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Consolidated Appropriations Act, 2023 (P.L. 117-328): Medicaid and CHIP Provisions

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Summary

The Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), enacted on December 29, 2022, provides appropriations to federal agencies for the remainder of FY2023, provides supplemental appropriations for disaster relief and to support Ukraine, extends several expiring authorities, and modifies or establishes various programs that address a range of policy areas.

The CAA 2023 includes numerous provisions related to Medicaid and the State Children’s Health Insurance Program (CHIP). These provisions impact the Medicaid program in the territories (i.e., American Samoa, the Commonwealth of the Northern Mariana Islands [CNMI], Guam, Puerto Rico, and the U.S. Virgin Islands [USVI]), Medicaid and CHIP coverage, Medicaid and CHIP mental health, and other issues.

Territories Provisions

The CAA 2023 includes numerous provisions that affect Medicaid financing for the territories. These provisions (1) provide annual federal capped Medicaid funding for Puerto Rico; (2) apply the asset verification program requirements to Puerto Rico; (3) provide increased federal medical assistance percentage (FMAP) rates to the territories; (4) extend reporting requirements for the territories; and (5) add Medicaid data systems improvement payments to American Samoa, CNMI, Guam, and USVI.

In addition, the CAA 2023 adds contracting and procurement oversight lead requirements for Puerto Rico. The CAA 2023 also adds a requirement for American Samoa, CNMI, Guam, and USVI to submit a four-year strategic plan to the Secretary of the Department of Health Human Services (HHS) no later than September 30, 2023, and an analysis of that strategic plan no later than September 30, 2027.

Medicaid and CHIP Coverage Provisions

The CAA 2023 extends numerous CHIP provisions for two years (i.e., FY2028 and FY2029). These provisions include the federal funding for CHIP, the Pediatric Quality Measures Program, the assurance of eligibility standard for CHIP and Medicaid children, the outreach and enrollment program, and the Express Lane Eligibility state plan option.

The CAA 2023 requires states to provide 12 months of continuous eligibility for Medicaid and CHIP enrollees under the age of 19 beginning January 1, 2024. The law also makes permanent the state plan option to provide 12 months of postpartum coverage in Medicaid and CHIP. In addition, the CAA 2023 extends the Medicaid Money Follows the Person program and the spousal impoverishment protections through FY2027.

Medicaid and CHIP Mental Health Provisions

The CAA 2023 amends the Medicaid requirements for certain justice-involved juveniles and aligns the CHIP requirements for certain justice-involved juveniles with the existing Medicaid requirements. The law includes a provision providing states with the option to provide Medicaid and CHIP coverage of “eligible juveniles” when such individuals are inmates of a public institution pending disposition of charges.

The CAA 2023 amends the provider directory requirements for Medicaid and CHIP fee-for-service and Medicaid primary care case management. The law also adds a provider directory requirement for Medicaid managed care entities and CHIP. In addition, the CAA 2023 requires the HHS Secretary to issue guidance and establish a technical assistance center to help states design, implement, or enhance a continuum of crisis response services for children, youth, and adults under Medicaid and CHIP.

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Other Provisions

The CAA 2023 ends the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase on December 31, 2023, and phases down the FFCRA FMAP increase from April 1, 2023, through December 31, 2023. In addition, this provision amends the requirements for states to be eligible for the FFCRA FMAP increase, adds state reporting requirements, and includes penalties for not complying with the requirements. The law also changes the amounts available in the Medicaid Improvement Fund.

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Introduction

The Consolidated Appropriations Act, 2023 (CAA 2023; P.L. 117-328), enacted on December 29, 2022, provides appropriations to federal agencies for the remainder of FY2023, provides supplemental appropriations for disaster relief and to support Ukraine, extends several expiring authorities, and modifies or establishes various programs that address a wide range of policy areas.

The CAA 2023 includes numerous provisions related to Medicaid and the State Children’s Health Insurance Program (CHIP) under Division FF Title V. Several provisions impact the Medicaid program for the territories (i.e., American Samoa, the Commonwealth of the Northern Mariana Islands [CNMI], Guam, Puerto Rico, and the U.S. Virgin Islands [USVI]). In addition, the CAA 2023 includes provisions impacting Medicaid and CHIP coverage, Medicaid payments for inmates, and provider directory requirements. The CAA 2023 also amends the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) federal medical assistance percentage (FMAP) increase and the amounts available in the Medicaid Improvement Fund.

This report provides information on the Medicaid- and CHIP-related provisions in the CAA 2023 as enacted. It will not be updated to reflect any future amendments or changes to affected programs or provisions. This report begins with short descriptions of the Medicaid and CHIP programs. These descriptions are followed by summaries of the provisions in the CAA 2023 impacting Medicaid and CHIP. These summaries are under the following headings: territories provisions, Medicaid and CHIP coverage provisions, Medicaid and CHIP mental health provisions, and other provisions.

Appendix A provides abbreviated summaries for each of the provisions in the CAA 2023 that impact Medicaid and CHIP. **Appendix B** includes a table with a list of the abbreviations used in this report.

Descriptions of Medicaid and CHIP

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 the Medicaid income eligibility thresholds in each state.¹ Both programs are designed and administered by states, and both are jointly financed by the federal government and states.

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 (LTSS), 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

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, December 2022.

² For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview* and CRS In Focus IF10322, *Medicaid Primer*.

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, though all states, the District of Columbia, and the territories choose to participate. 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

The State Children’s Health Insurance Program (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 is administered by the states.⁴ 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.⁵

Participation in CHIP is voluntary, and all states, the District of Columbia, and the territories participate. The federal government sets basic requirements for CHIP, but states have the flexibility to design their own version 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 premiums or enrollment fees, with a maximum allowable amount that is tied to annual family income.

Summaries of Provisions

The following are summaries for each of the provisions in the CAA 2023 that impact Medicaid and CHIP. For each provision, there is background and a summary of the provision as enacted by the CAA 2023. These summaries are under the following headings: territories provisions,

³ This enrollment figure is the average monthly enrollment from the Congressional Budget Office (CBO), Medicaid Baseline Projections, May 2023, at <https://www.cbo.gov/system/files/2023-05/51301-2023-05-medicaid.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, at <https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbeschbes/index.html>.

⁴ 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)*.

⁵ This enrollment figure is the average monthly enrollment from the Congressional Budget Office (CBO), CHIP Baseline Projections, May 2023, at <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, at <https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbeschbes/index.html>.

Medicaid and CHIP coverage provisions, Medicaid and CHIP mental health provisions, and other provisions.

Territories Provisions

Section 5101(a): Revising Allotments for Puerto Rico

Background

Medicaid financing for the territories (i.e., America Samoa, CNMI, Guam, Puerto Rico, and USVI) differs from Medicaid financing for the 50 states and the District of Columbia (DC). Federal Medicaid funding to the states and DC is open-ended, whereas Medicaid programs in the territories are subject to capped funding amounts.

Federal Medicaid funding for the territories comes from a few different sources.⁶ The permanent source of federal Medicaid funding for the territories is the annual capped funding (also referred to as *allotments*). These Medicaid capped amounts vary by territory and increase annually according to the change in the medical component of the Consumer Price Index for All Urban Consumers (CPI-U).

From July 1, 2011, through December 31, 2019, the annual capped funding for the territories has been supplemented by additional funding sources available for a limited time provided through various laws. Prior to the availability of these additional Medicaid funding sources, all five territories typically exhausted their federal Medicaid funding prior to the end of each fiscal year.

Instead of providing funding in addition to the annual capped funding, the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), as amended by the FFCRA, provided increased federal annual capped funding amounts for Medicaid to the territories for FY2020 and FY2021. For FY2022, the Centers for Medicare & Medicaid Services (CMS) construed the effect of the amendments that provided federal Medicaid funding to the territories in FY2020 and FY2021 as providing federal Medicaid funding to the territories comparable to the annual capped funding provided in either FY2020 (for Puerto Rico) or FY2021 (for the other territories).

The Extending Government Funding and Delivering Emergency Assistance Act (P.L. 117-43) included a provision for the Government Accountability Office (GAO) to provide a legal review of the statutory language on the most plausible plain reading of how such FY2022 allotment levels should be calculated. GAO's legal review concluded that CMS should have calculated Puerto Rico's FY2022 annual capped funding based on Puerto Rico's FY2019 funding (i.e., \$367 million) rather than its FY2020 funding (i.e., \$2,716 million).⁷ CMS sent a letter to Puerto Rico after GAO released the legal review contending that CMS had accurately calculated Puerto Rico's FY2022 funding amount.⁸

The Further Consolidated Appropriations Act, 2020, also included a provision that provided Puerto Rico an additional \$200 million in federal Medicaid funding for each of FY2020 and FY2021 if Puerto Rico established a floor for Medicaid physician payment rates that was 70% of

⁶ For more information about the federal Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*, and CRS Report R47601, *Legislative History of Medicaid Financing for the Territories*.

⁷ U.S. Government Accountability Office (GAO), *Department of Health and Human Services: Fiscal Year 2022 Medicaid Allotment for Puerto Rico*, GAO-B-333602, November 15, 2021, at <https://www.gao.gov/products/b-333602>.

⁸ Letter from Daniel Tsai, Deputy Administrator and Director, Centers for Medicare & Medicaid Services (CMS) Center for Medicaid & CHIP Services, to Edna Y. Marin-Ramos, Medicaid Director Puerto Rico Medicaid Program, November 18, 2021, at <https://www.medicare.gov/allotment/downloads/ltr-to-med-agen-puerto-rico.pdf>.

the Medicare Part B payment rate in Puerto Rico for those services. This funding also was provided in FY2022 through the Consolidated Appropriations Act, 2022 (P.L. 117-103). Puerto Rico received this funding in all three of those years (i.e., FY2020, FY2021, and FY2022).

Provision

5101(a). Revising Allotment for Puerto Rico

Section 5101(a) of the CAA 2023 amends the Social Security Act (SSA) Section 1108(g) (42 U.S.C. §1308(g)) to provide specific federal Medicaid annual capped funding amounts to Puerto Rico for FY2023 through FY2027. The provision also specifies the annual capped federal Medicaid funding to Puerto Rico for FY2028 and subsequent fiscal years. In addition, Section 5101(a) provides Puerto Rico additional federal Medicaid funding (1) if Puerto Rico establishes a floor for Medicaid physician payment rates and (2) if certain program integrity conditions are met.

The specified annual capped federal Medicaid funding amounts for Puerto Rico for FY2023 through FY2027 are as follows:

- \$3.275 million for FY2023
- \$3.325 million for FY2024
- \$3.475 million for FY2025
- \$3.645 million for FY2026
- \$3.825 million for FY2027

For FY2028, the annual capped federal Medicaid funding for Puerto Rico is to be calculated without regard to the actual funding provided to Puerto Rico for FY2020 through FY2027. The language in the CAA 2023 specifies how the FY2028 funding should be calculated. This calculation starts by establishing a hypothetical amount for FY2020 based on the actual annual capped federal Medicaid funding provided to Puerto Rico in FY2019 (i.e., \$367 million) increased by the medical component of the CPI-U. Then, for each of FY2021 through FY2027, additional hypothetical amounts are calculated by taking the hypothetical amount for the preceding fiscal year and increasing that amount by the medical component of the CPI-U. This hypothetical amount for FY2027 is used to establish the actual FY2028 annual capped federal Medicaid funding for Puerto Rico by increasing the FY2027 amount by the medical component of the CPI-U. This calculation would result in a significant reduction in actual federal Medicaid funding for Puerto Rico from FY2027 to FY2028.

For FY2029 and subsequent years, the federal Medicaid funding for Puerto Rico is the actual amount specified for the preceding year increased by the medical component of the CPI-U.

The provision specifies that the Secretary of the Department of Health and Human Services (HHS) may in no way take into account the actual federal Medicaid funding provided to Puerto Rico in FY2022 when determining the funding for Puerto Rico in FY2028 and FY2029.

For each fiscal year from FY2023 through FY2027, Puerto Rico can receive an additional \$300 million in federal Medicaid funding if Puerto Rico establishes a floor for Medicaid physician payment rates implemented through a directed payment arrangement that is 75% of the Medicare Part B rate in Puerto Rico for those services.⁹ In certifying this reimbursement floor for FY2023,

⁹ In general, states are not permitted to direct the expenditures of a Medicaid managed care plan under the contract between the state and the plan or to make payments to providers for services covered under the contract between the (continued...)

the HHS Secretary considered the managed care contract entered into or renewed after the date of enactment. For subsequent fiscal years through FY2027, the HHS Secretary shall disregard payments made under sub-capitated arrangements for services such as primary care case management. In addition, if the reimbursement floor satisfies this requirement for a fiscal year in which the managed care contract is entered, then the reimbursement floor shall be deemed to satisfy the requirement for the subsequent fiscal year.

For FY2023 through FY2027, Puerto Rico can receive an additional increase in federal Medicaid funding of \$75 million for each fiscal year if certain program integrity conditions are met. For FY2023 through FY2025, Puerto Rico is eligible for the additional \$75 million if the HHS Secretary determines that Puerto Rico has designated an officer (other than the Medicaid director) to serve as the Medicaid program integrity lead. For FY2026 and FY2027, Puerto Rico is eligible for the additional \$75 million if the HHS Secretary determines Puerto Rico meets the same requirement for a Medicaid program integrity lead and the new contracting and procurement oversight lead requirement that is added by Section 5101(e).

The \$300 million and \$75 million in additional federal Medicaid funding for Puerto Rico may not be taken into account in calculating the annual capped federal Medicaid funding amounts for Puerto Rico for FY2023 and subsequent fiscal years.

5101(b). Extension of Increased Federal Medical Assistance Percentages

Background

The federal share of most Medicaid expenditures is determined by the FMAP rate.¹⁰ The FMAP rates for the 50 states and DC are determined annually and vary by state according to each state's per capita income. The rates can range from 50% to 83%. By contrast, the FMAP rates for the territories have been set at 55% since July 1, 2011; this means each territory gets 55 cents back from the federal government for almost every dollar the territory spends on its Medicaid program up to the federal funding limits.

For FY2020 through FY2022, FMAP rates for the territories have been temporarily increased through a number of laws.¹¹ From December 21, 2019, through December 23, 2022, the FMAP rate for the territories was increased from 55% to 83% for American Samoa, CNMI, Guam, and USVI and from 55% to 76% for Puerto Rico.¹²

Provision

Section 5101(b) of the CAA 2023 amends SSA Section 1905(ff) (42 U.S.C. §1396d(ff)) to make permanent the 83% FMAP rate for American Samoa, CNMI, Guam, and USVI and to extend the 76% FMAP rate for Puerto Rico through FY2027 (i.e., September 30, 2027).

state and the plan. However, CMS permits state-directed payments that comply with certain requirements. (42 C.F.R. § 438.6(c)).

¹⁰ For more information about the federal share of Medicaid expenditures, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

¹¹ For more information, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

¹² Puerto Rico's FMAP rate reverted to 55% for the period of December 4, 2021, through December 30, 2021.

Section 5101(c). Application of Asset Verification Program Requirements to Puerto Rico

Background

SSA Section 1940 (42 U.S.C. §1396w) required that states verify assets of individuals applying for the aged, blind, or disabled Medicaid eligibility pathways using the states' asset verification programs. For states without an asset verification program, starting January 1, 2021, the regular FMAP rate for those states would be reduced by

- 0.12 percentage points for calendar quarters in 2021 and 2022;
- 0.25 percentage points for calendar quarters in 2023;
- 0.35 percentage points for calendar quarters in 2024; and
- 0.50 percentage points for calendar quarters in 2025 and each year thereafter.

The definition of *state* for SSA Section 1940 was the 50 states and DC. As a result, the territories were exempt from the asset verification program requirement.

Provision

Section 5101(c) of the CAA 2023 amends SSA Section 1940 (42 U.S.C. §1396w) to require Puerto Rico to implement an asset verification program by January 1, 2026. If Puerto Rico does not have an asset verification program, starting January 1, 2026, the regular FMAP rate for Puerto Rico is to be reduced by

- 0.12 percentage points for calendar quarters in FY2026 starting on or after January 1, 2026;
- 0.25 percentage points for calendar quarters in FY2027;
- 0.35 percentage points for calendar quarters in FY2028; and
- 0.50 percentage points for calendar quarters in FY2029 and each year thereafter.

Section 5101(d): Extension of Reporting Requirement

Background

The territories were required to submit annual reports to Congress no later than 30 days after the end of FY2020 and FY2021 describing how the territories increase access to health care under Medicaid using the additional Medicaid funding and the increased FMAP rates provided for those years.

Provision

Section 5101(d) of the CAA 2023 amends SSA 1108(g)(9) (42 U.S.C. §1308(g)(9)) to extend the annual reporting requirement. The requirement for American Samoa, CNMI, Guam, and USVI is extended for FY2023 and subsequent years, and for Puerto Rico, the reporting requirement is extended for FY2023 through FY2027.

Section 5101(e): Puerto Rico Program Integrity

Background

From January 1, 2020, through September 30, 2021, for Puerto Rico and for FY2021 for American Samoa, CNMI, Guam, and USVI, the temporarily increased FMAP rates for the territories (i.e., 76% for Puerto Rico and 83% for American Samoa, CNMI, Guam, and USVI) could have been reduced if the territories did not comply with certain program integrity requirements. All the territories were required to designate a program integrity lead. Puerto Rico also was required to publish (1) a plan to develop measures to satisfy the payment error rate measurement requirements; (2) a contracting reform plan to combat fraudulent, wasteful, or abusive Medicaid contracts; and (3) a plan to comply with the Medicaid eligibility quality control requirements.

Provision

Section 5101(e) of the CAA 2023 amends SSA Section 1108(g)(7)(A) (42 U.S.C. §1308(g)(7)(A)) to add a contracting and procurement oversight lead requirement for Puerto Rico.¹³

No later than six months after the enactment of the CAA 2023, Puerto Rico's Medicaid agency is to designate an officer to serve as the contracting and procurement oversight lead. This officer is to certify to the HHS Secretary that the contracts with an annual value exceeding \$150,000 (1) have met the federal general procurement standards (45 C.F.R. §75.327), competition requirements (45 C.F.R. §75.328), and procurement procedures (45 C.F.R. §75.329) or (2) that extenuating circumstances (including a lack of multiple entities competing for such contract) prevented the compliance of such contract with such standards. The certification is to be completed no later than 60 days after the end of each fiscal quarter beginning with the first fiscal quarter that began one year after the date of the CAA 2023's enactment.

The contracting and procurement oversight lead is to make certifications containing extenuating circumstances public no later than 30 days after the certification is made, including a description and justification of such extenuating circumstances.

The HHS Inspector General is required to submit to Congress a report on Puerto Rico's compliance with the contracting and procurement oversight lead requirement no later than two years after the date of the CAA 2023's enactment.

Section 5101(f): Medicaid Data Systems Improvement Payments

Background

Medicaid data systems are approved administrative expenditures under the Medicaid program. Under prior law, expenditures for Medicaid data systems for the territories were counted against the territories' annual federal capped funding for Medicaid.

¹³ Section 5101(a) of the Consolidated Appropriations Act, 2023 (P.L. 117-328), makes Puerto Rico eligible for an additional \$75 million in federal Medicaid funding for FY2026 and FY2027 if the Secretary of the Department of Health and Human Services determines that Puerto Rico meets this contracting and procurement oversight lead requirement, along with the requirement to designate a program integrity lead.

Provision

Section 5101(f) of the CAA 2023 adds subsection (i) to SSA 1108(g) (42 U.S.C. §1308) to provide funding to American Samoa, CNMI, Guam, and USVI for qualifying data system improvement expenditures incurred by such territory on or after October 1, 2023. The federal government is to pay 100% of these expenditures, and the expenditures are to be treated as though they are Medicaid payments. There should be no duplication of payment under Medicaid, CHIP, or any other provision of law.

The total amount of payments for the data system improvements is not to exceed \$20 million. The HHS Secretary is to specify an allotment for each territory so that each eligible territory receives an equitable allotment. These data system improvement payments are not to be taken into account for purposes of the territories' annual federal capped funding for Medicaid.

The qualifying data system improvement expenditures are for improving, updating, or enhancing a data system that is used by the eligible territories to carry out an administrative activity for which federal Medicaid funding is available under the Medicaid program.

Section 5101(g): Strategic Plan and Evaluation

Background

The 50 states and the District of Columbia are not required to submit strategic plans for their Medicaid programs.

Provision

Section 5101(g) of the CAA 2023 adds a requirement for American Samoa, CNMI, Guam, and USVI each to submit a four-year strategic plan to the HHS Secretary no later than September 30, 2023. The strategic plan is to outline the territory's goals relating to workforce development, financing, systems implementation and operation, and program integrity with respect to the territory's Medicaid program.

The provision also requires each of these territories to submit to the HHS Secretary an analysis of the extent to which the territory has achieved, or is making progress toward achieving, the goals described in such strategic plan and any policy changes relating to such goals. This analysis must be submitted no later than September 30, 2027.

Medicaid and CHIP Coverage Provisions

Section 5111(a) and (b)(2): CHIP Funding

Background

CHIP was funded through FY2027.¹⁴ Since CHIP was established in 1997 in the Balanced Budget Act of 1997 (P.L. 105-33), it has been funded through subsequent legislation, including the following major laws:

¹⁴ For more information about CHIP financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*.

- The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3), which provided federal CHIP funding for FY2009 through FY2013
- The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), which provided federal CHIP funding for FY2014 and FY2015
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10), which provided funding for FY2016 and FY2017
- The continuing resolution enacted on January 22, 2018 (P.L. 115-120), which provided funding for FY2018 through FY2023
- The Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123), which provided funding for FY2024 through FY2027

CHIP was funded through FY2023 with appropriated amounts specified in statute. The funding amounts for FY2024 through FY2026 were not specified; instead, such sums as necessary to fund allotments to states and territories were provided. However, under prior law, the funding for FY2027 was the combination of two semiannual appropriations of \$7.65 billion plus a one-time appropriation of such sums as necessary to fund the allotments to states after taking into account the semiannual appropriations.

Provision

Sections 5111(a) and (b)(2) of the CAA 2023 extend federal CHIP funding for an additional two years by adding federal appropriations for FY2028 and FY2029 under SSA Section 2104(a) (42 U.S.C. §1397dd(a)) and BBA 2018 Section 50101(b)(2). The CAA 2023 amends the funding amount for FY2027 to such sums as necessary to fund allotments to states, and the funding for FY2028 is also such sums as necessary to fund allotments to states.

The funding for FY2029 is structured as it was for FY2027, with semiannual appropriations of equal amounts plus a one-time appropriation. In FY2029, the semiannual appropriations are \$7.65 billion and the one-time appropriation provides such sums as necessary to fund the allotments to states after taking into account the semiannual appropriations.

Section 5111(b)(1): CHIP Allotments

Background

The federal government reimburses states and territories for a portion of every dollar they spend on CHIP, up to state-specific annual limits, called *allotments*. Allotments are the federal funds allocated to each state for the federal share of its CHIP expenditures. State CHIP allotment funds are provided annually, and the funds are available to states for two years. Prior to the enactment of the CAA 2023, CHIP allotments were authorized through FY2027.

Two formulas are used to determine state allotments: an even-year formula and an odd-year formula. In even years, such as FY2022, state CHIP allotments are based on each state’s federal allotment for the prior year. In odd years, such as FY2023, state CHIP allotments are based on each state’s spending for the prior year. In every year, the allotment amounts are adjusted for growth in per capita national health expenditures and child population in the state.

Provision

Section 5111(b)(1) of the CAA 2023 authorizes CHIP allotments for FY2028 and FY2029 under SSA Section 2104(m) (42 U.S.C. §1397dd(m)), maintaining the allotment formulas for odd- and even-year allotments.

Section 5111(c)(1): Pediatric Quality Measures Program

Background

SSA Section 1139A (42 U.S.C. §1320b-9a) authorized various activities related to pediatric quality measurement for health services paid for by Medicaid or CHIP. SSA Section 1139A(a) required the HHS Secretary to identify and publish an initial core set of pediatric quality measures by no later than January 1, 2010, for states to use for voluntary reporting on child health quality. This core measure set was developed and is reviewed and updated annually by CMS, in partnership with Mathematica.¹⁵ The review involves identifying measure gaps and suggesting updates to improve the measure set.

Under SSA Section 1139A(b), the HHS Secretary was required to establish a Pediatric Quality Measures Program (PQMP) by January 1, 2011. Established in 2011, as required, the PQMP first focused on the development and testing of new and enhanced pediatric quality measures and began the process of seeking endorsement by the National Quality Forum for many measures. Much of this activity was carried out through cooperative agreement grants establishing seven Centers of Excellence (COE). The PQMP shifted its focus to dissemination and implementation of measures in 2016. Since that time, it has focused specifically on “assessing the feasibility and usability of the newly developed PQMP-COE measures at the State, health plan, and provider levels.”¹⁶ The PQMP also has helped identify pediatric quality measure gaps and development priorities.

SSA Section 1139A(c) required states to submit annual reports to the HHS Secretary that include information about state-specific child health quality measures as applied by the state. BBA 2018 amended SSA Section 1139A(a) and (c) to make mandatory annual state reporting to the HHS Secretary of the pediatric core measure set, beginning with the report on FY2024. BBA 2018 also modified the triennial reporting requirement from the HHS Secretary to Congress to include the status of mandatory reporting by states, beginning with information provided in the state report to the Secretary required on January 1, 2025. SSA Section 1139A required other time-limited activities, which have been completed.

Funding for SSA Section 1139A (excluding subsection (e)) was originally appropriated in the amount of \$45 million for each of FY2009 through FY2013. Section 210 of the Protecting Access to Medicare Act of 2014 (PAMA; P.L. 113-93) extended funding for only the PQMP for FY2014 by requiring that not less than \$15 million of the \$60 million appropriated for adult health quality measures under SSA Section 1139B(e) for FY2014 be used to carry out Section 1139A(b). The appropriation in Section 1139A(i) for funding to carry out Section 1139A (except for subsection

¹⁵ Mathematica is under contract with the Center for Medicaid and CHIP Services (CMCS) to convene the Child and Adult Core Sets Annual Review Workgroup to support the annual review and update of the child and adult quality measure core sets. See Mathematica, “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Workgroup Review of the 2025 Child and Adult Core Sets,” August 2023, p. ix.

¹⁶ Agency for Healthcare Research and Quality, “What Is the PQMP?,” at <https://www.ahrq.gov/pqmp/about/what-is-pqmp.html>.

(e) expired in FY2013; the funding designated by PAMA specifically to carry out Section 1139A(b) expired in FY2014.

Since FY2014, appropriated funding for activities under SSA Section 1139A has excluded support for activities under subsections (e), (f), and (g). MACRA Section 304(b) amended SSA Section 1139A(i) to appropriate \$20 million for the period FY2016 through FY2017, and Section 3003(b) of the HEALTHY KIDS Act (Division C, P.L. 115-120) appropriated funding in the amount of \$90 million for the period of FY2018 through FY2023. Section 50102(a) of BBA 2018 further amended SSA Section 1139A(i) to appropriate \$60 million for the period of FY2024 through FY2027. These appropriations are available until expended.

Provision

Section 5111(c)(1) of the CAA 2023 amends SSA Section 1139A(i) (42 U.S.C. §1320b-9a(i)) to appropriate, out of any funds in the Treasury not otherwise appropriated, \$15 million for each of FY2028 and FY2029 for purposes of carrying out this section, other than the activities under subsections (e), (f), and (g).

Sections 5111(c)(2) and 5111(d)(2): Assurance of Eligibility Measures for Children

Background

Eligibility for CHIP and Medicaid is determined by both federal and state law, whereby states set individual eligibility criteria within federal standards. In general, CHIP eligibility builds on Medicaid eligibility. Title XXI of the SSA defined a *targeted low-income child* as one who is under the age of 19 with no health insurance and who would not have been eligible for Medicaid under the federal and state rules in effect when CHIP was first initiated in 1997. Statewide upper-income eligibility thresholds for CHIP-funded child coverage vary substantially across states, ranging from a low of 170% of the federal poverty level (FPL) to a high of 400% of FPL, as of July 2022.¹⁷

States are required to maintain the same eligibility standards, methodologies, and procedures for children up to the age of 19 under CHIP (SSA §2105(d)(3); 42 U.S.C. §1397ee(d)(3)) and Medicaid (SSA §1902(gg)(2); 42 U.S.C. §1396a(gg)(2)) that were in place on the date of enactment of the ACA through FY2027. The penalty to states for not complying with either the CHIP or the Medicaid Maintenance of Effort (MOE) requirements would be the loss of all federal Medicaid funds.

For FY2020 through FY2027, the CHIP and Medicaid MOE requirements apply only to children in families with annual income less than 300% of FPL. During this specified period, states are permitted to roll back CHIP and/or Medicaid eligibility for children in families with annual income that exceeds 300% of FPL without the loss of all federal Medicaid matching funds.

Provision

Sections 5111(c)(2) and 5111(d)(2) of the CAA 2023 extend the CHIP (SSA §2105(d)(3); 42 U.S.C. §1397ee(d)(3)) and Medicaid (SSA §1902(gg)(2); 42 U.S.C. §1396a(gg)(2)) MOE requirements for children for two years, from FY2028 through FY2029.

¹⁷ MACPAC, “Exhibit 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of FPL for Children and Pregnant Women by State,” *MACStats*, July 2022.

Under this MOE extension, states are required to maintain the same eligibility standards, methodologies, and procedures for children up to the age of 19 under CHIP and Medicaid that were in place on the date of enactment of the ACA through FY2029. The penalty to states for not complying with either the CHIP or the Medicaid MOE requirements is the loss of all federal Medicaid funds.

For FY2020 through FY2029, the CHIP and Medicaid MOE requirements apply only to children in families with annual income less than 300% of FPL. During this specified period, states are permitted to roll back CHIP and/or Medicaid eligibility for children in families with annual income that exceeds 300% of FPL without the loss of all federal Medicaid matching funds.

Section 5111(c)(3): Qualifying States Option

Background

In a few situations, federal CHIP funding is used to finance Medicaid expenditures. For instance, states that had significantly expanded Medicaid eligibility for children prior to the enactment of CHIP in 1997 are allowed to use their CHIP allotment funds to finance the difference between the Medicaid and CHIP matching rates (i.e., the FMAP and enhanced federal medical assistance percentage [E-FMAP] rates, respectively) for the cost of Medicaid-eligible children in families with income above 133% of FPL. Eleven states meet the definition: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. This provision is referred to as the *qualifying states option*. Prior to the enactment of the CAA 2023, FY2027 was the last year in which the qualifying states option was authorized.

Provision

Section 5111(c)(3) of the CAA 2023 extends the qualifying states option under SSA Section 2105(g)(4) (42 U.S.C. §1397ee(g)(4)) for FY2028 and FY2029.

Sections 5111(c)(4): Outreach and Enrollment Program

Background

CHIPRA Section 201 appropriated (out of funds in the Treasury that were not otherwise appropriated) \$100 million in outreach and enrollment grants for FY2009 through FY2013 to be used by eligible entities (e.g., states, local governments, community-based organizations, elementary and secondary schools) to conduct outreach and enrollment efforts that increase the participation of Medicaid- and CHIP-eligible children. Of the total appropriation, 10% was directed to a national campaign to improve the enrollment of underserved child populations and 10% was targeted at outreach for Native American children. The remaining 80% was distributed among eligible entities for the purpose of conducting outreach campaigns, focusing on rural areas and underserved populations. Grant funds also were targeted at proposals that address cultural and linguistic barriers to enrollment.

Since then, several laws have appropriated federal funds for CHIP outreach and enrollment grants for additional fiscal years and have provided direction for the use of such funds. Most recently, Section 50103 of BBA 2018 appropriated \$48 million for CHIP outreach and enrollment grants for the period of FY2024 through FY2027 and required 10% of such funds to be set aside for use by the HHS Secretary for evaluations and technical assistance. The provision also allowed

reserved national enrollment campaign funds to be used for technical assistance in the development of enrollment and retention strategies for underserved Medicaid and CHIP child populations.

Provision

Section 5111(c)(4) of the CAA 2023 amends SSA Section 2113 (42 U.S.C. §1397mm) to appropriate \$40 million for CHIP outreach and enrollment grants for the period of FY2028 through FY2029 with the same structure as was used for the grants for FY2024 through FY2027.

Section 5111(c)(5): Child Enrollment Contingency Fund

Background

CHIPRA established the Child Enrollment Contingency Fund to provide shortfall funding to certain states. It was funded with an initial deposit equal to 20% of the appropriated amount for CHIP for FY2009 (i.e., \$2.1 billion). In addition, for FY2010 through FY2027, such sums as were necessary for making Child Enrollment Contingency Fund payments to eligible states were to be deposited into this fund, but these transfers cannot exceed 20% of the appropriated amount for the fiscal year or period.

For FY2009 through FY2027, states with a funding shortfall and CHIP enrollment for children exceeding a state-specific target level receive a payment from the Child Enrollment Contingency Fund. This payment is equal to the amount by which the enrollment exceeds the target, multiplied by the product of projected per capita expenditures and the E-FMAP (i.e., the federal share of CHIP expenditures).

Provision

Section 5111(c)(5) of the CAA 2023 extends the funding mechanism for the Child Enrollment Contingency Fund under SSA Section 2104(n) (42 U.S.C. §1397dd(n)) and payments from the fund for FY2028 and FY2029.

Sections 5111(d)(1): Express Lane Eligibility Option

Background

CHIPRA created a state plan option for Express Lane Eligibility through September 30, 2013.¹⁸ Under this option, states are permitted to rely on a finding from certain agencies specified as Express Lane agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and the Supplemental Nutrition Assistance Program) for

- determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility for Medicaid or CHIP,
- eligibility redeterminations for Medicaid or CHIP, or
- renewal of eligibility coverage under Medicaid or CHIP.

¹⁸ Express Lane Eligibility is a state plan option to facilitate enrollment in Medicaid and/or CHIP by permitting states to rely on findings from other means-tested social programs.

Subsequent legislation extended this provision. Most recently, BBA 2018 extended the Express Lane Eligibility option through FY2027.

Provision

Section 5111(d)(1) of the CAA 2023 amends SSA Section 1902(e)(13)(I) (42 U.S.C. §1396a(e)(13)(I)) to extend authority for Express Lane Eligibility determinations for two years, FY2028 through FY2029.

Section 5112: Continuous Eligibility for Children Under Medicaid and CHIP

Background

States are permitted to provide up to 12 months of continuous eligibility for Medicaid- and CHIP-enrolled children under the age of 19 (or under a younger age as elected by the state). A continuous eligibility period begins on the effective date of the individual's eligibility as specified by the state and ends after the period specified by the state.

During a continuous eligibility period, a child's Medicaid or CHIP eligibility may not be terminated, regardless of any changes in circumstances, unless (1) the child attains the state-specified maximum age for continuous eligibility, (2) the child or child's representative requests a voluntary disenrollment, (3) the child ceases to be a state resident, (4) the agency determines that eligibility was erroneously granted, or (5) the child is deceased. Under CHIP, in general, states also may terminate eligibility for program enrollees during a period of continuous eligibility for failure to pay premiums after a grace period.

Provision

Section 5112 of the CAA 2023 amends SSA Section 1902(e)(12) (42 U.S.C. §1396a(e)) and SSA Section 2107(e)(1) (42 U.S.C. §1397gg(e)(1)) to require states to extend 12 months of continuous eligibility for Medicaid and CHIP enrollees under the age of 19. Child enrollees will be continuously eligible until the earlier of (1) the end of the 12-month continuous eligibility period, (2) the date the child attains the age of 19, or (3) the date the child enrollee ceases to be a state resident. The provision makes an exception for CHIP enrollees who are determined eligible for full Medicaid benefit coverage during the continuous eligibility period. Such enrollees may be transferred to Medicaid for the remainder of the continuous eligibility period.

The provision is effective beginning January 1, 2024.¹⁹

Section 5113: Modifications to Postpartum Coverage Under Medicaid and CHIP

Background

Section 9812 of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) added a new state plan option to Medicaid at Section 1902(e) (42 U.S.C. §1396(a)(e)) to extend full Medicaid benefit coverage during pregnancy and throughout the 12-month postpartum period to any women who received Medicaid coverage while pregnant during the five-year period beginning April 1, 2022, and ending March 31, 2027. In addition to any available pregnancy-related services

¹⁹ The provision is effective on the first day of the first fiscal quarter that begins on or after the date that is one year after the date of enactment of this act (i.e., beginning January 1, 2024).

and 60-day postpartum care to which an individual might be entitled under the Medicaid state plan (or waiver), pregnancy and postpartum coverage under this state plan option includes the full Medicaid benefit coverage that is available to other mandatory eligibility groups (or substantially equivalent benefit coverage, as determined by the HHS Secretary). This coverage is available during the pregnancy through the last day of the month of the 12-month period that begins on the last day of the individual's pregnancy. States that make this election for pregnant and postpartum women under Medicaid are required to take up the parallel state plan option under ARPA Section 9822 to extend child health assistance through the 12-month postpartum period for targeted low-income children or targeted low-income pregnant women under CHIP.

ARPA Section 9822 added a new paragraph to SSA Section 2107(e)(1) (42 U.S.C. §1397gg(e)(1)) to require states that elect to provide full Medicaid coverage during pregnancy and throughout the 12-month postpartum period under Medicaid to provide all items or services available to a targeted low-income child or a targeted low-income pregnant woman (SSA §2112(d)(2)(A); 42 U.S.C. §1397ll(d)(2)(A)) under the CHIP state plan (or waiver) to women during pregnancy and throughout the 12-month postpartum period under CHIP. Section 9822 is effective for state elections for such coverage under Medicaid and CHIP during the five-year period beginning April 1, 2022, and ending March 31, 2027.

Provision

Section 5113 of the CAA 2023 amends ARPA Section 9812 to make permanent the state plan option to provide 12 months of postpartum coverage in Medicaid (SSA §1902(e); 42 U.S.C. §1396(a)(e)) and CHIP (SSA §2107(e)(1); 42 U.S.C. §1397gg(e)(1)).

Section 5114: Extension of Money Follows the Person Rebalancing Demonstration

Background

The Money Follows the Person (MFP) Rebalancing Demonstration Program authorizes CMS to award competitive grants to states to transition Medicaid participants who reside in institutional settings that provide long-term services and supports (LTSS), such as nursing facilities, into community-based settings. MFP was designed to achieve the following objectives:

- **Rebalancing.** Increase the use of home- and community-based services (HCBS) rather than institutional LTSS.
- **Money Follows the Person.** Eliminate barriers that restrict the use of Medicaid funds, enabling eligible individuals to receive LTSS in the setting of their choice.
- **Continuity of Service.** Increase the state Medicaid program's ability to provide Medicaid HCBS to eligible individuals who choose to transition.
- **Quality Assurance and Quality Improvement.** Ensure procedures to provide quality assurance and continuous quality improvement for Medicaid HCBS.

MFP grant awards to states are for a five-year project period. After the initial grant award, states may receive supplemental awards in subsequent fiscal years. States may expend grant awards in the first fiscal year of an award and for up to four additional years after the award year. According

to CMS, states transitioned over 107,000 individuals to community living between 2008 and 2020.²⁰ A total of 43 states and DC have participated in MFP over the course of the program.²¹

The MFP program was first enacted in 2006 and has been extended with additional mandatory funding over time.²² Most recently, Division CC, Section 204, of the Consolidated Appropriations Act, 2021 (P.L. 116-260), amended the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) to extend program funding through September 30, 2023. It further authorized expansion of the MFP program to states that do not currently participate and reduced the minimum stay requirements for participant eligibility from 90 to 60 consecutive days in an inpatient facility, allowing for days admitted for short-term rehabilitative services, which were previously excluded, to be counted. The Consolidated Appropriations Act, 2021, appropriated \$450 million in federal funding for each of FY2021-FY2023, for a total of \$1.35 billion. From amounts appropriated, it made available to the HHS Secretary no more than \$1.1 million for each of FY2021-FY2023 for research and evaluation activities and no more than \$300,000 for each of FY2021-FY2022 for a report that contains findings and conclusions on best practices from MFP demonstration projects. It also provided, from amounts appropriated, \$3.0 million for oversight and technical assistance to states for upgrading the quality assurance and improvement processes under Medicaid HCBS waiver programs (to remain available until expended).

Provision

Section 5114 of the CAA 2023 extends the Medicaid MFP program by amending DRA Section 6071 (42 U.S.C. §1396a note) to appropriate \$450 million in federal funding for each of FY2024-FY2027 for a total of \$1.8 billion for competitive grants to states. In addition to amounts otherwise available, the provision appropriates \$5.0 million to states for FY2023 and for each subsequent three-year period through FY2029 (to remain available until expended) for carrying out quality assurance and improvement, technical assistance, oversight, research and evaluation. The provision also requires a report to the President and Congress.

The provision also adds language with respect to redistributing unexpended grant awards. It specifies that any portion of a state grant award for a fiscal year that is unexpended by the state at the end of the fourth succeeding fiscal year shall be rescinded by the HHS Secretary from the state and added to the appropriation for the fifth succeeding fiscal year.

Section 5115: Extension of Medicaid Protections Against Spousal Impoverishment for Recipients of Home and Community-Based Services

Background

When determining financial eligibility for Medicaid-covered LTSS, there are specific rules under SSA Section 1924 (42 U.S.C. §1396r-5) for the treatment of a married couple's assets when one spouse needs long-term care provided in an institution, such as a nursing home. Commonly referred to as *spousal impoverishment rules*, these rules attempt to equitably allocate income and assets to each spouse when determining Medicaid financial eligibility and are intended to prevent

²⁰ CMS, "Money Follows the Person," at <https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html>.

²¹ Rebecca Coughlin et al., *Money Follows the Person Demonstration: Overview of State Grantee Progress, January to December 2016*, Mathematica Policy Research, September 2017.

²² For more information, see CRS In Focus IF11839, *Medicaid's Money Follows the Person Rebalancing Demonstration Program*.

the impoverishment of the non-Medicaid spouse. For example, spousal impoverishment rules require state Medicaid programs to exempt all of a non-Medicaid spouse's income in his or her name from being considered available to the Medicaid spouse. Joint income of the couple is divided in half between the spouses, and the Medicaid spouse can transfer income to bring the non-Medicaid spouse up to certain income thresholds. Assets of the couple, regardless of whose name they are in, are combined and then split in half. The non-Medicaid spouse can retain assets up to an asset threshold determined by the state within certain statutory parameters.²³

Prior to enactment of the ACA, spousal impoverishment rules applied only in situations where the Medicaid participant was receiving LTSS in an institution. States had the option to extend these protections to certain HCBS participants under an SSA Section 1915(c) waiver program.²⁴

Beginning January 1, 2014, ACA Section 2404 temporarily amended the definition of *institutionalized spouse* under SSA Section 1924(h)(1) to include application of these spousal impoverishment protections to all married individuals who are eligible for HCBS authorized under certain specified authorities. Thus, beginning January 1, 2014, for a five-year period, the ACA required states to apply the spousal impoverishment rules to all married individuals who were eligible for HCBS under these specified authorities, not just those receiving institutional care.²⁵ This modified definition expired on December 31, 2018. However, Congress has extended the authority for these protections several times.²⁶ Prior to the CAA 2023, the Consolidated Appropriations Act, 2021 (P.L. 116-260), Division CC, Section 205, extended the authority for these protections through September 30, 2023.

Provision

Section 5115 of the CAA 2023 amends ACA Section 2404 (42 U.S.C. §1396r-5note) to extend spousal impoverishment protections to all married individuals who are eligible for Medicaid HCBS under specified authorities through September 30, 2027.

²³ See CMS, *2023 SSI and Spousal Impoverishment Standards*, at <https://www.medicaid.gov/federal-policy-guidance/downloads/ssi-spousal-cib-01-2023-508.pdf>.

²⁴ These home and community-based services (HCBS) recipients are eligible under the *special home- and community-based services waiver eligibility group*, or *217 Group*, in reference to the specific regulatory citation for this group at 42 C.F.R. §435.217. Prior to §2404 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), states that chose to apply spousal impoverishment protections as an option for the 217 Group also had the option to treat married HCBS recipients in the 217 Group as institutionalized for the purposes of post-eligibility treatment of income (PETI) rules.

²⁵ States that cover the 217 Group also must apply the PETI rules.

²⁶ For additional legislative history regarding Medicaid protections against spouse impoverishment for recipients of HCBS, see CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*.

Medicaid and CHIP Mental Health Provisions

Section 5121: Medicaid and CHIP Requirements for Health Screenings, Referrals, and Case Management Services for Eligible Juveniles in Public Institutions

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.

Enacted October 24, 2018, the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) 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”; instead, the law allows states to suspend Medicaid. *Eligible juveniles* are defined as individuals under 21 years of age and former foster youth up to the age of 26 who become incarcerated while enrolled in Medicaid or are determined eligible for Medicaid while incarcerated. The SUPPORT Act also required states to redetermine the eligibility of eligible juveniles whose Medicaid is suspended, or to accept and make timely eligibility determinations on new Medicaid applications for eligible juveniles, to enable full coverage upon release. 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 become inmates of public institutions on or after October 24, 2019.

CHIP

SSA Section 2110(b)(2) (42 U.S.C. §1397bb) explicitly excluded children who are inmates of a public institution or patients in an institution for mental disease from being eligible to enroll in child health coverage under CHIP.

Provision

Medicaid

Section 5121(a) of the CAA 2023 amends the SUPPORT Act requirements at SSA Section 1902(a)(84) (42 U.S.C. §1396a) to direct states to establish a plan within 30 days of the date that an eligible juvenile is scheduled to be released. Such plans must provide for the following:

- Medical, dental, and behavioral health screenings or diagnostic services (as determined by the state or indicated as medically necessary under early and periodic screening, diagnostic, and treatment [EPSDT] services). Such screenings and diagnostic services must occur in coordination with the public institution

- during the period that is 30 days prior to the eligible juvenile's release (or no later than one week, or as soon as practicable, after release).
- Targeted case management services during the 30 days prior to and for at least 30 days after release, including referrals to the appropriate care and services available within the geographic region of the eligible juvenile's home or residence (where possible).

Section 5121(b) amends SSA Section 1905(a) (42 U.S.C. §1396d(a)), Subdivision A, following paragraph (31), to clarify that services provided under such plans are not subject to Medicaid's inmate payment exclusion.

CHIP

Section 5121(c) of 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; redeterminations of coverage upon release; and coverage of certain screening, diagnostic, and case management services prior to release.

Specifically, the provision amends SSA Section 2102 (U.S.C. §1397bb) to prohibit states from terminating eligibility for CHIP enrollees who are inmates of a public institution; instead, the CAA 2023 allows states to suspend coverage during the enrollee's incarceration. The law requires states to redetermine eligibility prior to release for CHIP enrollees whose coverage is suspended. If the child continues to be eligible, the provision requires states to restore coverage upon release. States are required to accept and make timely eligibility determinations on new CHIP applications submitted by or on behalf of an incarcerated child to enable coverage upon 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 provision amends 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 are not subject to CHIP's inmate payment exclusion.

Effective Date

The Medicaid and CHIP changes under this provision are effective beginning January 1, 2025.²⁷

Section 5122: Removal of Limitations on Federal Financial Participation for Inmates Who Are Eligible Juveniles Pending Disposition of Charges

Background

As noted above, the federal Medicaid statute at SSA Section 1905(a) (42 U.S.C. §1396d(a)), Subdivision A, following paragraph (31) includes an inmate payment exclusion which generally prohibits the use of federal Medicaid funds to pay for the health care of an inmate of a public institution. CMS released sub-regulatory guidance clarifying Medicaid's definition of an *inmate of a public institution*, stating, "CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities

²⁷ The effective date for the Medicaid and CHIP changes under this provision is the first day of the first calendar quarter beginning 24 months after the date of enactment (i.e., beginning January 1, 2025).

in a public institution.”²⁸ Thus, for the purposes of Medicaid, CMS does not distinguish between individuals who are detained in a public institution pending disposition of charges and those who are incarcerated post-sentencing. According to this same CMS guidance, individuals are not considered inmates for the purposes of Medicaid if they have “freedom of movement” (e.g., ability to work outside a facility or to seek health treatment in a community setting). Therefore, individuals who are on probation or parole, under home confinement, or residing in halfway houses under the jurisdiction of state or local governments are not considered inmates for the purposes of Medicaid’s inmate payment exclusion.

SSA Section 2110(b)(2) (42 U.S.C. §1397bb) explicitly excluded children who are inmates of a public institution or patients in an institution for mental disease from being eligible to enroll in child health coverage under CHIP.

Provision

Section 5122 of the CAA 2023 amends SSA Section 1905(a) (42 U.S.C. §1396d(a)), Subdivision A, following paragraph (31), and SSA Section 2110(b)(2) (42 U.S.C. §1397bb) to permit states to receive federal payment for allowable medical assistance services provided to eligible juveniles under Medicaid and for allowable child health assistance services provided under CHIP during the period in which such enrollees are inmates of a public institution pending disposition of charges.

The effective date for the Medicaid and CHIP changes under this provision is the first day of the first calendar quarter beginning 24 months after the date of enactment (i.e., beginning January 1, 2025).

Section 5123: Requiring Accurate, Updated, and Searchable Provider Directories

Background

Medicaid and CHIP provider directory requirements are different for (1) fee-for-service (FFS) and primary care case management (PCCM) systems, and (2) managed care.²⁹ Below are definitions for each of these Medicaid delivery systems:

- Under the FFS delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee.
- Under PCCM, states contract with primary care providers to provide case management services to certain Medicaid enrollees.³⁰
- Under Medicaid managed care, services are delivered to Medicaid enrollees through the following entities: managed care organizations (MCOs), prepaid

²⁸ CMS, State Health Official Letter (SHO # 16- 007), “RE: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities,” April 28, 2016, at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/sho16007_41.pdf.

²⁹ For more information on Medicaid delivery systems, see CRS Report R43357, *Medicaid: An Overview*.

³⁰ Social Security Act (SSA) §1902(a)(83) makes a distinction between PCCM systems (defined at SSA §1915(b)(1)) and PCCM entities. SSA §1915(b)(1) allows states to implement a PCCM system or a specialty physician services arrangement, which restricts the provider from whom enrollees can obtain medical care services, when certain circumstances are met.

inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and PCCM entities (as defined in §SSA 1905(t)(2)).

Medicaid FFS and Primary Care Case Management (PCCM) System Provider Directory Requirements

Section 5006 of the 21st Century Cures Act (P.L. 114-255) required states that provide Medicaid services under a state plan or waiver on an FFS basis or through a PCCM system to make available a provider directory on the state’s public-facing Medicaid website no later than January 1, 2017, and to update this directory at least annually.³¹

Medicaid provider directories must contain certain data elements for physicians broken out by *FFS Physicians* and by *PCCM System Physicians*. At state option, directories may contain certain data elements for *FFS Other Providers* or *PCCM System Other Providers*, including the name of the physician or provider, the specialty of the physician or provider, the address at which the physician or provider provides services, and the telephone number of the physician or provider.

PCCM System Physicians also must include information on the following directory criteria (*PCCM System Other Providers* may provide this information at state option):

- Whether the physician or provider is accepting new Medicaid patients
- Cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician’s or provider’s office

At state option, *PCCM System Physicians* or *PCCM System Other Providers* also may include information on the following:

- The internet website of such physician or provider
- Whether the physician or provider is accepting new Medicaid patients

Medicaid Managed Care Provider Directory Requirements

The FFS provider directory requirements do not apply to Medicaid managed care entities.³² However, SSA Section 1932(a)(5)(B)(i) (42 U.S.C. §1396u-2(a)(5)(B)(i)) required Medicaid managed care entities to make available to their enrollees and potential enrollees information about providers that includes the identity, locations, qualifications, and availability of health care providers that participate with the managed care entity.

CHIP Provider Directory Requirements

CHIP does not have a provider directory requirement. However, SSA Section 2103(f)(3) (42 U.S.C. §1397cc(f)(3)) extended the Medicaid managed care entity requirements to provide information to enrollees and potential enrollees about participating health care providers under CHIP. The statute is silent regarding provider directory requirements for CHIP providers that deliver services via the fee-for-service delivery system.

³¹ Under the FFS delivery system, the state Medicaid program pays health care providers for each service they provide to a Medicaid enrollee. Under primary care case management (PCCM), states contract with primary care providers to provide case management services to certain Medicaid enrollees. Social Security Act (SSA) §1902(a)(83) makes a distinction between PCCM systems (defined at SSA §1915(b)(1)) and PCCM entities. SSA §1915(b)(1) allows states to implement a primary care case-management system or a specialty physician services arrangement, which restricts the provider from whom enrollees can obtain medical care services, when certain circumstances are met.

³² Medicaid managed care entities include managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case managers (as defined in SSA §1905(t)(2)).

Provision

Section 5123 of the CAA 2023 requires Medicaid and CHIP managed care entities to provide accurate, updated, and searchable provider directories and amends the Medicaid and CHIP FFS provider directory requirements. These provider directory requirements for FFS and managed care are similar.

Medicaid Managed Care Provider Directory Requirements

Section 5123(a) amends SSA Section 1932(a)(5) (42 U.S.C. §1396u–2(a)(5)) to add a provider directory requirement under Medicaid managed care. Each managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, and PCCM entity with a Medicaid contract with a state must publish a searchable directory of network providers on a public website. The directory is to be updated on at least a quarterly basis or more frequently, as required by the HHS Secretary. The directory shall include physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of LTSS, as appropriate, and such other providers as required by the HHS Secretary.

For each provider, the directory should include the name of the provider, the specialty of the provider, the address where services are provided, and the telephone number. In addition, the directory should include information regarding cultural and linguistic capabilities, whether the provider is accepting new patients, whether the office or facility has accommodations for individuals with physical disabilities, the website (if applicable), and whether the provider offers services via telehealth.

Network provider is defined as a provider, group of providers, or entity that has a network provider agreement with a managed care entity, or a subcontractor of such entity, and receives Medicaid payment (directly or indirectly) to order, refer, or render covered services as a result of a Medicaid managed care contract. A network provider shall not be considered to be a subcontractor by virtue of the network provider agreement.

Medicaid FFS and PCCM System Provider Directory Requirements

Section 5123(b) of the CAA 2023 amends the provider directory requirements at SSA Section 1902(a)(83) (42 U.S.C. §1395a) for states that provide Medicaid services under a state plan or waiver on an FFS basis or through a PCCM system and modifies the provider types that must comply. Specifically, the provision requires states to make available a provider directory on the state's public-facing Medicaid website and to update this directory at least quarterly (or more frequently, as required by the HHS Secretary) with information including the provider's name, specialty, location, telephone number, website address, and cultural and linguistic capabilities (including languages offered by the provider or by a skilled medical interpreter who provides interpretation services at the provider's office). The provider directory also must include information as to whether the provider is accepting new Medicaid patients, if the provider's office or facility has accommodations for individuals with physical disabilities (e.g., offices, exam rooms, equipment), whether the provider delivers covered services via telehealth, and any other relevant provider directory requirements or information as specified by the HHS Secretary.

The provision amends SSA Section 1902(mm) (42 U.S.C. §1396a(mm)) to identify the provider types that must comply with these provider directory requirements. The provider types include physicians, hospitals, and pharmacies, as well as providers of mental health and substance use disorder services; LTSS, as appropriate; and any others as required by the HHS Secretary. Other providers or provider types that must meet the specified provider directory requirements include (1) those that enroll with the state Medicaid agency as a condition of receipt of federal Medicaid payments as of the provider directory publication date (or update) and that received federal

Medicaid payments under the state plan in the 12-month period preceding such date, and (2) those that are not required to enroll with the state Medicaid agency but received federal Medicaid payments in the 12-month period preceding the provider directory publication date (or update).

CHIP Provider Directory Requirements

Section 5123(c) of the CAA 2023 amends SSA Section 2107(e)(1)(G) (42 U.S.C. §1397gg(e)(1)(G)) to add the Medicaid provider directory requirements applicable to states that provide Medicaid services under a state plan or waiver on an FFS basis, or through a PCCM system, and the provider types that must comply with such requirements to the list of Medicaid requirements that also apply to CHIP.

Effective Date

The provision is effective July 1, 2025.

Section 5124: Supporting Access to a Continuum of Crisis Response Services Under Medicaid and CHIP

Background

Crisis response services are intended to provide individuals who are experiencing a mental health and/or substance use disorder crisis with immediate mental health and substance use disorder stabilization and de-escalation services, as well as coordination with and referrals to health, follow-on mental health and substance use disorder services, social, and other services, as needed.

Provision

Section 5124 of the CAA 2023 requires the HHS Secretary—in coordination with the CMS Administrator and the Assistant Secretary for Mental Health and Substance Use—to, no later than July 1, 2025, issue guidance to states (and territories) and establish a technical assistance center to help states design, implement, or enhance a continuum of crisis response services for children, youth, and adults under Medicaid and CHIP. For these purposes, the provision appropriates to the HHS Secretary, out of any funds in the Treasury not otherwise appropriated, \$8 million to remain available until expended.

The guidance is to be developed in consultation with health care providers and stakeholders with expertise in mental health and substance use disorder crisis response services. It is to include recommendations for an effective continuum of crisis response services that will promote access to appropriate, timely mental health and substance use disorder crisis response services delivered in the least restrictive setting, as well as culturally competent, trauma-informed care and crisis de-escalation services. Crisis response services addressed in the guidance will include crisis call centers (including 988 crisis services hotlines); mobile crisis teams; crisis response services delivered in home, community, residential facility, and hospital settings; and coordination with follow-on mental health and substance use disorder services (e.g., intensive outpatient and partial hospitalization programs), as well as connections to social services and supports. The guidance also will include information, including state strategies and best practices, regarding the following:

- Existing Medicaid and CHIP authorities available to finance crisis response services across each stage of the care continuum
- Implementation of real-time crisis call centers (including 988 crisis services hotlines) and how to leverage existing Medicaid administrative funding and the

- Medicaid Information Technology Architecture 3.0 framework to establish or enhance regional or statewide crisis call centers
- Access to youth-focused crisis response (including behavioral disorder-specific crisis response) through mechanisms such as CHIP health services initiatives, trained peer support services, and youth-focused crisis call centers
 - How to meet the need for crisis response services for different patient populations (e.g., urban, rural, and frontier communities; different age groups; cultural and linguistic minorities; individuals with co-occurring mental health and substance use disorder conditions; and individuals with disabilities)
 - How to promote evidence-based suicide risk screenings and assessments
 - How to facilitate timely provision of and increased capacity for delivering crisis response services (e.g., delivery of crisis response services without requiring a diagnosis; use of presumptive eligibility and telehealth; 24/7 response in medically underserved regions; and identification and repurposing of available beds, space, and staff for crisis response services)
 - How to coordinate Medicaid and CHIP funding with other payers and federal funding sources for mental health and substance use disorder crisis response services and information on when Medicaid and CHIP serve individuals regardless of payer
 - How to establish effective connections with follow-on mental health and substance use disorder services and social services and supports
 - How to coordinate and finance a continuum of crisis response services through Medicaid managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and FFS delivery systems, including mental health or substance use disorder benefit carve-outs
 - How to measure and monitor use of, and outcomes related to, crisis response services

The technical assistance center is required to provide support to states (and territories) to leverage federal Medicaid and CHIP authority to finance mental health and substance use disorder crisis response services, coordinate with other sources of federal funding for mental health and substance use disorder crisis response services, and adopt best practices and strategies identified through the above-listed guidance. The HHS Secretary is also required to develop, review annually, and update as appropriate a publicly available compendium of best practices for continuum of crisis response services under Medicaid and CHIP.

Other Provisions

Section 5131: Transitioning from Medicaid FMAP Increase Requirements

Background

The federal government's share of a state's expenditures for most Medicaid services is called the FMAP. The regular FMAP varies by state and is inversely related to each state's per capita income. For FY2023, regular FMAP rates ranged from 50% (12 states) to 78% (Mississippi). The FFCRA provided an increase to the regular FMAP rate for all states, DC, and the territories of 6.2 percentage points. Prior to the enactment of the CAA 2023, the FFCRA FMAP increase was in effect beginning on the first day of the calendar quarter in which the Coronavirus Disease 2019

(COVID-19) public health emergency period began (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the last day of the COVID-19 public health emergency period ends.³³

To receive the FFCRA FMAP increase, states, DC, and the territories were required to (1) ensure their Medicaid “eligibility standards, methodologies, and procedures” are no more restrictive than those that were in effect on January 1, 2020; (2) not impose premiums exceeding the amounts in place as of January 1, 2020; (3) provide continuous coverage of Medicaid enrollees during the COVID-19 public health emergency period; and (4) provide coverage (without the imposition of cost sharing) for testing services and treatments for COVID-19 (including vaccines, specialized equipment, and therapies). Another condition to receive the FFCRA FMAP increase is that states, DC, and the territories cannot require local governments to fund a larger percentage of the state’s nonfederal Medicaid expenditures for the Medicaid state plan or Medicaid DSH payments than what was required on March 11, 2020.

Provision

Section 5131 of the CAA 2023 ends the FFCRA FMAP increase on December 31, 2023, and phases down the FFCRA FMAP increase from April 1, 2023, through December 31, 2023. In addition, the provision amends the requirements for states to be eligible for the FFCRA FMAP increase and adds state reporting requirements. The provision includes penalties for not complying with the requirements. The effective date for this provision was April 1, 2023.

Phasing Down of the FMAP Increase

Section 5131(a) amends FFCRA Section 6008 (42 U.S.C. §1396d note) to delink the FFCRA FMAP increase from the COVID-19 public health emergency period. The provision also adds an end date for the FFCRA FMAP increase of December 31, 2023. The 6.2 percentage point FFCRA FMAP increase continued through March 31, 2023, but began phasing down starting April 1, 2023, as follows:

- From April 1, 2023, through June 30, 2023: 5 percentage points
- From July 1, 2023, through September 30, 2023: 2.5 percentage points
- From October 1, 2023, through December 31, 2023: 1.5 percentage points

FFCRA FMAP Requirements

The continuous coverage requirement for states to be eligible for the FFCRA FMAP increase ended March 31, 2023, but the other state requirements for the FFCRA FMAP increase remain in place through December 31, 2023, with one modification. Specifically, the provision permits states to move enrollees who are no longer eligible for their current eligibility group due to a change in circumstances to a new eligibility group and charge higher premiums, as applicable. The provision also adds the following Medicaid unwinding conditions for states to receive the FFCRA FMAP increase during the transition period (i.e., April 1, 2023, through December 31, 2023):

- Conduct eligibility redeterminations in accordance with all federal requirements applicable to redeterminations, including renewal strategies or other alternative processes and procedures approved by the HHS Secretary

³³ The Coronavirus Disease 2019 (COVID-19) public health emergency period ended on May 11, 2023, so under prior law, the Family First Coronavirus Response Act (FFCRA) FMAP would have ended June 30, 2023 (i.e., the last day of the calendar quarter in which the last day of the COVID-19 public health emergency period ends).

- Attempt to ensure up-to-date contact information for each individual for whom the state conducts an eligibility redetermination using the National Change of Address Database Maintained by the United States Postal Service, state health and human services agencies, or other reliable sources of contact information
- Do not disenroll any individual who is determined ineligible for Medicaid pursuant to such a redetermination on the basis of returned mail unless the state first undertakes a good faith effort to contact the individual using more than one modality

Reporting Requirements

Section 5131(b) of the CAA 2023 adds subsection (tt) to SSA Section 1902 (42 U.S.C. §1396a) about requirements during the transition from the FFCRA FMAP increase. The provision requires states to submit monthly reports to the HHS Secretary beginning April 1, 2023, through June 30, 2024, on a timely basis, and the HHS Secretary is to make the reports publicly available.

The monthly reports are to include the following information:

- Number of renewals initiated
- Number of enrollees renewed, including counts of those renewed on an ex parte basis (i.e., the renewal was based on reliable information available to the agency without requiring information from the individual)
- Number of individuals whose coverage for medical assistance, child health assistance, or pregnancy-related assistance was terminated, including counts of those so terminated for procedural reasons
- Number of individuals who were enrolled in a separate CHIP program (or waiver)
- Call center information regarding volume, average wait times, and average abandonment rate for each call center
- Other information related to eligibility redeterminations as specified by the HHS Secretary

In addition, for states with a federal or state health benefits exchange where Medicaid and CHIP and exchange eligibility systems are *not* integrated and the CMS Administrator does not report such information, states are required to report counts of individuals for whom the exchange or a basic health program receives an account via electronic transfer from Medicaid or CHIP. For accounts that were electronically transferred, states must report the number of individuals who were determined eligible for a qualified health plan or a basic health program (as applicable), as well as the number of individuals who made a qualified health plan selection or enrolled in a basic health plan.

For states with a state health benefits exchange where Medicaid and CHIP and exchange eligibility systems *are* integrated and the CMS Administrator does not report such information, states are required to report the number of individuals determined eligible for a qualified health plan or a basic health program (if applicable), as well as counts of individuals who made a qualified health plan selection or enrolled in a basic health program.

For fiscal quarters between July 1, 2023, and June 30, 2024, if a state does not satisfy the reporting requirements, the regular FMAP rate for that state is to be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the state has failed to satisfy such requirements.

Corrective Action Plans

The HHS Secretary may assess a state’s compliance with all federal requirements applicable to eligibility redeterminations and the reporting requirements. If the HHS Secretary determines a state did not comply with the requirements during the period of April 1, 2023, through June 30, 2024, the HHS Secretary may require the state to submit a corrective action plan. The state must submit the corrective action plan no later than 14 days after receiving notice from the HHS Secretary about such plan. The corrective action plan is to be approved no later than 21 days after it is submitted to the HHS Secretary, and implementation of the corrective action plan is to begin no later than 14 days after approval of the plan.

If a state fails to submit or implement an approved corrective action plan, the HHS Secretary may require the state to suspend making all or some terminations of eligibility for medical assistance that are for procedural reasons until the state takes appropriate corrective action. In addition, the HHS Secretary may impose civil monetary penalties of not more than \$100,000 for each day a state is not in compliance.

Section 5141: 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 Medicaid Improvement Fund (MIF). SSA Section 1941 authorizes the HHS Secretary to use the MIF “to improve the management of the Medicaid program by the Centers for Medicare & Medicaid Services, 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.

Several laws have amended SSA Section 1941 to change the amount of money available to the MIF. For example, the Consolidated Appropriations Act, 2021 (P.L. 116-260), amended SSA Section 1941 to make \$0.00 available to the MIF. Since the MIF was established, the HHS Secretary has not expended any MIF money.

Provision

Section 5141 of the CAA 2023 amends SSA Section 1941 (42 U.S.C. §1396w–1(b)(3)(A)) by reducing funding available to the MIF for FY2025 and thereafter to \$0.00 and by increasing funding available to the MIF for FY2028 and thereafter to \$7 billion.

Appendix A. Abbreviated Summaries of Provisions

Table A-1 provides abbreviated summaries for each of the provisions in the Consolidated Appropriations Act, 2023 (CAA 2023, P.L. 117-328) that impact Medicaid and State Children’s Health Insurance Program (CHIP). For each provision, the table includes the relevant section of the CAA 2023, the provision title, a summary of the provision, and a CRS point of contact.

Table A-1. Abbreviated Summaries of Selected Provisions in the Consolidated Appropriations Act, 2023 (P.L. 117-328)

Section Number	Provision Title	Summary of Provision	CRS Contact
Territories Provisions			
5101(a)	Revising Allotment for Puerto Rico	Provides federal Medicaid annual capped funding amounts to Puerto Rico for FY2023 through FY2027. Provides Puerto Rico additional federal Medicaid funding (1) if Puerto Rico establishes a floor for Medicaid physician payment rates and (2) if certain program integrity conditions are met.	Alison Mitchell
5101(b)	Extension of Increased FMAPs	Makes permanent the 83% FMAP rate for American Samoa, CNMI, Guam, and USVI and extends the 76% FMAP rate for Puerto Rico through FY2027.	Alison Mitchell
5101(c)	Application of Asset Verification Program Requirements to Puerto Rico	Requires Puerto Rico to implement an asset verification program by January 1, 2026. If Puerto Rico does not have an asset verification program, starting January 1, 2026, the regular FMAP rate for Puerto Rico would be reduced.	Alison Mitchell
5101(d)	Extension of Reporting Requirement	Extends the annual reporting requirement for the territories regarding how the territories increase access to health care. The requirement for American Samoa, CNMI, Guam, and USVI is extended for FY2023 and subsequent years, and for Puerto Rico, the reporting requirement is extended for FY2023 through FY2027.	Alison Mitchell
5101(e)	Puerto Rico Program Integrity	Adds a contracting and procurement oversight lead requirement for Puerto Rico.	Alison Mitchell
5101(f)	Medicaid Data Systems Improvement Payments	Provides funding to American Samoa, CNMI, Guam, and USVI for qualifying data system improvement expenditures incurred by such territory on or after October 1, 2023.	Alison Mitchell
5101(g)	Strategic Plan and Evaluation	Adds a requirement for American Samoa, CNMI, Guam, and USVI to submit a four-year strategic plan to the HHS Secretary no later than September 30, 2023.	Alison Mitchell
Medicaid and CHIP Coverage Provisions			
5111(a)	CHIP Funding	Extends federal CHIP funding for an additional two years by adding federal appropriations for FY2028 and FY2029.	Alison Mitchell
5111(b)	CHIP Allotments	Authorizes CHIP allotments for an additional two years (i.e., FY2028 and FY2029).	Alison Mitchell
5111(c)(1)	Pediatric Quality Measures Program	Amends SSA Section 1139A(i) to appropriate \$15 million for each of FY2028 and FY2029 to carry out activities under the section (other than those in subsections (e), (f), and (g)).	Amanda Sarata

Section Number	Provision Title	Summary of Provision	CRS Contact
5111(c)(3)	Qualifying States Option	Extends the qualifying states option by two years for FY2028 and FY2029.	Alison Mitchell
5111(c)(2) and 5111(d)(2)	Assurance of Eligibility Measures for Children	Extends the assurance of eligibility standard for CHIP and Medicaid children for the period of FY2028 through FY2029.	Evelyne Baumrucker
5111(c)(4)	Outreach and Enrollment Program	Extends the outreach and enrollment program for two years by adding federal mandatory appropriations in the amount of \$40 million for the period FY2028 through FY2029.	Evelyne Baumrucker
5111(c)(5)	Child Enrollment Contingency Fund	Extends the funding mechanism for the Child Enrollment Contingency Fund and payments from the fund for FY2028 and FY2029.	Alison Mitchell
5111(d)(1)	Express Lane Eligibility Option	Extends the Express Lane Eligibility option for the period of FY2028 through FY2029.	Evelyne Baumrucker
5112	Continuous Eligibility for Children Under Medicaid and CHIP	Requires states to provide 12 months of continuous eligibility for Medicaid and CHIP enrollees under the age of 19. Permits states to transfer CHIP enrollees who are determined eligible for full Medicaid benefit coverage to Medicaid for the remainder of the continuous eligibility period. Effective beginning January 1, 2024.	Evelyne Baumrucker
5112	Modifications to Postpartum Coverage Under Medicaid and CHIP	Makes permanent the state plan option to provide 12 months of postpartum coverage in Medicaid and CHIP.	Evelyne Baumrucker
5114	Extension of Money Follows the Person Rebalancing Demonstration	Extends the Medicaid MFP program by appropriating \$450 million for each fiscal year from FY2024 through FY2027 for competitive grants to states. Appropriates \$5 million to states for FY2023 and for each subsequent three-year period through FY2029 for carrying out quality assurance and improvement, technical assistance, oversight, research, and evaluation.	Kirsten Colello
5115	Extension of Medicaid Protections Against Spousal Impoverishment for Recipients of Home- and Community-Based Services	Extends application of spousal impoverishment protections to all married individuals who are eligible for Medicaid HCBS under specified authorities through September 30, 2027.	Kirsten Colello

Medicaid and CHIP Mental Health Provisions

5121	Medicaid and CHIP Requirements for Health Screenings, Referrals, and Case Management Services for Eligible Juveniles in Public Institutions	Amends the Medicaid requirements for states to establish a plan that provides for specified screenings and referrals for treatment within 30 days of the date that an “eligible juvenile” in a public institution is scheduled to be released. Aligns CHIP rules with certain existing Medicaid rules for eligible juveniles who are inmates of public institutions. Effective beginning January 1, 2025.	Evelyne Baumrucker
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Section Number	Provision Title	Summary of Provision	CRS Contact
5122	Removal of Limitations on Federal Financial Participation for Inmates Who Are Eligible Juveniles Pending Disposition of Charges	Permits states to receive federal payment for allowable services for eligible juveniles under Medicaid and allowable child health assistance services under CHIP during the period in which such enrollees are inmates of a public institution pending disposition of charges. Effective beginning January 1, 2025.	Evelyne Baumrucker
5123	Requiring Accurate, Updated, and Searchable Provider Directories	Modifies provider directory requirements under Medicaid and CHIP FFS and Medicaid PCCM systems. Adds a provider directory requirement for Medicaid managed care entities and CHIP. Effective July 1, 2025.	Evelyne Baumrucker and Alison Mitchell
5124	Supporting Access to a Continuum of Crisis Response Services Under Medicaid and CHIP	Requires the HHS Secretary, in coordination with the CMS Administrator and the Assistant Secretary for Mental Health and Substance Use, to issue guidance and establish a technical assistance center to help states design, implement, or enhance a continuum of crisis response services for children, youth, and adults under Medicaid and CHIP no later than July 1, 2025. Appropriates to the HHS Secretary \$8 million to remain available until expended for this purpose.	Evelyne Baumrucker and Megan Houston
Other Provisions			
5131	Transitioning from Medicaid FMAP Increase Requirements	Ends the FFCRA FMAP increase on December 31, 2023, and phases down the FFCRA FMAP increase from April 1, 2023, through December 31, 2023. Amends the requirements for states to be eligible for the FFCRA FMAP increase and adds state reporting requirements. Includes penalties for not complying with the requirements. Effective April 1, 2023.	Alison Mitchell and Evelyne Baumrucker
5141	Medicaid Improvement Fund	Reduces funding available to the Medicaid Improvement Fund for FY2025 and thereafter to \$0.00 and increases funding available to the fund for FY2028 and thereafter to \$7 billion.	Cliff Binder

Source: Congressional Research Service analysis of the Consolidated Appropriations Act, 2023 (CAA; P.L. 117-328).

Notes: CHIP = State Children’s Health Insurance Program; CNMI = Commonwealth of the Northern Mariana Islands; CMS = Centers for Medicare and Medicaid Services; FFCRA = Families First Coronavirus Response Act (P.L. 116-127); FFS = Fee for Service; FMAP = Federal Medical Assistance Percentage; HCBS = Home and Community-Based Services; HHS = Department of Health and Human Services; MFP = Money Follows the Person; PCCM = Primary Care Case Management; SSA = Social Security Act; USVI = U.S. Virgin Islands.

Appendix B. Table of Common Acronyms

Table B-1. Table of Common Acronyms

Acronym	Full Name
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
ARPA	American Rescue Plan Act of 2021 (P.L. 117-2)
BBA 2018	Bipartisan Budget Act of 2018 (P.L. 115-123)
CAA 2023	Consolidated Appropriations Act, 2023 (P.L. 117-328)
CHIP	State Children’s Health Insurance Plan
CHIPRA	Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3),
CMS	Centers for Medicare & Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands
COE	Centers of Excellence
CPI-U	Consumer Price Index for All Urban Consumers
DRA	Deficit Reduction Act of 2005 (P.L. 109-171)
E-FMAP	Enhanced Federal Medical Assistance Percentage
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FFCRA	Family First Coronavirus Response Act (P.L. 116-127)
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
GAO	Government Accountability Office
HCBS	Home and Community-Based Services
HHS	Department of Health and Human Services
LTSS	Long-Term Services and Supports
MACRA	Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10)
MFP	Money Follows the Person
MIF	Medicaid Improvement Fund
MOE	Maintenance of Effort
PAHP	Prepaid Ambulatory Health Plans
PAMA	Protecting Access to Medicare Act of 2014 (P.L. 113-93)
PCCM	Primary Care Case-Management
PIHP	Prepaid Inpatient Health Plans
PQMP	Pediatric Quality Measures Program
SSA	Social Security Act
SUPPORT Act	Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)
USVI	U.S. Virgin Islands

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