

S. 1932, Deficit Reduction Act of 2005

Summary of the Conference Agreement: Medicare, Medicaid and other Health-Related Provisions

Prepared by Health Policy Alternatives, Inc.

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On December 19, 2005, the House agreed to the Conference Report (H. Report 109-362) for S. 1932, the Deficit Reduction Act of 2005, by a vote of 212 to 206. On December 21, 2005, the Senate agreed to the conference agreement by a vote of 51 to 50 with Vice President Cheney casting the tie-breaking vote, but only after the Senate voted to strike three health-related provisions ruled to be in violation of the Byrd Rule. The House has the option of either passing the amended Senate budget bill or heading back to conference if the Republican leaders want to reinstate the stripped provisions. The House will not take up the legislation until some time in January.

The Congressional Budget Office (CBO) estimates that the conference agreement for S. 1932 would result in close to \$40 billion in net savings over fiscal years 2006-2010. A significant portion of those savings comes from health-related provisions. About \$6.4 billion in savings would result from changes in Medicare and \$6.9 billion from changes in Medicaid. Some of the other major sources of program savings include telecommunications, agriculture, education programs and pension benefits, and human resources. Factored into the \$40 billion in savings are additional spending provisions. For example, freezing Medicare payments to physicians for 2006 is estimated to cost \$7.3 billion over FY 2006-2010. And targeted assistance through Medicaid and SCHIP to individuals and states adversely affected by Hurricane Katrina would cost \$2.1 billion. (All of the Katrina outlays would be incurred in FY 2006 and FY 2007.)¹

The following summary has been prepared by Health Policy Alternatives, Inc. For each Medicare, Medicaid or other health-related provision, the document includes a brief current law description² and a summary of the conference agreement. We have also included at the end of the document a list of House or Senate provisions that were dropped in the conference agreement, and we have attached the preliminary CBO scoring.

¹ Congressional Budget Office, *Preliminary CBO Estimate of the Budgetary Effects of Titles V of S. 1932, the Deficit Reduction Act of 2005*, tables, December 9, 2005; Congressional Budget Office, *Estimate of the Budgetary Effects of Titles VI of S. 1932, the Deficit Reduction Act of 2005*, tables, December 19, 2005.

² The current law descriptions were drawn largely from the Congressional Research Service, Memorandum, *Side-by-Side Comparison of Medicaid, State Child Health Insurance Program (SCHIP), and Medicare Provisions in S. 1932 and HR. 4241*, November 21, 2005 and the Conference Report for S. 1932, the Deficit Reduction Act of 2005, House Report 109-362, 109th Congress, first session.

S. 1932, Deficit Reduction Act of 2005

**Summary of the Conference Agreement:
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TITLE V – MEDICARE

Subtitle A—Provisions Relating to Part A

Hospital Quality Improvement (Section 5001)

Current Law

Operating payments to hospitals are increased each year based on the projected annual change in the hospital market basket (MB). Through FY2007, the inpatient prospective payment system (IPPS) operating under current law is the full MB rate for hospitals that submit specific quality information and is the MB rate minus 0.4 percentage points for hospitals that do not provide such information. The required data are the ten quality indicators established by the Secretary as of November 1, 2003. Beginning in FY2008, the IPPS update will be the full hospital MB rate. A MB reduction in a year does not carry forward when computing the applicable percentage increase in subsequent years.

For the purpose of establishing the correct IPPS payment, Medicare discharges are classified into diagnosis related groups (DRGs) primarily on the basis of the diagnosis and procedure code information included on the beneficiary's claim. The information includes the principal diagnosis (or main problem requiring inpatient care), up to eight secondary diagnoses codes as well as up to six procedures performed during the stay. Certain secondary diagnoses are considered to be complications or comorbidities (CC) that increase the DRG weight and the resulting payment when present. Currently, no distinction is made concerning whether the secondary diagnosis was present at the time of admission or developed subsequently.

Conference Agreement

Hospitals that do not submit the required data in FY2007 and each subsequent year will have the applicable MB percentage increase reduced by 2 percentage points. Each IPPS hospital is required to submit data on measures selected by the Secretary in the established form, manner, and specified time. Any reduction applies only to the fiscal year in question and does not affect subsequent fiscal years.

The conference agreement establishes that the Secretary will expand the number of quality indicators required to be reported by acute care hospitals. Beginning October 1, 2006 the Secretary will begin to adopt the baseline set of performance measures set forth in the November 2005 Institute of Medicine report that was required by section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Beginning October 1, 2007, the Secretary will add other measures that reflect consensus among the affected parties. To the extent feasible and practicable, these measures will include those established by national consensus building entities. The Secretary is permitted to vary and replace any measures in appropriate cases, such as where all hospitals are effectively in compliance or where measures have been shown not to represent the best clinical practice.

The Secretary is required to establish procedures for making the submitted quality data available to the public. These procedures will ensure that a hospital has the opportunity to review the data before they are made available to the public. The Secretary is required to report

quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to inpatient services on the Internet website of CMS.

The Secretary is required to develop a plan to implement a value-based purchasing program for IPPS payments to acute care hospitals beginning with FY2009. Among other elements, the plan will include the structure of value-based payment adjustments such as the determination of thresholds for a payment adjustment, the size of the payment adjustment and the sources of funding for the value-based payments. The Secretary is required to consult with relevant affected parties and consider experience with applicable demonstration programs.

Before amendment in the Senate due to the Byrd rule, the conference report required the Secretary to submit a report to Congress on the plan for the value-based purchasing program no later than August 1, 2007. Also, the Medicare Payment Advisory Commission (MedPAC) was required to submit a report with detailed recommendations on the structure of the valued based payment adjustments no later than June 1, 2007. These reports were deleted by the point of order in the Senate.

Starting for discharges on October 1, 2007, the conference agreement requires hospitals to report any secondary diagnosis codes applicable to patients at the time of admission. By October 1, 2007, the Secretary is required to identify diagnosis codes associated with at least 2 high cost or high volume conditions (or both high cost and high volume). Selected diagnosis codes are ones for which the DRG assignment has a higher payment weight when the diagnosis is present as a secondary diagnosis. These diagnosis codes also are to be ones that represent conditions, including certain hospital acquired infections, which reasonably could have been prevented through the application of evidence-based guidelines.

Starting with discharges on or after October 1, 2008, the DRG assigned to a discharge with one of the identified diagnosis codes will be the DRG that does not result in higher payments based on the presence of these secondary diagnosis codes unless the diagnosis code was present at the time of the patient's admission. Changes in aggregate payments that occur because of this provision are not budget neutral and such changes also are not considered in adjusting the relative DRG weights.

The list of selected diagnosis may be revised from time to time as long as there are at least two conditions selected for discharges occurring during any fiscal year. The Secretary is required to consult with the Centers for Disease Control and Prevention and other appropriate entities when selecting and revising the identified diagnosis codes. The list of diagnosis codes and DRGs is not subject to judicial review.

Clarification Of Determination Of Medicaid Patient Days For DSH Computation (Section 5002)

Current Law

Hospitals that serve a high percentage of low income Medicare and Medicaid beneficiaries receive a disproportionate share hospital (DSH) adjustment that increases their Medicare IPPS payments. The adjustment is based on a hospital's low-income patient percentage, which is defined in statute as the proportion of the hospital's total inpatient days provided to Medicaid recipients added to the proportion of the hospital's Medicare inpatient days provided to poor

Medicare beneficiaries (those who are eligible for Part A and receive Supplemental Security Income.)

The policy of whether inpatient days provided to a patient covered under a demonstration project established by Section 1115 waivers could be included in the Medicare DSH calculation has changed over time. Prior to January 20, 2000, hospitals could not include the inpatient hospital days attributable to patients made eligible for Medicaid pursuant to a state's Section 1115 waiver. Starting on January 20, 2000, hospitals could include days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. This policy was revised for discharges starting on October 1, 2003, when hospital inpatient days attributed to patients who do not receive coverage for inpatient benefits under Section 1115 demonstration projects could not be counted in the Medicare DSH calculation. These policies were established by regulation in January, 2000 and August, 2003.

Conference Agreement

The conference agreement permits the Secretary to include inpatient hospital days of patients eligible for medical assistance under a Section 1115 demonstration waiver in the Medicare DSH calculation. These days will be counted as if they were provided to patients who were eligible for medical assistance under an approved Medicaid state plan. The existing regulations and their effective date are ratified. No hospital cost reports that are closed as of the enactment date will be reopened to implement this provision.

Improvements to the Medicare-Dependent Hospital Program (MDH) (Section 5003)

Current Law

Special treatment under the inpatient prospective payment system is afforded to a rural hospital with 100 beds or less and that has at least 60% of its inpatient days or discharges during FY1987, or during two of the three most recently audited cost reporting periods (for which there is a settled cost report), attributed to patients covered under Medicare. These MDH hospitals are paid at national standardized rate or, if higher, 50% of their adjusted FY1982 or FY1987 hospital-specific costs. This special treatment will lapse for discharges starting on October 1, 2006.

Certain hospitals that serve a high proportion of Medicaid patients or poor Medicare beneficiaries qualify for a disproportionate share hospital (DSH) adjustment to their inpatient payments. Small urban and most rural hospitals (except for rural referral centers) have their DSH adjustment capped at 12%.

Conference Agreement

The conference agreement extends the MDH status for qualifying rural hospitals through discharges occurring before October 1, 2011. Starting for discharges on October 1, 2006, a MDH would be able to elect payments based on its FY2002 hospital-specific costs if that would result in higher Medicare payments. MDH payments would be based on 75% of the adjusted hospital-specific costs starting for discharges on October 1, 2006.

MDHs that qualify for a DSH adjustment would not have the adjustment capped at 12%.

Reduction In Payments To Skilled Nursing Facilities For Bad Debt (Section 5004)

Current Law

Medicare reimburses certain providers on a reasonable costs basis for debt unpaid by beneficiaries for their Medicare coinsurance and deductibles. SNFs currently are paid for 100% of this beneficiary bad debt although an earlier statutory change reduced the payment for hospitals' bad debt to 70% of the reasonable costs associated with beneficiaries' bad debt, effective with cost reports starting in FY2001. In 2003, CMS issued a proposed rule (42 CFR Part 413, Medicare Program; Provider Bad Debt Payment) in which it described its intent to reduce reimbursement of bad debt for certain providers, including SNFs, by 30%. A final rule was not issued.

Conference Agreement

The conference agreement reduces payments to SNFs for allowable bad debts attributable to Medicare coinsurance by 30% for those individuals who are not dually eligible for Medicare and Medicaid. Bad debt payments for the dual eligible population remain at 100%.

Extended Phase-In Of The Inpatient Rehabilitation Facility Classification Criteria (Section 5005)

Current Law

Inpatient Rehabilitation Facilities (IRFs) are freestanding hospitals or distinct-part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) used to pay short-term general hospitals. These facilities are paid based on a separate prospective payment system applicable to IRFs. The Medicare statute gives the Secretary discretion to establish the criteria that a facility must meet in order to be considered an IRF. Regulations issued in 2004 by CMS increased the proportion of patients who must have specified medical conditions for the facility to qualify as an IRF and receive higher Medicare payments. The regulation also changed the list of qualifying medical conditions. When fully phased in, 75 percent of patients must meet the specified conditions. CMS adopted a transition period for the compliance threshold as follows: 50% from July 1, 2004 and before July 1, 2005; 60% from July 1, 2005 and before July 1, 2006; 65 % from July 1, 2006 and before July 1, 2007; and 75% from July 1, 2007 and thereafter.

In April 2005, the GAO issued a final report recommending that CMS refine the rule to describe more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors in addition to condition, to help ensure that IRFs can be classified appropriately and that only patients needing IRF services are admitted.

Conference Agreement

The percentage of patients meeting the specified medical conditions is set at 60% during the 12-month period beginning on July 1, 2006; at 65% during the 12-month period beginning on July 1, 2007; and at 75% beginning on July 1, 2008 and subsequently. The conference report encourages CMS to conduct additional research and study on this issue.

Development of a Strategic Plan Regarding Physician Investment In Specialty Hospitals (Section 5006)

Current Law

Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Section 507 of MMA defined specialty hospitals and established that the exception for physician investment and self-referral would not extend to such hospitals for a period of 18-months from enactment (or until June 8, 2004). A specialty hospital is defined as a hospital that is primarily or exclusively engaged in the care and treatment of patients with a cardiac condition, an orthopedic condition, those receiving a surgical procedure, or other specialized category of patients or cases identified by the Secretary.

The MMA provision does not apply to a specialty hospital that is determined by the Secretary to be in operation or under development as of November 18, 2003, with the same number of physician investors as of such date that meets other specified requirements. For instance, an increase in the number of beds could occur only on the main campus of the hospital and could not exceed the greater of 50% of the number of beds in the hospital as of November 18, 2003 or 5 beds. Following the expiration of the MMA provision on June 8, the Secretary established a six month moratorium on enrollment of new specialty hospitals.

Conference Agreement

The Secretary is directed to develop a strategic and implementing plan regarding physician investment in specialty hospitals that addresses issues related to proportionality of investment return, bona fide investments, annual disclosure of investment information, and the provision of Medicaid and charity care by specialty hospitals. An interim report is due within three months and a final report no later than six months after date of enactment. The Secretary will continue the suspension on enrollment of new specialty hospitals until the earlier of the date of submission of the report or 6 months after date of enactment. If the Secretary fails to comply with the statutory requirement to submit the final report within the six month time period, then the suspension on enrollment will be extended an additional two months. In developing the strategic and implementing plan the Secretary may waive certain requirements under the Administrative Procedures Act.

Medicare Demonstration Projects to Permit Gainsharing Arrangements (Section 5007)

Current Law

The Medicare inpatient prospective payment system (IPPS) for acute care inpatient hospital services generally pays hospitals a flat amount for each discharge, which creates strong incentives for facilities to contain costs in order to live within that amount. On the other hand, Medicare generally pays physicians a separate fee for each service, which creates no incentives for cost containment. Since the inception of PPS, hospitals have sought ways to realign these incentives. One approach is something called "gain sharing", which -- loosely defined -- means an arrangement under which a hospital shares with physicians any cost-savings achieved through their participation in a program designed to contain hospital costs.

Until recently, however, legal barriers made it very difficult to pursue such a strategy. First, section 1128A(b)(1) of the Social Security Act (42 U.S.C. 1320a-7a(b)(1)) prohibits hospitals from making payments to physicians, directly or indirectly, to induce them to reduce or limit services to a Medicare or Medicaid beneficiary under their direct care. In a “Special Advisory Bulletin” issued in July 1999, the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) took the position that gain sharing arrangements violated this prohibition, and that it lacked the discretion to create any regulatory exceptions to this policy.

In early 2005, however, OIG issued six advisory opinions favorable to similarly structured gain sharing arrangements. All of the programs involve cardiac services and incorporate similar types of cost-cutting initiatives, such as opening packaged items only when needed, performing blood cross matching only when needed, substituting less costly items, and reviewing competing device products and designating some as generally preferred.

These programs also include several safeguards, such as: (1) defining the costs being measured as precisely as possible in order to preclude inflated savings estimates; (2) setting “floors” below which no savings would accrue to physicians; (3) providing that no savings would be credited to physicians for any patients from Federal health care programs to the extent that the number of patients during a gain sharing period exceeds those for the year before the program began; (4) providing that physicians could use non-preferred devices where they are clinically more appropriate and making a range of devices available at the hospital; (5) limiting participation in the gain sharing program to physicians with privileges at the hospital at the inception of the program; (6) limiting the duration of the program to one year and the amount of savings shared with physicians to fifty percent; and (7) providing that any savings accruing to physicians would be divided equally among them.

Other safeguards included in these programs include: monitoring the mix of patients treated at the hospital to prevent inappropriate steering of more costly patients to other hospitals; disclosing to patients that physicians will share in any cost savings from the program; applying the program equally to patients from all payers; keeping detailed records of the program and making them available for inspection; and providing credible medical support that the specific cost containment initiatives involved will not adversely affect quality of care.

Although similarly structured gain-sharing arrangements might be protected from sanctions under section 1128A(b)(1), such arrangements may also implicate other federal laws, such as the physician self-referral law (over which OIG has no jurisdiction) and the private inurement rules applicable to nonprofit organizations under the Internal Revenue Code. Their status under these laws remains unclear.

Conference Agreement

The Secretary will establish a gain sharing demonstration program to “test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve quality and efficiency of care provided to Medicare beneficiaries.” In addition, the demonstration projects are designed to improve financial and operational performance by sharing some of the hospital cost savings with the physicians. The Secretary will solicit applications 90 days after enactment and will

approve six gain sharing demonstration projects by November 1, 2006, two of which will be located in rural areas. (A project may be an individual hospital.)

The projects will meet certain requirements to maintain or improve quality while achieving cost savings. Such requirements include arrangements that allow hospitals to distribute a share of program savings to physicians, a written plan agreement outlining the project, patient notification, quality and efficiency monitoring, independent review, and referral limitations. Restrictions on incentive payments in a project are waived, and similar protections extend to existing arrangements.

The projects are to be operational by January 1, 2007. Not later than December 1, 2006, the Secretary will report to Congress on the number of demonstration projects. Not later than December 1, 2007, the Secretary will provide a project update to Congress including improvements toward quality and efficiency. By December 1, 2008, the Secretary will report to Congress on quality improvement and savings from the program. A final report will be submitted to Congress by May 1, 2010.

Post-Acute Care Payment Reform Demonstration (Section 5008)

Current Law

No provision.

Conference Agreement

By January 1, 2008, the Secretary shall establish a demonstration program to better understand costs and outcomes across different post-acute care sites. Under the program, for certain diagnoses specified by the Secretary, an individual receiving treatment for such diagnoses shall receive a comprehensive assessment on the date of discharge from a hospital providing acute care inpatient hospital services and paid under the prospective payment system. The assessment will include clinical characteristics and patient needs to determine appropriate placement of the patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute sites to measure functional status and other factors during treatment and discharge from each provider. Participants shall provide information on the fixed and variable cost for each individual and an additional comprehensive assessment shall be provided at the end of the individual's episode of care. The program will operate for a three year period, and shall be conducted with sufficient numbers to determine statistically reliable results. The Secretary will transfer \$6 million from the Hospital Insurance Trust Fund to carry out the demonstration. No later than 6 months after the end of the program, the Secretary will submit a report to Congress on results and recommendations.

Subtitle B—Provisions Relating to Part B

Chapter 1—Payment Provisions

Beneficiary Ownership of Certain Durable Medical Equipment (DME) (Section 5101)

Current Law

Medicare Part B pays for certain items of durable medical equipment such as hospital beds, nebulizers and non-customized wheelchairs under the capped rental category. Most items in this category are provided on a rental basis for a period that cannot exceed fifteen months. After using the equipment for ten months, beneficiaries must be given the option of purchasing it effective thirteen months after the start of the rental period. If they choose the purchase option, the title to the equipment is transferred to beneficiaries. If the purchase option is not chosen, the supplier retains ownership of the equipment. Beneficiaries can continue to use it, but Medicare rental payments to the supplier are terminated. In the case of a power-driven wheelchair, the supplier must offer the beneficiary the option of purchasing the equipment when it is first furnished.

Medicare payments to suppliers for maintenance and servicing differ based on whether the beneficiary has purchased the equipment or whether the supplier continues to own it. In the case of a purchase agreement, payment for repairs and extensive maintenance recommended by the manufacturer is covered. When the equipment remains in the ownership of the supplier and continues to be used by a beneficiary after the fifteen month rental period, Medicare makes a payment to the supplier every six months for servicing and maintenance regardless of whether any work is performed.

Oxygen equipment is not subject to existing capped rental policies and is paid under its own fee schedule.

Conference Agreement

For capped rental items for which the first rental month occurs on or after January 1, 2006, rental payments may not extend beyond 13 months of continuous use, and the supplier must transfer title to the beneficiary after the 13th month of rental. A technical correction is also made in current law to preserve a Medicare beneficiary's option of purchasing a power-driven wheelchair, on a lump-sum basis, at the time the wheelchair is initially furnished. Rental payments for capped rental items are set at 10 percent of the purchase price for each of the first 3 months and at 7.5 percent of the purchase price for the other 10 months. Following transfer of title to a beneficiary (or following the beneficiary's purchase of a power-driven wheelchair), Medicare payments for maintenance and servicing of the item will no longer be automatic but limited to reasonable and necessary services.

Effective January 1, 2006, Medicare payments for the rental of oxygen equipment may not extend beyond 36 months, and the supplier must transfer title to such equipment after the 36th month (Medicare payments for medically necessary oxygen would continue). Following transfer of title, Medicare payments for maintenance and servicing of the oxygen equipment will be limited to reasonable and necessary services.

Adjustments in Payment for Imaging Services (Section 5102)

Current Law

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. For imaging and certain other diagnostic tests, separate relative values are assigned for the technical component of the service (to cover the equipment, supplies and staff required to perform the test) and the professional component (the physician work and other costs related to the interpretation of the test results); the fee schedule also assigns relative values for the global service (the sum of the technical and professional components). The fee schedule assigns higher values when a service is provided in the physician's office than when the same service is provided in a hospital or other facility (to account for the fact that the physician's own equipment and staff are involved in providing the service in the office setting). The relative values are then converted into a dollar conversion payment amount by a conversion factor. The conversion factor for 2005 is \$37.8975.

In a final rule published November 21, 2005, CMS adopted a policy providing reduced payments for certain multiple imaging services. This was done on a budget neutral basis; in other words, projected savings were offset by upward adjustments in practice expense values for physicians' services other than the imaging services subject to the multiple imaging payment reduction policy.

Medicare has a separate prospective payment system for hospital outpatient services, under which services are categorized into ambulatory patient classification (APC) groups, with each APC assigned a set of relative values, which are in turn based on hospital claims and cost report data. These relative values are adjusted for geographic differences in hospital wages using the inpatient hospital wage index, and a conversion factor is applied to determine payment. For 2005, this conversion factor is \$56.983. Numerous exceptions, adjustments, and other special policies also govern the payment of certain services provided in the hospital outpatient setting.

Conference Agreement

For Medicare physician fee schedules beginning with 2007, projected savings from the multiple imaging payment reduction will be exempt from the budget-neutrality calculation; the savings will be retained by the Medicare program.

Effective January 1, 2007, imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography, will be subject to new payment caps. Payment for the technical component of these services (including the technical component of global fees) will be limited to the amount that would be paid for them under Medicare's outpatient hospital prospective payment system.

Limitation on Payments for Procedures in Ambulatory Surgical Centers (Section 5103)

Current Law

Medicare has separate payment systems for ambulatory surgical centers (ASCs) and hospital outpatient departments. These payment systems were developed using different data and there are many differences in the two systems. More than 2,500 surgical procedures (many of which are infrequently performed) may be performed on Medicare beneficiaries in both ASCs and hospital outpatient departments.

Conference Agreement

Effective January 1, 2007, Medicare payment for ASC services will be capped at the amount that would be paid for these services under Medicare's hospital outpatient prospective payment system.

Update for Physicians' Services for 2006 (Section 5104)

Current Law

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work, practice expenses, and malpractice costs. The relative values are then converted into a dollar conversion payment amount by a conversion factor. The conversion factor for 2005 is \$37.8975.

The conversion factor is the same for all services (other than anesthesiology services, which have their own conversion factor). This conversion factor is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculations of the formula. These include (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians' services; and (3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. In no case can the adjustment factor be less than minus seven percent or more than plus three percent. Under the current formula, a negative 4.4 percent update is slated to occur in 2006.

Conference Agreement

The conversion factor update for 2006 is set at 0 percent (rather than -4.4 percent), but this is not treated as a change in law and regulation and thus will not be taken into account in setting the SGR. No later than March 1, 2007, the Medicare Payment Advisory Commission (MedPAC) must submit a report to Congress on mechanisms that could be used to replace the SGR. Among other things, this report must: identify and examine alternative methods for assessing volume growth; review options to control the volume of physicians' services; and identify levels of application of volume controls, such as group practice, hospital medical staff, type of service, geographic area, and outliers.

Three-Year Transition of Hold Harmless Payments for Small Rural Hospitals Under the Prospective Payment System for Hospital Outpatient Department Services (Section 5105)

Current Law

The prospective payment system for OPD services was implemented in August 2000 for most acute care hospitals. Under hold harmless provisions, as modified by the MMA, rural hospitals with no more than 100 beds and sole community hospitals (SCHs) located in rural areas are paid no less under this payment system than they would have received under the prior reimbursement system for covered OPD services provided before January 1, 2006. A final rule published November 10, 2005, provided a 7.1 percent payment adjustment under the Medicare outpatient hospital prospective payment system for SCHs (but not other rural hospitals) for calendar year 2006, in recognition of the fact that these hospitals have higher costs than urban hospitals.

Conference Agreement

For 2006, 2007 and 2008, rural hospitals with no more than 100 beds (that are not sole community hospitals) for which the PPS amount is less than the pre-BBA amount will receive 95, 90, and 85 percent, respectively, of the difference between the amounts paid under Medicare's hospital outpatient prospective payment system and the amounts that would have been paid under prior cost-based reimbursement policies.

Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services (Section 5106)

Current Law

The MMA required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General reports.

The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.

Conference Agreement

Effective January 1, 2006, the composite rate for dialysis services is increased by 1.6 percent.

Revisions to Payments for Therapy Services (Section 5107)

Current Law

The Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services

provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient services provided by hospitals.

Beginning in 1999, there were two beneficiary limits. The first was a \$1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a \$1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare economic index (MEI) rounded to the nearest multiple of \$10.

The Balanced Budget Refinement Act of 1999 (BBRA) suspended application of the limits for 2000 and 2001. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) extended the suspension through 2002. Implementation of the provision was delayed until September 2003. The caps were implemented from September 1, 2003 through December 7, 2003. MMA reinstated the moratorium from December 8, 2003 through December 31, 2005. The caps are slated to go into effect again beginning January 1, 2006. In the November 2005 final physician fee schedule regulation for 2006, CMS announced that the two separate caps would be \$1,740 in 2006.

Conference Agreement

The current moratorium on therapy caps is allowed to end on December 31, 2005. For 2006 only, the Secretary must implement an exceptions process under which medically necessary services in excess of the applicable cap would be covered. Such an exception may be requested by a Medicare beneficiary or by a person on behalf of the beneficiary; a decision must be made on the request within 10 business days or it is deemed approved.

By no later than July 1, 2006, the Secretary must implement clinically appropriate code edits, including edits of clinically illogical combinations of procedure codes, to control inappropriate Medicare payments for therapy services.

Chapter 2 – Miscellaneous

Accelerated Implementation of Income-Related Reduction in Part B Premium Subsidy (Section 5111)

Current Law

Under provisions of the MMA, Medicare beneficiaries with incomes over \$80,000 for an individual or \$160,000 for a married couple will be subject to higher monthly Part B premiums beginning in 2007. Income thresholds will be adjusted for inflation annually after 2007. The higher premiums are phased in over a 5-year period. By 2011, depending on their income, higher income beneficiaries will pay premiums ranging from 35 to 80 percent of Part B costs (rather than the 25 percent paid by others).

Conference Report

The higher Part B premiums for higher income beneficiaries will be phased in more rapidly, over a 3-year period (2007-2009).

Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (Section 5112)

Current Law

Medicare covers services which are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of malformed body member. Medicare also covers certain preventive services specified in law.

Conference Report

Effective January 1, 2007, Medicare coverage is provided for ultrasound screening (or an alternative technology of commensurate accuracy and cost specified by the Secretary) for abdominal aortic aneurysm for individuals referred for such test as a result of their "Welcome to Medicare" physical examination, provided the individual has a family history of abdominal aortic aneurysm or manifests risk factors recommended for such screening by the United States Preventive Services Task Force. The Part B deductible will not apply to this service.

Improving Patient Access to, and Utilization of, Colorectal Cancer Screening (Section 5113)

Current Law

Medicare covers certain cancer screening tests, subject to coverage limitations based on the type of test and the individual's level of risk. Covered tests are fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy, and barium enema. Payment is made under the Medicare physician fee schedule, under which relative values are assigned to each service and a dollar conversion factor is applied to determine payment.

Conference Report

Effective January 1, 2007, colorectal cancer screening tests will not be subject to the Medicare Part B deductible. [Note: Language in S. 1932 that would have required minimum payments for various screening-related services and authorized an office visit or consultation in advance of a screening colonoscopy for patient education and other purposes was deleted.]

Delivery of Services at Federally Qualified Health Centers (Section 5114)

Current Law

By law, a Federally Qualified Health Center (FQHC) is required to provide certain primary care services by physicians and appropriate mid-level practitioners as well as other preventive services, including those required under certain sections of the Public Health Service Act. Prior to MMA, FQHC services were covered by a skilled nursing facility's (SNF's) consolidated billing requirement. FQHC services were bundled into the SNF per diem payment for the covered stay and not separately billable. MMA specified that a SNF Part A resident who receives FQHC services from a physician or appropriate practitioner would not be excluded from SNF consolidated billing and would be paid separately.

Conference Report

Effective January 1, 2006, the definition of FQHC services is modified by adding diabetes outpatient self-management training services and medical nutrition therapy services, and by deleting preventive services required by sections 329 and 340 of the Public Health Service Act. Services furnished by a health care professional under contract with a FQHC are excluded from the SNF consolidated billing requirement, and payment for such services is made to the FQHC.

Waiver of Part B Late Enrollment Penalty for Certain International Volunteers (Section 5115)

Current Law

Persons who delay enrollment in Medicare Part B beyond their initial enrollment period are subject to a penalty. This penalty is a surcharge equal to 10 percent of the premium amount for each 12 months of delayed enrollment. The penalty continues to apply for the entire time the individual is enrolled in Part B. Current law provides several exceptions to the delayed enrollment penalty.

Conference Report

An individual serving as a volunteer outside of the United States through a program that covers at least a 12-month period and that is sponsored by a not-for-profit organization and who demonstrates health insurance coverage while serving in such program will not be subject to the Part B late enrollment penalty during such service, and will be eligible for a special 6-month enrollment period for Medicare Part B upon conclusion of such service.

Subtitle C—Provisions Relating to Parts A and B

Home Health Payments (Section 5201)

Current Law

Payment rates under the home health prospective payment system are updated annually based on the projected change in the home health market basket (HHMB), with statutorily specified reductions applicable in some years. For the last three quarters of 2004 and all of 2005-2006, the home health update is the HHMB minus 0.8 percentage points. In 2007 and subsequent years, the payment update is the full HHMB.

The MMA provided for a one-year additional payment of 5% for home health services furnished in rural areas. The additional payment was applicable for the period April 1, 2004 through March 31, 2005 and is excluded from the base used to determine future years' payments. It also was not budget neutral.

Conference Agreement

The update for 2006 is eliminated, freezing payments at the 2005 level for one year. The 5% add-on for home health services provided in a rural area is re-instated for one year, CY 2006.

In 2007 and subsequent years, a home health agency that does not submit quality data specified by the Secretary would receive an update of HHMB minus two percentage points. Reductions apply only in one year and are not cumulative. The Secretary will develop procedures for sharing quality data with the public.

MedPAC is directed to report to Congress by June 1, 2007 on a value-based purchasing program for home health services.

Revision Of Period For Providing Payment For Claims That Are Not Submitted Electronically (Section 5202)

Current Law

Since July 1, 2005, most providers have been required to submit claims electronically to Medicare. Exceptions include: (1) small providers with fewer than 25 full-time equivalent employees (FTEs) and physicians, practitioners or suppliers with fewer than 10 FTEs; (2) dentists; and (3) other providers specified by CMS. Medicare contractors must pay 95% of all “clean” paper claims within 27-30 days of receipt.

Conference Agreement

The conference agreement directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors will pay 95% of all “clean” paper claims within 29-30 days of receipt.

Timeframe For Part A and B Payments (Section 5203)

Current Law

Medicare contractors accept, process, and pay claims submitted by providers for Medicare-covered services. Medicare contractors must pay interest on claims that are not paid promptly. The contractors must pay 95% of all “clean” claims within 14-30 days of receipt for electronically submitted claims, or within 27-30 days of receipt for paper claims. If the payment is not made within that time, interest begins accruing on the day after the required payment date and ends on the date on which the payment is made. The interest rate is set at the higher of the “private consumer rate”, or the “current value of funds”.

Conference Agreement

The conference agreement delays Medicare Part A and B payments by 9 days. Claims that would otherwise be paid on September 22, 2006, thru September 30, 2005, would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individual for any delay in a payment during the period.

Medicare Integrity Program Funding (Section 5204)

Current Law

Section 1817(k) (4) specifies certain amounts to be appropriated from the Hospital Insurance Trust Fund for anti-fraud activities under the Medicare Integrity Program (MIP). For FY2002 and subsequent years, the amount is established to be not less than \$710 million and not more than \$720 million.

Conference Agreement

The conference agreement increases MIP funding for FY2006 by \$100 million.

Subtitle D—Provisions Relating to Part C

Phase-Out of Risk Adjustment Budget Neutrality in Determining the Amount of Payments to Medicare Advantage Organizations (Section 5301)

Current Law

Medicare Advantage (MA) payment rates are “risk adjusted” to control for the variation in the cost of providing health care among beneficiaries. Rates are adjusted by demographic and health status indicators. Beginning in 2003, the Secretary applied a budget neutrality adjustment to the risk adjusted rates in order to avert payment reductions to health plans based on risk adjustment. Earlier this year, however, the Secretary proposed to phase-out the budget neutrality adjustment. The conference report attempts to capture savings from this policy through a modified codification of the Secretary’s proposal.

Conference Agreement

The conference agreement would phase out budget neutrality for risk adjustment between 2007 and 2010 by adjusting the MA benchmark payments.

The adjustment to the MA benchmark payments would be based on the percent change in overall payments to MA plans due to risk adjustment, multiplied by an applicable phase-out percentage. The phase-out percentage would be equal to 55% in 2007, 40% in 2008, 25% in 2009 and 5% in 2010. In calculating the percent change in overall payments, the Secretary would (a) use the most recent and representative MA risk scores available, (b) adjust risk scores to reflect changes in treatment and coding practices in fee-for-service, (c) adjust risk scores for differences in coding patterns between fee-for-service and Medicare Advantage plans, to the extent the Secretary has identified differences and (d) as necessary, adjust for late data submissions, lagged cohorts, and changes in MA enrollment.

During the phase-out of budget neutrality, the Secretary would be required to conduct a study of coding patterns in fee-for-service and Medicare Advantage and incorporate these findings into the risk scores in 2008, 2009 and 2010 only. The Secretary could not make any adjustments to MA benchmarks, other than those specified above.

Rural PACE Provider Grant Program (Section 5302)

Current Law

PACE is a program providing comprehensive Medicare and Medicaid services under a managed care arrangement to individuals over age 55 who are eligible for a nursing home level of care. PACE organizations, which are public or private non-profit entities, receive a fixed monthly Medicare and Medicaid payment to cover a comprehensive set of services for PACE participants. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.

Conference Agreement

The conference agreement authorizes a rural PACE provider grant program for up to 15 PACE pilot sites that are approved to serve participants in a rural area (or part of a rural area). Grants may not exceed \$750,000 per site and may be used for feasibility and planning studies, development of interdisciplinary teams, provider networks, claims processing and financial reporting, participant outreach and education, quality and patient satisfaction reporting, working capital funds, and start-up expenses. The Secretary is directed to provide technical assistance to states and participants. A total of \$7.5 million is appropriated for FY2006 and remains available for grants through FY2008. The Secretary is required to submit an evaluation report to Congress 5 years after the date of enactment.

The conference agreement also includes special provisions authorizing cost outlier payments for demonstration sites related to the costs of inpatient hospital and related physician and ancillary services for a demonstration participant. The amount of the outlier payment is equal to 80% of the amount that exceeds \$50,000 for such services within a 12 month period. Costs are the lesser of: 1) contract rates; 2) Medicare fee-for-service rates; or 3) actual payments. Outlier payments for an individual are available only during the first 3 years of the demonstration site and are capped at \$100,000 per year, and for a site at \$500,000 per year. Demonstration sites must submit documentation for outlier payments and must exhaust their risk reserves and working capital funds first. This program is funded at \$10 million for FY2006 and remaining amounts are available through FY2010.

TITLE VI — MEDICAID AND SCHIP

Subtitle A—Medicaid

Chapter 1—Payment for Prescription Drugs

Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions (Section 6001)

Modification of Federal Upper Payment Limit (FUL) for Multiple Source Drugs.—

Current Law

Payments to pharmacies for Medicaid-covered outpatient prescription drugs are set by States. Federal reimbursements to states for the federal share of those payments are subject to a ceiling, called the federal upper limit (FUL). The FUL applies, in the aggregate, to payments for multiple source drugs for which there are at least three therapeutically equivalent drugs sold by at least three suppliers. The FUL is 150% of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating the FULs are the lowest of the average wholesale price (AWP) for each group of drug equivalents. Brand name drugs are subject to an upper limit equal to pharmacists' acquisition costs.

Conference Agreement

The conference agreement modifies the definition of multiple source drugs so that a drug qualifies as a multiple source drug if there is at least one other therapeutically equivalent product available. Effective January 1, 2007, for those drugs, the FUL would be equal to 250% of the average manufacturer price (AMP) (exclusive of prompt pay discounts).

Disclosure of Price Information to States and the Public.—

Current Law

Manufacturers must report AMP and best price data to CMS within 30 days after entering into a rebate agreement and within 30 days after the last day of each rebate period. Those prices are kept confidential except for the purpose of carrying out the requirements of Medicaid rebates, or to permit GAO and CBO to review the information.

Conference Agreement

The conference agreement would require that AMP for single source and multiple source drugs be calculated and reported monthly to states beginning July 1, 2006. In addition, the agreement requires the Secretary to post AMP information on the internet at least quarterly.

Definition of Average Manufacturer Price.—

Current Law

The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as other specific kinds of sales are excluded from the calculation as AMP. Sales at prices that are “nominal” in amount (below 10% of the AMP) are excluded from the computation of best price. Manufacturers must report the AMP for all Medicaid covered outpatient drugs and best price for single source and innovator multiple source drugs to CMS.

Conference Agreement

The conference agreement amends the definition of AMP to exclude customary prompt pay discounts extended to wholesalers and would require manufacturers to report prompt pay discounts to the Secretary (along with AMP and best price information).

The agreement requires the HHS Inspector General to review the requirements for, and the manner in which AMP is determined, and to submit any recommendations for changes to the Secretary and Congress by June 1, 2006. The Secretary must promulgate regulations clarifying the requirements for and manner in which AMP is determined, taking the recommendations of the Inspector General into consideration, by July 1, 2007.

Exclusion of Sales at a Nominal Price from Determination of Best Price.—

Current Law

In addition to the AMP, pharmaceutical manufacturers are required to report the "best price" at which the manufacturer sells each of its drugs to certain purchasers for the purpose of calculating the rebate amounts. Nominal prices are excluded from this reporting requirement. Nominal prices are defined by CMS to be those that are below 10% of the average manufacturer's price.

Conference Agreement

The conference agreement modifies the manufacturer price reporting requirements. For calendar quarters beginning on or after January 1, 2007, manufacturers must report information on Medicaid covered drugs for sales that are made at a nominal price.

In addition, the agreement redefines nominal price by limiting nominal price sales to those made by a manufacturer only to certain entities: a) those eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider. In making the determination of safety net providers, the Secretary must consider: type of facility, services provided, patients served and the number of other facilities eligible for nominal pricing in the area. And finally, the agreement specifies that drugs purchased under the Federal Supply Schedule at nominal prices cannot be counted as nominal price sales.

Retail Survey Prices; State Payment and Utilization Rates; Performance Rankings.—

Current Law

No provision.

Conference Agreement

The conference agreement permits the Secretary to contract for services for the determination of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs. Such contract can also include notification of the Secretary when a therapeutically and pharmaceutically equivalent and bioequivalent drug becomes generally available. And within seven days following such notification, the Secretary must make a determination as to whether the drug meets the definition of a multiple source drug subject to the application of the FUL.

The agreement requires the Secretary to provide states with access to collected price information and retail survey prices, including information on single source drugs, at least monthly.

The agreement requires states to report payment rates for all covered drugs, dispensing fees and utilization of innovator multiple source drugs on an annual basis. The Secretary must then compare, for the 50 most widely prescribed drugs, the national retail sales price data for each state and report these rankings to Congress annually.

Effective Date.—

Unless otherwise specified, the provisions in this section take effect on January 1, 2007, regardless of whether final regulations have been promulgated.

Collection and Submission of Utilization Data for Certain Physician Administered Drugs (Section 6002)

Current Law

Certain drugs are exempt from Medicaid rebate requirements: outpatient prescription drugs provided through managed care organizations and outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs. Physician-administered drugs, such as chemotherapy, have also been excluded from the drug rebate program, although there is no specific statutory exclusion for these products. This is because a National Drug Code (NDC) number is necessary for states to bill manufacturers for rebates, but many states use Healthcare Common Procedure Coding System (HCPCS) J-codes.

Conference Agreement

The agreement requires states to provide for the collection and submission of utilization and coding information for each Medicaid single source physician-administered drug administered on or after January 1, 2006. For the 20 multiple source physician-administered drugs with the highest dollar volume (as identified by January 1, 2007 and updated annually by the Secretary), states must provide for the collection and submission of the same information for drugs

administered on or after January 1, 2008. Submissions from states will be based on NDC codes beginning January 1, 2007 unless the Secretary specifies an alternative coding system.

Improved Regulation of Drugs Sold Under a New Drug Application Approved Under Section 505(c) of the Federal Food, Drug, and Cosmetic Act (Section 6003)

Current Law

Pharmaceutical manufacturers participating in Medicaid must report the AMP for each product offered and, for each brand name product, the lowest price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or governmental entity. The term "best price" is defined in statute but only with respect to single source and innovator multiple source drugs since the best price is part of the rebate computation for only those drugs. These reported prices are used to calculate rebates, which are calculated separately for brand name drugs and generics.

Some pharmaceutical manufacturers produce both a brand name version of a drug while also selling or licensing a second manufacturer (or subsidiary) to produce the same product to be sold or re-labeled as a generic. These generics, called "authorized generics," are subject to a separate rebate calculation. The rebate calculation for brand name products includes the best price reported for each drug, but the price of products sold as authorized generics is often excluded from this calculation.

Conference Agreement

The conference agreement requires manufacturers to report AMP and best price information for "authorized generics" (along with other reporting requirements already in place for single source drugs and innovator multiple source drugs). The agreement also modifies the definition of best price to include drugs sold under a new drug application approved under section 505(c) of the Food, Drug, and Cosmetic Act (i.e., "authorized generics") effective January 1, 2007.

Children's Hospital Participation in Drug Discount Program (Section 6004)

Current Law

Section 340(B) of the Public Health Service Act allows certain health care providers, such as community health centers and disproportionate share hospitals, access to prescription drug prices that are similar to the prices paid by Medicaid agencies after being reduced by manufacturer rebates.

Conference Agreement

The conference agreement adds children's hospitals to the list of providers granted access to 340(B) discounted drug prices. The provision is effective for drugs purchased on or after the date of enactment.

Chapter 2 – Long-Term Care Under Medicaid

Subchapter A – Reform of Asset Transfer Rules

Look-Back and Penalty Period for Transfer of Assets (Section 6011)

Lengthening the Look-Back Period for All Disposals to 5 Years.—

Current Law

To determine whether an applicant has transferred assets for less than fair market value, states are expected to identify transfers of income and assets made by the individual during the look-back period of 36 months prior (3 years) to application for Medicaid, and 60 months (5 years) in the case of certain trusts.

Conference Agreement

The conference agreement lengthens the look back period for the transfer or disposal of all assets to 60 months (5 years) on or after the date of enactment.

Change in Beginning Date for Period of Ineligibility.—

Current Law

Current law requires states to delay Medicaid eligibility for those individuals applying for nursing home coverage, and, at state option, certain home and community-based services (HCBS), if they have transferred assets (all income and resources of the individual and of the individual's spouse) for less than fair market value on or after a "look-back date." The delay of Medicaid eligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

Conference Agreement

The conference agreement changes the start date of the penalty period for all transfers to the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the state plan and would be receiving certain long term care services but for the application of the penalty period, whichever is later, and does not occur during any other period of ineligibility as a result of an asset transfer policy. The provision is effective on the date of enactment.

Availability of Hardship Waivers.—

Current Law

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be

endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation. CMS guidance further requires that state procedures, at a minimum, provide for and discuss (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Conference Agreement

The conference agreement codifies the existing CMS guidance by defining a hardship as depriving the individual of medical care that would endanger their health or life, or would deprive the individual of food, clothing, shelter, or other necessities of life. The agreement also includes requirements for the state to give notice concerning the hardship exception, provide a timely process for making a hardship determination, and provide for appeals of adverse determinations. Facilities may apply for a hardship exception on behalf of its residents with their consent, and a state may make payments to nursing facilities to hold beds for up to 30 days while a hardship exception is pending.

Disclosure and Treatment of Annuities (Section 6012)

Current Law

Current law specifies that the term “trust,” for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary defines them as such.

Conference Agreement

The conference agreement requires individuals, at the initial application or recertification for certain Medicaid long-term care services, to disclose to the state a description of any interest the individual has in an annuity (or similar financial instrument) regardless of whether the annuity is irrevocable or is treated as an asset. The application also provides for the state to be designated as a remainder beneficiary to the extent of the medical assistance furnished to the individual. The state may require the issuer of the annuity to notify the state when there is a change in the amount of income or principal withdrawn and for such amounts to be taken into account in determining the state’s payments for medical assistance. This provision would also add that the purchase of an annuity would be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

Finally, the agreement provides that in order for an annuity not to be considered an asset and to be excluded from penalties, it must be irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments. In addition, annuities that are defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or those purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as

defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC are not subject to asset transfer penalties.

These provision are effective for transactions (including the purchase of an annuity) occurring on or after the date of enactment.

Application of “Income-First” Rule in Applying Community Spouse’s Income Before Assets in Providing Support of Community Spouse (Section 6013)

Current Law

For a couple, when one spouse is institutionalized, current law exempts all of the community spouse’s income (e.g., pension or Social Security) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, current law provides for the establishment of a minimum monthly maintenance needs allowance that may include income or resources attributable to the institutionalized spouse. If the community spouse’s monthly income amount is less than the minimum monthly maintenance needs allowance, the institutionalized spouse may choose to transfer an amount of his or her income to make up for the shortfall. Within federal limits, states set the maximum monthly income level that community spouses may retain.

In allocating income and resources between spouses, states have employed two methods. Under the method used by most states, known as the “income-first” method, the institutionalized spouse’s income is first allocated to the community spouse to enable the community spouse sufficient income to meet the minimum monthly maintenance needs allowance; the remainder, if any, is applied to the institutionalized spouse’s cost of care. Under this method, the assets of an institutionalized spouse (e.g. an annuity or other income producing asset) cannot be transferred to the community spouse to generate additional income for the community spouse unless the other income transferred by the institutionalized spouse would not enable the community spouse’s total monthly income to reach the monthly maintenance needs allowance. This method generally requires a couple to deplete a larger share of their assets than the resources-first method. Under the “resources-first” method, the couple’s resources can be protected first for the benefit of the community spouse to the extent necessary to ensure that the community spouse’s total income meets the community spouse’s minimum monthly maintenance needs allowance. This method more effectively protects the couple’s assets.

Conference Agreement

The conference agreement requires that any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a minimum monthly income allowance be first made from income of the institutionalized spouse. Only when sufficient income is not available to the community spouse could resources of the institutionalized spouse be transferred or allocated. This provision is effective to transfers and allocations made on or after the date of enactment.

Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity (Section 6014)

Current Law

Current Medicaid and SSI asset counting practices exclude the entire value of an applicant's home. However, if an individual moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. Further, if an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there.

Conference Agreement

The conference agreement excludes from Medicaid eligibility for nursing facility or other long-term care services, those individuals with an equity interest in their home of greater than \$500,000 or up to \$750,000 at a state's option. (The Secretary would establish a process to waive application of this provision for demonstrated cases of hardship.) This amount would be increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers. This provision would not apply if the individual's spouse or dependent or disabled child is living in the home. This provision is effective for applications for medical assistance filed on or after January 1, 2006.

Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts (Section 6015)

Current Law

Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to older persons as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay entrance fees. CCRCs are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Although the majority of CCRC residents do not meet the financial criteria for Medicaid, some do. Current law prohibits a Medicaid-certified nursing facility from requiring oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under Medicaid or Medicare.

Conference Agreement

The conference agreement allows state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources and income allowances for community spouses) on their care before they apply for Medicaid. In addition, entrance fees for CCRCs will be counted as an asset (available to the applicant) for purposes of Medicaid eligibility if the individual can use them to pay for care when other income and assets are insufficient, and if the individual is eligible for a refund at death or on leaving the CCRC, so long as the fee does not confer an ownership interest in the CCRC.

Additional Reforms of Medicaid Asset Transfer Rules (Section 6016)

Requirement to Impose Partial Months of Ineligibility.—

Current Law

Under current law, states have the discretion to disregard or round down portions of a month during which they would otherwise be subject to the penalty period because of the transfer of assets at less than fair market value.

Conference Agreement

The conference agreement includes a provision that prohibits a state from disregarding or rounding down any fractional period of ineligibility resulting from a transfer of assets at less than fair market value.

Authority for States to Accumulate Multiple Transfers Into One Penalty Period.—

Current Law

CMS guidance currently provides that when a number of assets are transferred for less than fair market value on or after the lookback date during different months, determination of the penalty period varies based upon whether there is an overlap in any of the periods. If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

Conference Agreement

The conference agreement provides, in the case of an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, that the state may determine the penalty period by treating the total, cumulative, uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers (either the month of the first transfer or the application date for medical assistance, whichever is later).

Inclusion of Transfer of Certain Notes and Loans Assets.—

Current Law

Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets. States may apply additional rules that are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

Conference Agreement

The conference agreement provides that assets include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral or balloon payments, and prohibit the cancellation of the balance upon the death of the lender. In the case of those instruments that do not satisfy these conditions, the value of the instrument will be the outstanding balance due as of the date of the individual's application for medical assistance.

Inclusion of Transfers to Purchase Life Estates.—

Current Law

Current law does not specify whether life estates should be treated as countable or noncountable assets for purposes of Medicaid asset transfer rules. Under CMS guidance, however, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life, certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

Conference Agreement

The conference agreement redefines the term 'assets,' to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

Effective Dates.—

The conference agreement provides that the provisions of this section apply to Medicaid payments for calendar quarters beginning on or after enactment without regard to whether final regulations have been promulgated. These amendments do not apply to Medicaid services furnished before enactment, assets disposed of on or before the date of enactment and trusts established on or before the date of enactment. The agreement also provides that where new state legislation is required to carry out the provisions of this section, states have until the first calendar quarter beginning after the close of the first regular session of their legislature that begins after the date of enactment.

Subchapter B – Expanded Access to Certain Benefits

Expansion of State LTC Partnership Program (Section 6021)

Current Law

Under Medicaid's long-term care (LTC) insurance partnership program in selected states, individuals who have exhausted the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate

recovery is generally applied. In general, states allow individuals to retain no more than \$2,000 in countable assets. Current law allows states with approved Partnership programs to disregard some or all of the assets of persons applying for Medicaid who have purchased long-term care insurance policies and to exempt them from some or all Medicaid estate recovery. States with an approved state plan amendment as of May 14, 1993 include California, Connecticut, Indiana, Iowa, and New York. States have either chosen to allow for the exemption of the amount of the assets equivalent to the value of the benefit package paid by the policy purchased, or to allow all assets to be protected if an applicant purchased a certain policy, or a combination of both models.

Conference Agreement

The conference agreement expands the opportunity for states to enter into the partnership program and imposes additional requirements on those states with approved programs.

For existing state partnership programs, the consumer protection standards for private long-term care policies (including a certificate issued under a group insurance contract) may not be less stringent than such standards that were in effect under the state's plan as of December 31, 2005.

For state partnership programs approved after May 14, 1993, individuals may be exempt from estate recovery procedures if the state program provides for the disregard of any assets in an amount equal to the private long-term care insurance benefits paid on behalf of the individual. Private long-term care policies and partnership programs must meet the following requirements:

1. the covered individual is a resident of the state when private coverage begins;
2. the policy meets IRS requirements;
3. the policy meets NAIC model LTC insurance act and regulations (adopted October 2000);
4. the policy provides compound inflation protection for purchasers under age 61, some level of inflation protection for purchasers between age 61 and 75, and may provide some inflation protection for purchasers age 76 and older;
5. the state Medicaid agency provides technical assistance related to the training of individuals selling these policies;
6. the issuer of the policy reports to the Secretary the amount of benefits paid, and when the policy terminates; and
7. the state applies any requirements affecting the terms or benefits of these policies to all long-term care policies sold in the state.

The Secretary, in consultation with other appropriate governmental agencies, the NAIC, and consumer representatives, shall develop recommendations to Congress to fund a uniform minimum data set to be supplied electronically by all policy issuers qualified for a partnership program and to be maintained in a secure, centralized data bank that is accessible to states, HHS, and other federal agencies.

The NAIC model LTC insurance act provisions that apply include:

- | | |
|---------------------------------------|--|
| -- preexisting conditions; | -- outline of coverage; |
| -- prior hospitalization; | -- certification under group plans; |
| -- contingent nonforfeiture benefits; | -- policy summary; and |
| -- right of return; | -- monthly reports on accelerated death benefits |

The NAIC model LTC insurance regulation provisions that apply include:

- guaranteed renewal/noncancellability;
- prohibitions on limitations/exclusions;
- extension of benefits;
- continuation or conversion of coverage;
- discontinuation/replacement of policies;
- unintentional lapse;
- disclosure;
- required disclosure of rating practices to consumers;
- prohibition of post-claims underwriting;
- minimum standards;
- application forms and replacement coverage;
- reporting requirements;
- filing requirements for marketing;
- standards for marketing (including inaccurate completion of medical histories);
- prohibition of preexisting conditions/probationary periods in replacement policies;
- contingent nonforfeiture for those who decline offer of nonforfeiture protection;
- appropriateness of recommended purchase;
- standard format outline of coverage; and
- delivery of shopper's guide.

If the state insurance commissioner certifies that the LTC insurance policies offered in a partnership program meet the above requirements, these policies will be deemed to meet the applicable requirements of the NAIC model act and regulation. Within one year of any change issued by the NAIC to the model act or regulation, the Secretary shall determine whether or not the changes should be incorporated into the requirements for policies available in partnership programs. A state plan amendment may be made effective in a state no earlier than the first day of the calendar quarter in which the amendment is submitted to the Secretary.

To ensure portability of LTC insurance policies purchased under a partnership program, the Secretary will develop (in consultation with the NAIC, states, and consumer representatives) standards for uniform reciprocal recognition of such policies in states with qualified partnership programs by January 1, 2007. States with partnership programs will be subject to meeting these standards unless the state elects to be exempt.

The Secretary shall report to Congress annually on the partnership program and its impact on access to long-term care and on federal and state Medicare and Medicaid expenditures.

The Secretary shall establish a National Clearinghouse for Long-term Care Information by contract or interagency agreement. The Clearinghouse will provide education on Medicaid long-term care benefits and eligibility requirements, objective information regarding the purchase of long-term care insurance, contact information on objective counseling services to assist in planning for long-term care needs, and a list of states with approved partnership programs. The Clearinghouse is prohibited from recommending a specific long-term care insurance product or provider.

Chapter 3 – Eliminating Fraud, Waste, and Abuse in Medicaid

Encouraging Enactment of State False Claims Acts (Section 6032)

Current Law

Under the federal False Claims Act, anyone who knowingly submits a false claim to the federal government is liable for damages up to three times the amount of the government's damages plus mandatory penalties for each false claim submitted. Under the whistle blower provisions of the act, private citizens with knowledge of potential violations may file suit on behalf of the government and are entitled to receive a share of the proceeds of the action or settlement of the claim. States may have a variety of laws in place to facilitate prosecution of Medicaid fraud, and some have established their own versions of a false claims act. With limited exceptions, a state must repay the federal share (generally determined by the federal medical assistance percentage, or FMAP) of any provider overpayment within 60 days of discovering the overpayment, regardless of whether or not the state has recovered the overpayment to the provider.

Conference Agreement

Under the conference agreement, if a state has in effect a law relating to false or fraudulent claims that meets certain requirements (described below), the FMAP that is repayable to the federal government for any amounts recovered by the state under such a law will be decreased by 10 percentage points. The state law relating to false and fraudulent claims must be determined by the Inspector General of HHS (Inspector General), in consultation with the Attorney General, to: (1) establish liability to the state for false or fraudulent claims described in the federal False Claims Act, with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating qui tam actions as those in the federal False Claims Act, (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, and (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act. The provision is effective January 1, 2007.

Employee Education About False Claims Recovery (Section 6033)

Current Law

No provision.

Conference Agreement

Under the conference agreement, a state will be required to provide that any entity receiving annual Medicaid payments of at least \$5 million must: (1) establish written policies for all employees of the entity (as well as any contractor or agent of the entity) that includes a detailed discussion of the federal False Claims Act, federal administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistle blower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, (2) include in such written materials detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to

be protected as whistle blowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The provision is effective January 1, 2007, except that in the case of a state which the Secretary determines that state legislation is required for compliance, the state will not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment.

Prohibition on Restocking and Double Billing of Prescription Drugs (Section 6034)

Current Law

No provision.

Conference Agreement

The conference agreement prohibits federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable re-stocking fee). It is effective on the first day of the first fiscal quarter beginning after enactment.

Medicaid Integrity Program (Section 6035)

Current Law

States and the federal government share in the responsibility for safeguarding Medicaid program integrity. States must comply with federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare and Medicaid Services (CMS) is the primary federal agency responsible for providing oversight of states' activities and facilitating their program integrity efforts. The HHS Office of Inspector General (OIG) also plays a role in Medicaid fraud and abuse detection and prevention efforts through its investigations, audits, evaluations, issuances of program recommendations, and other activities.

As part of its program integrity activities, CMS operates a Medicare-Medicaid (Medi-Medi) data match project that analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation (e.g., providers submitting claims to both programs for procedures that add up to more than 24 hours of patient care in a single day). The Medi-Medi project began with one state in 2001, and was subsequently expanded to include eight others. It is primarily supported by "wedge" funds from the Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (Medicare Part A) trust fund. HCFAC wedge funds are divided between the Department of Justice, the HHS Office of Inspector General, CMS, and other HHS agencies. The HCFAC account also funds the Medicare Integrity Program and activities of the Federal Bureau of Investigation related to health care fraud. Annual minimum and maximum HCFAC appropriations are specified in statute.

Conference Agreement

The conference agreement establishes a Medicaid Integrity Program under title XIX. The Secretary will enter into contracts with eligible entities to carry out the program's activities, which

include: (1) review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, (2) audit of claims for payment for items or services furnished or for administrative services rendered, (3) identification of overpayments to individuals or entities receiving federal funds under Medicaid, and (4) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

An entity is eligible to enter into a contract to carry out Medicaid Integrity Program activities if it meets eligibility and contracting requirements similar to those under the Medicare Integrity Program. Beginning in FY2006 and every fifth fiscal year thereafter, the Secretary— in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the OIG, and state officials with responsibility for controlling provider fraud and abuse under Medicaid — will establish a comprehensive plan for ensuring Medicaid program integrity by combating fraud, waste, and abuse.

Appropriations for the Medicaid Integrity Program will total \$5 million in FY2006, \$50 million in each of FY2007 and FY2008, \$75 million in each of fiscal year thereafter. No later than 180 days after the end of each fiscal year (beginning with FY2006), the Secretary will submit a report to Congress that identifies the use and effectiveness of the use of such funds.

States will be required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program.

For each of fiscal years 2006 through 2010, \$25 million are appropriated for Medicaid activities of the Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended). No later than 180 days after the end of each fiscal year (beginning with FY2006), the Inspector General will submit a report to Congress that identifies the use and effectiveness of the use of such funds.

The Secretary will significantly increase the number of full-time equivalent CMS employees whose duties consist solely of ensuring the integrity of the Medicaid program.

The conference agreement also expands the Medicare-Medicaid data match pilot project to a national program (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program under Title XVIII of the Social Security Act. The Secretary will enter into contracts with eligible entities to ensure that the Medi-Medi Program is conducted for the purpose of: (1) identifying program vulnerabilities in Medicare and Medicaid through the use of computer algorithms to look for payment anomalies, (2) working with states, the Attorney General, and the Inspector General to coordinate appropriate actions to protect Medicare and Medicaid expenditures, and (3) increasing the effectiveness and efficiency of both programs through cost avoidance, savings, and recoupment of fraudulent, wasteful, or abuse expenditures. At least quarterly, the Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General, and the states. In addition to HCFAC appropriations for the Medicare Integrity Program (which have a statutory floor and ceiling), the Medi-Medi Program will receive \$12 million in FY2006, \$24 million in

FY2007, \$36 million in FY2008, \$48 million in FY2009, and \$60 million in FY2010 and each fiscal year thereafter.

Enhancing Third Party Identification and Payment (Section 6036)

Current Law

Third-party liability (TPL) refers to the legal obligation of third parties to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. In general, federal law requires Medicaid to be the payor of last resort. States are required to take all reasonable measures to determine the legal liability of third parties to pay for care and services available under the state Medicaid plan. To this end, they must: (1) collect health insurance information from individuals at the time of initial application for Medicaid and during any subsequent redeterminations of eligibility, (2) match data provided by Medicaid applicants and recipients to certain files maintained by government agencies (e.g., state wage and income, Social Security Administration wage and earnings, state workers' compensation, state motor vehicle accident reports), (3) identify claims with diagnosis codes that would indicate trauma-related injury for which a third party may be liable for payment, and (4) follow up on TPL leads identified through these information-gathering activities. If the state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method. As a condition of eligibility for Medicaid, individuals are required to assign to the state Medicaid agency their rights to medical support and payment for medical care from any third party. This assignment of rights facilitates TPL recovery by allowing the state to collect, on behalf of Medicaid enrollees, amounts owed by third parties for claims paid by Medicaid.

Conference Agreement

The conference agreement amends the list of third parties named in section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include: (1) self-insured plans, (2) pharmacy benefit managers, and (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It also amends that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual. In addition, it will require a state to provide assurances satisfactory to the Secretary that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state, to: (1) provide, upon request of the state, information to determine during what period an individual or their spouses and dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary; (2) provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid, (3)

accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the state, (4) respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided, and (5) agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim. The provision is effective January 1, 2006, except that in the case of a state which the Secretary determines that state legislation is required for compliance, the state will not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

Improved Enforcement of Documentation Requirements (Section 6037)

Current Law

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien (e.g., a legal permanent resident, refugee, alien granted asylum or related relief) who meets all other Medicaid program eligibility criteria. Non-qualified aliens (e.g., those who are unauthorized or illegally present, nonimmigrants admitted for a temporary purpose such as education or employment, short-term parolees) who would otherwise be eligible for Medicaid except for their immigration status may only receive Medicaid care and services that are necessary for the treatment of an emergency medical condition and are not related to an organ transplant procedure.

As a condition of an individual's eligibility for Medicaid benefits, Section 1137(d) of the Social Security Act requires a state to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. If an individual declares that he or she *is* a citizen or national, the state is not required to obtain additional documentary evidence but may choose to do so.

If an individual declares that he or she *is not* a citizen or national, the individual must declare that he or she is a qualified alien and must present satisfactory documentation.

Under the conference agreement, states are prohibited from receiving federal reimbursement for medical assistance provided under Medicaid to an individual who has not provided satisfactory documentary evidence of citizenship or nationality.

An individual could satisfy this requirement by presenting any one of the following documents: a United States passport; Form N-550 or N-570 (Certificate of Naturalization); Form N-560 or N-561 (Certificate of United States Citizenship); a state-issued driver's license or other identity document described in section 274(A)(b)(1)(D) of the Immigration and Nationality Act, but only if the state issuing the license or such document requires proof of U.S. citizenship before issuance or obtains a Social Security number from the applicant and verifies before certification that such number is valid and assigned to an applicant who is a citizen; or such other document that the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

As an alternative, satisfactory documentary evidence would also include a document from each of the following lists:

a certificate of birth in the United States; Form FS-545 or Form DS-1350 (Certificate of Birth Abroad); Form I-97 (United States Citizen Identification Card); Form FS-240 (Report of Birth Abroad of a Citizen of the United States); or such other document as the Secretary may specify (excluding a document specified by the Secretary as described above) that provides proof of United States citizenship or nationality; and

any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act; or any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

The documentary requirements will not apply to an alien who is: (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on the basis of receiving Supplemental Security Income benefits, or (3) eligible for Medicaid on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

The provision will apply to determinations of initial eligibility for Medicaid made on or after July 1, 2006, and to redeterminations made after such date in the case of individuals for whom the new documentary requirements were not previously met.

Chapter 4—Flexibility in Cost Sharing and Benefits

State Option for Alternative Medicaid Premiums and Cost Sharing (Section 6041)

Current Law

With some exceptions, premiums and enrollment fees are generally prohibited under Medicaid. When applicable, nominal amounts for such charges are between \$1 and \$19 depending on family income. States are allowed to establish nominal service-related cost-sharing requirements that are generally between \$0.50 and \$3, depending on the cost of the service provided. The regulations that specify nominal premium and service-related cost-sharing amounts were published and amended in the late 1970s and the early 1980s. These amounts are not adjusted by any factor. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules.

Under certain circumstances, families qualifying for transitional Medicaid, pregnant women and infants with income over 150% FPL, medically needy groups, and workers with disabilities may be charged premiums for Medicaid coverage. All service-related cost-sharing is prohibited for: (1) children under 18 years of age; (2) pregnant women for any services that relate to the pregnancy or to any other medical condition which may complicate pregnancy; (3) services furnished to individuals who are inpatients in a hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care; (4) services furnished to individuals receiving hospice care; (5) emergency services; and (6) family planning services and supplies. For most other beneficiaries and services, states may impose nominal service-related cost-sharing (described above). For workers with disabilities, service-related cost-sharing may be required that exceeds nominal amounts as long as they are set on a sliding scale based on income.

Under the state Medicaid plan, providers must not deny care or services to Medicaid beneficiaries due to the individual's inability to pay a cost-sharing charge. However, this requirement does not eliminate the beneficiary's liability for payment of such charges. For certain groups of pregnant women and infants for which monthly premiums may be charged, states must not require prepayment and must not terminate Medicaid eligibility for failure to pay such premiums until such failure continues for at least 60 days. States may waive those premiums when such payments would cause undue hardship.

States may offer Medicaid to certain uninsured women who are under age 65, and are in need of treatment for breast or cervical cancer based on screening services provided by an early detection program run by the CDC. This group has access to the same Medicaid services offered to the categorically needy in a given state, and are subject to Medicaid's nominal cost-sharing rules.

Conference Agreement

States are given the option to impose premiums and cost-sharing on certain groups of Medicaid recipients (and such premiums and cost-sharing may vary from group to group) provided that certain conditions are met. Premiums may not be imposed on individuals with family income between 100 and 150 percent of poverty, any cost-sharing may not exceed 10 percent of the cost of an item or service, and the total aggregate amount of cost-sharing imposed on the families of such individuals may not exceed 5 percent of the family's income. For individuals with family income above 150 percent, cost-sharing may not exceed 20 percent of the cost of an item or service, and the total aggregate amount of both premiums and cost-sharing imposed on the family of such an individual may not exceed 5 percent of the family's income.

Premiums are not permitted for the following: mandatory groups of children under 18 years of age; pregnant women; any terminally ill individual receiving hospice care; any inpatient of a medical institution if such individual is required to spend for costs of medical care all but a minimum amount of their income required for personal needs; and women who are receiving medical care for breast or cervical cancer based on screening provided by an early detection program.

Cost-sharing is not permitted for the following: services provided to mandatory groups of children under 18 years of age; preventive services provided to children under 18 years of age regardless of family income; pregnancy-related services; services furnished to terminally ill individuals receiving hospice care; services furnished to an inpatient of a medical institution if such individual is required to spend for costs of medical care all but a minimum amount of their income required for personal needs; emergency services; family planning services and supplies; and services furnished women who are receiving medical care for breast or cervical cancer based on screening provided by an early detection program.

States may condition the provision of medical assistance upon prepayment of imposed premiums. States may also terminate eligibility for such medical assistance if an individual fails to pay such premiums for a period of not less than 60 days. States may also waive payment of any premium where requiring such payment would create undue hardship. States may also permit providers to condition receipt of items or services upon payment of applicable cost-sharing, but providers are still allowed to reduce or waive such cost-sharing on a case-by-case basis.

Nominal cost-sharing amounts under Medicaid are increased annually each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (rounded up in an appropriate manner).

Cost-sharing-related provisions are effective for items and services furnished on or after March 31, 2006.

Special Rules for Cost Sharing for Prescription Drugs (Section 6042)

Current Law

States are allowed to establish nominal service-related cost-sharing requirements (defined in regulation) that are generally between \$0.50 and \$3, depending on the cost of the service provided. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules. As with other Medicaid benefits, nominal cost-sharing may be imposed on prescribed drugs, and states may vary nominal cost-sharing amounts for referred and non-preferred drugs. States may also implement prior authorization for prescribed drugs.

Conference Agreement

Effective March 31, 2006, States are given the option to impose additional cost-sharing for some or all non-preferred drugs and reduce or waive cost-sharing for some or all preferred drugs. Such cost-sharing must be nominal for individuals whose family income does not exceed 150 percent of the poverty line (including those not otherwise subject to cost-sharing as delineated in section 6041 above). For individuals whose family income exceeds 150 percent of the poverty line, cost-sharing for non-preferred drugs must not exceed 20 percent of the drug's cost. If a prescribing physician determines that the preferred drug either would not be as effective as a non-preferred drug or would have adverse effects for the individual, the State must apply preferred drug cost-sharing to the non-preferred drug. Aggregate cost-sharing for drugs and other items and services must not exceed 5 percent of family income (as provided above in section 6041).

Emergency Room Copayments for Non-Emergency Care (Section 6043)

Current Law

Waivers may be used to allow states to impose up to twice the otherwise applicable nominal cost-sharing amounts for non-emergency services provided in a hospital emergency room (ER). States may impose these higher amounts if they have established that Medicaid beneficiaries have available and accessible alternative sources of non-emergency, outpatient services.

Conference Agreement

Effective January 1, 2007, States are given the option to permit hospitals to impose cost-sharing for non-emergency care provided in an emergency department under certain circumstances. An alternate non-emergency services provider (a physician's office, health care clinic, community health center, hospital outpatient department, or similar

provider) must be actually available and accessible to provide clinically appropriate and contemporaneous care without cost-sharing. For individuals with family income between 100 and 150 percent of the poverty line, cost-sharing may not exceed twice the usual nominal amounts. For individuals not otherwise subject to cost-sharing (see section 6041 above), nominal cost-sharing would be allowed for non-emergency care provided that no cost-sharing is imposed when such care is received through an outpatient department or other alternative provider. Under this new authority, hospitals must continue to provide a medical screening examination and stabilizing examination and treatment of any emergency medical condition, and provide a referral to coordinate scheduling of non-emergency care at an alternate provider. Up to \$50 million is provided during the 4-year period beginning with 2006 for grants to States to establish alternate non-emergency service providers. Preference for such grants is given to States developing programs to serve rural or underserved areas or providing for alternate providers that are in partnership with local community hospitals. [Under the Byrd rule, language providing liability protection for hospitals imposing cost-sharing under this section was stricken during Senate consideration of the conference report.]

Use of Benchmark Benefit Packages (Section 6044)

Current Law

Categorically needy (CN) eligibility groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. Some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, and physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

As described above, some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, FQHC services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, and physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid children in CN groups are guaranteed access to all federally coverable routine and follow-up dental services necessary to treat a dental problem. EPSDT may be

offered to MN children. Both the services provided by rural health clinics (RHCs) and federally qualified health services (FQHCs) are required benefits for CN groups under Medicaid. Among other mandatory benefits for MN groups, states must offer ambulatory services for persons under 21 and those entitled to institutional services. Such ambulatory services may include RHC and FQHC services at state option. In general, RHCs and FQHCs are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services.

Conference Agreement

Effective March 31, 2006, States are given the option of providing benchmark or benchmark-equivalent benefits and, for mandatory groups of children under 19, wrap-around benefits consisting of early and periodic screening, diagnostic, and treatment services., but this option is limited to eligibility categories established under the State plan on or before the date of the enactment of this bill. States may require full-benefit eligible individuals to obtain benefits through benchmark or benchmark-equivalent coverage unless they fall in one of the following categories: (1) mandatory pregnant women; (2) blind and disabled individuals; (3) dual eligibles; (4) terminally ill hospice patients; (5) inpatients in medical institutions required to spend all income but a minimal amount for personal needs; (6) medically frail and special medical needs individuals; (7) beneficiaries qualifying for long-term care services; (8) children in foster care receiving child welfare services or receiving foster care or adoption assistance; (9) Temporary Assistance for Needy Families (TANF) and section 1931 parents; (10) women in the breast or cervical cancer program; and (11) limited services beneficiaries. [Note: The definition of full-benefit eligible individuals excludes medically needy and spend-down populations.]

Benchmark benefit packages include the following: FEHBP-equivalent health insurance coverage provided under the standard Blue Cross/Blue Shield preferred provider option; State employee coverage; coverage offered through an HMO's plan that has the largest insured commercial, non-Medicaid enrollment of the plans offered by such HMO in a State; and other Secretary-approved coverage. Benchmark-equivalent coverage is coverage that: (1) includes basic services (inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and other preventive services designated by the Secretary); (2) has an aggregate actuarial value at least equivalent to one of the benchmark packages; and (3) provides at least 75 percent of the actuarial value of certain other services (prescription drugs, mental health services, vision services and hearing services) provided by the benchmark package used under #2. In addition, individuals enrolled in benchmark or benchmark-equivalent coverage must continue to have access to rural health clinic and Federally qualified health center services paid on a cost basis.

Chapter 5 – State Financing Under Medicaid

Managed Care Organization Provider Tax Reform (6051)

Current Law

States' ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes such taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be "broad-based" (i.e., uniformly applied to all providers or services within the provider class). The federal statute identifies each of the classes of providers or services for the purpose of determining whether a tax is broad-based.

Medicaid managed care organizations (MCOs) are identified as a separate class of providers for the purposes of determining if a tax is broad-based. This class is unlike all of the other classes of providers or services because it is limited to only Medicaid providers. Other classes of providers or services identified in statute, such as inpatient hospital services, outpatient hospital services, physicians, are not restricted to Medicaid providers or Medicaid services.

Conference Agreement

The conference agreement expands the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. The provision applies upon enactment except in states with taxes based on the current law Medicaid MCO provider class as of December 8, 2005. In the case of those latter states, the provision becomes effective on October 1, 2009.

The conference agreement also provides a clarification related to a state's use of Intergovernmental transfers as the non-federal share of Medicaid expenditures where such funds are transferred from or certified by a publicly owned regional medical center located in another state. Use of such funds for the state share would be permitted so long as the Secretary determined that such use of funds is proper and in the interest of the Medicaid program. A center is defined as a publicly-owned regional medical center that: (a) provides level 1 trauma and burn care services, (2) provides level 3 neonatal care services, (c) is obligated to serve all patients, regardless of state of origin; (d) is located within an SMSA that includes at least 3 states; (e) serves as a tertiary care provider for patients residing within a 125 mile radius, and (f) meets the criteria for a DSH under 1923. This provision applies through December 31, 2006.

Reforms of Case Management and Targeted Case Management (6052)

Current Law

Case management is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. Case

management services are an optional benefit under the Medicaid state plan. “Targeted case management” (TCM) refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather only to specific classes of Medicaid eligible individuals as defined by the state (e.g., those with chronic mental illness), or persons who reside in a specific area.

Several states extend the TCM benefit to individuals who may also be receiving case management services as a component of another state and/or federal program. For example, a state may provide TCM services for Medicaid beneficiaries in foster care, regardless of whether or not they are Medicaid beneficiaries. Existing federal guidance is conflicting with respect to the process states should follow to claim Medicaid reimbursement for TCM services when another program also covers case management services for the same beneficiary.

Conference Agreement

The conference agreement differentiates between *case management* and *targeted case management services*. “Case management services” is defined in federal law as services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other specified services. Services not reimbursable as case management services would include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred.

“Targeted case management services” is defined as case management services that are provided to specific classes of individuals or to individuals who reside in specific areas. In cases where a case management provider contacts individuals who are not Medicaid eligible, or who are not part of the TCM target population, the activity could be billed as case management services if the purpose of the contact is directly related to the management of the *eligible* individual’s care. If the contact is related to the identification and management of the non-eligible or non-targeted individual’s needs and care, the activity may not be billed as case management services.

Consistent with existing Medicaid law, the conference agreement provides that federal Medicaid funding only be available for case management (or TCM) services if no other third parties are liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. If case management (or TCM) services are reimbursable by another federally-funded program, the state is required to allocate the costs of these services using OMB Circular A-87 (or any related or successor guidance or regulations).

In addition, the conference agreement establishes that (1) nothing in the provision affects the application of rules with respect to third party liability under programs or activities carried out under Title XXVI of the Public Health Service Act (the HIV Health Care Services Program) or the Indian Health Service; and (2) requires the Secretary to promulgate regulations to carry out the changes made by this provision. The provision applies as of January 1, 2006.

Additional FMAP Adjustments (6053)

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under the State Children's Health Insurance Program (SCHIP), subject to the availability of funds from a state's SCHIP allotment. When state FMAPs are calculated by HHS for an upcoming fiscal year, the state and U.S. amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). BEA revises its estimates of state per capita personal income annually to incorporate revised Census Bureau population figures and newly available source data. It also undertakes a comprehensive data revision — reflecting methodological and other changes — every few years that may result in upward and downward revisions to each of the component parts of personal income.

P.L. 106-554 (Consolidated Appropriations Act, 2001), provided that for fiscal years 2001 through 2005, the Medicaid and SCHIP FMAPs for Alaska be calculated using the state's per capita income divided by 1.05. Dividing by 1.05 lowered the state's per capita income, thereby increasing its FMAP.

Conference Agreement

Alaska FMAP. For purposes of Medicaid and SCHIP, if the FMAP for Alaska for FY 2006 or FY 2007 is less than the FMAP for the state for FY 2005, the FY 2005 FMAP will be used instead.

Hold Harmless for Katrina Impact. The agreement provides that in computing Medicaid and SCHIP, FMAPs for years after 2006 for a state that the Secretary determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary would disregard such evacuees and their incomes.

DSH Allotment for the District of Columbia (6054)

Current Law

States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments, however, is capped at a statewide ceiling. This is referred to as the state's DSH allotment.

Conference Agreement

The conference agreement clarifies that the increased amounts paid to the District of Columbia calculated based on the modified allotments for FYs 2000, 2001, and 2002 only apply to DSH expenditures applicable to FY 2006 and for subsequent fiscal years that are paid on or after October 1, 2006.

Increase in Medicaid Payments to Insular Areas (6055)

Current Law

In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to contribute its share of the matching funds. In the territories, however, Medicaid programs are subject to spending caps. For FY 1999 and subsequent fiscal years, these caps are increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers. The federal Medicaid matching rate is statutorily set at 50% of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps.

Conference Agreement

For each of FYs 2006 and 2007, the total annual cap on federal funding for the Medicaid programs in Puerto Rico, the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be increased by specified amounts. For FY 2008 and subsequent fiscal years, the total annual cap on federal funding for these Medicaid programs would be calculated by increasing the FY2007 ceiling, as modified by this provision.

Chapter 6 – Other Provisions

Subchapter A – Family Opportunity Act

Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children (“Family Opportunity Act”) (6062)

Current Law

For children with disabilities, there is a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. For some of these groups, disability status or medical need is directly related to Medicaid eligibility (e.g., children receiving SSI with family income below 75% FPL). However, there are other pathways through which such children may qualify for Medicaid coverage for which disability status and/or medical need are not relevant (e.g., children under age 6 with family income below 133% FPL). All of the Medicaid eligibility pathways for children require income levels that are generally below 300% of the federal poverty level (FPL) with some state-specific exceptions.

States may require Medicaid beneficiaries to apply for coverage in certain employer sponsored group health plans (in which such persons are eligible) when it is cost-

effective to do so. Third party liability rules apply to coverage in a group health plan; that is, such plans, not Medicaid, must pay for all covered services under the plan.

For certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. States are specifically prohibited from requiring payment of deductions, cost sharing or similar charges for services furnished to children under 18 (up to age 21, or reasonable subcategories, at state option). In certain circumstances, states may impose monthly premiums for Medicaid.

Unless otherwise specified for a given coverage group, Medicaid eligibility for children is limited to those in families with income up to 133 and 1/3% of the applicable AFDC payment standard in place as of July 16, 1996. In addition, targeted low-income children under SCHIP are defined as those who would not qualify for Medicaid under the state plan in effect on March 31, 1997. Payments for services provided to children who receive Medicaid benefits through an expansion of eligibility under SCHIP are reimbursed by the federal government at the enhanced federal medical assistance percentage (E-FMAP) rate, and funds based on this rate are drawn from annual SCHIP allotments. The SCHIP E-FMAP builds on the Medicaid FMAP.

Conference Agreement

The conference agreement provides that at state option, eligible families of disabled children would be able to purchase Medicaid coverage for those children. Qualifying children are those considered disabled under the SSI program without regard to any income or asset eligibility requirements that apply under SSI for children and whose family income does not exceed 300% FPL. Medicaid coverage would be phased in, beginning with children through age 6 in the second through fourth quarters of FY2007, then covering children through age 12 beginning in FY2008, and finally, covering children through age 18 beginning in FY2009. If an employer of a parent of a qualified child offered family group health coverage, the state would have to require the parent to apply for, enroll in, and pay premiums for such coverage as a condition of the parent's child being or remaining eligible for Medicaid if the parent is determined eligible for the employer coverage and the employer contributes at least 50% of the total cost of the premium. If employer coverage were to be obtained, states would have to reduce the Medicaid premiums by an amount that reasonably reflected the premium contribution made by the parent for that coverage on behalf of the disabled child. States could pay any portion of the required premiums on behalf of eligible children under employer group health plans. Medicaid would be secondary payer to the employer plans.

States would be permitted to impose income-related premiums. For children in families with income that does not exceed 200% FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing charges could not exceed 5% of family income. For children in families with income between 200% FPL and 300% FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing could not exceed 7.5% of family income. The provisions are effective as of January 1, 2007.

Demonstration Projects: Home and Community-based Alternative to Psychiatric Residential Treatment Facilities for Children (6063)

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allows states to provide a broad range of home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation (ICF-MR). Federal approval for these waivers is contingent on the state's documentation of the waiver's cost-neutrality. Cost-neutrality is met if, on average, the per person cost with the HCBS waiver is no higher than the cost if the person were residing in a hospital, nursing home, or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

For children with psychiatric disabilities, many states provide Medicaid funding for inpatient psychiatric residential treatment facilities. However, because the waiver cost-neutrality calculation does not allow a comparison of HCBS waiver expenditures to expenditures in these psychiatric residential treatment facilities, most states have had difficulty covering HCBS waiver services for children with psychiatric disabilities. Four states (Indiana, Kansas, New York and Vermont) have been able to offer HCBS waiver services for children with psychiatric disabilities by documenting the cost-neutrality of the waiver compared to the state's hospital expenditures. However, given the cost-neutrality requirement, those states that have limited the use of hospitals for children with psychiatric disabilities may be unable to develop HCBS waivers for this population.

Conference Agreement

The conference agreement provides that the Secretary may conduct demonstration projects in up to 10 states during FY2007- FY2011 to test the effectiveness of improving or maintaining the child's functional level, and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment, for children enrolled in Medicaid. The demonstration states would be selected through a competitive bidding process. At the end of the demonstration period, the state could allow children enrolled in the project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project. The demonstration projects would have to follow the requirements of the HCBS waiver program and meet other specified conditions.

The agreement would appropriate \$218 million for FY2007 through FY2011 for the state demonstration projects and required federal evaluations and a report. Total expenditures for state demonstration projects would not be allowed to exceed \$21 million in FY2007, \$37 million in FY2008, \$49 million in FY2009, \$53 million in FY2010, and \$57 million in FY2011.

Development and Support of Family-to-Family Health Information Centers (6064)

Current Law

Family-to-family health centers provide information and assistance to help families of children with special health care needs navigate the system of care and make decisions

about the needs and available supports for their child. No provision in current law specifically authorizes a dedicated amount of funds for these family-to-family health information centers. However, since 2002, HHS has awarded approximately \$6.9 million to develop these information centers in 36 states under various program authorities, including Special Projects of Regional and National Significance Program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) operated by the Health Resources Services Administration (HRSA). Federal funding for these projects has been time-limited. HRSA intends to fund additional family-to-family health information centers awarding up to \$2.4 million to six projects for a four-year period starting in FY2006

Conference Agreement

The conference agreement would appropriate an additional \$3 million for FY2007, \$4 million for FY2008, and \$5 million for FY2009 for family-to family health information centers funded through SPRANS. Funds would remain available until expended. The Centers would perform specific functions as enumerated by the legislation. The Secretary would be required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.

Restoration of Medicaid Eligibility for Certain SSI Beneficiaries (6065)

Current Law

SSI and Medicaid eligibility is effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date that the individual is determined eligible.

Conference Agreement

The conference agreement would extend Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application was filed, or (2) the date SSI eligibility was granted. This provision would be effective one year after the date of enactment.

Subchapter B – Money Follows the Person Rebalancing Demonstration

Money Follows the Person Rebalancing Demonstration (Section 6071)

Current Law

Under Medicaid, states can offer a variety of home and community-based services to Medicaid beneficiaries who need long-term care. Some of these services may be offered as part of Medicaid state plan and others may be offered through a home and community-based services waiver. These latter waivers allow states to provide a broad range of home and community-based services to individuals who would otherwise require the level of care provided in certain types of institutions. Current law requires that these waivers meet cost neutrality requirements.

Medicaid beneficiaries who are residents of an institution and who would like to leave that institution are entitled to receive those Medicaid services covered by the Medicaid

state plan. Such individuals, however, may not be able to access the broader range of services under a waiver request because many states have waiting lists for the waiver.

Conference Agreement

The conference agreement would authorize the Secretary, starting in 2007, to conduct a demonstration project in states to increase the use of home and community-based care ("HCBC") as an alternative to institutional care. The provision would appropriate \$250 million for the portion of FY2007, which begins on January 1, 2007; \$300 million in FY2008; \$350 million in FY2009; \$400 million in FY2010; and \$450 million in FY 2011 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through FY2011

States awarded a demonstration grant would receive an enhanced matching rate ("MFP-enhanced FMAP") equal to the state's current FMAP rate increased by half of the difference between the states normal FMAP rate and 100%, except that no MFP-enhanced FMAP rate can exceed 90%. The state would receive the MFP-enhanced FMAP rate for the costs of the home and community-based long term care services for 12 months following the demonstration participant's transition from an institution into the community. Payments for HCBC under the demonstration project would be in lieu of payment that would otherwise be paid for by Medicaid. If a state, however, exhausted its grant funding in a particular year, the state could use Medicaid to pay for HCBC.

Individuals would be eligible to participate in the demonstration if they 1) are residents of a hospital, nursing facility, an intermediate care facility for individuals who are mentally retarded (ICF-MR), or an institution for mental disease (IMD) when such services are offered as part of the state plan; 2) have resided in the facility for no less than six months or longer period as may be specified by the state (up to a maximum of two years); 3) are receiving Medicaid benefits for the services in this facility; and 4) will continue to require the level of care that resulted in his or her admission to the facility.

The state's application for a demonstration project would have to include certain specified information including assurances that the project defers to individual choice and that the state will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible. The state application must also include assurances that it will meet a maintenance of effort for Medicaid HCBS expenditures and will continue to operate a HCBS waiver. The state would also be required to describe a plan for quality assurance and improvement of HCBC services under Medicaid.

In evaluating the merits of a states application, the Secretary would be required to consider a balance of target groups and geographic distribution and to give preference to states that cover multiple groups or offer project participants the opportunity to self-direct their services. The Secretary would be authorized to waive certain sections of Medicaid law to achieve the purpose of the demonstrations.

The Secretary would be able to use up to \$2.4 million during FY2007 (after January 1, 2007) and FY2008 to carry out technical assistance and quality assurance activities during the demonstration period. The Secretary would be required to report evaluation and findings to the President and Congress no later than September 30, 2011.

Subchapter C – Miscellaneous

Medicaid Transformation Grants (Section 6081)

Current Law:

None.

Conference Agreement:

The conference agreement would provide for additional payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing Medicaid. The provision would provide \$75 million per year in FY2007 and FY2008.

Examples of innovative methods include: 1) methods for reducing patient error rates through the use of electronic health records, electronic clinical decision support tools, or e-prescribing programs; 2) methods for improving rates of collection from estates; 3) methods to reduce waste, fraud, and abuse under Medicaid; 4) implementation of a medication risk management program as part of a drug use review program; 5) methods for reducing Medicaid expenditures for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generics and 6) methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital clinic systems.

The Secretary would be required to develop an appropriate application process, payment methodology, and method for allocating the funds among the states. Such a method would provide preference for states that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. The method would allocate at least 25% of the funds among states whose populations as of July 1, 2004 were more than 105% of their populations in April 1, 2000.

Health Opportunity Accounts (6082)

Current Law

Medicaid's basic benefit rules require all states to provide certain "mandatory" services as listed in Medicaid statute. Federal matching payments are also available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each service to be provided within broad federal guidelines including: (1) amount, duration, and scope; (2) comparability, (3) statewideness, and (4) freedom of choice.

States may generally impose nominal cost-sharing on beneficiaries, with certain exceptions. Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts. For the most part, states establish their own rates to pay Medicaid providers for services.

By regulation these rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. All providers are required to accept payments under the program as payment in full for covered services except where states require nominal cost-sharing by beneficiaries.

Conference Agreement

The conference agreement would require the Secretary to establish a demonstration program under which states may provide under their Medicaid programs (including a plan operating under a statewide 1115 waiver) for qualified alternative benefits (a high deductible plan and a health opportunity account (HOA)) for eligible population groups in one or more areas of the state. Demonstrations would begin January 1, 2007. The Secretary could approve no more than 10 states to conduct these demonstrations, with each state demonstration covering one or more areas. The Secretary could extend a state demonstration beyond the first five years and permit other states to implement demonstration programs unless he found that the demonstrations had been unsuccessful, taking into account cost-effectiveness, quality of care, and other criteria. At the end of the first five years, the GAO would be required to report to Congress within 3 months evaluating the demonstration programs (\$550,000 would be appropriated for this purpose.) Secretarial approval of a demonstration would be conditioned upon it meeting specified criteria, including providing incentives for preventive services and access to negotiated provider payment rates. A program would not have to meet the statewideness requirement.

Eligibility for HOAs would be determined by the state, though individuals age 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, would be among those precluded from participating during the initial five years. Participation in HOAs by eligible individuals would be voluntary. A 1-year moratorium would apply to individuals who, for any reason, disenroll from the State demonstration program.

Annual deductibles would have to be at least 100% but not more than 110% of the annualized amount of contributions to the HOA. Enrollees would have to be provided access to negotiated provider payment rates. Restrictions that would otherwise apply to cost-sharing and comparability requirements would not apply with respect to the high deductible plan. A state could use tiered deductibles and cost sharing based on the income of the family involved so long as such benefit design did not favor families with high incomes over those with lower income.

States would specify the amounts contributed to the HOAs. A state could limit the maximum contribution that could be deposited to an HOA and could limit contributions to the HOA once the accounts reached a specified level. Total federal and state shares of the contribution could not exceed \$2,500 for each individual or family member who is an adult and \$1,000 for each individual who is a child. These amounts would be indexed.

Once account holders were no longer eligible for Medicaid, they could continue to make HOA withdrawals under state-specified conditions for a period of three years, though no additional account contributions could be made and the account balances would be reduced by 25%. For ineligible individuals who participated in the demonstration program for at least one year, accounts could then also be used to pay for health

insurance or, at state option, for additional expenditures such as job training or education.

State Option to Establish Non-Emergency Medical Transportation Program (6083)

Current Law

Federal regulations require states to ensure necessary transportation for beneficiaries to and from providers. When states offer transportation as an optional benefit, federal reimbursement uses the FMAP rate which varies by state and ranges from 50% to 83%. FMAP reimbursement is only available if transportation is furnished by a provider to whom a direct payment can be made. Beneficiaries must have freedom of choice among transportation providers and such services must be equal in amount, duration and scope for all beneficiaries classified as categorically needy (CN). This comparability requirement also applies among medically needy (MN) groups. Other arrangements, such as payments to a broker who manages and pays transportation vendors, must be claimed as an administrative expense rather than as a benefit. Such costs are reimbursed by the federal government at 50%, and fewer federal requirements must be met.

Conference Agreement

The conference agreement would allow states to establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care but have no other means of transportation. The state would not be required to provide comparable services for all Medicaid enrollees, nor freedom of choice among providers. In addition, non-emergency medical transportation brokerage programs would not have to be available statewide. The program would include wheelchair van, taxi, stretcher car, bus passes and tickets, and other transportation methods deemed appropriate by the Secretary, and could be conducted under contract with a broker who meets specified criteria. These provisions would be effective upon enactment.

The HHS Office of the Inspector General would be required to submit a report to Congress examining the non-emergency medical transportation brokerage program implemented under this provision no later than January 1, 2007.

Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program (6084)

Current Law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). States are currently required to provide TMA to families losing eligibility for Medicaid under two scenarios: one related to child or spousal support, and one related to work. While Section 1902(e)(1) of the Social Security Act permanently requires states to provide four months of TMA to families losing Medicaid eligibility due to an increase in hours of work or income from employment, the Family Support Act (FSA) of 1988 expanded state TMA requirements under Section 1925 of the Social Security Act. States must provide TA for loss of work for at least 6, and up to 12 months. Unless this provision is extended, the required

duration of TA for loss of work/employment-related income will fall back to 4 months as of January 1, 2006.

A state's allotment of abstinence education block grant program funding is based on the proportion of low-income children in the state as compared to the national total. Funding for the abstinence education block grant has been extended through December 31, 2005 by temporary extension measures.

Conference Agreement

The conference agreement extends TMA under Section 1925 of the Social Security Act through December 31, 2006. It also extends the \$50 million annual appropriation for the abstinence education block grant program through fiscal year 2006 and provides an additional \$12.5 million for the program for the first quarter of fiscal year 2007 (i.e., through December 31, 2006).

Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Enrollees (6085)

Current Law

Medicaid law provides certain protections for beneficiaries enrolled in managed care, including assuring coverage of emergency services under each managed care contract awarded by the state.

Conference Agreement

The agreement provides that any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity and that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received fee-for-service Medicaid. In a state where Medicaid rates paid to hospitals are negotiated and not publicly released, the applicable payment amount would be the average contract rate that would apply for general acute care hospitals or the average rate that would apply for tertiary hospitals. The provision applies as of January 1, 2007.

Expanded Access to Home & Community-Based Services (Section 6086)

Current Law

Medicaid home and community-based service (HCBS) waivers allow states to provide certain designated services to Medicaid beneficiaries who would require care in a nursing facility. The services may include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, respite care, and other services approved by the HHS Secretary. States with waivers may target specific populations or geographic areas, and may limit the number of participants. All waivers must meet a budget neutrality test defined as average costs per person under the waiver equal to or less than the costs of providing nursing facility care.

Conference Agreement

The conference agreement establishes home and community-based services as an optional Medicaid benefit (without any waiver requirement) for qualified individuals with incomes up to 150% of the federal poverty level. Covered services would include those available under the existing waiver program. Eligible individuals do not have to be certified as needing nursing facility care. States may target specific geographic areas and may limit the number of individuals who can be served and may revise the eligibility criteria without prior approval if enrollment exceeds projections. If eligibility criteria are modified, the state must give 60 days notice to the public and the Secretary and provide continuing coverage for current enrollees for at least one year.

States electing this optional benefit are required to establish needs-based criteria for determining individual eligibility and the specific services that will be covered. The needs-based criteria must be based on an individual assessment that takes into account the person's support needs and their inability to perform two or more activities of daily living (ADLs). The state must arrange for a face-to-face, independent assessment that determines service needs, supports an individualized plan of care, and involves consultations with family and relevant health professionals. The care plan must be reviewed at least annually or as needed when there is a significant change in circumstances.

States may elect to permit an eligible individual (or their representative) to self-direct the purchase and control of the covered services identified in the individual's care plan. In this case, an assessment must be completed and a service plan developed that includes risk management techniques and a person-centered planning process. The service plan may also include an individualized budget identifying specific dollar amounts available for the covered services approved for the individual. The state plan amendment must include information on how the budget is developed and implemented.

Additional requirements for states electing this option include meeting federal and state guidelines for quality assurance, preventing any conflicts of interest, and providing an appeals process for adverse eligibility redeterminations. States may provide presumptive eligibility for participants for up to 60 days while the independent evaluation and assessment process is underway. The Secretary (acting through the Agency for Healthcare Research and Quality) shall develop program performance indicators and participant function and satisfaction measures to assess outcomes. The Secretary is required to disclose to the public best practices and comparative performance data.

This provision is effective on January 1, 2007.

Self-Directed Personal Assistance Services – Cash & Counseling (Section 6087)

Current Law

Under current law, Medicaid programs have the option of covering personal care services and may also cover a broad set of other services through a home and community-based services waiver. Under the Medicaid personal care benefit, states can offer self-directed programs that permit beneficiaries to hire personal care providers, train and supervise them and terminate their services. However, Medicaid funds are not given directly to a beneficiary to pay for personal care services. States are not allowed to

pay legally responsible persons (e.g., parents of a minor child or a spouse) for personal care services except under extraordinary circumstances and only for participants in a home and community-based services waiver program.

Conference Agreement

The conference agreement permits states to cover the costs of self-directed personal care services for individuals who would be eligible for personal care benefits or eligible for enrollment in a home and community-based services waiver program. States may target specific populations or geographic areas and may limit the number of persons approved for the self-directed option. Personal care services must be provided pursuant to a written plan of care, assure financial accountability, and may not be provided to individuals residing in a home that is owned or operated by a provider of services (not related by blood or marriage).

States must also identify those beneficiaries who are eligible for personal care services or enrollment in a HCBS waiver program and inform them about these options as well as the option to self-direct these services. Individuals must be assessed and counseled prior to approval for the self-directed option to determine their ability to manage budgets. Participating individuals will have an approved self-directed services plan and budget to purchase personal assistance and related services, and to hire, fire, supervise, and manage the providers of service. Individuals may be allowed to use legally responsible individuals as providers (capable of providing the covered services), and may use funds for the purchase of items that increase independence and reduce the need for personal care services.

An approved self-directed services plan and budget must ensure that the individual (or his/her guardian/representative) exercises control over the budget and purchase of services including the amount, duration and location of the services. There must be an assessment of the needs, strengths, and preferences of the participant and a plan based on a person-centered process that is inclusive and promotes the individual's choices and preferences. The budget for these services must be approved by the state. Finally, the state must apply quality assurance mechanisms and risk management techniques that assure the appropriateness of the individual's plan and budget. States may contract with financial management entities to make payments to providers, track costs, and report results.

The provision is effective January 1, 2007.

Subtitle B—SCHIP

Additional Allotments to Eliminate FY 2006 Funding Shortfalls (Section 6101)

Current Law

Funds for the SCHIP program are authorized and appropriated annually for FY1998 through FY2007. States receive an allotment from each year's appropriation based on a statutory formula. These funds are available to states for three years – the year in which they are appropriated and for two additional fiscal years. At the end of the three year period, unspent funds from the original allotment are reallocated. The original SCHIP law specifies that only states that spend all of their original allotment within the three years

are eligible to receive redistributed funds from the other states' unspent allotments, based on a process determined by the Secretary. And these redistributed funds are available for one year.

Subsequent legislation superseded the reallocation of unspent FY1998 to FY2001 original allotments, although the redistribution of unspent FY2002 allotments was determined by the Secretary in accordance with the default redistribution rules.

Conference Agreement

The conference agreement authorizes and appropriates \$283 million to provide additional SCHIP allotments to states facing a funding shortfall in FY2006. Shortfall states are defined as those identified by the Secretary such that projected expenditures exceed the sum of all funds available to that state in FY2006 (based on the most current data available). These additional allotments would be distributed to each shortfall state based on its estimated shortfall, and the additional allotments are available for one year only. On October 1, 2006, any remaining unspent additional allotments would not be subject to redistribution, but would instead revert to the Treasury.

The conference agreement also specifies that these allotments are only available for amounts expended for child health assistance for targeted low-income children. The amendments made by this section of the agreement apply to items and services furnished on or after October 1, 2005, without regard to whether regulations are issued.

Prohibition Against Covering Nonpregnant Childless Adults with SCHIP Funds (Section 6102)

Current Law

Section 1115 of the Social Security Act gives the Secretary broad authority to modify most aspects of the Medicaid and SCHIP programs. Section 1115 specifically identifies Section 1902 of Medicaid (e.g., freedom of choice of provider, comparability, and statewideness) as requirements that could be waived in a demonstration project approved under this waiver authority. The statute provides no specific sections or requirements of SCHIP subject to waiver, however, nor does it restrict waivers of any SCHIP requirements. The previous administration supported waivers under the 1115 authority to expand SCHIP coverage to parents of Medicaid or SCHIP-eligible children, as well as to certain pregnant women. The current administration, under the Health Insurance Flexibility and Accountability (HIFA) initiative, has used the 1115 authority to approve waivers that use SCHIP funding to expand coverage to childless adults.

Conference Agreement

The conference agreement would limit the Secretary's 1115 waiver authority by prohibiting new waivers or demonstration projects that allow federal SCHIP funds to provide child health assistance or other health benefits coverage to nonpregnant childless adults. Caretaker relatives of Medicaid or SCHIP-eligible children are not considered childless adults. States that are already using SCHIP funds to cover childless adults would be allowed to continue providing such coverage, as the restriction would only apply to waivers approved on or after October 1, 2005.

Continued Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures (Section 6103)

Current Law

Prior to the enactment of the SCHIP program in 1997, several states had already expanded health coverage to low-income children above 184% of the federal poverty level through Medicaid. These states were at a disadvantage when SCHIP passed, because the funds were intended to be used to expand coverage to populations that these states already covered.

To level the playing field for states that had expanded health coverage to low-income children prior to 1997, current law permits these states (and certain other states with waivers under Section 1115 demonstration authority) to use federal SCHIP funds to pay the difference between the SCHIP enhanced federal matching rate and the regular Medicaid matching rate for services delivered to Medicaid beneficiaries under the age of 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150% of the federal poverty level. The maximum amount that qualifying states may claim under this allowance is the lesser of: (1) 20% of the state's available FY1998 through FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% spending. No 20% spending will be permitted in FY2006 or any fiscal year thereafter.

Conference Agreement

The conference agreement continues the authority for qualifying states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the bill would allow qualifying states to use any available FY2004 and FY2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds) for such Medicaid services made on or after October 1, 2005 under the 20% allowance. The provision applies to expenditures made on or after October 1, 2005.

Subtitle C—Katrina Relief

Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations (6201)

Current Law

A number of states (17 as of December 15, 2005) have been granted Section 1115 waivers to provide Medicaid and SCHIP services to certain individuals affected by Hurricane Katrina. These waivers are referred to as being part of a multi-state demonstration project. For purposes of FMAP reimbursement, Section 1115 waivers are deemed to be part of a state's Medicaid or SCHIP state plan (i.e., its "regular" Medicaid or SCHIP program). All of the waivers granted thus far under the Hurricane Katrina multi-state Section 1115 demonstration create a temporary eligibility period, not to exceed five months, during which certain Hurricane Katrina evacuees will be granted access to Medicaid and SCHIP services in the host state (i.e., the state that has been granted a Section 1115 waiver) based on simplified eligibility criteria. In addition to

creating temporary Medicaid or SCHIP eligibility for evacuees, waivers for some states also create an uncompensated care pool that may be used through January 31, 2006, to augment Medicaid and SCHIP services for evacuees and to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP.

Disaster declarations were issued after Katrina pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, which authorizes the President to issue such declarations to speed a wide range of federal aid — including individual assistance (e.g., housing for individuals and families) and public assistance (e.g., repair of community infrastructure) — to states determined to be overwhelmed by hurricanes or other catastrophes. FEMA makes the decision as to when a major disaster or emergency is “closed out” for administrative purposes.

Conference Agreement

The conference agreement appropriates \$2 billion (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those who have provided care to affected individuals or evacuees under a Section 1115 project) for the following purposes: (a) the non-federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Katrina and continue to reside in the same state) and evacuees (affected individuals who have been displaced to another state) under approved multi-state Section 1115 demonstration projects (includes Medicaid, SCHIP, uncompensated care costs; and premium assistance); (b) reasonable administrative costs related to such projects; (c) the non-federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP state plans; and (d) other purposes, if approved by the Secretary, to restore access to health care in impacted communities.

The non-federal share paid to eligible states shall not be regarded as federal funds for purposes of Medicaid matching requirements. No payment obligations may be incurred under approved multi-state Section 1115 projects for costs of: (1) health care provided as Medicaid or SCHIP medical assistance incurred after June 30, 2006 and (2) uncompensated care or services and supplies beyond those included as Medicaid or SCHIP medical assistance incurred after January 31, 2006.

State High Risk Health Insurance Pool Funding (6202)

Current Law

As of December 2004, 33 states operate high risk health insurance pool programs. These programs target individuals who cannot otherwise obtain or afford health insurance in the private health insurance market, primarily because of pre-existing health conditions. Many states also use their high-risk pools to provide access to health insurance to individuals eligible under the guaranteed issue and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). In general, high-risk pools are operated through state-established nonprofit organizations that contract with private insurance companies to collect premiums, administer benefits,

and pay claims. These programs tend to be small and enroll a small percentage of the uninsured.

Conference Agreement

The conference agreement would authorize and appropriate for FY2006 \$75 million for grants to help fund existing qualified state high risk pools and \$15 million for grants to assist states to create and initially fund qualified high risk pools. This funding would also apply upon the enactment of the State High Risk Pool Funding Extension Act of 2005.

Implementation Funding (6203)

Current Law

Medicare is administered by the Centers for Medicare and Medicaid Services Care and is financed through two trust funds – one for Hospital Insurance (HI) and one for Supplementary Medical Insurance (SMI). Medicaid is administered by CMS and is financed through general revenues.

Conference Agreement

The agreement provides that for purposes of implementing the provisions of and amendments made by the Medicare and Medicaid titles of the bill (V and VI respectively), the Secretary shall provide for the transfer in appropriate part from the HI and SMI trust funds of \$30 million, and another \$30 million from general Treasury funds to the Centers for Medicare and Medicaid Services Program Management Account for FY 2006.

House of Senate Provisions Not Included in the Conference Agreement

- Senate provisions establishing Medicare value-based purchasing programs.
- Senate provision to eliminate Medicare Advantage regional plan stabilization fund.
- Senate provision to cover marriage and family therapist services and mental health counselor services under Part B of Medicare.
- Senate provision to increase Medicaid drug rebate paid by single source and multiple source innovator drug manufacturers from 15.1% to 18.1% and on noninnovator drugs (generics) from 11% to 17%.
- Senate provision extending Medicaid drug rebates to managed care organizations.
- House and Senate provisions addressing outpatient drug dispensing fees.
- Senate provision establishing limitations on contingency fee arrangements between State Medicaid programs and administrative contractors.
- Senate provision to authorize a demonstration project regarding Medicaid coverage of low-income HIV infected individuals.
- Senate provision requiring podiatrists to be treated under Medicaid as they are under Medicare.
- Senate provision to authorize a demonstration project regarding Medicaid reimbursement for stabilization of emergency medical conditions of Medicaid-eligible individuals ages 21 to 64 by non-publicly owned institutions for mental diseases.
- The House provision requiring re-computation of Health Professional Shortage Areas, Medically Underserved Areas, and Medically Underserved Population designations within Hurricane Katrina affected areas.
- The House provision to waive certain requirements applicable to health care provided to Katrina impacted areas by Federally Qualified Health Centers and National Health Service Corps personnel.

Provisions Dropped Based on Procedural Objections in the Senate

In the debate on the Senate floor on final passage of the S. 1932 conference agreement, Senator Conrad raised a point of order regarding four provisions, which he claimed violated the "Byrd Rule" prohibiting inclusion of extraneous matters in a reconciliation bill. These provisions include:

- Section 6043 (provision to limit the liability of hospitals and physicians who require individuals to pay certain costs as a condition of receiving non-emergency care in hospital emergency rooms).
- Sections 5001(b)(3) and (b)(4) (provisions requiring Reports to Congress by the Secretary and MedPAC respectively on the Medicare value based purchasing program established under provisions included in the bill).
- Section 7404 (provision to make it harder for states to provide federally funded foster care benefits to certain relatives, such as grandparents, who are raising children because their parents are unable to do so).

Senator Gregg made a motion to waive the point of order raised against the bill based on the Byrd Rule, which requires 60 votes to succeed. The motion failed, 52-48. The Parliamentarian then ruled a point of order against three of the provisions - all except section 7404. Following the ruling by the Senate Parliamentarian, the Senate agreed to the conference agreement on December 21, 2005 by a vote of 51 to 50 with Vice President Cheney casting the tie-breaking vote.

As noted in the introduction to this document, the House has the option of either passing the amended Senate budget bill or heading back to conference if the Republican leaders want to reinstate the stripped provisions. The House will not take up the legislation until some time in January.

Preliminary CBO Estimate of Medicare.008 with modification discussed with staff:
Change oxygen rental period to 36 months
 by fiscal year, in billions of dollars

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006- 2010	2006- 2015
Title V: Medicare												
5001	0	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.8
5002	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-1.2	-3.0
5003	0	*	*	*	*	*	*	*	*	*	*	*
5004	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
5005	0	0.1	*	*	0	0	0	0	0	0	0.1	0.1
5006	*	*	0	0	0	0	0	0	0	0	*	*
5007	0	*	*	*	0	0	0	0	0	0	*	*
5008	0	0	*	*	*	0	0	0	0	0	*	*
5101	0	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.7	-1.9
5102	0	-0.5	-0.7	-0.8	-0.8	-0.9	-1.0	-1.1	-1.1	-1.2	-2.8	-8.1
5103	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.8
5104	1.5	2.3	2.2	1.6	-0.3	-1.6	-2.2	-1.9	-1.3	-0.7	7.3	-0.4
5105	*	*	*	*	0	0	0	0	0	0	0.1	0.1
5106	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.5	1.3
5107	0.5	0.1	*	*	0	0	0	0	0	0	0.5	0.5
5111	0	-0.2	-0.4	-0.6	-0.4	0	0	0	0	0	-1.6	-1.6
5112	0	*	*	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.2	1.3
5113	0	*	*	*	*	*	*	*	*	*	*	*
5114	*	*	*	*	*	*	*	*	*	*	*	*
5115	0	*	*	*	*	*	*	*	*	*	*	0.1
5201	-0.1	-0.4	-0.5	-0.5	-0.5	-0.6	-0.7	-0.7	-0.8	-0.9	-2.0	-5.7
5202	-0.1	*	*	*	*	*	*	*	*	*	-0.1	-0.1
5203	-5.2	5.2	0	0	0	0	0	0	0	0	0	0
5204	0.1	*	0	0	0	0	0	0	0	0	0.1	0.1
5301	0	0	-1.4	-2.1	-2.9	-3.0	-3.0	0.1	0.8	0.9	-6.5	-4.1
5302	*	*	*	*	*	*	*	*	*	*	*	0.1
Interactions with Medicare Advantage Payments	0	0.2	0.1	*	-0.4	-0.6	-0.7	-0.7	-0.6	-0.6	-0.1	-3.4
Interactions with Premium Receipts	0	-0.2	-0.2	-0.2	0.8	0.8	0.9	0.8	0.6	0.5	0.3	3.9
Total, Change in Direct Spending	-3.4	6.2	-1.2	-3.0	-5.0	-3.7	-3.9	-3.2	-2.8	-2.3	-6.4	-22.3

* = Costs or savings of less than \$50 million.

CBO's Estimate of the Budgetary Effects of Title VI of S. 1932, the Deficit Reduction Act of 2005

Based on the conference agreement available at http://www.rules.house.gov/109/text/s1932cr/109s1932_text.pdf.

Figures are outlays by fiscal year, in millions of dollars. Costs or savings of less than \$500,000 are noted with an asterisk.

Section	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-10	2006-15
Changes in Direct Spending												
SUBTITLE A – MEDICAID												
Chapter 1 – Prescription drugs												
6001	5	-645	-830	-965	-1,150	-1,280	-1,440	-1,625	-1,810	-2,020	-3,595	-11,760
6002	-5	-10	-20	-20	-20	-20	-15	-15	-15	-20	-70	-155
6003	0	-15	-35	-45	-55	-60	-70	-80	-95	-110	-150	-565
6004	-5	-10	-10	-10	-15	-15	-20	-20	-20	-25	-50	-150
Chapter 2 – Asset transfers												
6011	-125	-290	-290	-350	-420	-450	-470	-490	-520	-560	-1,475	-3,965
6012	-18	-50	-70	-70	-70	-80	-80	-80	-80	-80	-278	-898
6013	-9	-20	-20	-20	-20	-20	-20	-20	-20	-20	-89	-189
6014	-10	-50	-70	-80	-90	-90	-100	-120	-130	-140	-300	-880
6015	-9	-10	-20	-20	-20	-20	-20	-30	-30	-30	-79	-209
6016	-23	-23	-40	-45	-45	-45	-60	-60	-60	-70	-182	-477
6021	4	4	4	9	9	5	10	15	15	15	30	90
Chapter 3 – Fraud, waste, and abuse												
6032	0	1	-1	-7	-18	-32	-44	-60	-77	-96	-25	-333
6033	0	0	-1	-2	-4	-7	-9	-12	-16	-19	-7	-70
6034	*	*	*	*	*	*	*	*	*	*	*	*
6035	35	86	109	140	158	139	135	135	135	135	529	1,207
6036	-20	-70	-120	-170	-190	-200	-210	-220	-240	-260	-570	-1,700
6037	-5	-20	-45	-70	-80	-85	-95	-105	-110	-120	-220	-735
Chapter 4 – Cost sharing and benefits												
6041	-10	-60	-170	-300	-420	-540	-640	-710	-750	-820	-960	-4,420
6042	-20	-60	-150	-290	-440	-610	-780	-920	-990	-1,100	-990	-5,350
6043	5	10	5	0	-30	-40	-50	-60	-60	-70	-10	-290
6044	-30	-90	-250	-380	-500	-630	-780	-960	-1,150	-1,290	-1,250	-6,060
Chapter 5 – State financing												
6051	5	-15	-15	-20	-390	-430	-460	-500	-530	-560	-435	-2,835
6052	-30	-100	-180	-230	-220	-230	-250	-260	-280	-290	-760	-2,070
6053	65	60	0	0	0	0	0	0	0	0	125	125
6054	20	20	20	20	20	21	21	22	22	23	100	209
6055	20	28	29	31	32	33	35	37	38	40	140	323

(Continued)

CBO's Estimate of the Budgetary Effects of Title VI of S. 1932, the Deficit Reduction Act of 2005 (continued)

Based on the conference agreement available at http://www.rules.house.gov/109/text/s1932cr/109s1932_text.pdf.

Figures are outlays by fiscal year, in millions of dollars. Costs or savings of less than \$500,000 are noted with an asterisk.

Section	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-10	2006-15
Chapter 6 – Other provisions												
6062	0	10	140	510	720	860	930	1,000	1,080	1,170	1,360	6,420
6063	0	2	8	11	15	31	14	13	10	6	36	110
6064	0	2	3	4	2	*	*	0	0	0	0	11
6065	0	20	25	30	30	35	40	40	45	50	105	315
6071	0	5	30	95	210	375	435	375	275	175	340	1,975
6081	0	75	75	0	0	0	0	0	0	0	150	150
6082	5	11	16	16	16	25	35	40	50	55	64	269
6083	15	5	-15	-30	-30	-30	-35	-35	-40	-40	-55	-235
6084	139	645	69	6	2	1	0	0	0	0	761	762
6085	0	-10	-10	-15	-15	-15	-15	-15	-15	-20	-50	-130
6086	1	41	161	266	301	320	345	365	395	420	770	2,615
6087	0	5	20	35	40	45	50	50	55	60	100	360
Total, Subtitle A	0	-624	-1,643	-1,966	-2,686	-3,039	-3,613	-4,305	-4,918	-5,641	-6,919	-28,435
SUBTITLE B – SCHIP												
6101-03	170	-25	-30	-45	-50	-65	-65	-65	0	-60	20	-235
SUBTITLE C – KATRINA RELIEF												
6201	2,000	0	0	0	0	0	0	0	0	0	2,000	2,000
6202	40	40	0	0	0	0	0	0	0	0	80	80
6203	30	30	0	0	0	0	0	0	0	0	60	60
Total, Subtitle C	2,070	70	0	0	0	0	0	0	0	0	2,140	2,140
Net changes in direct spending	2,240	-579	-1,673	-2,011	-2,736	-3,104	-3,678	-4,370	-4,918	-5,701	-4,759	-26,530

Notes:

- CCRC = continuing care retirement community
- DSH = disproportionate share hospital
- FMAP = federal medical assistance percentage
- IGT = intergovernmental transfer
- MCO = managed care organization
- SCHIP = State Children's Health Insurance Program
- SSI = Supplemental Security Income
- TMA = transitional medical assistance

Changes in budget authority would be identical to the estimated changes in outlays for all provisions except sections 6035, 6043, 6063, 6064, 6071, 6084, 6102, 6103, 6202, and 6203.