primary care practice; and
- Delivering integrated primary care and MH or SUD care in the home or in community-based settings for individuals who are recipients of Medicaid home- and community-based services.

Section 208: Funding for Implementation and Operations

Background

See “Section 202: Collection and Reporting of Comprehensive Data for Specified Populations Enrolled in Medicaid and CHIP”; “Section 203: Monitoring Prescribing of Antipsychotic Medications”; “Section 206: Addressing Operational Barriers to Promote Continuity of Care for Medicaid and CHIP Beneficiaries Following Incarceration”; and “Section 207: Guidance Relating to Improving the Behavioral Health Workforce and Integration of Care Under Medicaid and CHIP.”

Provision

Section 208 of the CAA 2024 appropriates out of any funds in the Treasury not otherwise appropriated to the HHS Secretary \$5 million for FY2024 for the purpose of carrying out CAA 2024 Sections 203 (and the amendments made by such section), 206, and 207, to remain available until expended, and \$10 million for the recurring collection, analysis, and publication of health care data under SSA Section 1948, as added by Section 202.

Section 209: Certified Community Behavioral Health Clinic Services Under Medicaid

Background

Section 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) authorized a Medicaid demonstration program that established certified community behavioral health clinics (CCBHCs).¹⁹ CCBHCs are facilities operated by nonprofit, governmental, or tribal entities that offer a comprehensive range of behavioral health services. The HHS Secretary was required to publish criteria relating to staffing, care coordination, and other requirements for states to use to certify clinics.²⁰ States participating in the CCBHC demonstration program receive the enhanced federal medical assistance percentage (E-FMAP; i.e., the federal reimbursement rate used for CHIP) for CCBHC services provided to Medicaid enrollees during the applicable demonstration period. In addition, the CCBHCs in these states receive greater Medicaid payment rates for the services provided to Medicaid enrollees through a prospective payment system (PPS)

¹⁹ The Consolidated Appropriations Act of 2018 (P.L. 115-141) authorized a certified community behavioral health clinics (CCBHC) expansion grant program, which was further funded by additional laws passed in 2021 and 2022. Expansion grants provide supplemental funds directly to clinics to increase access and improve the quality of their behavioral health services. For more information about the CCBHC expansion grant program, see CRS In Focus IF12494, *Certified Community Behavioral Health Clinics (CCBHCs)*.

²⁰ HHS issued the original CCBHC certification criteria in 2015, which outlined standards for staffing, provider credentialing, training requirements, linguistic competence, and timely access, among others. In March 2023, HHS issued updated criteria, which were informed by public input and included updates to the standards related to developments in the field.

methodology. There are currently eight states participating in the demonstration with varying expirations. The Bipartisan Safer Communities Act of 2022 (P.L. 117-159) authorized the HHS Secretary to select up to 10 additional states for the Medicaid demonstration program beginning July 1, 2024, and every two years after that.

CCBHCs can be supported by a Medicaid demonstration program for states and/or discretionary grant funding for clinics from the Substance Abuse and Mental Health Services Administration. States that are not part of the CCBHC Medicaid demonstration program are able to make Medicaid payments to CCBHCs, but these states are not required to pay CCBHCs through a PPS. In addition, only states participating in the Medicaid demonstration program are eligible for the E-FMAP for CCBHC services.

Provision

Section 209 of the CAA 2024 amends SSA Section 1905 (42 U.S.C. §1396d) to add CCBHC services to the list of Medicaid optional service categories under traditional Medicaid. The provision adds a definition of CCBHC services, which includes the same services that CCBHCs are required to provide in the demonstration program (e.g., crisis MH services, psychiatric rehabilitation). A CCBHC is defined as an organization that (1) furnishes CCBHC services; (2) agrees to furnish data as required as a condition of certification; and (3) has been certified by a state to meet the criteria issued by the HHS Secretary as of January 1, 2024, and any subsequent updates to those criteria, regardless of whether the state is participating in the Medicaid demonstration program. The effective date for this provision is the date of enactment (March 9, 2024).

Section 210: Eliminating Certain Disproportionate Share Hospital Payment Cuts

Background

SSA Section 1923 requires states to make Medicaid DSH payments to hospitals treating large numbers of low-income patients.²¹ Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. The ACA included a provision directing the HHS Secretary to make aggregate reductions in Medicaid DSH allotments for FY2014 through FY2020, but subsequent laws amended the Medicaid DSH reductions and the reductions have not gone into effect.²²

Prior to the enactment of the CAA 2024, aggregate reductions to the Medicaid DSH allotments equaled \$8.0 billion for part of FY2024 (i.e., March 9, 2024, through September 30, 2024) and \$8.0 billion for each fiscal year from FY2025 through FY2027, which totaled \$32.0 billion. In FY2028, DSH allotments were to rebound to the pre-reduced levels, with annual inflation adjustments for FY2024-FY2027.

²¹ For more information about Medicaid disproportionate share hospital (DSH) payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

²² For more information about the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid DSH reductions, see CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

Provision

Section 210 of the CAA 2024 further amends the Medicaid DSH reductions under SSA Section 1923(f)(7)(A) (42 U.S.C. §1396r-4(f)(7)(A)) by eliminating the reductions for FY2024 and making the reductions for FY2025 apply to the period beginning January 1, 2025, and ending September 30, 2025. The reductions for FY2026 and FY2027 were unchanged. The aggregate reduction amount for FY2024 through FY2027 decreased from \$32.0 billion under prior law to \$24.0 billion.

Section 211: Promoting Value in Medicaid Managed Care

Background

The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP) rate. It varies by state and ranges from 50% to 83%, depending on each state's per capita income.²³ Exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. For instance, all states receive a 90% federal share for Medicaid expansion expenditures.²⁴

Under Medicaid managed care, Medicaid enrollees get most, or all, of their services through Medicaid managed care entities (i.e., managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans) that are under contract with a state.²⁵ Effective for rating periods starting on or after July 1, 2017, a state may choose to mandate a minimum MLR of at least 85% for Medicaid managed care entities. The MLR is the ratio of a managed care entity's incurred claims plus its expenditures on quality and fraud prevention activities to its adjusted premium revenue.

States opting to mandate a minimum MLR may require managed care entities to pay a remittance if an entity's MLR for a reporting year does not meet a state's minimum MLR standard. A remittance is a payment by a managed care entity to a state to reimburse the state for capitation payments that were determined to be excessive because the entity did not meet the MLR requirement.

If a state elects to impose a remittance requirement through its managed care contracts, any remittance is treated as a Medicaid overpayment and the state must reimburse the federal government for an amount equal to the federal share of the remittance.

The SUPPORT Act temporarily (i.e., FY2021 through FY2023) lowered the federal share of MLR remittances, specific to the Medicaid expansion, from 90% to each state's regular FMAP rate. The temporary change meant states were required to return a smaller portion of their MLR remittances, specific to the Medicaid expansion, to the federal government for FY2021 through FY2023.

²³ For more information about the federal medical assistance percentage, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

²⁴ For more information about the Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

²⁵ For more information about Medicaid service delivery systems, such as managed care, see CRS Report R43357, *Medicaid: An Overview*.

Provision

Section 211 of the CAA 2024 amends SSA Section 1903(m)(9)(A) (42 U.S.C. §1396b(m)(9)(A)) to remove the expiration date for the SUPPORT Act provision lowering the federal share of MLR remittances, specific to the Medicaid expansion, from 90% to each state’s regular FMAP rate. This change makes the provision permanent under current law.

Section 212: Medicaid Improvement Fund

Background

Section 7002(b) of the Supplemental Appropriations Act of 2008 (P.L. 110-252) added SSA Section 1941, requiring the HHS Secretary to establish the MIF. SSA Section 1941 authorized the HHS Secretary to use the MIF “to improve the management of the Medicaid program by the CMS, including oversight of contracts and contractors and evaluation of demonstration projects.” P.L. 110-252 authorized \$100 million to be available for expenditures in FY2014 and \$150 million for FY2015 through FY2018.

A number of laws amended SSA Section 1941 to change the amount of money available to the MIF. For example, Section 122 of the Further Additional Continuing Appropriations and Other Extensions Act, 2024 (P.L. 118-35), amended SSA Section 1941 to reduce funding available to the MIF from \$5.796 billion to \$5.140 billion.

Provision

Section 212 of the CAA 2024 amends SSA Section 1941 (42 U.S.C. §1396w-1(b)(3)(A)) to reduce funding available to the MIF from \$5.14 billion to \$0.00.

Subtitle C—Medicare

Section 301: Extension of Funding for Quality Measure Endorsement, Input, and Selection

Background

Under SSA Section 1890 (42 U.S.C. §1395aaa), the HHS Secretary is required to contract with a consensus-based entity (e.g., the National Quality Forum [NQF]) to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting, measure endorsement, measure maintenance, and annual reporting to Congress. SSA Section 1890A (42 U.S.C. §1395aaa-1) required the HHS Secretary to establish a pre-rulemaking process to select quality measures for use in the Medicare program. As part of this process, the HHS Secretary makes publicly available measures under consideration for use in Medicare quality programs and broadly disseminates the quality measures that are selected to be used, while the consensus-based entity with a contract gathers multi-stakeholder input and annually transmits that input to the HHS Secretary. NQF held this contract until recently and fulfilled this requirement through its Measure Applications Partnership (MAP),²⁶ an entity that convened multi-stakeholder groups to provide input on the selection of quality measures for use

²⁶ National Quality Forum, “Measure Applications Partnership,” <https://www.qualityforum.org/map/>.

in Medicare and other federal programs. MAP published annual reports with recommendations for selection of quality measures in February of each year, with the first report published in February 2012. The contract is currently held by Battelle, which carries out this work under its Partnership for Quality Measurement.²⁷

Provision

Section 301 of the CAA 2024 amends SSA Section 1890(d)(2) (42 U.S.C. §1395aaa(d)(2)) to provide for the transfer of \$9 million from the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds to the CMS Program Management Account, for the period beginning October 1, 2023, and ending December 31, 2024, to carry out SSA Section 1890 and 1890A (other than subsections (e) and (f)). Amounts transferred remain available until expended.

Section 302: Extension of Funding Outreach and Assistance for Low-Income Programs

Background

In addition to annual discretionary funding for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAA), and Aging and Disability Resource Centers (ADRCs), beginning in FY2009, Section 119 of the Medicare Improvements for Patients and Providers Act (MIPPA; P.L. 110-275) provided mandatory funding for outreach and assistance to low-income Medicare beneficiaries. This funding includes assistance to those who may be eligible for the Low-Income Subsidy Program, Medicare Savings Program, and Medicare Part D Prescription Drug Program. MIPPA also provided mandatory funding to the National Center for Benefits and Outreach Enrollment, which helps organizations enroll older adults and individuals with disabilities in benefit programs that they may be eligible for, such as Medicare, Medicaid, the Supplemental Security Income program, and the Supplemental Nutrition Assistance Program, among others. MIPPA funding is administered by the Administration for Community Living (ACL) within HHS. MIPPA funding was extended multiple times, most recently in the Consolidated Appropriations Act, 2021 (CAA 2021; P.L. 116-260), through FY2023. The HHS Secretary is required to transfer specified amounts for MIPPA program activities from the Medicare HI and SMI Trust Funds to CMS for SHIP funding and the Administration on Aging within ACL for AAA and ADRC funding and funding for the National Center for Benefits and Outreach Enrollment. MIPPA funding directly appropriated to CMS is then made available to ACL.

Provision

Section 302 of the CAA 2024 amends specified subsections of MIPPA Section 119 (42 U.S.C. §1395b-3 note) to extend authority for these programs through December 31, 2024. For the period beginning October 1, 2023, and ending December 31, 2024, it provides for a total of \$62.50 million to be transferred from the Medicare HI and SMI Trust Funds in the following amounts: SHIPs, \$18.75 million; AAAs, \$18.75 million; ADRCs, \$6.25 million; and the contract with the National Center for Benefits and Outreach Enrollment, \$18.75 million.

²⁷ Battelle, “Partnership for Quality Measurement,” <https://p4qm.org/>.

Section 303: Extension of the Work Geographic Index Floor Under the Medicare Program

Background

Medicare payments for services of physicians and certain nonphysician practitioners are based on a fee schedule (SSA §1848(e)(1)(E); 42 U.S.C. §1395w-4(e)(1)(E)). The Medicare physician fee schedule (MPFS) is adjusted geographically for three categories of inputs to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indexes—known as Geographic Practice Cost Indexes (GPCIs)—that reflect how each area compares to the national average in a “market basket” of goods. A value of 1.00 represents the average across all areas. These indexes are used to calculate the payment rate under the MPFS.

Since January 1, 2004, several laws have established a “floor” on the physician work GPCI where the index has been increased to 1.0 for all geographic regions in which the calculation of the GPCI would have been less than 1.0. Recently, the Further Continuing Appropriations and Other Extensions Act, 2024 (P.L. 118-22), extended the floor from December 31, 2023, through January 19, 2024, and the Further Additional Continuing Appropriations and Other Extensions Act, 2024, extended the floor through March 8, 2024.

Provision

Section 303 of the CAA 2024 amends SSA Section 1848(e)(1)(E) (42 U.S.C. §1395w-4(e)(1)(E)) to extend the floor value for the physician work geographic index used in the calculation of payments under the MPFS at 1.0 through December 31, 2024.

Section 304: Extending Incentive Payments for Participation in Eligible Alternative Payment Models

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) introduced a new merit-based incentive payment system based on fee-for-service payments and put in place processes for developing, evaluating, and adopting APMs designed to incentivize improvements in the quality and efficiency of care as well as increase patient satisfaction. Eligible Medicare professionals are incentivized to participate in Medicare APMs through higher payments. As established under SSA Section 1833(z) (42 U.S.C. §1395l(z)), beginning in 2019 and ending in 2024, eligible professionals in a qualifying APM that is providing covered services receive an incentive (bonus) payment for the services furnished during that year as well as an amount equal to 5% of the estimated aggregate payment amounts for covered professional services furnished during the preceding year. For 2025, the bonus amount is to equal 3.5%. The incentive payment is made in a lump sum on an annual basis.

Provision

Section 304 of the CAA 2024 amends SSA Section 1833(z) (42 U.S.C. §1395l(z)) to extend the APM bonus at 3.5% for 2025 and at 1.88 % for 2026. The provision also makes conforming amendments regarding partial qualifying APM participants in 2025 and 2026.

Section 305: Temporary Payment Increase Under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances and Atypical Timing of Enactment

Background

In 2020, payments to physicians and nonphysician practitioners under the MPFS were subject to many changes due to a combination of statutory, technical, and circumstantial factors including the impact of questions about the application of sequestration and PAYGO (“pay as you go”) requirements, the redefinition of certain medical codes, and uncertainty regarding the impact of the Coronavirus Disease 2019 pandemic on health care professionals. CAA 2021 established a 3.75% increase in MPFS payments to support physicians and other professionals for services furnished in 2021 (SSA §1848(t)(1); 42 U.S.C. §1395w-4(t)(1)). The Protecting Medicare and American Farmers from Sequester Cuts Act (P.L. 117-71) extended the increase through 2022 at the reduced level of 3%. CAA 2023 extended the increase through 2023 at 2.5% and through 2024 at 1.25%.

Provision

Section 305 of the CAA 2024 amends SSA Section 1848(t)(1) (42 U.S.C. §1395w-4(t)(1)) to set the percentage increase in MPFS payments for services furnished on or after January 1, 2024, and before March 9, 2024, at 1.25%. For services furnished on or after March 10, 2024, and before January 1, 2025, the increase is set at 2.93%.

Section 306: Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals

Background

Under Medicare, qualifying hospitals receive increased payments to account for the higher incremental costs associated with a low volume of discharges. The HHS Secretary is required to determine an empirically appropriate percentage increase per discharge, up to a ceiling of 25%, for low-volume hospitals (LVHs) more than 25 road miles from another acute-care hospital. These hospitals could have as many as 800 total discharges in a fiscal year. Based on its analysis, CMS determined that hospitals that have fewer than 200 total (Medicare and non-Medicare) discharges and that are located more than 25 road miles from another acute-care hospital qualified for a 25% increase per discharge.

ACA Section 3125, as modified by ACA Section 10314, changed the number of patient discharges eligible for LVH adjustment to no more than 1,600 *Medicare* discharges in a fiscal year and modified the distance requirement to more than 15 road miles for FY2011 and FY2012. Under the temporary, modified requirements, qualifying hospitals with 200 or fewer Medicare discharges received a payment increase of 25% per discharge; the low-volume percentage adjustment diminished to zero for the Medicare discharges greater than 1,600.

Provision

Section 306 of the CAA 2024 amends SSA Section 1886 (42 U.S.C. §1395ww(d)(12)) to extend the enhanced low-volume adjustment through December 31, 2024. Absent Congress extending or

modifying the ACA requirements, the LVH criteria will revert to 800 total discharges and more than 25 road miles.

Section 307: Extension of the Medicare-Dependent Hospital Program

Background

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239, §6003(f)(1)), established criteria and payment for Medicare-dependent hospitals (MDHs) for the period April 1, 1990, through March 31, 1993. MDHs are small, rural hospitals with a high proportion of patients who are Medicare beneficiaries. MDHs receive special treatment, including higher payments, under the Medicare Inpatient Prospective Payment System (IPPS). To be eligible for the MDH program, hospitals must have no more than 100 beds and at least 60% of their acute inpatient days or discharges must have been attributable to Medicare in FY1987 or in two of the three most recently audited cost-reporting periods. In anticipation of the MDH program's expiration, qualifying MDHs may apply for a rural-to-urban reclassification to obtain higher Medicare payments in lieu of receiving the MDH payments.²⁸

Provision

Section 307 of the CAA 2024 amends SSA Section 1886 (42 U.S.C. §1395ww(d)(5)(G)) by extending the MDH program through December 31, 2024, and permits hospitals to decline a rural-to-urban reclassification in lieu of qualifying for MDH in the case that Congress extends the program.

Section 308: Extension of Adjustment to Calculation of Hospice Cap Amount Under Medicare

Background

The Medicare hospice benefit covers services designed to provide palliative care and management of a terminal illness. These services are provided to Medicare beneficiaries with a life expectancy of six months or less for two 90-day periods, followed by an unlimited number of 60-day periods. Hospice care is provided in lieu of most other Medicare services related to the curative treatment of the terminal illness. Beneficiaries electing hospice care from a hospice program may receive curative services for illnesses or injuries unrelated to their terminal illness, and they may disenroll from hospice care at any time.

Payment for hospice care is based on one of four prospectively determined rates (which correspond to four different levels of care) for each day a beneficiary is under the care of a Medicare-certified hospice agency. The four rate categories are (1) routine home care, (2) continuous home care, (3) inpatient respite care, and (4) general inpatient care. Payment rates are adjusted to reflect differences in geographic area wage levels, using the hospital wage index. Annual payments to a hospice agency are limited by two caps; the first limits the number of days of inpatient care to 20% or less of total patient care days that the agency provided in a year,²⁹ and

²⁸ SSA §1886(d)(10) (42 U.S.C. §1395ww(d)10)).

²⁹ 42 C.F.R. §418.108(d).

the second, as required under law,³⁰ limits a hospice agency's average annual payment per beneficiary. The latter cap is set at \$33,494.01 for FY2024,³¹ that amount is not adjusted by geographic location.

The average annual payment cap amount is adjusted for increases or decreases in medical care expenditures. As required by SSA Section 1814(i)(2)(B), the average annual payment cap, currently and through FY2032, is updated annually through rulemaking by the general hospice base payment update rather than through use of the Consumer Price Index for All Urban Consumers (CPI-U) for medical care expenditures. The CPI-U is published by the U.S. Bureau of Labor Statistics. Federal law mandates that the average annual payment cap for, and after, FY2033 be adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the CPI-U.

Provision

Section 308 of the CAA 2024 amends SSA Section 1814 (42 U.S.C. §1395f(i)(2)(B)) by extending the update of the Medicare hospice average annual payment cap using the general hospice base payment update (rather than using the CPI-U) through FY2033. The average annual payment cap is set to update using the CPI-U for and after FY2034.

Section 309: Medicare Improvement Fund

Background

MIPPA added SSA Section 1898 (42 U.S.C § 1395iii), which authorized the HHS Secretary to establish the Medicare Improvement Fund (MIF). The amounts in the Medicare MIF are available to the HHS Secretary “to make improvements under the original Medicare fee-for-service program under parts A and B ... including adjustments to payments for items and services furnished by providers of services and suppliers under such original Medicare fee-for-service program.” Many subsequent laws have modified the amount in the fund, but to date none of the monies have been expended. Most recently, the Further Additional Continuing Appropriations and Other Extensions Act, 2024, modified SSA Section 1898 to make \$2.2 billion available during and after FY2022.

Provision

Section 309 amends SSA Section 1898(b)(1) (42 U.S.C. §1395iii(b)(1)) to change the amount available in the fund for services furnished during and after FY2022 to \$0.

³⁰ SSA §1814(i)(2)(B).

³¹ CMS, “Hospice Payments: FY2024 Update,” MM13289, August 10, 2023, <https://www.cms.gov/files/document/mm13289-hospice-payments-fy-2024-update.pdf>.

Appendix A. Abbreviated Summaries of Provisions

Table A-1. Abbreviated Summaries of Selected Provisions in the Consolidated Appropriations Act, 2024 (P.L. 118-42)

Section Number	Provision Title	Summary of Provision	CRS Contact
Subtitle B—Medicaid			
201	Requirement for State Medicaid Plans to Provide Coverage for Medication-Assisted Treatment	Changes the temporary state Medicaid requirement to cover all MAT drugs used to treat OUD to permanent.	Cliff Binder
202	Collection and Reporting of Comprehensive Data for Specified Populations Enrolled in Medicaid and CHIP	Requires the HHS Secretary to link, analyze, and publish annually data relating to MH and SUD services provided to Medicaid and CHIP enrollees diagnosed with MH and/or SUD conditions no later than September 9, 2025, and no later than January 1 each calendar year thereafter.	Evelyne P. Baumrucker
203	Monitoring Prescribing of Antipsychotic Medications	Expands state Medicaid requirements to monitor and manage antipsychotic drug utilization by children to Medicaid beneficiaries over the age of 18 housed in institutional care settings and expands required reporting on antipsychotic drug utilization.	Cliff Binder
204	Extension of State Option to Provide Medical Assistance for Certain Individuals in Institutions for Mental Diseases	Makes permanent a state plan option to provide Medicaid coverage of certain individuals who are patients in eligible institutions for mental diseases.	Megan B. Houston
205	Prohibition on Termination of Enrollment Due to Incarceration	Expands the population for whom states are prohibited from terminating Medicaid eligibility to include <i>all</i> individuals who are considered an “inmate of a public institution,” beginning March 9, 2024, and “eligible juveniles” while detained pending disposition of charges, beginning January 1, 2026. Expands the population for whom states are prohibited from terminating CHIP eligibility to include targeted low-income pregnant women enrollees who are inmates of a public institution, beginning January 1, 2026.	Evelyne P. Baumrucker
206	Addressing Operational Barriers to Promote Continuity of Care for Medicaid and CHIP Beneficiaries Following Incarceration	Requires the HHS Secretary to award grants to states to develop operational capabilities and continuity of care for Medicaid and CHIP enrollees who are inmates of a public institution no later than March 9, 2025. Appropriates to the HHS Secretary \$113.5 million for FY2024 to remain available until expended for this purpose.	Evelyne P. Baumrucker

Section Number	Provision Title	Summary of Provision	CRS Contact
207	Guidance Relating to Improving the Behavioral Health Workforce and Integration of Care Under Medicaid and CHIP	Requires the HHS Secretary to issue guidance on (1) opportunities to increase access to MH and SUD providers that participate in Medicaid and CHIP and (2) opportunities to promote the integration of MH or SUD services with primary care services no later than March 9, 2026.	Evelyne P. Baumrucker
208	Funding for Implementation and Operations	Appropriates to the HHS Secretary \$5 million for FY2024 for the purpose of carrying out §§203, 206, and 207, to remain available until expended, and \$10 million for the recurring collection, analysis, and publication of health care data under SSA §1948, as added by CAA 2024 §202.	Evelyne P. Baumrucker
209	Certified Community Behavioral Health Clinic Services Under Medicaid	Adds certified community behavioral health clinic services to the list of Medicaid optional service categories under traditional Medicaid.	Megan B. Houston
210	Eliminating Certain Disproportionate Share Hospital Payment Cuts	Eliminates the Medicaid DSH reductions for FY2024 and applies the reductions for FY2025 to the period beginning January 1, 2025, and ending September 30, 2025.	Alison Mitchell
211	Promoting Value in Medicaid Managed Care	Removes the end date for the temporary provision lowering the federal share of MLR remittances specific to the Medicaid expansion from 90% to each state's regular FMAP rate.	Alison Michell
212	Medicaid Improvement Fund	Reduces Medicaid Improvement Fund funding from \$5.140 billion to \$0.00.	Cliff Binder
Subtitle C—Medicare			
301	Extension of Funding for Quality Measure Endorsement, Input, and Selection	Amends SSA §1890(d)(2) to transfer from the Medicare HI and SMI Trust Funds \$9 million for the period beginning October 1, 2023, through December 31, 2024, to carry out activities under SSA §1890 and 1890A (other than subsections (e) and (f)).	Amanda K. Sarata
302	Extension of Funding Outreach and Assistance for Low-Income Programs	Extends outreach and assistance to low-income Medicare beneficiaries including those who may be eligible for the Low-Income Subsidy Program, Medicare Savings Program, and Medicare Part D Prescription Drug Program by providing a total of \$62.5 million in funding to specific entities through December 31, 2024.	Kirsten J. Colello

Section Number	Provision Title	Summary of Provision	CRS Contact
303	Extension of the Work Geographic Index Floor Under the Medicare Program	Extends the floor value for the physician work geographic index under the Medicare physician fee schedule at 1.0 through December 31, 2024.	Jim Hahn
304	Extending Incentive Payments for Participation in Eligible Alternative Payment Models	Extends the APM bonus at 3.5% for 2025 and at 1.88 % in 2026.	Jim Hahn
305	Temporary Payment Increase Under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances and Atypical Timing of Enactment	Sets at 2.93% the percentage increase in Medicare physician fee schedule payments for services furnished on or after March 10, 2024, and before January 1, 2025.	Jim Hahn
306	Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals	Increases Medicare IPPS payments to hospitals to account for the higher incremental costs associated with a low volume of total discharges.	Marco A. Villagrana
307	Extension of the Medicare-Dependent Hospital Program	Extends the MDH program for small rural hospitals with a high proportion of patients who are Medicare beneficiaries. These hospitals receive special treatment, including higher payments, under Medicare.	Marco A. Villagrana
308	Extension of Adjustment to Calculation of Hospice Cap Amount Under Medicare	Extends the update of the Medicare hospice average annual payment cap using the general hospice base payment update (rather than the Consumer Price Index for All Urban Consumers) through FY2033.	Phoenix Voorhies
309	Medicare Improvement Fund	Removes all funds, leaving \$0 balance.	Jim Hahn

Source: Congressional Research Service analysis of the Consolidated Appropriations Act, 2024 (CAA 2024; P.L. 118-42).

Notes: APM = Alternative Payment Models; CHIP = State Children’s Health Insurance Program; DSH = Disproportionate Share Hospital; FMAP = Federal Medical Assistance Percentage; HHS = Department of Health and Human Services; HI = Hospital Insurance; IPPS = Inpatient Prospective Payment System; MAT = Medication-Assisted Treatment; MDH = Medicare-Dependent Hospital; MH = Mental Health; MLR = Medical Loss Ratio; OUD = Opioid Use Disorder; SMI = Supplementary Medical Insurance; SSA = Social Security Act; SUD = Substance Use Disorder.

Appendix B. Table of Common Abbreviations

Table B-1. Table of Common Abbreviations

Acronym	Full Name
AAA	Area Agencies on Aging
ACA	Patient Protection and Affordable Care Act (P.L. 111-148)
ACL	Administration for Community Living
ADRC	Aging and Disability Resource Center
APM	Alternative Payment Model
BBA 1997	Balanced Budget Act (P.L. 105-33)
CAA 2021	Consolidated Appropriations Act, 2021 (P.L. 116-260)
CAA 2023	Consolidated Appropriations Act, 2023 (P.L. 117-328)
CAA 2024	Consolidated Appropriations Act, 2024 (P.L. 118-42)
CCBHC	Certified Community Behavioral Health Clinic
CHIP	State Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPI-U	Consumer Price Index for All Urban Consumers
DSH	Disproportionate Share Hospital
DUR	Drug Utilization Review
E-FMAP	Enhanced Federal Medical Assistance Percentage
FMAP	Federal Medical Assistance Percentage
GPCI	Geographic Practice Cost Index
HHS	Department of Health and Human Services
HI	Hospital Insurance
IMD	Institutions for Mental Diseases
IPPS	Inpatient Prospective Payment System
LVH	Low-Volume Hospital
MAP	Measure Applications Partnership
MAT	Medication-Assisted Treatment
MDH	Medicare-Dependent Hospital
MH	Mental Health
MIF	Medicare Improvement Fund
MIPPA	Medicare Improvements for Patients and Providers Act (P.L. 110-275)
MLR	Medical Loss Ratio
MOE	Maintenance of Effort
MPFS	Medicare Physician Fee Schedule
MSIS	Medicaid Statistical Information System
NQF	National Quality Forum

Acronym	Full Name
PPS	Prospective Payment System
SHIP	State Health Insurance Assistance Programs
SMI	Supplementary Medical Insurance
SORN	System of Records Notice
SSA	Social Security Act
SUD	Substance Use Disorder
SUPPORT Act	SUPPORT for Patients and Communities Act (P.L. 111-148)
T-MSIS	Transformed-Medicaid Statistical Information System

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