115TH CONGRESS
1ST SESSION

S. 520

To amend title XIX of the Social Security Act to reform payment to States under the Medicaid program.

IN THE SENATE OF THE UNITED STATES

MARCH 2, 2017

Mr. CASSIDY introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend title XIX of the Social Security Act to reform payment to States under the Medicaid program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicaid Accountability and Care Act of 2017''.

SEC. 2. MEDICAID PAYMENT REFORM.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1903 the following section:

"SEC. 1903A. REFORMED PAYMENT TO STATES.

''(a) REFORMED PAYMENT SYSTEM.—

''(1) IN GENERAL.—For quarters beginning on or after the implementation date (as defined in subsection (k)(1)), in lieu of amounts otherwise payable to a State under this title (including any payments attributable to section 1923), except as otherwise provided in this section, the amount payable to such State shall be equal to the sum of the following:

''(A) ADJUSTED AGGREGATE BENEFICIARY-BASED AMOUNT.—The aggregate beneficiary-based amount specified in subsection (b) for the quarter and the State, adjusted under subsection (e).

''(B) CHRONIC CARE QUALITY BONUS.—The amount (if any) of the chronic care quality bonus payment specified in subsection (f) for the quarter for the State.

''(2) REQUIREMENT OF STATE SHARE.—

''(A) IN GENERAL.—A State shall make, from non-Federal funds, expenditures in an amount equal to its State share (as determined under subparagraph (B)) for a quarter for items, services, and other costs for which, but for paragraph (1), Federal funds would have been payable under this title.

''(B) STATE SHARE.—The State share for a State for a quarter in a fiscal year is equal to the product of—

''(i) the aggregate beneficiary-based amount specified in subsection (b) for the quarter and the State; and

''(ii) the ratio of—

''(I) the State percentage described in subparagraph (D)(ii) for such State and fiscal year; to

''(II) the Federal percentage described in subparagraph (D)(i) for such State and fiscal year.

''(C) NONPAYMENT FOR FAILURE TO PAY STATE SHARE.—

''(i) IN GENERAL.—If a State fails to expend the amount required under subparagraph (A) for a quarter in a fiscal year, the amount payable to the State under paragraph (1) shall be reduced by the product of the amount by which the State payment is less than the State share and the ratio of—

"(I) the Federal percentage described in subparagraph (D)(i) for such State and fiscal year; to

"(II) the State percentage described in subparagraph (D)(ii) for such State and fiscal year.

"(ii) GRACE PERIOD.—A State shall not be considered to have failed to provide payment of its required State share for a quarter under subparagraph (A) if the aggregate State payment towards the State's required State share for the 4-quarter period beginning with such quarter exceeds the required State share amount for such 4-quarter period.

"(D) FEDERAL AND STATE PERCENTAGES.—In this paragraph, with respect to a State and a fiscal year:

"(i) FEDERAL PERCENTAGE.—The Federal percentage described in this clause is 75 percent or, if higher, the Federal medical assistance percentage for such State for such fiscal year.

"(ii) STATE PERCENTAGE.—The State percentage described in this clause is 100

percent minus the Federal percentage described in clause (i).

''(E) RULES FOR CREDITING TOWARD STATE SHARE.—

''(i) GENERAL LIMITATION TO MATCHABLE EXPENDITURES.—A payment for expenditures shall not be counted toward the State share under subparagraph (A) unless Federal payments may be used for such expenditures consistent with paragraph (3)(B).

''(ii) FURTHER LIMITATIONS ON ALLOWABLE EXPENDITURES.—A payment for expenditures shall not be counted towards the State share under subparagraph (A) if the expenditure is for any of the following:

''(I) ABORTION.—Expenditures for an abortion.

''(II) INTERGOVERNMENTAL TRANSFERS.—An expenditure that is attributable to an intergovernmental transfer.

''(III) CERTIFIED PUBLIC EXPENDITURES.—An expenditure that is

attributable to certified public expenditures.

''(iii) CREDITING FRAUD AND ABUSE RECOVERIES.—Amounts recovered by a State through the operation of its Medicaid fraud and abuse control unit described in section 1903(q) shall be fully counted toward the State share under subparagraph (A).

''(F) CONSTRUCTION.—Nothing in the paragraph shall be construed as preventing a State from expending, from non-Federal funds, an amount under this title in excess of the amount of the State share.

''(G) DETERMINATION BASED UPON SUBMITTED CLAIMS.—In applying this paragraph with respect to expenditures of a State for a quarter, the determination of the expenditures for such State for such quarter shall be made after the end of the period (which, as of the date of the enactment of this section, is 2 years) for which the Secretary accepts claims for payment under this title with respect to such quarter.

''(3) USE OF FEDERAL PAYMENTS.—

''(A) APPLICATION OF MEDICAID LIMITATIONS.—A State may only use Federal payments received under paragraph (1) for expenditures for which Federal funds would have been payable under this title but for this section.

''(B) LIMITATION FOR CERTAIN ELIGIBLES.—

''(i) APPLICATION OF 100 PERCENT FEDERAL POVERTY LINE LIMIT ON ELIGIBILITY.—Subject to clause (iii), a State may not use such Federal payments to provide medical assistance for an individual who has an income (as determined under clause (ii)) that exceeds 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

''(ii) DETERMINATION OF INCOME USING MODIFIED ADJUSTED GROSS INCOME WITHOUT ANY 5 PERCENT INCREASE.—In determining income for purposes of clause (i) under section 1902(e)(14) (relating to modified adjusted gross income), the following rules shall apply:

"(I) APPLICATION OF SPEND DOWN.—The State shall take into account the costs incurred for medical care or for any other type of remedial care recognized under State law in the same manner and to the same extent that such State takes such costs into account for purposes of section 1902(a)(17).

"(II) DISREGARD OF 5 PERCENT INCREASE.—Subparagraph (I) of section 1902(e)(14) (relating to a 5 percent reduction) shall not apply.

"(iii) EXCEPTION.—Clause (i) shall not apply to an individual who is—

"(I) a woman described in clause (i) of section 1903(v)(4)(A);

"(II) a child who is an individual described in clause (i) of section 1905(a);

"(III) enrolled in a State plan under this title as of the date of the enactment of this section for the period of continuous enrollment; or

"(IV) described in section 1902(e)(14)(D) (relating to modified adjusted gross income).

"(iv) CLARIFICATION RELATED TO COMMUNITY SPOUSE.—Nothing in this subparagraph shall supersede the application of section 1924 (related to community spouse income and assets).

"(4) EXCEPTIONS FOR PASS-THROUGH PAYMENTS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply, and amounts shall continue to be payable under this title (and not under this subsection), in the case of the following payments (and related administrative costs and expenditures):

"(i) PAYMENTS TO TERRITORIES.—Payments to a State other than the 50 States and the District of Columbia.

"(ii) MEDICARE COST SHARING.—Payments attributable to Medicare cost sharing under section 1905(p).

"(iii) PEDIATRIC VACCINES.—Payments attributable to section 1928.

"(iv) EMERGENCY SERVICES FOR CERTAIN INDIVIDUALS.—Payments for treatment of emergency medical conditions attributable to the application of section 1903(v)(2).

"(v) INDIAN HEALTH CARE FACILITIES.—Payments for medical assistance described in the third sentence of section 1905(b).

"(vi) EMPLOYER-SPONSORED INSURANCE (ESI).—Payments for medical assistance attributable to payments to employers for employer-sponsored health benefits coverage.

"(vii) OTHER POPULATIONS WITH LIMITED BENEFIT COVERAGE.—Other payments that are determined by the Secretary to be related to a specified population for which the medical assistance under this title is limited and does not include any inpatient, nursing facility, or long-term care services.

"(B) CERTAIN EXPENSES.—Paragraph (1) shall not apply, and amounts shall continue to

be payable under this title (and not under this subsection), in the case of the following:

''(i) ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG BENEFIT.—Expenditures described in section 1935(b) (relating to administration of the Medicare prescription drug benefit).

''(ii) PAYMENTS FOR HIT BONUSES.—Payments under section 1903(a)(3)(F) (relating to payments to encourage the adoption and use of certified EHR technology).

''(iii) PAYMENTS FOR DESIGN, DEVELOPMENT, AND INSTALLATION OF MMIS AND ELIGIBILITY SYSTEMS.—Payments under subparagraphs (A)(i) and (H)(i) of section 1903(a)(3) for expenditures for design, development, and installation of the Medicaid management information systems and mechanized verification and information retrieval systems (related to eligibility).

''(5) PAYMENT OF AMOUNTS.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide, amounts shall be payable to a State under this subsection in the same manner as amounts are payable under

subsection (d) of section 1903 to a State under subsection (a) of such section.

''(B) INFORMATION AND FORMS.—

''(i) SUBMISSION.—As a condition of receiving payment under this subsection, a State shall submit such information, in such form, and manner, as the Secretary shall specify, including information necessary to make the computations under subsections (c)(2)(C) and (e).

''(ii) UNIFORM REPORTING.—The Secretary shall develop such forms as may be needed to assure a system of uniform reporting of such information across States.

''(C) REQUIRED REPORTING OF INFORMATION ON MEDICAL LOSS RATIOS FOR MANAGED CARE.—The information required to be reported under subparagraph (B)(i) shall include information on the medical loss ratio with respect to coverage provided under each Medicaid managed care plan with a contract with the State under section 1903(m) or 1932.

''(b) AGGREGATE BENEFICIARY-BASED AMOUNT.—

''(1) IN GENERAL.—The aggregate beneficiary-based amount specified in this subsection for a State for a quarter is equal to the sum of the products, for each of the categories of Medicaid beneficiaries specified in paragraph (2), of the following:

''(A) BENEFICIARY-BASED QUARTERLY AMOUNT.—The beneficiary-based quarterly amount for such category computed under subsection (c) for such State for such quarter.

''(B) NUMBER OF INDIVIDUALS IN CATEGORY.—Subject to subsection (d), the average number of Medicaid beneficiaries enrolled in such category in the State in such quarter.

''(2) CATEGORIES.—The categories specified in this paragraph are the following:

''(A) ELDERLY.—A category of Medicaid beneficiaries who are 65 years of age or older.

''(B) BLIND OR DISABLED.—A category of Medicaid beneficiaries not described in subparagraph (A) who are described in section 1937(a)(2)(B)(ii).

''(C) CHILDREN.—A category of Medicaid beneficiaries not described in subparagraph (B) who are under 21 years of age.

''(D) OTHER ADULTS.—A category of any Medicaid beneficiaries who are not described in a previous subparagraph of this paragraph.

''(c) COMPUTATION OF PER BENEFICIARY, PER CATEGORY QUARTERLY AMOUNT.—

''(1) IN GENERAL.—For a State, for each category of beneficiary for a quarter—

''(A) FIRST REFORM YEAR.—For quarters in the first reform year (as defined in subsection (k)(2)), the beneficiary-based quarterly amount is equal to ¼ of the base average per beneficiary Federal payments for such State for such category determined under paragraph (2), increased by a factor that reflects the sum of the following:

''(i) HISTORICAL MEDICAL CARE COMPONENT OF CPI THROUGH PREVIOUS REFORM YEAR.—The percentage increase in the historical medical care component of the Consumer Price Index for all urban consumers (U.S. city average) from the midpoint of the base fiscal year (as defined in paragraph (6)) to the midpoint of the fiscal year preceding the first reform year.

"(ii) PROJECTED MEDICAL CARE COMPONENT OF CPI FOR THE FIRST REFORM YEAR.—The percentage increase in the projected medical care component of the Consumer Price Index for all urban consumers (U.S. city average) from the midpoint of the previous fiscal year referred to in clause (i) to the midpoint of the first reform year.

"(B) SECOND AND THIRD REFORM YEARS.—The beneficiary-based quarterly amount for a State for a category for quarters in the second reform year or the third reform year is equal to the beneficiary-based quarterly amount under this paragraph for such State and category for the previous reform year increased by the per beneficiary percentage increase (as defined in subparagraph (E)) for such category and reform year.

"(C) FOURTH THROUGH TENTH REFORM YEARS.—The beneficiary-based quarterly amount for a State for a category for quarters in a reform year beginning with the fourth reform year and ending with the tenth reform year is—

''(i) in the case of a State that is a high per beneficiary State or a low per beneficiary State (as defined in paragraph (4)(B)(iii)) for the category, the amount determined under clause (i) or (ii) of paragraph (4)(B) for such State, category, and reform year; or

''(ii) in the case of any other State, the beneficiary-based quarterly amount under this paragraph for such State and category for the previous reform year increased by the per beneficiary percentage increase for such category and reform year.

''(D) ELEVENTH REFORM YEAR AND SUBSEQUENT REFORM YEARS.—The beneficiary-based quarterly amount for a State for a category for quarters in a reform year beginning with the eleventh reform year is equal to the beneficiary-based quarterly amount under this paragraph for such State and category for the previous reform year increased by the per beneficiary percentage increase for such category and reform year.

''(E) ANNUAL PERCENTAGE INCREASE BEGINNING WITH SECOND REFORM YEAR.—For purposes of this subsection, the term 'per beneficiary percentage increase' means, for a reform year, the sum of—

''(i) the projected percentage change in nominal gross domestic product from the midpoint of the previous reform year to the midpoint of the reform year for which the percentage increase is being applied; and

''(ii) one percentage point.

''(2) BASE PER BENEFICIARY, PER CATEGORY AMOUNT FOR EACH STATE.—

''(A) AVERAGE PER CATEGORY.—

''(i) IN GENERAL.—The Secretary shall determine, consistent with this paragraph and paragraph (3), a base per beneficiary, per category amount for each of the 50 States and the District of Columbia equal to the average amount, per Medicaid beneficiary, of Federal payments under this title, including payments attributable to disproportionate share hospital payments under section 1923, for each of the

categories of beneficiaries under subsection (b)(2) for the base fiscal year for each of the 50 States and the District of Columbia.

''(ii) BEST AVAILABLE DATA.—The determination under clause (i) shall initially be estimated by the Secretary, based upon the best available data at the time the determination is made.

''(iii) UPDATES.—The determination under clause (i) shall be updated by the Secretary on an annual basis based upon improved data. The Secretary shall adjust the amounts under subsection (a)(1)(A) to reflect changes in the amounts so determined based on such updates.

''(B) EXCLUSION OF PASS-THROUGH PAYMENTS.—In computing base per beneficiary, per category amounts under subparagraph (A)(i) the Secretary shall exclude payments described in subsection (a)(4).

''(C) STANDARDIZATION.—

''(i) IN GENERAL.—In computing each such amount, the Secretary shall stand-

ardize the amount in order to remove the variation attributable to the following:

''(I) RISK FACTORS.—Such risk factors as age, health and disability status (including high cost medical conditions), gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence.

''(II) GEOGRAPHIC.—Variations in costs on a county-by-county basis.

''(ii) METHOD OF STANDARDIZATION.—

''(I) CONSULTATION IN DEVELOPMENT OF RISK STANDARDIZATION.—In developing the methodology for risk standardization for purposes of clause (i)(I), the Secretary shall consult with the Medicaid and CHIP Payment and Access Commission, the Medicare Payment Advisory Commission, and the National Association of Medicaid Directors.

"(II) METHOD FOR RISK STANDARDIZATION.—In carrying out clause (i)(I), the Secretary may apply the hierarchal condition category methodology under section 1853(a)(1)(C). If the Secretary uses such methodology, the Secretary shall adjust the application of such methodology to take into account the differences in services provided under this title compared to title XVIII, such as the coverage of long term care, pregnancy, and pediatric services.

"(III) METHOD FOR GEOGRAPHIC STANDARDIZATION.—The Secretary shall apply the standardization under clause (i)(II) in a manner similar to that applied under section 1853(c)(4)(A)(iii).

"(iii) APPLICATION ON A NATIONAL, BUDGET NEUTRAL BASIS.—The standardization under clause (i) shall be designed and implemented on a uniform national basis and shall be budget neutral so as to

not result in any aggregate change in payments under subsection (a).

''(iv) RESPONSE TO NEW RISK.—Subject to clause (iii), the Secretary may adjust the standardization under clause (i) to respond promptly to new instances of communicable diseases and other public health hazards.

''(v) REFERENCE TO APPLICATION OF RISK ADJUSTMENT.—For rules related to the application of risk adjustment to amounts under subsection (a)(1)(A), see subsection (e).

''(D) ADJUSTMENT FOR TEMPORARY FMAP INCREASES.—In computing each base per beneficiary, per category amounts under subparagraph (A)(i) the Secretary shall disregard portions of payments that are attributable to a temporary increase in the Federal matching rates, including those attributable to the following:

''(i) PPACA DISASTER FMAP.—Section 1905(aa).

''(ii) ARRA.—Section 5001 of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 1396d note).

''(iii) EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.—Section 614 of the Children's Health Insurance Program Reauthorization Act of 2009 (42 U.S.C. 1396d note).

''(3) ALLOCATION OF NONMEDICAL ASSISTANCE PAYMENTS.—The Secretary shall establish rules for the allocation of payments under this title (other than those payments described in paragraph (1) or (5) of section 1903(a) and including such payments attributable to section 1923)—

''(A) among different categories of beneficiaries; and

''(B) between payments included under subsection (a)(1) and payments described in subsection (a)(4).

''(4) TRANSITION TO A CORRIDOR AROUND THE NATIONAL AVERAGE.—

''(A) DETERMINATION OF NATIONAL AVERAGE BASE PER BENEFICIARY, PER CATEGORY AMOUNT.—Subject to subparagraph (C), the Secretary shall determine a national average

base per beneficiary, per category amount equal to the average of the base per beneficiary, per category amounts for each of the 50 States and the District of Columbia determined under paragraph (2), weighted by the average number of beneficiaries in each such category and State as determined by the Secretary consistent with subsection (d) for the base fiscal year.

''(B) TRANSITION ADJUSTMENT.—

''(i) HIGH PER BENEFICIARY STATES.—In the case of a high per beneficiary State (as defined in clause (iii)(I)) for a category, the beneficiary-based quarterly amount for such State and category for a quarter in a reform year (beginning with the fourth reform year and ending with the tenth reform year) is equal to the sum of—

''(I) the product of the State-specific factor for such reform year (as defined in clause (iv)) and the beneficiary-based quarterly amount that would otherwise be determined under paragraph (1) for such State and category if the State were a State de-

scribed in clause (ii) of paragraph (1)(C), instead of a State described in clause (i) of such paragraph; and

''(II) the product of 1 minus the State-specific factor for such reform year and the beneficiary-based quarterly amount that would otherwise be determined under paragraph (1) for a State and category if the base per beneficiary, per category amount determined under paragraph (2) for the State and category were equal to 110 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

''(ii) LOW PER BENEFICIARY STATES.—In the case of a low per beneficiary State (as defined in clause (iii)(II)) for a category, the beneficiary-based quarterly amount for such State and category for a quarter in a reform year (beginning with the fourth reform year and ending with the tenth reform year) is equal to the sum of—

''(I) the product of the State-specific factor for such reform year and the beneficiary-based quarterly amount that would otherwise be determined under paragraph (1) for such State and category if the State were a State described in clause (ii) of paragraph (1)(C), instead of a State described in clause (i) of such paragraph; and

''(II) the product of 1 minus the State-specific factor for such reform year and the beneficiary-based quarterly amount that would otherwise be determined under paragraph (1) for a State and category if the base per beneficiary, per category amount determined under paragraph (2) for the State and category were equal to 90 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

''(iii) HIGH AND LOW PER BENEFICIARY STATES DEFINED.—In this subparagraph:

''(I) HIGH PER BENEFICIARY STATE.—The term 'high per beneficiary State' means, with respect to a category, a State for which the base per beneficiary, per category amount determined under paragraph (2) for such category is greater than 110 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

''(II) LOW PER BENEFICIARY STATE.—The term 'low per beneficiary State' means, with respect to a category, a State for which the base per beneficiary, per category amount determined under paragraph (2) for such category is less than 90 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

"(iv) STATE-SPECIFIC FACTOR.—In this subparagraph, the term 'State-specific factor' means—

"(I) for the fourth reform year, 7/8; and

"(II) for a subsequent reform year, the State-specific factor under this clause for the previous reform year minus 1/8.

"(C) NO ADDITIONAL EXPENDITURES.—

"(i) DETERMINATION OF INCREASE IN FEDERAL EXPENDITURES.—For each category for each reform year (beginning with the fourth reform year and ending with the tenth reform year), the Secretary shall determine whether the application of this paragraph—

"(I) to the category for the reform year will result in an aggregate increase in the aggregate Federal expenditures under subsection (a); and

"(II) to all the categories for the reform year will result in a net aggregate increase in the aggregate Federal expenditures under subsection (a).

"(ii) ADJUSTMENT.—If the Secretary determines under clause (i)(II) that the application of this paragraph to all the categories for a reform year will result in a net aggregate increase in the aggregate Federal expenditures under subsection (a), the Secretary shall reduce the national average base per beneficiary, per category amount computed under subparagraph (A) for each of the categories determined under clause (i)(I) for which there will be an aggregate increase in the aggregate Federal expenditures under subsection (a) by such uniform percentage as will ensure that there is no net aggregate Federal expenditure increase described in clause (i)(II) for the reform year.

"(5) REPORTS ON PER BENEFICIARY RATES; APPEALS.—

"(A) REPORT TO STATES.—Not later than 8 months after the date of the enactment of this section, the Secretary shall submit to each State the Secretary's initial determination of—

"(i) the base per beneficiary, per category amounts under paragraph (2) for such State; and

"(ii) the national average base per beneficiary, per category amounts under paragraph (4)(A).

"(B) OPPORTUNITY TO APPEAL.—Not later than 3 months after the date a State receives notice of the Secretary's initial determination of such base per beneficiary, per category amounts for such State under subparagraph (A)(i), the State may file with the Secretary, in a form and manner specified by the Secretary, an appeal of such determination.

"(C) DETERMINATION ON APPEAL.—Not later than 3 months after receiving such an appeal, the Secretary shall make a final determination on such amounts for such State. If no such appeal is received for a State, the Secretary's initial determination under subparagraph (A)(i) shall become final.

"(6) BASE FISCAL YEAR DEFINED.—In this section, the term 'base fiscal year' means the latest fiscal year, ending before the date of the enactment of this section, for which the Secretary determines

that adequate data are available to make the computations required under this subsection.

''(d) NOT COUNTING INDIVIDUALS TO ACCOUNT FOR EXCLUDED PAYMENTS.—Under rules specified by the Secretary, individuals shall not be counted as Medicaid beneficiaries for purposes of subsection (b)(1)(B) and subsection (c)(2)(A) in proportion to the extent that such individuals are receiving medical assistance for which payments described under subsection (a)(4)(A) are made.

''(e) RISK ADJUSTMENT.—

''(1) IN GENERAL.—The amount under subsection (a)(1)(A) shall be adjusted under this subsection in an appropriate manner, specified by the Secretary and consistent with paragraph (2), to take into account—

''(A) the factors described in subsection (c)(2)(C)(i)(I) within a category of beneficiaries; and

''(B) variations in costs on a county-by-county basis for medical assistance and administrative expenses.

''(2) METHOD OF ADJUSTMENT.—

''(A) IN GENERAL.—The adjustments under paragraph (1) shall be made in a manner similar to the manner in which similar adjust-

ments are made under subsection (c)(2)(C) and consistent with the requirements of clause (iii) of such subsection and subparagraph (B).

''(B) BIANNUAL UPDATE OF RISK ADJUSTMENT METHODOLOGY.—In applying clause (i)(I) of subsection (c)(2)(C) for purposes of subparagraph (A), the Secretary shall, in consultation with the entities described in clause (ii)(I) of such subsection, update the risk adjustment methodology applied as appropriate not less often than every 2 years.

''(f) CHRONIC CARE QUALITY BONUS PAYMENTS.—

''(1) DETERMINATION OF BONUS PAYMENTS.—If the Secretary determines that, based on the reports under paragraph (5), with respect to categories of chronic disease for which chronic care performance targets had been established under paragraph (3) for each category of Medicaid beneficiaries specified under subsection (b)(2) such targets have been met by a State for a reform year, the Secretary shall make an additional payment to such State in the amount specified in paragraph (6) for each quarter in the succeeding reform year. Such payments shall be made in a manner specified by the Secretary

and may only be used consistent with subsection (a)(3).

''(2) IDENTIFICATION OF CATEGORIES OF CHRONIC DISEASE.—The Secretary shall determine the categories of chronic disease for which bonus payments may be available under this subsection for each category of Medicaid beneficiaries.

''(3) ADOPTION OF QUALITY MEASUREMENT SYSTEM AND IDENTIFICATION OF PERFORMANCE TARGETS.—

''(A) SYSTEM AND DATA.—With respect to the categories of chronic disease under paragraph (2), the Secretary shall adopt a quality measurement system that uses data described in paragraph (4) and is similar to the Five-Star Quality Rating System used to indicate the performance of Medicare Advantage plans under part C of title XVIII.

''(B) TARGETS.—Using such system and data, the Secretary shall establish for each reform year the chronic care performance targets for purposes of the payments under paragraph (1). Such performance targets shall be established in consultation with States, associations representing individuals with chronic illnesses,

entities providing treatment to such individuals for such chronic illnesses, and other stakeholders, including the National Association of Medicaid Directors and the National Governors Association.

''(4) DATA TO BE USED.—The data to be used under paragraph (3) shall include—

''(A) data collected through methods such as—

''(i) the 'Healthcare Effectiveness Data and Information Set' (also known as 'HEDIS') (or an appropriate successor performance measurement tool);

''(ii) the 'Consumer Assessment of Healthcare Providers and Systems' (also known as 'CAHPS') (or an appropriate successor performance measurement tool); and

''(iii) the 'Health Outcomes Survey' (also known as 'HOS') (or an appropriate successor performance measurement tool); and

''(B) other data collected by the State.

''(5) REPORTS.—

''(A) IN GENERAL.—Each State shall collect, analyze, and report to the Secretary, at a frequency and in a manner to be established by the Secretary, data described in paragraph (4) that permit the Secretary to monitor the State's performance relative to the chronic care performance targets established under paragraph (3).

''(B) REVIEW AND VERIFICATION.—The Secretary may review the data collected by the State under subparagraph (A) to verify the State's analysis of such data with respect to the performance targets under paragraph (3).

''(6) AMOUNT OF BONUS PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), with respect to each category of Medicaid beneficiaries, in the case of a State that the Secretary determines, based on the chronic care performance targets set under paragraph (3) for a reform year for such category, performs—

''(i) in the top five States in such category, subject to subparagraph (C)(ii), the amount of the bonus for each quarter in the succeeding reform year shall be 10 per-

cent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category;

''(ii) in the next five States in such category, subject to subparagraph (C)(ii), the amount of the bonus for each such quarter shall be 5 percent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category;

''(iii) in the next five States in such category, subject to clauses (i) and (iii) of subparagraph (C), the amount of the bonus for each such quarter shall be 3 percent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category;

''(iv) in the next five States in such category, subject to clauses (i) and (iii) of subparagraph (C), the amount of the bonus for each such quarter shall be 2 percent of the payment amount otherwise paid to the State under subsection (a) for indi-

viduals enrolled under the plan within such category; and

''(v) in the next five States in such category, subject to clauses (i) and (iii) of subparagraph (C), the amount of the bonus for each such quarter shall be 1 percent of the payment amount otherwise paid to the State under subsection (a) for individuals enrolled under the plan within such category.

''(B) AGGREGATE ANNUAL LIMIT FOR EACH CATEGORY OF MEDICAID BENEFICIARIES.—

''(i) IN GENERAL.—In no case may the aggregate amount of bonuses under this subsection for quarters in a reform year for a category of Medicaid beneficiaries exceed the limit specified in clause (ii) for the reform year.

''(ii) LIMIT.—The limit specified in this clause—

''(I) for the second reform year is equal to $250,000,000; or

''(II) for a subsequent reform year is equal to the limit specified in

this clause for the previous reform year increased by the per beneficiary percentage increase determined under paragraph (1)(E) of subsection (c).

''(C) LIMITATION AND PRORATION OF BONUSES BASED ON APPLICATION OF AGGREGATE LIMIT.—

''(i) NO BONUS FOR THIRD OR SUBSEQUENT TIERS UNLESS AGGREGATE LIMIT NOT REACHED ON FIRST TWO TIERS.—No bonus shall be payable under clause (iii), (iv), or (v) of subparagraph (A) for a category of Medicaid beneficiaries for a quarter in a reform year unless the aggregate amount of bonuses under clauses (i) and (ii) of such subparagraph for such category and reform year is less than the limit specified in subparagraph (B)(ii) for the reform year.

''(ii) PRORATION FOR FIRST TWO TIERS.—If the aggregate amount of bonuses under clauses (i) and (ii) of subparagraph (A) for a category of Medicaid beneficiaries for quarters in a reform year exceeds the limit specified in subparagraph

(B)(ii) for the reform year, the amount of each such bonus shall be prorated in a manner so the aggregate amount of such bonuses is equal to such limit.

''(iii) PRORATION FOR NEXT THREE TIERS.—If the aggregate amount of bonuses under clauses (i) and (ii) of subparagraph (A) for a category of Medicaid beneficiaries for quarters in a reform year is less than the limit specified in subparagraph (B)(ii) for the reform year, but the aggregate amount of bonuses under clauses (i) through (v) of subparagraph (A) for the category and such quarters in the reform year exceeds the limit specified in subparagraph (B)(ii) for the reform year, the amount of each bonus in clauses (iii), (iv), and (v) of subparagraph (A) shall be prorated in a manner so the aggregate amount of all the bonuses under subparagraph (A) is equal to such limit.

''(g) STATE OPTION FOR RECEIVING MEDICARE PAYMENTS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—Under this subsection a State may elect for quarters beginning on or after the implementation date in a reform year to receive payment from the Secretary under paragraph (3). As a condition of receiving such payment, the State shall agree to provide to full-benefit dual eligible individuals eligible for medical assistance under the State plan—

''(A) the medical assistance to which such eligible individuals would otherwise be entitled under this title; and

''(B) any items and services which such eligible individuals would otherwise receive under title XVIII.

''(2) PROVIDER PAYMENT REQUIREMENT.—

''(A) IN GENERAL.—A State electing the option under this subsection shall provide payment to health care providers for the items and services described under paragraph (1)(B) at a rate that is not less than the rate at which payments would be made to such providers for such items and services under title XVIII.

''(B) FLEXIBILITY IN PAYMENT METHODS.—Nothing in subparagraph (A) shall be construed as preventing a State from using al-

ternative payment methodologies (such as bundled payments or the use of accountable care organizations (as such term is used in section 1899)) for purposes of making payments to health care providers for items and services provided to dual eligible individuals in the State under the option under this subsection.

''(3) PAYMENTS TO STATES IN LIEU OF MEDICARE PAYMENTS.—With respect to a full-benefit dual eligible individual, in the case of a State that elects the option under paragraph (1) for quarters in a reform year—

''(A) the Secretary shall not make any payment under title XVIII for items and services furnished to such individual for such quarters; and

''(B) the Secretary shall pay to the State, in addition to the amounts paid to such State under subsection (a), the amount that the Secretary would, but for this subsection, otherwise pay under title XVIII for items and services furnished to such an individual in such State for such quarters.

''(4) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this subsection, the term

'full-benefit dual eligible individual' means an individual who meets the requirements of section 1935(c)(6)(A)(ii).

''(h) AUDITS.—The Secretary shall conduct such audits on the number and classification of Medicaid beneficiaries under such subsections and expenditures under this section as may be necessary to ensure appropriate payments under this section.

''(i) TREATMENT OF WAIVERS.—

''(1) NO IMPACT ON CURRENT WAIVERS.—In the case of a waiver of requirements of this title pursuant to section 1115 or other law that is in effect as of the date of the enactment of this section, nothing in this section shall be construed to affect such waiver for the period of the waiver as approved as of such date.

''(2) APPLICATION OF BUDGET NEUTRALITY TO SUBSEQUENT WAIVERS AND RENEWALS TAKING SECTION INTO ACCOUNT.—In the case of a waiver of requirements of this title pursuant to section 1115 or other law that is approved or renewed after the date of the enactment of this section, to the extent that such approval or renewal is conditioned upon a demonstration of budget neutrality, budget neutrality

shall be determined taking into account the application of this section.

''(j) REPORT TO CONGRESS.—Not later than January 1 of the second reform year, the Secretary shall submit to Congress a report on the implementation of this section.

''(k) DEFINITIONS.—In this section:

''(1) IMPLEMENTATION DATE.—The term 'implementation date' means—

''(A) July 1, 2018, if this section is enacted on or before July 1, 2017; or

''(B) July 1, 2019, if this section is enacted after July 1, 2017.

''(2) REFORM YEARS.—

''(A) The term 'reform year' means a fiscal year beginning with the first reform year.

''(B) The term 'first reform year' means the fiscal year in which the implementation date occurs.

''(C) The terms 'second', 'third', and successive similar terms mean, with respect to a reform year, the second, third, or successive reform year, respectively, succeeding the first reform year.''.

(b) CONFORMING AMENDMENTS.—

(1) CONTINUED APPLICATION OF CLAWBACK PROVISIONS.—

(A) CONTINUED APPLICATION.—Subsections (a) and (c)(1)(C) of section 1935 of such Act (42 U.S.C. 1396u–5) are each amended by inserting ''or 1903A(a)'' after ''1903(a)''.

(B) TECHNICAL AMENDMENT.—Section 1935(d)(1) of the Social Security Act (42 U.S.C. 1396u–5(d)(1)) is amended by inserting ''except as provided in section 1903A(g)'' after ''any other provision of this title''.

(2) PAYMENT RULES UNDER SECTION 1903.—

(A) Section 1903(a) of such Act (42 U.S.C. 1396b(a)) is amended, in the matter before paragraph (1), by inserting ''and section 1903A'' after ''except as otherwise provided in this section''.

(B) Section 1903(d) of such Act (42 U.S.C. 1396b(d)) is amended—

(i) in paragraph (1), by inserting ''and under section 1903A'' after ''subsections (a) and (b)'';

(ii) in paragraph (2)—

(I) in subparagraph (A), by inserting ''or section 1903A'' after ''was made under this section''; and

(II) in subparagraph (B), by inserting ''or section 1903A'' after ''under subsection (a)'';

(iii) in paragraph (4)—

(I) by striking ''under this subsection'' and inserting '', with respect to this section or section 1903A, under this subsection''; and

(II) by striking ''under this section'' and inserting ''under the respective section''; and

(iv) in paragraph (5), by inserting ''or section 1903A'' after ''overpayment under this section''.

(3) CONFORMING WAIVER AUTHORITY.—Section 1115(a)(2)(A) of the Social Security Act (42 U.S.C. 1315(a)(2)(A)) is amended by striking ''or 1903'' and inserting ''1903, or 1903A''.

(4) REPORT ON ADDITIONAL CONFORMING AMENDMENTS NEEDED.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit

to Congress a report that includes a description of any additional technical and conforming amendments to law that are required to properly carry out this Act.

○