DIVISION H—DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2023

Title II—Department of Health and Human Services

Division FF – Health and Human Services

TITLE V—MEDICAID AND CHIP PROVISIONS

Subtitle A—Territories

Sec. 5101. Medicaid adjustments for the territories. (p. 3808)

- Funding for Puerto Rico at $3.275B for FY 2023, allotments then increase yearly thru FY 2027 and then by CPI-M thereafter; FMAP will be 76% through FY 2027;
    - additional $300 mil if Puerto Rico implements payment floor of not less than 75% of Medicare physician services payments (FY 2023-2027)
    - additional $75 mil possible if Puerto Rico meets other requirements specified in the bill (FY 2023-2027)
- Other territories – FMAP will be 83% through FY 2027

Subtitle B—Medicaid and CHIP Coverage

Sec. 5111. Funding extension of the Children's Health Insurance Program and related provisions. (p. 3824)

- Extends funding thru FY 2029
- Express lane eligibility also extended thru FY 2029

Sec. 5112. Continuous eligibility for children under Medicaid and CHIP. (p. 3830)

- 1 year continuous eligibility for children up to age 19 – this is a PERMANENT provision
- Becomes effective 1st day of 1st fiscal quarter that begins on/after the date 1 year after the date of enactment (likely 1/1/2024)

Sec. 5113. Modifications to postpartum coverage under Medicaid and CHIP. (p. 5113)

- Post-partum state option becomes PERMANENT (it had been a 5-year option; but this is ***not*** mandatory post-partum coverage)

Sec. 5114. Extension of Money Follows the Person Rebalancing demonstration (p. 3832)

- MFP extended through 9/30/2027
- $450 mil appropriated for FY 2024-FY 2027

Sec. 5115. Extension of Medicaid protections against spousal im poverishment for recipients of home and community-based services (p. 3833)

- Spousal impoverishment provisions extended through 9/30/2027

Subtitle C—Medicaid and CHIP Mental Health

Sec. 5121. Medicaid and CHIP requirements for health screenings, referrals, and case management services for eligible juveniles in public institutions. (p. 3834)

- Medicaid can provide coverage 30 days prior to release and up to 1 week after release -- any screening or diagnostic service which meets reasonable standards of medical and dental practice, as determined by the State, or as indicated as medically necessary,
- Medicaid can provide coverage 30 days prior to release and up to 30 days following release -- targeted case 19 management services,
- CHIP – cannot terminate eligibility for a child who is an inmate of a public institution, may suspend coverage; prior to release the state shall conduct a redetermination of eligibility and if child continues to meet the eligibility requirement, the state shall restore coverage
- CHIP – for 30 days pre-release of a child released from a public institution following adjudication, state shall have in place a plan for providing, and shall provide in accordance with such plan, screenings, diagnostic services, referrals, and case management services otherwise covered under the State child health plan (or waiver of such plan)

Sec. 5122. Removal of limitations on Federal financial participation for inmates who are eligible juveniles pending disposition of charges. (p. 3839)

- State option to continue Medicaid/CHIP for a juvenile while charges are pending even if individual is an inmate in a public institution
- Effective date - The amendments made by this section shall take effect on the first day of the first calendar quarter that begins after the date that is 24 months after the date of enactment of this Act and shall apply to items and services furnished for periods beginning on or after such date.

Sec. 5123. Requiring accurate, updated, and searchable provider directories. (p. 3841)

- MCOs, PIHPs, PAHPs and when appropriate PCCMs must publish and update on at least a quarterly basis, a searchable directory of network providers which shall include physicians, hospitals, pharmacies, providers of mental health services, providers of substance use disorder services, providers of long term services and supports as appropriate, and such other providers as required by the Secretary
- Directory shall include: name of provider, specialty, address, phone, information regarding language offered by provider or skilled medical interpreter, whether provider is accepting new patients, whether provider's office/facility has accommodations for individuals with physical disabilities, internet website, whether it offers telehealth, other relevant information as required by Secretary
- State has similar requirements for publishing network directory for FFS/PCCM

Sec. 5124. Supporting access to a continuum of crisis response services under Medicaid and CHIP. (p. 3848)

- CMS must issue guidance by 7/1/2025 that provides recommendations for effective continuum of crisis response services that includes 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, such as intensive outpatient and partial hospitalization programs, as well as connections to social services and supports;
    - promotes access to appropriate and timely mental health and substance use disorder crisis response services in the least restrictive setting appropriate to an individual's needs; and

    - promotes culturally competent, trau16 ma-informed care, and crisis de-escalation.
- More details in the section

Subtitle D—Transitioning From Medicaid FMAP Increase Requirements

Sec. 5131. Transitioning from Medicaid FMAP increase requirements. (p. 3854)

- FMAP has a glide path rather than abrupt end when PHE ends
    - 1/1/2023-3/31/2023 – FMAP bump stays at 6.2% (existing FFRCA bump)
    - 4/1/2023-6/30/2023—FMAP bump is 5%
    - 7/1/2023-9/30/2023 – FMAP bump is 2.5%
    - 10/1/2023-12/31/2023 – FMAP bump is 1.5%

- Eligibility redeterminations during transition period (4/1/2023-12/31/2023) – to continue receiving enhanced FMAP, state has to comply with federal requirements for redeterminations (inc. renewal strategies under 1902(e)(14)(A) or other processes/procedures approved by HHS Sec)
    - State shall attempt to ensure it has up-to-date contact information for each individual subject to redetermination (using 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)
    - Before disenrolling individual if a redetermination notice is returned to the state, the state must undertake a good faith effort to contact individual using more than one modality
- Reporting requirements from 4/1/2023-6/30/2024, state must submit a monthly report on the activities of the state related to eligibility redeterminations including:
    - Number of eligibility renewals initiated, those renewed on a total and ex parte basis, and individuals who were terminated
    - Number of individuals whose eligibility was terminated for procedural reasons
    - Where applicable, number of individuals enrolled in child health plan or waiver under 2101(a)(1)
    - In a state with a marketplace that does not have integrated Medicaid-marketplace eligibility, the state must report the number of individuals received by electronic transfer and number who were determined eligible

for a QHP or BHP, number of individuals who made a QHP selection or were enrolled in BHP (unless CCIIO reports this data on behalf of a state)
    - In a state with integrated Medicaid-marketplace eligibility, the state must report the number of individuals determined eligible for a QHP or BHP and number of individuals who made a QHP selection or were enrolled in BHP
    - Total call center volume, average wait times, average abandonment rates
    - Other information related to eligibility redeterminations and renewals as identified by the Secretary
- Enforcement and corrective action from 7/1/2023-6/30/2024 –
    - if a state doesn't provide the reporting, the FMAP for the state's entire Medicaid program shall be reduced by .25% multiplied by the number of quarters the state failed to report (not to exceed 1%)
    - If CMS determines a state doesn't comply with federal requirements applicable to eligibility redeterminations and reporting requirements, the Secretary shall require the state to submit and implement a corrective action plan; if a state fails to implement the CAP, the Secretary may reduce the enhanced FMAP and require the state to suspend making all or some terminations for procedural reasons until the state takes appropriate corrective action and may impose a civil money penalty of not more than $100k/day

Subtitle E -- Medicaid Improvement Fund

Sec. 5141. Medicaid Improvement Fund (p. 3866)

- $7 billion added to Medicaid Improvement Fund under Section 1941(b)(3)(A)