

115TH CONGRESS  
1ST SESSION

**S.** \_\_\_\_\_

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

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

---

**A BILL**

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

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicaid Account-  
5 ability and Care Act of 2017”.

6 **SEC. 2. MEDICAID PAYMENT REFORM.**

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

1 **“SEC. 1903A. REFORMED PAYMENT TO STATES.**

2 “(a) REFORMED PAYMENT SYSTEM.—

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

10 “(A) ADJUSTED AGGREGATE BENE-  
11 FICIARY-BASED AMOUNT.—The aggregate bene-  
12 ficiary-based amount specified in subsection (b)  
13 for the quarter and the State, adjusted under  
14 subsection (e).

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

19 “(2) REQUIREMENT OF STATE SHARE.—

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

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

4           “(i) the aggregate beneficiary-based  
5 amount specified in subsection (b) for the  
6 quarter and the State; and

7           “(ii) the ratio of—

8           “(I) the State percentage de-  
9 scribed in subparagraph (D)(ii) for  
10 such State and fiscal year; to

11           “(II) the Federal percentage de-  
12 scribed in subparagraph (D)(i) for  
13 such State and fiscal year.

14           “(C) NONPAYMENT FOR FAILURE TO PAY  
15 STATE SHARE.—

16           “(i) IN GENERAL.—If a State fails to  
17 expend the amount required under sub-  
18 paragraph (A) for a quarter in a fiscal  
19 year, the amount payable to the State  
20 under paragraph (1) shall be reduced by  
21 the product of the amount by which the  
22 State payment is less than the State share  
23 and the ratio of—

1                   “(I) the Federal percentage de-  
2                   scribed in subparagraph (D)(i) for  
3                   such State and fiscal year; to

4                   “(II) the State percentage de-  
5                   scribed in subparagraph (D)(ii) for  
6                   such State and fiscal year.

7                   “(ii) GRACE PERIOD.—A State shall  
8                   not be considered to have failed to provide  
9                   payment of its required State share for a  
10                  quarter under subparagraph (A) if the ag-  
11                  gregate State payment towards the State’s  
12                  required State share for the 4-quarter pe-  
13                  riod beginning with such quarter exceeds  
14                  the required State share amount for such  
15                  4-quarter period.

16                  “(D) FEDERAL AND STATE PERCENT-  
17                  AGES.—In this paragraph, with respect to a  
18                  State and a fiscal year:

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

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



1                   attributable to certified public expend-  
2                   itures.

3                   “(iii) CREDITING FRAUD AND ABUSE  
4                   RECOVERIES.—Amounts recovered by a  
5                   State through the operation of its Medicaid  
6                   fraud and abuse control unit described in  
7                   section 1903(q) shall be fully counted to-  
8                   ward the State share under subparagraph  
9                   (A).

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

15                  “(G) DETERMINATION BASED UPON SUB-  
16                  MITTED CLAIMS.—In applying this paragraph  
17                  with respect to expenditures of a State for a  
18                  quarter, the determination of the expenditures  
19                  for such State for such quarter shall be made  
20                  after the end of the period (which, as of the  
21                  date of the enactment of this section, is 2  
22                  years) for which the Secretary accepts claims  
23                  for payment under this title with respect to  
24                  such quarter.

25                  “(3) USE OF FEDERAL PAYMENTS.—

1           “(A) APPLICATION OF MEDICAID LIMITA-  
2           TIONS.—A State may only use Federal pay-  
3           ments received under paragraph (1) for expend-  
4           itures for which Federal funds would have been  
5           payable under this title but for this section.

6           “(B) LIMITATION FOR CERTAIN ELIGI-  
7           BLES.—

8                   “(i) APPLICATION OF 100 PERCENT  
9                   FEDERAL POVERTY LINE LIMIT ON ELIGI-  
10                  BILITY.—Subject to clause (iii), a State  
11                  may not use such Federal payments to  
12                  provide medical assistance for an indi-  
13                  vidual who has an income (as determined  
14                  under clause (ii)) that exceeds 100 percent  
15                  of the poverty line (as defined in section  
16                  2110(c)(5)) applicable to a family of the  
17                  size involved.

18                   “(ii) DETERMINATION OF INCOME  
19                   USING MODIFIED ADJUSTED GROSS IN-  
20                   COME WITHOUT ANY 5 PERCENT IN-  
21                   CREASE.—In determining income for pur-  
22                   poses of clause (i) under section  
23                   1902(e)(14) (relating to modified adjusted  
24                   gross income), the following rules shall  
25                   apply:

1                   “(I) APPLICATION OF SPEND  
2                   DOWN.—The State shall take into ac-  
3                   count the costs incurred for medical  
4                   care or for any other type of remedial  
5                   care recognized under State law in the  
6                   same manner and to the same extent  
7                   that such State takes such costs into  
8                   account for purposes of section  
9                   1902(a)(17).

10                   “(II) DISREGARD OF 5 PERCENT  
11                   INCREASE.—Subparagraph (I) of sec-  
12                   tion 1902(e)(14) (relating to a 5 per-  
13                   cent reduction) shall not apply.

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

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

18                   “(II) a child who is an individual  
19                   described in clause (i) of section  
20                   1905(a);

21                   “(III) enrolled in a State plan  
22                   under this title as of the date of the  
23                   enactment of this section for the pe-  
24                   riod of continuous enrollment; or



1                   “(IV) described in section  
2                   1902(e)(14)(D) (relating to modified  
3                   adjusted gross income).

4                   “(iv) CLARIFICATION RELATED TO  
5                   COMMUNITY SPOUSE.—Nothing in this  
6                   subparagraph shall supersede the applica-  
7                   tion of section 1924 (related to community  
8                   spouse income and assets).

9                   “(4) EXCEPTIONS FOR PASS-THROUGH PAY-  
10                  MENTS.—

11                  “(A) IN GENERAL.—Paragraph (1) shall  
12                  not apply, and amounts shall continue to be  
13                  payable under this title (and not under this  
14                  subsection), in the case of the following pay-  
15                  ments (and related administrative costs and ex-  
16                  penditures):

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

20                  “(ii) MEDICARE COST SHARING.—  
21                  Payments attributable to Medicare cost  
22                  sharing under section 1905(p).

23                  “(iii) PEDIATRIC VACCINES.—Pay-  
24                  ments attributable to section 1928.

1           “(iv) EMERGENCY SERVICES FOR CER-  
2           TAIN INDIVIDUALS.—Payments for treat-  
3           ment of emergency medical conditions at-  
4           tributable to the application of section  
5           1903(v)(2).

6           “(v) INDIAN HEALTH CARE FACILI-  
7           TIES.—Payments for medical assistance  
8           described in the third sentence of section  
9           1905(b).

10           “(vi) EMPLOYER-SPONSORED INSUR-  
11           ANCE (ESI).—Payments for medical assist-  
12           ance attributable to payments to employers  
13           for employer-sponsored health benefits cov-  
14           erage.

15           “(vii) OTHER POPULATIONS WITH  
16           LIMITED BENEFIT COVERAGE.—Other pay-  
17           ments that are determined by the Sec-  
18           retary to be related to a specified popu-  
19           lation for which the medical assistance  
20           under this title is limited and does not in-  
21           clude any inpatient, nursing facility, or  
22           long-term care services.

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

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

3 “(i) ADMINISTRATION OF MEDICARE  
4 PRESCRIPTION DRUG BENEFIT.—Expendi-  
5 tures described in section 1935(b) (relating  
6 to administration of the Medicare prescrip-  
7 tion drug benefit).

8 “(ii) PAYMENTS FOR HIT BONUSES.—  
9 Payments under section 1903(a)(3)(F) (re-  
10 lating to payments to encourage the adop-  
11 tion and use of certified EHR technology).

12 “(iii) PAYMENTS FOR DESIGN, DEVEL-  
13 OPMENT, AND INSTALLATION OF MMIS AND  
14 ELIGIBILITY SYSTEMS.—Payments under  
15 subparagraphs (A)(i) and (H)(i) of section  
16 1903(a)(3) for expenditures for design, de-  
17 velopment, and installation of the Medicaid  
18 management information systems and  
19 mechanized verification and information  
20 retrieval systems (related to eligibility).

21 “(5) PAYMENT OF AMOUNTS.—

22 “(A) IN GENERAL.—Except as the Sec-  
23 retary may otherwise provide, amounts shall be  
24 payable to a State under this subsection in the  
25 same manner as amounts are payable under

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

3 “(B) INFORMATION AND FORMS.—

4 “(i) SUBMISSION.—As a condition of  
5 receiving payment under this subsection, a  
6 State shall submit such information, in  
7 such form, and manner, as the Secretary  
8 shall specify, including information nec-  
9 essary to make the computations under  
10 subsections (c)(2)(C) and (e).

11 “(ii) UNIFORM REPORTING.—The  
12 Secretary shall develop such forms as may  
13 be needed to assure a system of uniform  
14 reporting of such information across  
15 States.

16 “(C) REQUIRED REPORTING OF INFORMA-  
17 TION ON MEDICAL LOSS RATIOS FOR MANAGED  
18 CARE.—The information required to be reported  
19 under subparagraph (B)(i) shall include infor-  
20 mation on the medical loss ratio with respect to  
21 coverage provided under each Medicaid man-  
22 aged care plan with a contract with the State  
23 under section 1903(m) or 1932.

24 “(b) AGGREGATE BENEFICIARY-BASED AMOUNT.—

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

6                   “(A) BENEFICIARY-BASED QUARTERLY  
7                   AMOUNT.—The beneficiary-based quarterly  
8                   amount for such category computed under sub-  
9                   section (c) for such State for such quarter.

10                   “(B) NUMBER OF INDIVIDUALS IN CAT-  
11                   EGORY.—Subject to subsection (d), the average  
12                   number of Medicaid beneficiaries enrolled in  
13                   such category in the State in such quarter.

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

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

18                   “(B) BLIND OR DISABLED.—A category of  
19                   Medicaid beneficiaries not described in subpara-  
20                   graph (A) who are described in section  
21                   1937(a)(2)(B)(ii).

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

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

4                   “(c) COMPUTATION OF PER BENEFICIARY, PER CAT-  
5                   EGORY QUARTERLY AMOUNT.—

6                   “(1) IN GENERAL.—For a State, for each cat-  
7                   egory of beneficiary for a quarter—

8                   “(A) FIRST REFORM YEAR.—For quarters  
9                   in the first reform year (as defined in sub-  
10                  section (k)(2)), the beneficiary-based quarterly  
11                  amount is equal to  $\frac{1}{4}$  of the base average per  
12                  beneficiary Federal payments for such State for  
13                  such category determined under paragraph (2),  
14                  increased by a factor that reflects the sum of  
15                  the following:

16                  “(i) HISTORICAL MEDICAL CARE COM-  
17                  PONENT OF CPI THROUGH PREVIOUS RE-  
18                  FORM YEAR.—The percentage increase in  
19                  the historical medical care component of  
20                  the Consumer Price Index for all urban  
21                  consumers (U.S. city average) from the  
22                  midpoint of the base fiscal year (as defined  
23                  in paragraph (6)) to the midpoint of the  
24                  fiscal year preceding the first reform year.

1                   “(ii) PROJECTED MEDICAL CARE COM-  
2                   PONENT OF CPI FOR THE FIRST REFORM  
3                   YEAR.—The percentage increase in the  
4                   projected medical care component of the  
5                   Consumer Price Index for all urban con-  
6                   sumers (U.S. city average) from the mid-  
7                   point of the previous fiscal year referred to  
8                   in clause (i) to the midpoint of the first re-  
9                   form year.

10                  “(B) SECOND AND THIRD REFORM  
11                  YEARS.—The beneficiary-based quarterly  
12                  amount for a State for a category for quarters  
13                  in the second reform year or the third reform  
14                  year is equal to the beneficiary-based quarterly  
15                  amount under this paragraph for such State  
16                  and category for the previous reform year in-  
17                  creased by the per beneficiary percentage in-  
18                  crease (as defined in subparagraph (E)) for  
19                  such category and reform year.

20                  “(C) FOURTH THROUGH TENTH REFORM  
21                  YEARS.—The beneficiary-based quarterly  
22                  amount for a State for a category for quarters  
23                  in a reform year beginning with the fourth re-  
24                  form year and ending with the tenth reform  
25                  year is—

1                   “(i) in the case of a State that is a  
2                   high per beneficiary State or a low per  
3                   beneficiary State (as defined in paragraph  
4                   (4)(B)(iii)) for the category, the amount  
5                   determined under clause (i) or (ii) of para-  
6                   graph (4)(B) for such State, category, and  
7                   reform year; or

8                   “(ii) in the case of any other State,  
9                   the beneficiary-based quarterly amount  
10                  under this paragraph for such State and  
11                  category for the previous reform year in-  
12                  creased by the per beneficiary percentage  
13                  increase for such category and reform  
14                  year.

15                  “(D) ELEVENTH REFORM YEAR AND SUB-  
16                  SEQUENT REFORM YEARS.—The beneficiary-  
17                  based quarterly amount for a State for a cat-  
18                  egory for quarters in a reform year beginning  
19                  with the eleventh reform year is equal to the  
20                  beneficiary-based quarterly amount under this  
21                  paragraph for such State and category for the  
22                  previous reform year increased by the per bene-  
23                  ficiary percentage increase for such category  
24                  and reform year.



1           “(E) ANNUAL PERCENTAGE INCREASE BE-  
2           GINNING WITH SECOND REFORM YEAR.—For  
3           purposes of this subsection, the term ‘per bene-  
4           ficiary percentage increase’ means, for a reform  
5           year, the sum of—

6                   “(i) the projected percentage change  
7                   in nominal gross domestic product from  
8                   the midpoint of the previous reform year to  
9                   the midpoint of the reform year for which  
10                  the percentage increase is being applied;  
11                  and

12                   “(ii) one percentage point.

13           “(2) BASE PER BENEFICIARY, PER CATEGORY  
14           AMOUNT FOR EACH STATE.—

15                   “(A) AVERAGE PER CATEGORY.—

16                   “(i) IN GENERAL.—The Secretary  
17                   shall determine, consistent with this para-  
18                   graph and paragraph (3), a base per bene-  
19                   ficiary, per category amount for each of  
20                   the 50 States and the District of Columbia  
21                   equal to the average amount, per Medicaid  
22                   beneficiary, of Federal payments under  
23                   this title, including payments attributable  
24                   to disproportionate share hospital pay-  
25                   ments under section 1923, for each of the

1 categories of beneficiaries under subsection  
2 (b)(2) for the base fiscal year for each of  
3 the 50 States and the District of Colum-  
4 bia.

5 “(ii) BEST AVAILABLE DATA.—The  
6 determination under clause (i) shall ini-  
7 tially be estimated by the Secretary, based  
8 upon the best available data at the time  
9 the determination is made.

10 “(iii) UPDATES.—The determination  
11 under clause (i) shall be updated by the  
12 Secretary on an annual basis based upon  
13 improved data. The Secretary shall adjust  
14 the amounts under subsection (a)(1)(A) to  
15 reflect changes in the amounts so deter-  
16 mined based on such updates.

17 “(B) EXCLUSION OF PASS-THROUGH PAY-  
18 MENTS.—In computing base per beneficiary,  
19 per category amounts under subparagraph  
20 (A)(i) the Secretary shall exclude payments de-  
21 scribed in subsection (a)(4).

22 “(C) STANDARDIZATION.—

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

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

3                               “(I) RISK FACTORS.—Such risk  
4                               factors as age, health and disability  
5                               status (including high cost medical  
6                               conditions), gender, institutional sta-  
7                               tus, and such other factors as the  
8                               Secretary determines to be appro-  
9                               priate, so as to ensure actuarial  
10                              equivalence.

11                             “(II) GEOGRAPHIC.—Variations  
12                             in costs on a county-by-county basis.

13                             “(ii) METHOD OF STANDARDIZA-  
14                             TION.—

15                               “(I) CONSULTATION IN DEVEL-  
16                               OPMENT OF RISK STANDARDIZA-  
17                               TION.—In developing the methodology  
18                               for risk standardization for purposes  
19                               of clause (i)(I), the Secretary shall  
20                               consult with the Medicaid and CHIP  
21                               Payment and Access Commission, the  
22                               Medicare Payment Advisory Commis-  
23                               sion, and the National Association of  
24                               Medicaid Directors.

1                   “(II) METHOD FOR RISK STAND-  
2                   ARDIZATION.—In carrying out clause  
3                   (i)(I), the Secretary may apply the  
4                   hierarchal condition category method-  
5                   ology under section 1853(a)(1)(C). If  
6                   the Secretary uses such methodology,  
7                   the Secretary shall adjust the applica-  
8                   tion of such methodology to take into  
9                   account the differences in services  
10                  provided under this title compared to  
11                  title XVIII, such as the coverage of  
12                  long term care, pregnancy, and pedi-  
13                  atric services.

14                  “(III) METHOD FOR GEOGRAPHIC  
15                  STANDARDIZATION.—The Secretary  
16                  shall apply the standardization under  
17                  clause (i)(II) in a manner similar to  
18                  that applied under section  
19                  1853(e)(4)(A)(iii).

20                  “(iii) APPLICATION ON A NATIONAL,  
21                  BUDGET NEUTRAL BASIS.—The standard-  
22                  ization under clause (i) shall be designed  
23                  and implemented on a uniform national  
24                  basis and shall be budget neutral so as to

1 not result in any aggregate change in pay-  
2 ments under subsection (a).

3 “(iv) RESPONSE TO NEW RISK.—Sub-  
4 ject to clause (iii), the Secretary may ad-  
5 just the standardization under clause (i) to  
6 respond promptly to new instances of com-  
7 municable diseases and other public health  
8 hazards.

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

14 “(D) ADJUSTMENT FOR TEMPORARY FMAP  
15 INCREASES.—In computing each base per bene-  
16 ficiary, per category amounts under subpara-  
17 graph (A)(i) the Secretary shall disregard por-  
18 tions of payments that are attributable to a  
19 temporary increase in the Federal matching  
20 rates, including those attributable to the fol-  
21 lowing:

22 “(i) PPACA DISASTER FMAP.—Sec-  
23 tion 1905(aa).

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

4                   “(iii) EXTRAORDINARY EMPLOYER  
5                   PENSION CONTRIBUTION.—Section 614 of  
6                   the Children’s Health Insurance Program  
7                   Reauthorization Act of 2009 (42 U.S.C.  
8                   1396d note).

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

15                  “(A) among different categories of bene-  
16                  ficiaries; and

17                  “(B) between payments included under  
18                  subsection (a)(1) and payments described in  
19                  subsection (a)(4).

20                  “(4) TRANSITION TO A CORRIDOR AROUND THE  
21                  NATIONAL AVERAGE.—

22                  “(A) DETERMINATION OF NATIONAL AVER-  
23                  AGE BASE PER BENEFICIARY, PER CATEGORY  
24                  AMOUNT.—Subject to subparagraph (C), the  
25                  Secretary shall determine a national average

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

9 “(B) TRANSITION ADJUSTMENT.—

10 “(i) HIGH PER BENEFICIARY  
11 STATES.—In the case of a high per bene-  
12 ficiary State (as defined in clause (iii)(I))  
13 for a category, the beneficiary-based quar-  
14 terly amount for such State and category  
15 for a quarter in a reform year (beginning  
16 with the fourth reform year and ending  
17 with the tenth reform year) is equal to the  
18 sum of—

19 “(I) the product of the State-spe-  
20 cific factor for such reform year (as  
21 defined in clause (iv)) and the bene-  
22 ficiary-based quarterly amount that  
23 would otherwise be determined under  
24 paragraph (1) for such State and cat-  
25 egory if the State were a State de-

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

4                   “**(II)** the product of 1 minus the  
5                   State-specific factor for such reform  
6                   year and the beneficiary-based quar-  
7                   terly amount that would otherwise be  
8                   determined under paragraph (1) for a  
9                   State and category if the base per  
10                  beneficiary, per category amount de-  
11                  termined under paragraph (2) for the  
12                  State and category were equal to 110  
13                  percent of the national average base  
14                  per beneficiary, per category amount  
15                  determined under subparagraph (A)  
16                  for such category.

17                  “**(ii)**    LOW    PER    BENEFICIARY  
18                  STATES.—In the case of a low per bene-  
19                  ficiary State (as defined in clause (iii)(II))  
20                  for a category, the beneficiary-based quar-  
21                  terly amount for such State and category  
22                  for a quarter in a reform year (beginning  
23                  with the fourth reform year and ending  
24                  with the tenth reform year) is equal to the  
25                  sum of—



1                   “(I) the product of the State-spe-  
2                   cific factor for such reform year and  
3                   the beneficiary-based quarterly  
4                   amount that would otherwise be deter-  
5                   mined under paragraph (1) for such  
6                   State and category if the State were  
7                   a State described in clause (ii) of  
8                   paragraph (1)(C), instead of a State  
9                   described in clause (i) of such para-  
10                  graph; and

11                  “(II) the product of 1 minus the  
12                  State-specific factor for such reform  
13                  year and the beneficiary-based quar-  
14                  terly amount that would otherwise be  
15                  determined under paragraph (1) for a  
16                  State and category if the base per  
17                  beneficiary, per category amount de-  
18                  termined under paragraph (2) for the  
19                  State and category were equal to 90  
20                  percent of the national average base  
21                  per beneficiary, per category amount  
22                  determined under subparagraph (A)  
23                  for such category.

1                   “(iii) HIGH AND LOW PER BENE-  
2                   FICIARY STATES DEFINED.—In this sub-  
3                   paragraph:

4                   “(I) HIGH PER BENEFICIARY  
5                   STATE.—The term ‘high per bene-  
6                   ficiary State’ means, with respect to a  
7                   category, a State for which the base  
8                   per beneficiary, per category amount  
9                   determined under paragraph (2) for  
10                  such category is greater than 110 per-  
11                  cent of the national average base per  
12                  beneficiary, per category amount de-  
13                  termined under subparagraph (A) for  
14                  such category.

15                  “(II) LOW PER BENEFICIARY  
16                  STATE.—The term ‘low per bene-  
17                  ficiary State’ means, with respect to a  
18                  category, a State for which the base  
19                  per beneficiary, per category amount  
20                  determined under paragraph (2) for  
21                  such category is less than 90 percent  
22                  of the national average base per bene-  
23                  ficiary, per category amount deter-  
24                  mined under subparagraph (A) for  
25                  such category.

1                   “(iv) STATE-SPECIFIC FACTOR.—In  
2 this subparagraph, the term ‘State-specific  
3 factor’ means—

4                   “(I) for the fourth reform year,  
5                    $\frac{7}{8}$ ; and

6                   “(II) for a subsequent reform  
7 year, the State-specific factor under  
8 this clause for the previous reform  
9 year minus  $\frac{1}{8}$ .

10                   “(C) NO ADDITIONAL EXPENDITURES.—

11                   “(i) DETERMINATION OF INCREASE IN  
12 FEDERAL EXPENDITURES.—For each cat-  
13 egory for each reform year (beginning with  
14 the fourth reform year and ending with the  
15 tenth reform year), the Secretary shall de-  
16 termine whether the application of this  
17 paragraph—

18                   “(I) to the category for the re-  
19 form year will result in an aggregate  
20 increase in the aggregate Federal ex-  
21 penditures under subsection (a); and

22                   “(II) to all the categories for the  
23 reform year will result in a net aggre-  
24 gate increase in the aggregate Federal  
25 expenditures under subsection (a).

1                   “(ii) ADJUSTMENT.—If the Secretary  
2                   determines under clause (i)(II) that the  
3                   application of this paragraph to all the cat-  
4                   egories for a reform year will result in a  
5                   net aggregate increase in the aggregate  
6                   Federal expenditures under subsection (a),  
7                   the Secretary shall reduce the national av-  
8                   erage base per beneficiary, per category  
9                   amount computed under subparagraph (A)  
10                  for each of the categories determined  
11                  under clause (i)(I) for which there will be  
12                  an aggregate increase in the aggregate  
13                  Federal expenditures under subsection (a)  
14                  by such uniform percentage as will ensure  
15                  that there is no net aggregate Federal ex-  
16                  penditure increase described in clause  
17                  (i)(II) for the reform year.

18                  “(5) REPORTS ON PER BENEFICIARY RATES;  
19                  APPEALS.—

20                  “(A) REPORT TO STATES.—Not later than  
21                  8 months after the date of the enactment of  
22                  this section, the Secretary shall submit to each  
23                  State the Secretary’s initial determination of—

1                   “(i) the base per beneficiary, per cat-  
2                   egory amounts under paragraph (2) for  
3                   such State; and

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

7                   “(B) OPPORTUNITY TO APPEAL.—Not  
8                   later than 3 months after the date a State re-  
9                   ceives notice of the Secretary’s initial deter-  
10                  mination of such base per beneficiary, per cat-  
11                  egory amounts for such State under subpara-  
12                  graph (A)(i), the State may file with the Sec-  
13                  retary, in a form and manner specified by the  
14                  Secretary, an appeal of such determination.

15                  “(C) DETERMINATION ON APPEAL.—Not  
16                  later than 3 months after receiving such an ap-  
17                  peal, the Secretary shall make a final deter-  
18                  mination on such amounts for such State. If no  
19                  such appeal is received for a State, the Sec-  
20                  retary’s initial determination under subpara-  
21                  graph (A)(i) shall become final.

22                  “(6) BASE FISCAL YEAR DEFINED.—In this  
23                  section, the term ‘base fiscal year’ means the latest  
24                  fiscal year, ending before the date of the enactment  
25                  of this section, for which the Secretary determines

1 that adequate data are available to make the com-  
2 putations required under this subsection.

3 “(d) NOT COUNTING INDIVIDUALS TO ACCOUNT FOR  
4 EXCLUDED PAYMENTS.—Under rules specified by the  
5 Secretary, individuals shall not be counted as Medicaid  
6 beneficiaries for purposes of subsection (b)(1)(B) and sub-  
7 section (c)(2)(A) in proportion to the extent that such in-  
8 dividuals are receiving medical assistance for which pay-  
9 ments described under subsection (a)(4)(A) are made.

10 “(e) RISK ADJUSTMENT.—

11 “(1) IN GENERAL.—The amount under sub-  
12 section (a)(1)(A) shall be adjusted under this sub-  
13 section in an appropriate manner, specified by the  
14 Secretary and consistent with paragraph (2), to take  
15 into account—

16 “(A) the factors described in subsection  
17 (c)(2)(C)(i)(I) within a category of bene-  
18 ficiaries; and

19 “(B) variations in costs on a county-by-  
20 county basis for medical assistance and admin-  
21 istrative expenses.

22 “(2) METHOD OF ADJUSTMENT.—

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

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

4                   “(B) BIENNIAL UPDATE OF RISK ADJUST-  
5           MENT METHODOLOGY.—In applying clause  
6           (i)(I) of subsection (c)(2)(C) for purposes of  
7           subparagraph (A), the Secretary shall, in con-  
8           sultation with the entities described in clause  
9           (ii)(I) of such subsection, update the risk ad-  
10          justment methodology applied as appropriate  
11          not less often than every 2 years.

12          “(f) CHRONIC CARE QUALITY BONUS PAYMENTS.—

13                   “(1) DETERMINATION OF BONUS PAYMENTS.—  
14          If the Secretary determines that, based on the re-  
15          ports under paragraph (5), with respect to cat-  
16          egories of chronic disease for which chronic care per-  
17          formance targets had been established under para-  
18          graph (3) for each category of Medicaid beneficiaries  
19          specified under subsection (b)(2) such targets have  
20          been met by a State for a reform year, the Secretary  
21          shall make an additional payment to such State in  
22          the amount specified in paragraph (6) for each quar-  
23          ter in the succeeding reform year. Such payments  
24          shall be made in a manner specified by the Secretary

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

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

8 “(3) ADOPTION OF QUALITY MEASUREMENT  
9 SYSTEM AND IDENTIFICATION OF PERFORMANCE  
10 TARGETS.—

11 “(A) SYSTEM AND DATA.—With respect to  
12 the categories of chronic disease under para-  
13 graph (2), the Secretary shall adopt a quality  
14 measurement system that uses data described  
15 in paragraph (4) and is similar to the Five-Star  
16 Quality Rating System used to indicate the per-  
17 formance of Medicare Advantage plans under  
18 part C of title XVIII.

19 “(B) TARGETS.—Using such system and  
20 data, the Secretary shall establish for each re-  
21 form year the chronic care performance targets  
22 for purposes of the payments under paragraph  
23 (1). Such performance targets shall be estab-  
24 lished in consultation with States, associations  
25 representing individuals with chronic illnesses,



1 entities providing treatment to such individuals  
2 for such chronic illnesses, and other stake-  
3 holders, including the National Association of  
4 Medicaid Directors and the National Governors  
5 Association.

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

8 “(A) data collected through methods such  
9 as—

10 “(i) the ‘Healthcare Effectiveness  
11 Data and Information Set’ (also known as  
12 ‘HEDIS’) (or an appropriate successor  
13 performance measurement tool);

14 “(ii) the ‘Consumer Assessment of  
15 Healthcare Providers and Systems’ (also  
16 known as ‘CAHPS’) (or an appropriate  
17 successor performance measurement tool);  
18 and

19 “(iii) the ‘Health Outcomes Survey’  
20 (also known as ‘HOS’) (or an appropriate  
21 successor performance measurement tool);  
22 and

23 “(B) other data collected by the State.

24 “(5) REPORTS.—

1           “(A) IN GENERAL.—Each State shall col-  
2 lect, analyze, and report to the Secretary, at a  
3 frequency and in a manner to be established by  
4 the Secretary, data described in paragraph (4)  
5 that permit the Secretary to monitor the State’s  
6 performance relative to the chronic care per-  
7 formance targets established under paragraph  
8 (3).

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

14           “(6) AMOUNT OF BONUS PAYMENTS.—

15           “(A) IN GENERAL.—Subject to subpara-  
16 graphs (B) and (C), with respect to each cat-  
17 egory of Medicaid beneficiaries, in the case of  
18 a State that the Secretary determines, based on  
19 the chronic care performance targets set under  
20 paragraph (3) for a reform year for such cat-  
21 egory, performs—

22                   “(i) in the top five States in such cat-  
23 egory, subject to subparagraph (C)(ii), the  
24 amount of the bonus for each quarter in  
25 the succeeding reform year shall be 10 per-

1 cent of the payment amount otherwise paid  
2 to the State under subsection (a) for indi-  
3 viduals enrolled under the plan within such  
4 category;

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

12 “(iii) in the next five States in such  
13 category, subject to clauses (i) and (iii) of  
14 subparagraph (C), the amount of the  
15 bonus for each such quarter shall be 3 per-  
16 cent of the payment amount otherwise paid  
17 to the State under subsection (a) for indi-  
18 viduals enrolled under the plan within such  
19 category;

20 “(iv) in the next five States in such  
21 category, subject to clauses (i) and (iii) of  
22 subparagraph (C), the amount of the  
23 bonus for each such quarter shall be 2 per-  
24 cent of the payment amount otherwise paid  
25 to the State under subsection (a) for indi-



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

5                   “(C) LIMITATION AND PRORATION OF BO-  
6                   NUSES BASED ON APPLICATION OF AGGREGATE  
7                   LIMIT.—

8                   “(i) NO BONUS FOR THIRD OR SUBSE-  
9                   QUENT TIERS UNLESS AGGREGATE LIMIT  
10                  NOT REACHED ON FIRST TWO TIERS.—No  
11                  bonus shall be payable under clause (iii),  
12                  (iv), or (v) of subparagraph (A) for a cat-  
13                  egory of Medicaid beneficiaries for a quar-  
14                  ter in a reform year unless the aggregate  
15                  amount of bonuses under clauses (i) and  
16                  (ii) of such subparagraph for such category  
17                  and reform year is less than the limit spec-  
18                  ified in subparagraph (B)(ii) for the re-  
19                  form year.

20                  “(ii) PRORATION FOR FIRST TWO  
21                  TIERS.—If the aggregate amount of bo-  
22                  nuses under clauses (i) and (ii) of subpara-  
23                  graph (A) for a category of Medicaid bene-  
24                  ficiaries for quarters in a reform year ex-  
25                  ceeds the limit specified in subparagraph

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

5 “(iii) PRORATION FOR NEXT THREE  
6 TIERS.—If the aggregate amount of bo-  
7 nuses under clauses (i) and (ii) of subpara-  
8 graph (A) for a category of Medicaid bene-  
9 ficiaries for quarters in a reform year is  
10 less than the limit specified in subpara-  
11 graph (B)(ii) for the reform year, but the  
12 aggregate amount of bonuses under clauses  
13 (i) through (v) of subparagraph (A) for the  
14 category and such quarters in the reform  
15 year exceeds the limit specified in subpara-  
16 graph (B)(ii) for the reform year, the  
17 amount of each bonus in clauses (iii), (iv),  
18 and (v) of subparagraph (A) shall be pro-  
19 rated in a manner so the aggregate  
20 amount of all the bonuses under subpara-  
21 graph (A) is equal to such limit.

22 “(g) STATE OPTION FOR RECEIVING MEDICARE PAY-  
23 MENTS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVID-  
24 UALS.—

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

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

12           “(B) any items and services which such eli-  
13 gible individuals would otherwise receive under  
14 title XVIII.

15           “(2) PROVIDER PAYMENT REQUIREMENT.—

16           “(A) IN GENERAL.—A State electing the  
17 option under this subsection shall provide pay-  
18 ment to health care providers for the items and  
19 services described under paragraph (1)(B) at a  
20 rate that is not less than the rate at which pay-  
21 ments would be made to such providers for such  
22 items and services under title XVIII.

23           “(B) FLEXIBILITY IN PAYMENT METH-  
24 ODS.—Nothing in subparagraph (A) shall be  
25 construed as preventing a State from using al-

1           ternative payment methodologies (such as bun-  
2           dled payments or the use of accountable care  
3           organizations (as such term is used in section  
4           1899)) for purposes of making payments to  
5           health care providers for items and services pro-  
6           vided to dual eligible individuals in the State  
7           under the option under this subsection.

8           “(3) PAYMENTS TO STATES IN LIEU OF MEDI-  
9           CARE PAYMENTS.—With respect to a full-benefit  
10          dual eligible individual, in the case of a State that  
11          elects the option under paragraph (1) for quarters in  
12          a reform year—

13                 “(A) the Secretary shall not make any pay-  
14                 ment under title XVIII for items and services  
15                 furnished to such individual for such quarters;  
16                 and

17                 “(B) the Secretary shall pay to the State,  
18                 in addition to the amounts paid to such State  
19                 under subsection (a), the amount that the Sec-  
20                 retary would, but for this subsection, otherwise  
21                 pay under title XVIII for items and services  
22                 furnished to such an individual in such State  
23                 for such quarters.

24           “(4) FULL-BENEFIT DUAL ELIGIBLE INDI-  
25          VIDUAL DEFINED.—In this subsection, the term



1 ‘full-benefit dual eligible individual’ means an indi-  
2 vidual who meets the requirements of section  
3 1935(c)(6)(A)(ii).

4 “(h) AUDITS.—The Secretary shall conduct such au-  
5 dits on the number and classification of Medicaid bene-  
6 ficiaries under such subsections and expenditures under  
7 this section as may be necessary to ensure appropriate  
8 payments under this section.

9 “(i) TREATMENT OF WAIVERS.—

10 “(1) NO IMPACT ON CURRENT WAIVERS.—In  
11 the case of a waiver of requirements of this title pur-  
12 suant to section 1115 or other law that is in effect  
13 as of the date of the enactment of this section, noth-  
14 ing in this section shall be construed to affect such  
15 waiver for the period of the waiver as approved as  
16 of such date.

17 “(2) APPLICATION OF BUDGET NEUTRALITY TO  
18 SUBSEQUENT WAIVERS AND RENEWALS TAKING SEC-  
19 TION INTO ACCOUNT.—In the case of a waiver of re-  
20 quirements of this title pursuant to section 1115 or  
21 other law that is approved or renewed after the date  
22 of the enactment of this section, to the extent that  
23 such approval or renewal is conditioned upon a dem-  
24 onstration of budget neutrality, budget neutrality

1 shall be determined taking into account the applica-  
2 tion of this section.

3 “(j) REPORT TO CONGRESS.—Not later than Janu-  
4 ary 1 of the second reform year, the Secretary shall submit  
5 to Congress a report on the implementation of this section.

6 “(k) DEFINITIONS.—In this section:

7 “(1) IMPLEMENTATION DATE.—The term ‘im-  
8 plementation date’ means—

9 “(A) July 1, 2018, if this section is en-  
10 acted on or before July 1, 2017; or

11 “(B) July 1, 2019, if this section is en-  
12 acted after July 1, 2017.

13 “(2) REFORM YEARS.—

14 “(A) The term ‘reform year’ means a fiscal  
15 year beginning with the first reform year.

16 “(B) The term ‘first reform year’ means  
17 the fiscal year in which the implementation date  
18 occurs.

19 “(C) The terms ‘second’, ‘third’, and suc-  
20 cessive similar terms mean, with respect to a  
21 reform year, the second, third, or successive re-  
22 form year, respectively, succeeding the first re-  
23 form year.”.

24 (b) CONFORMING AMENDMENTS.—

1           (1) CONTINUED APPLICATION OF CLAWBACK  
2 PROVISIONS.—

3           (A) CONTINUED APPLICATION.—Sub-  
4 sections (a) and (c)(1)(C) of section 1935 of  
5 such Act (42 U.S.C. 1396u-5) are each amend-  
6 ed by inserting “or 1903A(a)” after “1903(a)”.

7           (B) TECHNICAL AMENDMENT.—Section  
8 1935(d)(1) of the Social Security Act (42  
9 U.S.C. 1396u-5(d)(1)) is amended by inserting  
10 “except as provided in section 1903A(g)” after  
11 “any other provision of this title”.

12           (2) PAYMENT RULES UNDER SECTION 1903.—

13           (A) Section 1903(a) of such Act (42  
14 U.S.C. 1396b(a)) is amended, in the matter be-  
15 fore paragraph (1), by inserting “and section  
16 1903A” after “except as otherwise provided in  
17 this section”.

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

20           (i) in paragraph (1), by inserting  
21 “and under section 1903A” after “sub-  
22 sections (a) and (b)”;

23           (ii) in paragraph (2)—

1 (I) in subparagraph (A), by in-  
2 serting “or section 1903A” after “was  
3 made under this section”; and

4 (II) in subparagraph (B), by in-  
5 serting “or section 1903A” after  
6 “under subsection (a)”; and

7 (iii) in paragraph (4)—

8 (I) by striking “under this sub-  
9 section” and inserting “, with respect  
10 to this section or section 1903A,  
11 under this subsection”; and

12 (II) by striking “under this sec-  
13 tion” and inserting “under the respec-  
14 tive section”; and

15 (iv) in paragraph (5), by inserting “or  
16 section 1903A” after “overpayment under  
17 this section”.

18 (3) CONFORMING WAIVER AUTHORITY.—Section  
19 1115(a)(2)(A) of the Social Security Act (42 U.S.C.  
20 1315(a)(2)(A)) is amended by striking “or 1903”  
21 and inserting “1903, or 1903A”.

22 (4) REPORT ON ADDITIONAL CONFORMING  
23 AMENDMENTS NEEDED.—Not later than 6 months  
24 after the date of the enactment of this Act, the Sec-  
25 retary of Health and Human Services shall submit

1 to Congress a report that includes a description of  
2 any additional technical and conforming amend-  
3 ments to law that are required to properly carry out  
4 this Act.