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Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions

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January 26, 2006

Abstract. The House and Senate approved the conference report (H.Rept. 109-62) on H.Con.Res. 95, the Concurrent Resolution on the FY2006 Budget, on April 28, 2005. The Senate Committee on Finance was instructed to meet a budget reconciliation target of $10 billion in direct spending savings over a five-year period, FY2006- FY2010. On October 25, 2005, the Senate Finance Committee reported its reconciliation proposal to the Senate Budget Committee, which subsequently incorporated the proposal into S. 1932, The Deficit Reduction Omnibus Reconciliation Act of 2005. In the House, the Committee on Energy and Commerce had budget reconciliation instructions that specified a mandatory savings target of $14.734 billion between FY2006 and FY2010. The Committee's recommendations were incorporated into the House Budget Committee's bill, The Deficit Reduction Act of 2005. The House passed its version of the bill on November 18, 2005.

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Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions

Summary

The House and Senate approved the conference report (H.Rept. 109-62) on H.Con.Res. 95, the Concurrent Resolution on the FY2006 Budget, on April 28, 2005. The Senate Committee on Finance was instructed to meet a budget reconciliation target of $10 billion in direct spending savings over a five-year period, FY2006-FY2010. On October 25, 2005, the Senate Finance Committee reported its reconciliation proposal to the Senate Budget Committee, which subsequently incorporated the proposal into S. 1932, The Deficit Reduction Omnibus Reconciliation Act of 2005. In the House, the Committee on Energy and Commerce had budget reconciliation instructions that specified a mandatory savings target of $14.734 billion between FY2006 and FY2010. The Committee's recommendations were incorporated into the House Budget Committee's bill, The Deficit Reduction Act of 2005. The House passed its version of the bill on November 18, 2005.

The Senate bill proposes changes to Medicaid, the State Children's Health Insurance program (SCHIP), and Medicare. Based on Congressional Budget Office (CBO) estimates, the largest Medicaid savings amounts are the result of changes in the reimbursement of outpatient prescription drugs. Other areas of Medicaid savings include changes to some asset transfer rules for Medicaid-eligible individuals applying for long-term care services and changes to the Medicaid program designed to combat fraud, waste, and abuse. Increases in Medicaid spending would largely result from temporary federal medical assistance percentage (FMAP) increases targeted to help Medicaid recipients from selected Louisiana parishes and counties in Alabama and Mississippi devastated by Hurricane Katrina, and also from the limiting of any FY2006-FY2007 FMAP decrease to Alaska and the re-computation of FMAPs for FY2006. The bill includes a number of Medicaid demonstration projects and some benefit and eligibility expansions. The proposal would alter the method for redistribution of SCHIP funds to the states. Medicare savings would result from changes in Medicare's Part C (Medicare Advantage) and the establishment of variations in provider payments that reflect quality differences (value-based purchasing, or "pay for performance"). The proposal would also provide for a 1% Medicare payment update for physicians in 2006.

The House bill's health program provisions are largely limited to changes in the Medicaid program. The House bill achieves its largest savings with cost-sharing and benefit changes. The bill also foresees savings from changes in prescription drug reimbursement and asset transfer rules. Increased spending provisions are focused on long-term care service benefits, the establishment of health opportunity account demonstrations, and Hurricane Katrina health program relief.

On December 19, 2006 the House agreed to a conference report on S. 1932. However, the Senate amended the report. The amended agreement passed the Senate on December 21, 2006, and was returned to the House for further action. It is expected that the agreement will be taken up in the early part of the session.

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FY2006 Budget Reconciliation Targets

The House and Senate approved the conference report (H.Rept. 109-62) on H.Con.Res. 95, the Concurrent Resolution on the FY2006 Budget, on April 28, 2005. The annual concurrent resolution on the budget sets forth the congressional budget. When the federal deficit is expected to be large, budget resolutions often require reductions in mandatory spending. In such instances, the budget resolution includes reconciliation instructions that require authorizing committees to report changes to legislation to reduce spending on mandatory programs under their jurisdictions. The FY2006 budget resolution includes reconciliation instructions that direct authorizing committees to report legislation to reduce mandatory spending for the FY2006-FY2010 period. Subsequently, these proposals are to be combined in a single reconciliation bill by each of the House and Senate Budget Committees.

The Senate Committee on Finance was instructed to meet a budget reconciliation target of $10 billion in mandatory spending savings over the five-year period. On October 25, 2005, the Senate Finance Committee reported its reconciliation proposal to the Senate Budget Committee, which subsequently incorporated the proposal into S. 1932, The Deficit Reduction Omnibus Reconciliation Act of 2005. The Finance Committee met its reconciliation instruction by making changes in Medicaid, Medicare, and the State Children's Health Insurance program (SCHIP). In the House, the Committee on Energy and Commerce had budget reconciliation instructions specifying a mandatory savings target of $14.734 billion between FY2006 and FY2010. The Energy and Commerce Committee mark-up took place on October 27, 2005. In the health care area, its recommendations resulted in changes in Medicaid. The Committee's recommendations were incorporated into the House Budget Committee bill, H.R. 4241, the Deficit Reduction Act of 2005, and reported on November 7, 2005.

A budget reconciliation conference agreement on S. 1932 was filed on December 19, 2005. The House agreed to the report by a vote of 212-206 that day. On December 21, the Senate removed extraneous provisions form the legislation pursuant to a point of order raised under the "Byrd rule," passed the amended agreement and returned the measure to the House. Final action on the conference agreement is expected when the House reconvenes later this month.

Senate Bill

Like a number of Senate committees, the Senate Committee on Finance achieves its reconciliation instruction budget mark through recommended program changes that result in both direct spending increases and decreases. The Committee's Medicaid saving proposals include (a) changes in the payment methods for prescription drugs; (b) changes in eligibility and benefit rules for long-term care services; (c) changes in the program's approach to limit fraud; and, (d) changes in some components of state Medicaid financing. The Finance Committee also recommended a number of changes that would result in Medicaid spending increases. These proposals include (a) temporary financial relief for Medicaid costs of individuals who resided prior to Hurricane Katrina in selected parishes in Louisiana and counties in Alabama and Mississippi, and a provision not to allow Alaska's federal medical assistance percentage to fall below its FY2005 level; (b) an increase in the disproportionate share hospital payment allotment in the District of Columbia; and (c) a number of demonstrations and program expansions.

The legislation also contains several provisions that affect the State Children's Health Insurance Program (SCHIP), including (1) provisions to redistribute unspent FY2003-through-FY2005 original allotments to states that fully spent their original allotments, and (2) to prohibit additional states from using SCHIP funds to cover childless adults. The Medicare provisions include both direct spending savings and increases. The three major areas of Committee recommendations include (a) changes to the Medicare Advantage component of Medicare; (b) the development of value-based reimbursement for Medicare providers; and (c) a 1% update for physician reimbursement rates in 2006. The Finance Committee provisions include a number of other Medicare-related provisions.

Based on Congressional Budget Office (CBO) estimates, changes in the Medicare program would amount to $5.7 billion in savings from FY2006 to FY2010; changes in the Medicaid and the SCHIP program would amount to $4.3 billion in savings over the period.[1] The change in Medicare's payment for physician services would result in a $10.8 billion increase over the five-year period. But this would be offset by $12 billion in Medicare Advantage plan savings, and an additional $4.5 billion in savings from value-based purchasing. A temporary increase in federal medical assistance percentage (FMAP) payment rates for individuals in selected Louisiana parishes and counties in Alabama and Mississippi affected by Hurricane Katrina would increase Medicaid spending by $1.8 billion. The largest Medicaid savings proposal is the result of changes in the reimbursement for outpatient prescription drugs. The Finance Committee proposals result in a $6.3 billion reduction over the five-year period.

The health provisions in the Senate Finance Committee proposal were modified by several floor amendments. The amendments included changes that (1) would require that FY2006 FMAPs would be recalculated, and it would limit any reductions

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[1] Congressional Budget Office Cost Estimate, Reconciliation, *Recommendations of the Senate Committee on Finance*, as approved by the Senate Committee on Finance on Oct. 25, 2005.

in a State's FY2006 FMAP rate. The estimated increased cost of this provision would be offset by extending outpatient prescription drug rebates to most managed care organizations. Other amendments would 1) authorize the continued provision of certain adult day health care services or medical adult day care services under a State Medicaid plan; (2) exclude discounts provided to mail order and nursing facility pharmacies from the determination of average manufacturer price and to extend the discounts offered under fee-for-service Medicaid for prescription drugs to managed care organizations; (3) amend Medicare to make a technical correction regarding purchase agreements for powerdriven wheelchairs, provide for coverage of ultrasound screening for abdominal aortic aneurysms under part B, improve patient access to, and utilization of, the colorectal cancer screening benefit, and provide for the coverage of marriage and family therapist services and mental health counselor services under part B of such title; (4) modify the quality measurement system defined in the Medicare value-based purchasing section of the proposal; (5) provide for a Medicaid demonstration project for low-income HIV-infected individuals; and (6) modify the Federal Upper Payment limit for independent pharmacies located in rural and frontier areas. Information on these amendments are incorporated in the Senate bill provision descriptions.

Medicaid

Medicaid Outpatient Prescription Drugs

The major Medicaid outpatient prescription drug provisions alter the upper limits that apply to federal reimbursement of state spending on prescription drugs, alter the formulas for calculating the rebates that prescription drug manufacturers are required to pay to states, and establish special reporting requirements for the prices of certain "authorized" generic drugs and certain outpatient drugs administered in physicians' offices.

Federal Upper Limits. Under current law, state Medicaid programs set the prices paid to pharmacies for Medicaid outpatient drugs. Federal reimbursements for those drugs, however, are limited to a federal upper limit (FUL). The FUL that applies to drugs available from multiple sources (generic drugs, for the most part) is calculated by the Centers for Medicare and Medicaid Services (CMS) to be equal to 150% of the lowest published average wholesale price (AWP) for the least costly therapeutic equivalent. The upper limit that applies to brand-name and other drugs is equal to the acquisition cost as estimated by the states.

The Senate bill would replace the current FUL requirement so that state payments for single source drugs provided in pharmacies that are not critical access pharmacies would qualify for federal reimbursement up to 105% of the average manufacturer price (AMP) as reported to CMS by the manufacturers. FULs for multiple source drugs provided in pharmacies that are not critical access pharmacies would be equal to 115% of the weighted AMP for those drugs. State payments for single source drugs provided in critical access retail pharmacies would qualify for federal reimbursement up to the lesser of 108% of the AMP or the wholesale acquisition cost for the drug. FULs for multiple source drugs provided in critical

access pharmacies would qualify for federal reimbursement up to the lesser of 140% of the AMP or the wholesale acquisition cost for the drug. Critical access retail pharmacies are defined as those retail pharmacies that are not within 20 miles of any other retail pharmacy. In addition, the bill includes interim upper payment limits that would apply during calendar year 2006, before the new FULs become effective..

In addition, this section of the bill would modify the definitions of the prices that manufacturers are currently required to provide to CMS. The definition of AMP, an important price point for calculating Medicaid drug rebates and for the proposed FULs, would become more specified than under current law. For example, one of the new specifications would direct manufacturers to include cash and volume discounts in the computation of AMP. The bill would also define weighted AMP for the purpose of calculating FULs for multiple source drugs, and would establish that dispensing fees for multiple source drugs may be higher than those for single source drugs.

Rebates. Under current law, prescription drug manufacturers that participate in the Medicaid program are required to pay rebates to states for drugs provided to Medicaid beneficiaries for which fee for service payments are required. The rebates are calculated based on a formula in statute. For single source and "innovator" multiple source drugs (those drugs that had formerly been sold under a patent, but are now off patent) basic rebates are equal to the greater of 15.1% of the AMP or the difference between the reported AMP and the best price for each drug. The rebate for all other multiple source drugs is equal to 11% of the AMP. The Senate bill makes two major changes to Medicaid rebate policy. The bill would require manufacturers to begin paying rebates for drugs provided to Medicaid beneficiaries who are enrolled in most managed care organizations and would raise the rebate percentages for all drugs. The basic rebate for single source and innovator multiple source drugs would be raised to the greater of 18.1% of the AMP or the difference between the reported AMP and the best price for each drug. The rebate for all other multiple source drugs would be raised to 17% of the AMP. States would have the option of collecting rebates from pharmaceutical manufacturers for those drugs provided to enrollees of MCOs, or alternatively, allowing the MCOs to collect the rebates in exchange for reduced MCO payment rates.

Authorized Generics and Physician-Administered Drugs. Authorized generic drugs are generics that are produced by the same manufacturer that produces the brand-name version of the drug; or by a different manufacturer with the authorization of the manufacturer that holds the patent on the brand-name version. The Senate bill would establish a requirement that a manufacturer reporting the AMP and best price for a brand-name product must also include the prices at which authorized generic versions are sold. This provision is estimated to increase rebates that result in savings to the Medicaid program, since authorized generic drugs are generally less expensive than brand-name versions of the same drug. In addition, the bill would require states to provide utilization and coding information to CMS for physician-administered outpatient drugs. This would improve the ability of CMS to ensure manufacturers pay rebates for those drugs.

Long-Term Care Under Medicaid

Medicaid is a means-tested program. Current law regarding eligibility, asset transfers, and estate recovery are designed to restrict access to Medicaid's long-term care services to people who are poor or have very high medical or long-term care expenses, and who apply their income and assets toward the cost of their care. Under current law, states must impose penalties on individuals applying for Medicaid who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair-market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, states must delay Medicaid eligibility for individuals receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings who have transferred assets for less than fair-market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

Calculating the Length of the Penalty Period. The length of the delay in Medicaid eligibility is determined by dividing the total cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. States use different methods for counting transfers and determining the length of a penalty period when more than one transfer is made during a limited time period. The Senate bill would impose certain requirements on how these calculations would be made in an attempt to ensure that such calculations result in longer, rather than shorter, penalty periods. Specifically, the provisions would (1) require states to count cumulative transfers (transfers made during *different* months) as one transfer, and (2) prohibit states from rounding down to shorten the penalty period.

Changing Non-Countable Assets to Countable Assets. Not all assets that an applicant may have are counted for the purposes of determining an applicant's eligibility for Medicaid long-term care services, or for determining if a transfer for less than fair-market value has been made — states generally follow rules established by the Supplemental Security Income (SSI) program for counting income and assets of applicants. Provisions in the Senate bill would change the status of certain types of assets from non-countable (or exempt) assets to countable assets to decrease the ways in which individuals might protect assets to meet Medicaid's means-testing requirements sooner than they otherwise would. Under this proposal, certain types of assets that are currently exempt, including certain types of annuities, promissory notes, loans, mortgages, and life estates, would be counted for the purposes of Medicaid eligibility determinations. The bill would also require that states treat the purchase of an annuity 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 (or in the second position after the community spouse) for at least the total amount of Medicaid expenditures paid on behalf of the annuitant.

Undue Hardship Waivers. To protect beneficiaries from unintended consequences of asset transfer penalties, current law requires states to establish procedures for waiving penalties for persons who, according to criteria established

by the Secretary, show that a penalty would impose an undue hardship. The ways in which states implement this requirement vary significantly by state. Whereas a few states have formal application processes and specified eligibility criteria to apply to each application, most states have informal methods for evaluating each application and no formal method for notifying applicants of the availability of undue hardship waivers. The Senate bill would impose requirements on state practices to formalize and standardize the waiver application process. The bill would specify criteria that states would use to determine eligibility for a waiver and require states to provide notice to applicants about the availability of undue hardship waivers.

Medicaid Estate Recovery. Current law requires states to recover the private assets (e.g., countable and non-countable assets) of the estates of deceased beneficiaries who have received certain long-term care services. Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21 and no surviving child who is blind or has a disability. Estate recovery is limited to the amounts paid by Medicaid for services received by the individual and is limited only to certain assets that remain in the estate of the beneficiary upon his or her death. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate. The Senate provision would make any remaining balance of an annuity subject to recovery by the state after a beneficiary's death.

Long-Term Care Insurance Partnership Program. Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) 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-eligible individuals. 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. Under current law, these provisions are limited to selected states.[2]

The Senate Committee's provision would allow additional states to implement long-term care partnership programs as long as the state long-term care insurance programs would provide for the disregard of assets in an amount equal to the amount of payments made to, or on behalf of, the LTC insurance policyholder. Long-term care partnership programs would be required to meet certain requirements. The Senate's bill would also require LTC insurance partnership programs already in existence to meet most of the specified requirements on or after two years after enactment.

[2] Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66) allows states with an approved state plan amendment as of May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval for such exemptions. All of these states, except Iowa, have implemented partnership programs.

LTC insurance policies sold under the LTC insurance partnership plan would be required to meet certain requirements specified in the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act. In addition, the Secretary, in consultation with specified entities, would be required to develop uniform standards for reciprocity, minimum reporting requirements, suitability, incontestability, nonforfeiture, independent certification for benefits assessment, rating requirements, and dispute resolution.

Fraud, Waste, and Abuse

Third Party Liability. With certain exceptions, Medicaid is a payer of last resort, meaning that states must ascertain the legal liability of third parties to pay for Medicaid care and services. They must also seek reimbursement for Medicaid costs from third parties when necessary. Examples of potentially liable third parties specified in current Medicaid law include health insurers, group health plans, service benefit plans, and health maintenance organizations. With respect to third-party liability, the Senate bill would clarify the right of states to obtain reimbursement from specific third parties — self-insured plans and pharmacy benefit managers — that are legally responsible for payment of claims for health care items or services provided to Medicaid beneficiaries. The bill would also require each state to have laws that in effect require third parties to provide eligibility and claims payment data for Medicaid-eligible individuals and to cooperate with payment and recovery efforts by Medicaid.

Medicaid Integrity Program. Under current law, states and the federal government — acting primarily through CMS and the Office of Inspector General within the Department of Health and Human Services (HHS) — share in the responsibility for safeguarding Medicaid program integrity. The Senate bill would establish a Medicaid Integrity Program, under which entities that meet certain contracting requirements (modeled after the Medicare Integrity Program) would review the actions of Medicaid providers, audit claims for payment, identify and recover overpayments, and provide education on payment integrity and benefit quality assurance issues. Appropriations for the Medicaid Integrity Program would total $50 million in FY2006, $49 million in each of FY2007 and FY2008, $74 million in each of FY2009 and FY2010, and $75 million in FY2011 and beyond. A Medicaid Chief Financial Officer and Medicaid Integrity Program Oversight Board would also be established, and an additional $25 million would be appropriated in each of FY2006-FY2010 for Medicaid activities of the Office of Inspector General in HHS.

Other Provisions. Other fraud, waste, and abuse provisions in the Senate bill would require states to adhere to compensation standards for Medicaid consultants and other contractors issued by the Inspector General of HHS; encourage states to enact laws modeled after the federal False Claims Act by decreasing the percentage of Medicaid amounts recovered under such laws that must be repaid to the federal government; require that any entity receiving annual Medicaid payments of $1 million or more educate its employees about state and federal false-claims laws, whistle-blower protections, and policies and procedures for detecting fraud, waste, and abuse; and prohibit states from billing Medicaid twice for the same drugs.

State Financing and Medicaid

Temporary FMAP Increases. Two provisions in the Senate bill would affect federal Medicaid reimbursement for states. First, for items and services furnished between August 28, 2005 and May 15, 2006, states would receive 100% reimbursement for Medicaid assistance provided to individuals who resided prior to Hurricane Katrina in one of the parishes in Louisiana or counties in Mississippi and Alabama specified in the bill. Costs directly attributable to related administrative activities would also be reimbursed at 100%. Second, the bill would provide that if Alaska's calculated federal medical assistance percentage (FMAP, which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average and vice versa) for FY2006 or FY2007 is less than its FY2005 FMAP, the FY2005 FMAP shall apply.

Managed Care Organization Provider Tax Reform. States sometimes raise their share of Medicaid program costs by establishing provider taxes that federal law requires to be broad based. The statute defines broad based taxes as those that apply to all providers within a class of providers. Two examples of classes of providers are hospitals and physicians. One of the classes of providers that current law allows a state provider tax to apply to is Medicaid managed care organizations. The Senate bill would modify this class of providers (both Medicaid and non-Medicaid) to encompass all managed care organizations, so that, in the future, these taxes would be required to be more broad than are allowed under current law. States with existing provider specific taxes levied against Medicaid managed care organizations would be allowed to keep those taxes.

Disproportionate Share Hospital Allotment for the District of Columbia. Medicaid requires states to make payments to hospitals that treat disproportionate numbers of Medicaid beneficiaries and those who cannot pay for their care. The Senate bill would increase allotments for the District of Columbia for making such disproportionate share hospital (DSH) payments. The increased allotments would become available on October 1, 2005.

Changes to Medicaid Targeted Case Management Benefit. Targeted case management (TCM) is an optional benefit under the Medicaid state plan that is designed to help Medicaid beneficiaries access needed medical, social, educational, and other services. States that cover the TCM service do not have to offer the benefit statewide and can limit the service to specific groups of Medicaid beneficiaries (e.g., those with chronic mental illness). Several states extend the TCM services to individuals who may also be receiving certain case management services as part of another state and/or federal program (e.g., foster care, juvenile justice).

This proposal would clarify the activities that can be considered a TCM service, and those activities (primarily foster care-related activities) that may not be reimbursed as TCM services. The proposal also states that Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. The proposal would take effect January 1, 2006.

Inclusion of Podiatrists as Physicians. Currently, states may provide Medicaid coverage for podiatrist services under an optional benefit category of "other practitioners." In contrast, physician services are a mandatory Medicaid benefit. The proposal would treat podiatrists as physicians, as is the case under Medicare, thereby making it mandatory for states to provide Medicaid coverage for the medical services of podiatrists.

Demonstration Project Providing Medicaid Coverage for Institutions for Mental Disease to Stabilize Emergency Medical Conditions. Current law prohibits Medicaid payments for residents of an Institution for Mental Disease (IMD) between the ages of 22 and 64. This proposal would require the Secretary of HHS to establish a three-year demonstration project in eligible states to provide Medicaid coverage for IMD services (not publicly-owned or operated) for Medicaid eligible individuals who are between the ages of 21 and 64, and who require IMD services to stabilize an emergency medical condition. Eligible states include Arizona, Arkansas, Louisiana, Maine, North Dakota, Wyoming, and four additional states to be selected by the Secretary. The proposal appropriates $30 million for FY2006 for the demonstration which would be available through December 31, 2008. The proposal also requires the Secretary to submit annual and final reports to Congress regarding the progress of the demonstration project.

Limitation on FMAP Reduction. The federal medical assistance percentage (FMAP), which has a statutory minimum of 50% and maximum of 83%, is the rate at which states are reimbursed for most Medicaid service expenditures. An enhanced FMAP is available for both services and administration under 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 (usually in the preceding November), the state and U.S. per capita personal income 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). When BEA undertakes a comprehensive revision of its income data (reflecting methodological and other changes) every few years, there may be upward and downward revisions to each of the component parts of personal income (e.g., wages and salaries, supplements to wages and salaries such as employer contributions for employee pension and insurance funds, etc.). To calculate FMAPs for FY2006, HHS used per capita personal income data for 2001, 2002, and 2003 that reflected BEA's latest comprehensive revision. Under the Senate bill, FY2006 FMAPs would be re-computed so that no FY2006 FMAP would be less than the greater of (1) a state's FY2005 FMAP minus 0.5 percentage points (0.1 in the case of Delaware and Michigan, 0.3 in the case of Kentucky) or (2) the FY2006 FMAP that would have been determined for a state if per capita incomes for 2001 and 2002 that were used to calculate the state's FY2005 FMAP (i.e., pre-revision BEA data, which are not available for 2003) were used.

Authority to Continue Providing Certain Adult Day Health Care Services or Medical Adult Day Care Services. Adult day care services are generally community-based daytime programs for adults with disabilities or chronic conditions that provide health, social, and related support services in a setting outside the person's home. Most states currently offer these services to Medicaid beneficiaries through the rehabilitation or clinic benefits of the Medicaid state plan

(in approximately 10 states) or, more commonly, through a home and community-based (HCBS) waiver under Section 1915(c) of the Social Security Act (in approximately 44 states through 102 HCBS separate waiver programs).[3] Because states define the state plan service criteria and tailor the HCBS waivers to specific groups of beneficiaries, states offer adult day care services under *both* the state plan and HCBS waiver(s) or under multiple HCBS waivers.

The way in which a state covers a Medicaid benefit makes a difference in terms of who can receive the benefit and what administrative steps may be necessary. The Medicaid state plan must be available statewide, and individuals who need the service are entitled to receive it. The HCBS waiver program, on the other hand, can be limited by the state, both in the number of people covered and its statewide availability. In addition, the HCBS waiver program is designed as an alternative to institutions (i.e., nursing home, hospital or intermediate care facility for those with mental retardation) and must meet a cost-neutrality provision (on average, the per-person cost of the HCBS waiver can not exceed the per-person cost of a comparable institution). This provision would prohibit the Secretary of HHS from denying federal Medicaid funding or withdrawing federal approval for adult day health care services or medical adult day care services under the Medicaid state plan, as defined by the state and approved by the Secretary on or before 1982.

Demonstration Project Regarding Medicaid Coverage of Low-Income HIV-Infected Individuals. Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid program. Among other projects, the Secretary has used the Section 1115 waiver authority to approve benefit-specific demonstrations that provide targeted services to certain individuals so as to divert them from full Medicaid eligibility. For example, under existing HIV/AIDS demonstration waivers, the Secretary approved programs that provide a limited set of Medicaid benefits (e.g., case management, and pharmacy services) to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid. Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or SCHIP) state plan for purposes of federal reimbursement. Project costs associated with waiver programs are subject to that state's FMAP. Unlike regular Medicaid, CMS waiver guidance specifies that costs associated with waiver programs must be budget neutral to the federal government over the life of the waiver program. The federal and state government negotiate a budget neutrality spending cap beyond which the federal government has no fiscal responsibility.

This section of the bill would require the Secretary to allow states to seek approval for five-year Section 1115 demonstration projects that provide full Medicaid medical assistance coverage to specified HIV-infected individuals. For fiscal years 2006 through 2010 only, $450,000,000 in federal funds would be appropriated for such demonstrations. From these federal funds, the Secretary would allocate money to states and territories (without regard to existing federal Medicaid spending caps) with approved HIV Section 1115 demonstrations based on the

[3] CRS analysis of Medicaid state chart as published by CCH: Internet Research Network and the Home- and Community-based waiver database from the Centers for Medicare and Medicaid Services, July 2003.

availability of such funds. Allotment of funds among states and territories with approved demonstrations would be equal to the state's enhanced federal medical assistance percentage (enhanced-FMAP) for quarterly expenditures associated with medical assistance provided to individuals under the waiver up to the specified cap. Not later than December 31, 2010, the Secretary would be required to submit a report to Congress evaluating the cost-effectiveness and the impacts of the demonstrations on the Medicare, Medicaid, and Supplemental Security Income programs. This provision would be effective on January 1, 2006.

Improving the Medicaid and State Children's Health Insurance Programs

Family Opportunity Act. This provision would create a new optional Medicaid eligibility group for children with disabilities up to age 18 who meet the severity of disability required under the Supplemental Security Income (SSI) program, but whose family income is above the financial standards for SSI but below 300% of the federal poverty level (FPL). Under current law, children with disabilities have generally had to qualify for Medicaid using an income standard that is lower than 300% of FPL. Medicaid coverage for this optional group would be initially effective January 1, 2008 and would be fully phased in starting in FY2010. Within certain limits, states would be permitted to charge monthly premiums (based on income) and other cost-sharing fees under this new group. Finally, under this option, states must require the parents of Medicaid beneficiaries to enroll in any available employer-sponsored private insurance meeting certain criteria.

Demonstration Projects Regarding Home- and Community-Based Alternative to Psychiatric Residential Treatment Facilities for Children. This proposal would establish a five-year demonstration project in which up to 10 states could provide a broad range of home- and community-based services to children who would otherwise require services in a psychiatric residential treatment facility. Though these types of home- and community-based services are often allowed for other types of disability groups (e.g., children with developmental disabilities) under Section 1915(c) waivers of the Social Security Act, the waiver requirements prohibit states from developing home- and community-based services as an alternative to a psychiatric residential treatment facility. The demonstration would test the effectiveness of improving or maintaining the child's functional level, and the cost-effectiveness of providing these types of services as an alternative to psychiatric residential treatment services. These projects must also follow the existing requirements of the Section 1915(c) waiver. The demonstration project must be budget neutral and there must be an assurance that an interim and final evaluations will be conducted by an independent third party. The Secretary will also be required to complete evaluations of the project and report the findings to Congress. This proposal would authorize a total of $218 million for FY2007-FY2011 to carry out the demonstration.

Development and Support of Family-to-Family Health Information. This proposal would increase funding under the Special Projects of Regional and National Significance program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) for the development and support of new

family-to-family health information centers. These family-to-family health information centers would assist families of children with disabilities to make informed decisions about health care options and available resources. The proposal would appropriate a total of $12 million for FY2007-FY2009, and would authorize an additional $5 million, each year, for FY2010 and FY2011. 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. The provision 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. Currently, SSI and Medicaid eligibility is effective on the first day of the month *following* the dates specified above. This provision would be effective one year after the date of enactment.

Grants to Promote Innovative Outreach and Enrollment Under Medicaid and SCHIP. The provision would establish a new grant program under SCHIP to finance outreach and enrollment efforts to increase the participation of eligible children in both SCHIP and Medicaid. Currently, SCHIP administrative activities, which include outreach, cannot exceed 10% of total SCHIP expenditures. Various entities would be eligible to receive these grants, such as: state or local governments, Indian tribes, schools, non-profit organizations, and certain faith-based organizations. The proposal specifies several criteria the Secretary must use to prioritize grant awards, for example, entities that target geographic areas where there are a large number of eligible but not enrolled children. The provision would appropriate $25 million for FY2007 for these grants; 10% of the appropriation would be for grants to certain organizations that specifically provide health care services to Indian children.

Money Follows the Person Rebalancing Demonstration. The proposal would authorize the Secretary to award demonstration projects to states that provide 90% federal Medicaid reimbursement for home- and community-based long-term care services for 12 months for certain individuals relocating from an institution into the community. To participate in the demonstration, a person must be a Medicaid beneficiary who is residing in a hospital, nursing facility, intermediate care facility for a person with mental retardation, or an institution for mental disease (IMD) (to the extent that IMD services are covered in the state), and must have resided there for six months (up to a maximum of two years, as specified by the state).

State demonstrations must operate for at least two years in a five-year period starting in FY2007, and services for individuals must continue following the demonstration, so long as the person remains eligible for these services. States must also take steps to eliminate barriers to using Medicaid funding to provide long-term care services in the setting of a person's choosing, and meet maintenance of effort requirements. The Secretary would be required to provide technical assistance and oversight to state grantees and conduct and report the findings of a national evaluation. This proposal would appropriate $1.75 billion from January 1, 2009 through FY2013 (September 30, 2013) to carry out the demonstration.

State Children's Health Insurance Program (SCHIP)

Under current law, each state's federal SCHIP annual allotment is available for three years. At the end of the three-year period of availability, the unspent funds from the original allotment are reallocated based on methodologies that vary depending on the fiscal year. Unspent original allotments from FY2003 forward are to be redistributed according to the original Balanced Budget Act of 1997 (BBA97) methodology. That is, redistributed funds will go only to those states that spend all of their original allotments by the applicable three-year deadline, with the redistributed amounts determined by the Secretary of HHS and made available for one year only.

The provision would reduce the period of availability of the FY2004 and FY2005 original allotments from three years to two years, and would specify rules for the reallocation of unspent FY2003, FY2004, and FY2005 SCHIP original allotments. The reallocated FY2003 and FY2004 funds would be available in FY2006; the reallocated FY2005 funds would be available in FY2007. The proposal is projected to eliminate state shortfalls in FY2006. The proposal is projected to nearly eliminate state shortfalls in FY2007. Each of the 15 states expected to face a shortfall in FY2007 under the proposal would still be able to cover at least 97% of their federal SCHIP demand.

In addition, the provision would limit the types of payments that could be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the FY2003, FY2004, and FY2005 redistributed funds available to shortfall states. Specifically, the enhanced FMAP would be available for "targeted low-income children" but all other SCHIP expenses, such as, benefit expenditures for adults (other than pregnant women) would be matched at the regular FMAP. The provision would also limit the Secretary of HHS's Section 1115 waiver authority by prohibiting the approval of demonstration projects that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. Finally, the proposal would permit the 11 qualifying states to use FY2004 and FY2005 funds under the 20% allowance, and would permit all states to use up to 10% of their FY2006 and FY2007 original allotments for expenditures on outreach activities incurred during FY2006 and FY2007 respectively.

Medicare

Physicians

Physicians are paid under the fee schedule which assigns relative values to services based on physician work, practice expense costs and malpractice costs. The relative values are then adjusted for geographic variations in costs. These adjusted relative values are converted into dollar payment amounts by a conversion factor. The conversion factor is updated annually according to a complex formula specified in the law. CMS has announced that the update for 2006 will be a *negative* 4.4%. The bill would override the formula by setting a minimum update for 2006 at a *positive* 1%.

Medicare Value-Based Purchasing Programs

The Medicare statute would be amended to establish value-based purchasing systems for each of the different Medicare providers. There would be separate value-based purchasing programs for hospitals, physicians and other practitioners, Medicare managed health care plans, ESRD providers and facilities, home health agencies, and skilled nursing facilities. Medicare payments to providers currently are not based on any measures of quality. The value-based purchasing programs, sometimes referred to as "pay-for-performance" programs, would introduce variations in provider payments reflecting differences in measured quality. Although the specifics of each program differ in the details, they all share some general principles:

- The value-based purchasing programs would begin collecting data on quality measures in the initial year of establishment, with incentive payments disbursed in subsequent years. Data from the initial year would be used to inform providers what their payments would have been for the year had the value-based purchasing program already been in place.

- Each value-based purchasing program would create an incentive pool funded by withholding up to 2% of total payments to that category of provider. The percentage of funds that goes towards the incentive pool would not decrease over time, and all funds collected for the incentive pool must be paid to providers as incentive payments.

- Participation in the value-based purchasing program would be voluntary, but providers would be required to report quality data in order to be eligible for incentive payments.

- Incentive payments would be paid to providers who meet certain thresholds for quality measurement. These thresholds would be based on either relative or absolute standards.

- The quality measures would be specific to each category of providers and would be revised over time, but the measures would be required to be evidence-based, easy to collect and report, address process, structure, outcomes, beneficiary experience, efficiency, over- and underuse of health care and to address disparities in health care provided and health outcomes between majority and minority groups. In the initial year, the measures would include at least one measure of health information technology infrastructure.

Because all the funds collected under the value-based purchasing programs would be paid out as incentive payments, the total payments over time would not change as a result of these provisions, but the timing of the incentive payments would be delayed a year compared to payments made in the absence of the value-based purchasing programs.

Medicare Advantage

Under Medicare Advantage (MA), Part C of the Medicare program, private health plans agree to provide Medicare covered benefits to beneficiaries who enroll in their plans. MA plans are paid a per capita monthly fee for providing all required Part A and Part B services to each plan enrollee, regardless of the amount of services used. An MA plan's per capita payment is adjusted to reflect the higher health care use of sicker enrollees. Though payments to plans are risk adjusted based on the demographics and health history of each enrollee, the risk adjustment method is imperfect and cannot account for all of the variation in health care use.

Phase-Out of Risk Adjustment Budget Neutrality. Medicare payments to private plans under the Medicare Advantage program are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. Congress urged the Secretary of HHS to implement risk adjustment without reducing overall payments to plans. The Secretary applied a budget neutrality adjustment to the risk adjusted rates to keep them from being reduced overall.

This provision directs the Secretary to (1) change the way the MA benchmarks are calculated to, in part, exclude budget neutrality, and (2) phase-out the budget-neutral implementation of risk adjustment. Overall, these changes will lower payments to plans. Budget neutrality is to be completely phased-out by 2011.

Elimination of Stabilization Fund. The Secretary is to establish an MA Regional Plan Stabilization Fund to provide incentives for plan entry in each region and plan retention in certain MA regions with below average MA penetration. Initially, $10 billion is to be available for expenditures from the fund beginning on January 1, 2007 and ending on December 31, 2013. Additional funds are to be available in an amount equal to 12.5% of average per capita monthly savings from regional plans that bid below the benchmark. The section which created this fund under the Medicare Modernization Act is repealed.

Other Medicare Provisions

The Senate provisions would make several other changes to the Medicare program, as described below.

Medicare Dependent Hospitals. Under current law, special reimbursement for facilities with Medicare dependent hospital (MDH) status will lapse in 2006. Certain rural hospitals with 100 beds or less that have at least 60% of their discharges or inpatient days attributable to Medicare patients in two of the last three years are classified as MDH hospitals. This provision would extend their status through discharges occurring before October 1, 2011. Also, MDHs could elect payment based on their adjusted FY2002 hospital-specific costs, beginning in FY2005, if that would result in higher Medicare payments.

Skilled Nursing Facility Bad Debt. Beginning October 1, 2005, the amount of bad debts otherwise treated as allowed costs, which are attributable to deductible

and coinsurance amounts, would be reduced by 30% for services furnished in skilled nursing facilities (SNF).

Inpatient Rehabilitation Facilities. CMS requires that a facility treat a certain proportion of patients with specified medical conditions in order to qualify as an inpatient rehabilitation facility (IRF) and receive higher Medicare payments. The "75% rule" established in regulation requires IRFs to meet a compliance threshold of 60% from July 1, 2005 and before July 1, 2006, 65% from July 1, 2006 and before July 1, 2007 and 75% thereafter. This legislation would reduce the current required proportion, or threshold to 50% from July 1, 2005 through June 30, 2007.

Physician Self Referrals. The prohibition on Medicare and Medicaid referrals to physician-owned limited service hospitals or specialty hospitals would be effective on or after December 8, 2003. Certain exceptions would be made to the definition of such hospitals, to include those hospitals where: (1) the percent investment by physician investors is no greater than the percent on June 8, 2005, (2) the percent investment by any physician investor is no greater than the percent on June 8, 2005, (3) the number of operating rooms is no greater than the number on June 8, 2005 and (4) the number of beds is no greater than the number on June 8, 2005.

Hold Harmless Provision for Small Rural and Sole Community Hospitals. Under current law, most services provided by hospital outpatient departments are paid under a prospective payment system, which began August 2000. Rural hospitals with no more than 100 beds and sole community hospitals located in rural areas, are to be held harmless through January 2006, that is they are to be paid no less under the prospective system than they would have been paid under prior law. This legislation would extend the hold harmless provisions through January 1, 2007.

Composite Rate for Dialysis Services. Medicare payments for dialysis services furnished either at a facility or in a patient's home are based on a basic case-mix adjusted prospective payment system. The system has two components: (1) the composite rate, which does not have to be updated annually; and (2) a drug add-on adjustment, which the Secretary of HHS is required to update annually beginning in 2006. The legislation would increase the composite rate by 1.6% for services beginning January 1, 2006.

Therapy Caps. The Balanced Budget Act of 1997 established annual per beneficiary payment limits on all outpatient therapy services provided by non-hospital providers beginning in 1999. Subsequent legislation suspended application of the limits beginning in 2000. A moratorium has been in place since then, except for a brief period in 2003. Under current law, the caps are again slated to go into effect in 2006. The bill would extend the moratorium for an additional year, through 2006.

Durable Medical Equipment Rentals. This provision would eliminate the semi-annual maintenance payment currently allowed for capped rental equipment and pay only for repairs when needed. The Secretary would determine the amount of payments for maintenance and service, which would only be made if deemed

reasonable and necessary. With the exception of power-driven wheelchairs, the title to durable medical equipment in the capped rental category would be transferred by the supplier to the Medicare beneficiary after a 13-month rental period. The current option for beneficiaries to purchase power wheelchairs when initially furnished would be retained and the amount of any necessary maintenance and servicing payments would be established by the Secretary.

Rural Program of All-Inclusive Care for the Elderly (PACE) Provider Grant Program. The Program for All-Inclusive Care for the Elderly (PACE) makes available all services covered under Medicare and Medicaid without amount, duration or scope limitations, and without application of any deductibles, copayments or other cost sharing. Under the program, certain low-income individuals age 55 and older, who would otherwise require nursing home care, receive all health, medical, and social services they need. An interdisciplinary team of physicians, nurses, physical therapists, social workers, and other professionals develop and monitor care plans for enrollees. Monthly capitated payments are made to providers from both the Medicare and Medicaid programs. As specified in Medicare and Medicaid statutes, the amount of these payments from both programs must be less than what would have otherwise been paid for a comparable frail population not enrolled in PACE program. Payments are also adjusted to account for the comparative frailty of PACE enrollees. PACE providers assume the risk for expenditures that exceed the revenue from the capitation payments. The Balanced Budget Act of 1997 made PACE a permanent benefit category under Medicare and a state plan optional benefit under Medicaid.

The provision would create site development grants and provide technical assistance to establish PACE providers in rural areas. It would also create a fund for rural PACE providers to provide partial reimbursement for incurred expenditures above a ceratin level. The proposal would require the Secretary of HHS to establish a process and criteria for awarding up to $7.5 million in site development grants in up to 12 qualified PACE providers that have been approved to serve a geographic service area that is in whole or in part in a rural area, with each grant award not to exceed $750,000.

Waiver of Part B Late Enrollment Penalty. Generally, individuals who delay enrollment in Medicare Part B past their initial period of eligibility are subject to a penalty equal to 10% of the premium amount for each 12 months of delay. This provision would allow certain individuals to delay enrollment without a penalty, specifically those individuals who volunteered outside of the United States through a 12-month or longer program sponsored by a tax-exempt organization (defined by the Internal Revenue Code). Upon return to the United States, they would have a special enrollment period.

Federally Qualified Health Centers. This provision would allow federally qualified health centers (FQHC) to provide diabetes outpatient self management training services and medical nutrition therapy services provided by a registered dietician or nutritional professional. It would modify the definition of FQHC services so that only the primary preventative required services would be retained. Services would include those furnished to an outpatient of an FQHC that are

provided by a health care professional under contract with the center, and payments would be made directly to the FQHC.

Delay of Medicare Payments. Medicare Parts A and B payments for services made by fiscal intermediaries and carriers would be delayed for seven business days at the end of FY2006. These payments would be made at the beginning of FY2007, thereby shifting payments from one fiscal year to the next.

Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms. The provision would authorize Medicare coverage of ultrasound screening for abdominal aortic aneurysms for individuals who (1) received referrals for such screenings as a result of an initial preventive physical exam performed for new Medicare enrollees; (2) had not previously had such a test covered by Medicare; and (3) had a family history of abdominal aortic aneurysm or manifested risk factors included in a beneficiary category (not related to age) identified by the United States Preventive Services Task Force. The Part B deductible would not apply to these services.

Improving Patient Access to and Utilization of Colorectal Cancer Screening Services. The provision would establish national minimum payment amounts for specified facility and non-facility service codes that reflect a 5% increase above current amounts. The provision would also authorize Medicare coverage for an office visit or consultation prior to a screening colonoscopy or in connection with a beneficiary's decision to obtain such a screening. The Part B deductible would not apply for colorectal cancer screening tests.

Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services Under Medicare Part B. The provision would authorize coverage of marriage and family therapist services and mental health counselor services for the diagnosis and treatment of mental illness that the therapist or counselor is legally authorized to perform in the state.

House Bill

Under the budget resolution instructions, the House Energy and Commerce Committee was required to obtain $2 million in savings in FY2006 and $14.734 billion over the five-year budget period, FY2006-FY2010. The total House Energy and Commerce proposal, which includes changes in areas outside of health, is estimated to reduce federal outlays by $17.1 billion over the five-year budget window.[4] Proposed changes to the Medicaid program would result in an $11.9 billion reduction in spending over the five-year period. Katrina health care and energy relief would increase spending by $3.6 billion. Additional savings would result from Digital Television transition. This report summarizes provisions dealing

[4] Congressional Budget Office. Cost Estimate. Reconciliation Recommendations of the House Committee on Energy and Commerce, as approved by the House Committee on Energy and Commerce on October 28, 2005.

only with Medicaid and SCHIP.[5] These provisions were incorporated into the larger bill reported by the House Budget Committee on November 3, 2005, the Deficit Reduction Act of 2005. Under a House rule, an amended Committee bill was introduced. The bill passed the House on November 18, 2005.

Subtitle A of Title III in the House bill reduces federal Medicaid spending by $11.9 billion over the FY2006-FY2010 five year budget period. Changes in outpatient prescription drug payments would result in $2.1 billion in savings over the period. Changes in Medicaid cost-sharing and benefits would result in $6.5 billion in savings over the period. Changes in asset transfer rules would reduce Medicaid spending by an additional $2.5 billion over the five year period. Changes in other provisions (e.g., changes in the treatment of state taxes on health care providers, and changes aimed at reducing Medicaid overpayment when a Medicaid recipient also has private insurance) would reduce Medicaid spending by an additional $1.8 billion over the five year period. Benefit expansions would add $1 billion in Medicaid spending. These expansions would include changes in benefits for individuals with long-term care needs in the community, and the establishment of health opportunity account demonstration programs (Medicaid-funded savings accounts that beneficiaries would use to pay for certain health care services). Under subtitle B, federal government spending for Medicaid and SCHIP would be temporarily increased for Medicaid-eligible individuals who lived or currently live in parts of Alabama, Louisiana, and Mississippi affected by Hurricane Katrina. The overall effect of this subtitle's changes would result in an increase in spending over the FY2006- FY2010 period of $2.5 billion. In total, the two health subtitles in the House Energy and Commerce proposal is estimated by CBO to result in net Medicaid and SCHIP savings of $9.3 billion over the five year budget period.

Medicaid

Medicaid Outpatient Prescription Drugs

The Medicaid outpatient prescription drug provisions in the House bill would alter the federal upper limits that apply to Medicaid outpatient prescription drugs, provide for a minimum dispensing fee for multiple source drugs, and establish special reporting requirements for the prices of certain "authorized" generic drugs and certain outpatient drugs administered in physicians' offices. In addition, the bill would allow certain children's hospitals access to discounted drug prices and places an additional requirement on state prior authorization programs that seeks to limit access to atypical antipsychotic or antidepressant single source drugs.

Federal Upper Limits. The House bill would also replace the current FUL requirement so that state payments for single source drugs would qualify for federal reimbursement up to 106% of the RAMP, defined as the average price paid to a

[5] Specifically, this report does not discuss provisions that alter the Public Health Services Act (PHSA). These provisions are in sections 3202, 3203, and 3204. In addition, the report does not discuss subtitle C, Katrina and Rita Energy Relief, and subtitle D, Digital Television Transition of Title III.

manufacturer by wholesalers as reported to CMS by the manufacturers. FULs for multiple source drugs would be equal to 120% of the volume weighted average RAMP for all drug products in the same multiple source drug billing and payment code. The provision would provide the Secretary with the authority to enter into contracts and engage the services of vendors to determine RAMP, and would allow the Secretary to implement an alternative FUL methodology based on survey prices. The implementation of the changes to the FUL would be delayed, however, if GAO were to find that the average prices paid by pharmacies are above the new reimbursable amounts.

In addition, this section of the bill would allow state Medicaid programs to have access to manufacturers' reported prices and would establish minimum dispensing fees of $8 for pharmacies dispensing multiple-source drugs.

Authorized Generics and Physician-Administered Drugs. The House bill would establish that when a manufacturer reports AMP and best price for their brand name product, they would include the prices of all drugs sold under the new drug application (which would include authorized generic versions). This provision is estimated to increase rebates resulting in savings to the Medicaid program, since authorized generic drugs are generally less expensive than brand name versions of the same drug. In addition, the provision would require states to provide utilization and coding information to CMS for all single source physician-administered outpatient drugs and for the 20 most frequently provided physician administered multiple source drugs. This would improve the ability of CMS to ensure manufacturers pay rebates for those drugs.

Children's Hospitals and Access to Discounted Drug Products. The House bill includes a provision allowing Children's Hospitals access to the discounted outpatient prescription drugs prices negotiated under Section 340(B) of the Public Health Service Act. Section 340(B) allows certain health care providers, including many 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.

Prior Authorization for Mental Health Drugs. The bill would limit the ability of states to place atypical antipsychotic or antidepressant single source drugs on prior authorization lists imposing other restrictions unless a drug use review board has determined that doing so is not likely to harm patients or increase overall medical costs. It also would require states to pay for a 30 day supply of such drugs in cases where a request for authorization is not responded to within 24 hours after the prescription is transmitted.

Reform of Asset Transfer Rules

Lengthening Look-back Period for all Disposals to five years. Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals

applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts. The penalty, or period of ineligibility, begins with the first month during which the assets were transferred. The House bill would lengthen the look-back date to five years, or 60 months, for all income and assets disposed of by the individual. It would also change the start date of the ineligibility period for all transfers to the first day of a month during or before 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 if it where not for the penalty, whichever is later.

Availability and Provisions Concerning Hardship Waivers. 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 of DHHS, can show that a penalty would impose an undue hardship. The House bill would add to existing law criteria for approving or disapproving applications for undue hardship waivers. It would also require states to provide applicants with notice about the availability of undue hardship waivers; to review applications under a timely process; and to establish an appeal process for beneficiaries who receive an adverse determination. The bill would also permit facilities to apply for waivers on behalf of, and with the consent of, institutionalized individuals. In addition, if the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Disclosure and Treatment of Annuities and of Large Transactions. Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary of DHHS defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal). If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place. The House bill would require applicants and their community spouses to report their ownership interest in annuities (or similar financial instruments). It would also require disclosure of all transfers greater than $100,000. Further it would also require that all transactions $5,000 or more within a single year would be treated as a single transaction.

Subject to certain requirements, the bill would also require the state to be made the remainder beneficiary under such annuities or similar financial instruments. The

bill would also give the Secretary authority to provide guidance to states on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as an asset transfer for fair market value.

Application of "Income-First" Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse. Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules. The law allows community spouses with more limited income to retain at least a state specified amount set within federal guidelines. If the community spouse's monthly income amount is less than this amount, the institutionalized spouse *may* choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e. the difference between the community spouse's monthly income and the state- specified minimum monthly maintenance needs allowance). The House bill would require that any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a community spouse's monthly income allowance be first made from income of the institutionalized spouse. Only when sufficient income is not available, could resources of the institutionalized spouse be transferred or allocated.

Disqualification for Long-term Care Assistance for Individuals with Substantial Home Equity. Under current law, states set asset standards, within federal parameters, that applicants must meet to qualify for coverage. These standards specify a limit on the amount of countable assets a person may have to qualify, as well as define which assets are not counted. In general, countable assets cannot exceed $2,000 for an individual. States generally follow SSI rules for computing both countable and non-countable assets. Current Medicaid and SSI asset counting practices exclude the entire value of an applicant's home. The House bill would exclude from Medicaid eligibility for nursing facility or other long-term care services, those individuals with an equity interest in their home of greater than $750,000. (The Secretary of DHHS 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, rounded to the nearest $1,000. Individuals whose spouse, child under age 21, or child who is blind or disabled resides in the individual's home would *not* be excluded from eligibility.

Enforceability of Continuing Care Retirement Communities and Life Care Community Admission Contracts. The House bill would allow state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRC) or a life care 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), declared for the purposes of admission, on their care before they apply for Medicaid. It would also allow certain entrance fees for CCRCs or life care communities to be considered by states to be countable resources for purposes of the Medicaid eligibility determination.

Flexibility in Cost Sharing and Benefits

Many of the provisions in this chapter allow for changes to existing cost-sharing and benefit requirements through Medicaid state plan amendments, rather than the special waiver process that is required under current law.

State Option for Alternative Medicaid Premiums and Cost-Sharing. Under current law, premiums are generally prohibited under Medicaid except under specific circumstances. For example, for pregnant women and infants with family income that exceeds 150% of the federal poverty level (FPL), states are allowed to implement nominal premiums or enrollment fees (between $1 and $19 per month depending on family income) as defined in regulations. Other restrictions apply to service-related cost-sharing. For example, all service-related cost-sharing is prohibited for children under 18. Service-related cost-sharing is also prohibited for pregnant women for any pregnancy-related services or for services to treat other medical conditions that complicate pregnancy. Other groups and services are also exempt from service-related cost-sharing (e.g., emergency care, family planning services, services delivered to persons receiving Medicaid hospice care). For most other beneficiaries and services, nominal service-related cost-sharing (between $0.50 and $3 depending on the cost of the service provided) may be imposed.

The House bill would allow states to impose premiums and cost-sharing for any group of individuals for any type of service subject to several specific restrictions. Certain groups would be exempted from paying premiums (e.g., children under 18 in mandatory coverage groups, inpatients in certain medical institutions who must spend nearly all their income on medical care before Medicaid pays for services). Also, cost-sharing would be prohibited for specified services (e.g., preventive care for all children under 18, services provided to hospice patients, emergency care). The total amount of annual cost-sharing for all individuals in a family would be capped at 5% of family income for all families regardless of income. States would be allowed to impose higher cost-sharing amounts than is allowed under current law for individuals with family income over 100% of the FPL. States may exempt additional classes of individuals or services from premiums and service-related cost-sharing. Beginning in 2006, for individuals in families with incomes below 100% FPL, the Secretary of HHS would be required to increase nominal cost-sharing amounts over time based on the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

The House bill would also allow states to condition the provision of medical assistance on the payment of premiums, and to terminate eligibility for Medicaid when the failure to pay a premium continues for at least 60 days. States may apply this provision to some or all groups, and may waive premium payments when they would be an undue hardship. In addition, states could permit Medicaid providers to require a Medicaid beneficiary to pay authorized cost-sharing as a condition of receiving services. Providers would also be allowed to reduce or waive cost-sharing amounts.

GAO would be required to conduct a study of the impact of premiums and cost-sharing under Medicaid on access to and utilization of services, with a report of findings due to Congress no later than January 1, 2008. All provisions would be

effective for cost-sharing imposed on items and services furnished on or after January 1, 2006.

Special Rules for Cost-Sharing for Prescribed Drugs. Under current law, cost-sharing for outpatient prescription drugs follows the rules described above for all cost-sharing amounts. Many states require cost-sharing amounts that are slightly lower for generic drugs or for drugs listed on a preferred drug list.

The House bill would allow states to impose cost-sharing amounts that exceed the proposed state option limits described above for certain state-identified non-preferred drugs if specific conditions are met. Under this option, states may impose higher cost-sharing for non-preferred drugs within a class; waive or reduce cost-sharing otherwise applicable for preferred drugs within such class; and must not apply such cost-sharing for preferred drugs to persons exempt from service-related cost-sharing. Cost-sharing for non-preferred drugs would be based on multiples of the nominal amounts based on family income. For persons generally exempt from cost-sharing, the cost-sharing for non-preferred drugs may be applied. Such cost-sharing may not exceed nominal amounts, and aggregate caps on cost-sharing would still apply.

When a prescribing physician determines that the preferred drug would not be effective or would have adverse health effects or both, the state may impose the cost-sharing amount for preferred drugs on the prescribed non-preferred product.

States may exclude specified drugs or classes of drugs from these special cost-sharing rules. Finally, states would be prohibited from implementing these special cost-sharing rules for outpatient prescription drugs unless the state has instituted a system for prior authorization and related appeals processes. All provisions would be effective for cost-sharing imposed on items and services furnished on or after October 1, 2006.

Emergency Room Copayments for Non-Emergency Care. Under 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 only impose these higher amounts if they have established that Medicaid beneficiaries have available and accessible alternative sources of non-emergency, outpatient services.

The House bill would allow states, through state plan amendments rather than waivers, to impose increased cost-sharing on state-specified groups for non-emergency services provided in an ER, when certain conditions are met. First, alternative non-emergency providers must be available and accessible to the person seeking care. Second, after initial screening but before the non-emergency care is provided at the ER, the beneficiary must be told: (1) the hospital can require a higher co-payments, (2) the name and location of an alternative non-emergency provider and that this provider uses a lower co-payments, and (3) the hospital can provide a referral. When these conditions are met, states could apply or waive cost-sharing for services delivered by the alternate provider.

For persons with income below 100% FPL, cost-sharing for non-emergency services in an ER could not exceed twice the nominal amounts. Individuals exempt from premiums or service-related cost-sharing may be subject to nominal copayments for non-emergency services in an ER, only when no cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers in the area served by the hospital ER. Aggregate caps on cost-sharing would still apply.

Finally, the House bill would require the Secretary to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. It also authorizes and appropriates $100 million for paying such providers for the four-year period beginning with 2006. The Secretary would be required to give a preference to states that establish or provide for alternate non-emergency services providers (or networks) that serve rural or underserved areas where beneficiaries may have limited access to primary care providers, or in partnership with local community hospitals.

Use of Benchmark Benefit Packages. Medicaid benefits may differ for what are called categorically needy (CN) versus medically needy (MN) groups. In general, CN groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. These financial criteria are tied to rules under two federal cash assistance programs — the former AFDC program for poor families with children or the SSI program for the poor elderly and persons with disabilities. Some groups of the elderly, pregnant women, and children must meet financial standards tied to specified percentages of the FPL instead. MN groups include the same types of individuals, but different, typically higher financial standards apply. Medical expenses (if any) may be subtracted from income in determining financial eligibility for the MN. For nearly all CN groups, medical expenses are not considered in determining Medicaid eligibility.

Examples of benefits that are mandatory for CN groups include inpatient and outpatient hospital services, services provided by federally qualified health centers (FQHC), physician services, and nursing facility care for persons age 21 and over. Examples of optional benefits for CN groups that are offered by many states include physician-directed clinic services, routine dental care, other licensed practitioner services (e.g., optometrists, podiatrists, psychologists), physical therapy, inpatient psychiatric care for the elderly and persons under age 21, and prescribed drugs (all states). In general, states may offer a more restrictive benefit package to the MN, but at a minimum, must offer (1) prenatal and delivery services, (2) ambulatory services for persons under 18 and those entitled to institutional services, and (3) home health services for those entitled to nursing facility care. Within a state, services available to all CN groups must be equal in amount, duration and scope. Likewise, services available to all MN groups must be equal in amount, duration and scope.

The House bill would give states the option to provide Medicaid to state-specified groups of beneficiaries through enrollment in benchmark and benchmark-equivalent coverage (described below). States could implement this option through a Medicaid state plan amendment rather than a waiver as would be required under current law. States could require "full-benefit eligible individuals" to enroll in such coverage. A full-benefit eligible would be a person eligible for all services covered

for the CN, or under any other category of eligibility for full services as defined by the Secretary. Some individuals would be excluded from the definition of a full-benefit eligible (e.g., the MN, persons who spend-down their income for medical care to meet the financial requirements for Medicaid coverage). Several other specific groups would also be exempted from this option (e.g., mandatory pregnant women and children, dual eligibles, hospice patients, persons with special medical needs, individuals who qualify for Medicaid long-term care services). States could only apply this option to eligibility categories established before the date of enactment of this provision.

The benchmark and benchmark equivalent packages would be nearly identical to those offered under the State Children's Health Insurance Program (SCHIP), with some additions beyond the basic elements of SCHIP. Under this option, benchmark coverage would include (1) the standard Blue Cross/Blue Shield preferred provider option plan under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage offered and generally available to state employees, or (3) the health coverage offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment. Benchmark-equivalent coverage would be defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages. Such coverage would include each of the benefits in the "basic benefits category," including (1) inpatient and outpatient hospital services, (2) physician's surgical and medical services, (3) lab and x-ray services, (4) well-baby and well-child care, including age-appropriate immunizations, and (5) other appropriate preventive services (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional service category," including (1) prescription drugs, (2) mental health services, (3) vision services, and (4) hearing services.

Both benchmark and benchmark equivalent coverage would also include qualifying child benchmark dental coverage. A qualifying child would be a person under 18 with family income below 133% of the FPL. Benchmark dental coverage would be equivalent to or better than the dental plan that covers the greatest number of individuals in the state who are not eligible for Medicaid.

Finally, states could only enroll eligible beneficiaries in benchmark and benchmark-equivalent coverage if such persons have access to services provided by rural health clinics (RHC) and FQHCs, and the Medicaid prospective payment system for both types of providers remains in effect.

State Option to Establish Non-Emergency Medical Transportation Program. Federal regulations require states to ensure necessary transportation for recipients to and from providers and to describe the methods that they will use to meet this requirement in their Medicaid state plan. States may choose whether to provide transportation as an optional Medicaid service or claim it as an administrative expense.

If a state chooses to provide transportation as an optional Medicaid service, costs are reimbursed by the federal government using the federal medical assistance percentage (FMAP), which varies by state and has a statutory floor of 50% and ceiling of 83%. Under this option, states must meet a number of federal requirements

that apply to all Medicaid services (e.g., enrollees must have freedom to choose among qualified providers) unless they have an approved waiver. Costs are only allowable for FMAP reimbursement if the transportation is furnished by a provider to whom a direct payment can be made. Other arrangements (e.g., payment to a broker who manages and pays transportation providers) must be claimed as an administrative expense. If a state chooses to claim transportation as an administrative expense, costs are reimbursed by the federal government at a rate of 50%, which is lower than the FMAP in many states, but there are fewer federal requirements that must be met.

Under the House bill, a state would have the option to establish a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for Medicaid enrollees who need access to medical care or services and have no other means of transportation. Under the program, the state would not be required to provide comparable services for all Medicaid enrollees or freedom to choose among providers. The program could 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: (1) is selected through a competitive bidding process, (2) meets oversight requirements, (3) is subject to regular auditing by the state, and (4) complies with requirements related to prohibitions on referrals and conflict of interest established by the Secretary. Also, the HHS Inspector General would be required to submit a report to Congress examining this new program no later than January 1, 2007.

Exempting Women Covered under Breast or Cervical Cancer Program. Under current law, 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 under an early detection program run by the CDC. This group has access to the same Medicaid services offered to the CN in a given state, and are subject to Medicaid's nominal cost sharing rules.

Under the House bill, none of the proposed cost-sharing or benefit provisions described above would apply to women who qualify for Medicaid under the breast and cervical cancer eligibility group.

Benefit Expansions

Expanded Access to Home and Community-based Services for the Elderly and Disabled. Under current law, states may provide a broad range of home and community-based services under a Medicaid waiver authorized by Section 1915(c) of the Social Security Act. These services, which may include, for example, respite, adult day care, and personal care, may be provided to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR), or hospital. Approval of a Medicaid waiver is contingent on a state documenting the waiver's cost-neutrality (the average per person cost under the waiver cannot exceed the average per person cost of services in an institution.)

This proposal would allow states to cover these types of home and community-based services under the Medicaid state plan *without* requiring the state to seek a

waiver or document the waiver's cost-neutrality. To cover this option, a state's existing waiver must have expired. Similar to rules governing the current waiver program, states would be able to: 1) define which services will be covered (room and board may not be paid for); 2) offer the waiver on a less-than-statewide basis; 3) limit the number of individuals who are eligible for services; and 4) establish a waiting list for services. This section would be effective for home and community-based services furnished on or after October 1, 2006.

Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling). Traditionally, Medicaid personal care and other related benefits have been provided to beneficiaries through a local public or private agency. However, in the last decade, Medicaid programs have been increasing the discretion that Medicaid beneficiaries have over key elements of the service (e.g., what time a service provider comes to the home, who provides the service). This proposal would allow a state to establish and operate a program in which the Medicaid beneficiary could hire, supervise and manage the individuals providing his or her services (including personal care and related services or other home and community-based services). The beneficiary would have significant discretion within an approved service plan and budget. As part of this option, a state may limit the population eligible to receive these types of services and may limit the number of persons served.

Expansion of State Long-term Care Partnership Program. Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) 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 (allowed with Secretary's approval, without changes to current law); and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied. Current law allows states with an approved state plan amendment *as of* May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. Except for Iowa, all of these states have implemented partnership programs.

This provision would allow additional groups of individuals in states with state plan amendments approved *after* May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. New partnership programs would disregard any assets or resources of a Medicaid applicant and beneficiary in the amount equal to the amount of insurance benefit paid to or on behalf of an individual who is a beneficiary under a long-term care policy. Policies sold under new LTC partnership programs would be tax-qualified, cover an insured who was a resident of such state when coverage first became effective under the policy, require that policyholders be offered a policy with some level of inflation protection, and impose certain requirements on states concerning seller training. It would also require insurers to report information, as specified by the Secretary, concerning benefit payments, policy terminations, among others. Existing Partnership programs (programs in California, Connecticut, Indiana, Iowa, and New York) would not be subject to these requirements. The Secretary

would also be subject to certain requirements concerning data reporting and the development of recommendations for certain uniform standards. Under the House bill, the Secretary would be permitted to develop portability standards for reciprocal recognition of partnership policies among certain states.

Health Opportunity Accounts. The bill would require the Secretary to establish demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2006. No more than ten state programs could be established the first five years, though afterwards other programs would be allowed if the earlier ones were not unsuccessful. Among other things, state programs would have to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care. Eligibility for HOAs would be determined by the state, though individuals who are disabled, pregnant, or receiving terminal care or long-term care, would be among those who could not participate.

Participants would have both an HOA and coverage for medical items and services that, after an annual deductible is met, were available under the existing Medicaid state plan and waiver authorities. The deductible would have to be at least 100%, but no more than 110%, of the annual state contributions to the HOA. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

HOAs would be used to pay health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Withdrawals would be made by electronic transfer. Once account holders were no longer eligible for Medicaid they could continue to make withdrawals under these conditions, though accounts could then also be used to pay for health insurance or, at state option, for job training or education. Participants generally would be able to obtain services from Medicaid providers or managed care organizations at the same payment rates that would be applicable if the coverage deductible did not apply, or from any provider for payment rates not exceeding 125% of those rates.

HOA contributions could be made by the state or by other persons or entities, including charitable organizations. Including federal shares, state contributions generally could not exceed $2,500 for each adult and $1,000 for each child.

Other Medicaid Provisions

Managed Care Organization Provider Tax Reform. The House bill would, like the Senate bill, modify the class of providers that states can tax under the provider tax rules. The current law class of Medicaid managed care providers would be changed to encompass all managed care organizations, so that, in the future, these taxes would be required to be more broad than are allowed under current law. States with existing provider specific taxes levied against Medicaid managed care organizations would be allowed to keep those taxes in 2008, and would have to reduce the tax by half in 2009. After that, all states would be subject to the new rule.

Third Party Liability. With certain exceptions, Medicaid is a payer of last resort, meaning that states must ascertain the legally liability of third parties to pay for Medicaid care and services. They must also seek reimbursement for Medicaid costs from third parties when necessary. Examples of potentially liable third parties specified in current Medicaid law include health insurers, group health plans, service benefit plans, and health maintenance organizations. With respect to third party liability, the House proposal would clarify the right of states to obtain reimbursement from specific third parties — self-insured plans and pharmacy benefit managers — that are legally responsible for payment of claims for health care items or services provided to Medicaid beneficiaries. The proposal would also require each state to have laws in effect requiring third parties to provide eligibility and claims payment data for Medicaid-eligible individuals and to cooperate with payment and recovery efforts by Medicaid.

Reforms of Targeted Case Management Benefit. Targeted case management (TCM) is an optional benefit under the Medicaid state plan that is designed to help Medicaid beneficiaries access needed medical, social, educational, and other services. States that cover the TCM service do not have to offer the benefit statewide and can limit the service to specific groups of Medicaid beneficiaries (e.g., those with chronic mental illness). Several states extend the TCM services to individuals who may also be receiving certain case management services as part of another state and/or federal program (e.g., foster care, juvenile justice).

This proposal would clarify the activities that can be considered a TCM service, and those activities (primarily foster care-related activities) that may not be reimbursed as TCM services. The proposal also states that Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. The proposal would take effect January 1, 2006.

Increase in Payments to Insular Areas. 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 contrast, Medicaid programs in the territories are subject to spending caps. These spending caps were set in FY1998 and adjusted for inflation in subsequent years. For each of fiscal years 2006 and 2007, the provision would increase the total annual cap on federal funding for the Medicaid programs in each of Puerto Rico, the Virgin Islands, Guam, the Northern Marianas, and American Samoa. For Puerto Rico the total annual Medicaid cap would be increased by $12 million; for the Virgin Islands and Guam, the FY2006 total annual Medicaid caps would be increased by $2.5 million and the FY2007 caps would be increased by $5.0 million. For the Northern Marianas, the FY2006 total annual Medicaid cap would be increased by $1.0 million and the FY2007 cap would be increased by $2.0 million. For American Samoa, the FY2006 total annual Medicaid cap would be increased by $2.0 million and the FY2007 cap would be increased by $4.0 million. For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in each of Puerto Rico, the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be calculated by increasing the FY2007 ceiling for inflation.

Medicaid Transformation Grants. Under the House proposal, in addition to the normal federal Medicaid reimbursement received by states, Secretary of DHHS would provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency of Medicaid. Examples of innovative methods for which such funds may be used include (1) methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs, (2) methods for improving rates of collection from estates owed to Medicaid, (3) methods for reducing waste, fraud, and abuse under Medicaid, (4) implementation of a medication risk management program as part of a drug use review program, and (5) methods for reducing expenditures for covered outpatient drugs by increasing generic utilization. Total payments under this provision would equal and not exceed $50 million in each of FY2007 and FY2008.

Citizenship Documentation. 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. Under current law, 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 additional documentary evidence. If an individual declares that he or she is a U.S. citizen or national, the state is not required to obtain additional evidence but may choose to do so. Under the House proposal, states would be required to obtain documentary evidence from individuals who declare that they are U.S. citizens or nationals.

Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Enrollees. 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.

Under the House bill, a Medicaid provider that does not have a contract with a Medicaid managed care entity (MCE) that furnishes emergency care to a beneficiary enrolled with that MCE must accept as payment in full the amount otherwise applicable outside of managed care (e.g., in the fee-for-service setting) — minus any payments for indirect costs of medical education and direct costs of graduate medical education. This provision would be effective on January 1, 2007.

FMAP Computation for Employer Pension Contributions. When state FMAPs are calculated by HHS for an upcoming fiscal year (usually in the preceding November), the state and U.S. per capita personal income 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). The definition of personal income used by BEA is comprised of many parts, including supplements to wages and salaries such as employer contributions for employee pension and insurance funds. When BEA undertakes a comprehensive revision of its income data every few years, there may be upward and downward revisions to each of these parts, the sum of which has a net effect on overall personal income. For example, in describing its most recent comprehensive revision, BEA reported that upward revisions to employer contributions for pensions beginning with 1989 were the result of methodological

improvements and more complete source data. However, BEA reported upward and downward revisions to other parts of personal income as well (e.g., wages and salaries). Under the House proposal, for purposes of computing states FMAPs beginning with FY2006, employer contributions toward pensions that exceed a specified threshold would be excluded from the per capita income of a state.

Katrina Health Care Relief

Targeted Medicaid Relief. The federal medical assistance percentage (FMAP), which has a statutory minimum of 50% and maximum of 83%, is the rate at which states are reimbursed for most Medicaid service expenditures. Medicaid administrative costs are generally reimbursed at a flat rate of 50%. An enhanced FMAP is available for both services and administration under SCHIP, subject to the availability of funds from a state's SCHIP allotment. Under the House proposal, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to: (1) any individual residing in a parish of Louisiana, a county of Mississippi, or a major disaster county of Alabama and (2) individuals who resided during the week preceding Hurricane Katrina in a parish or county for which a major disaster has been declared as a result of the hurricane and for which the President has determined, as of September 14, 2005, warrants individual assistance under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Costs directly attributable to related administrative activities would also be reimbursed at 100%.

FMAP Hold Harmless. When state FMAPs are calculated by HHS for an upcoming fiscal year (usually in the preceding November), the state and U.S. per capita personal income 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). For example, to calculate FY2006 FMAPs, HHS used per capita personal income data for 2001, 2002, and 2003 that became available from BEA in October 2004. Under the House bill, in computing Medicaid and SCHIP FMAPs for any year after 2006 for a state that the Secretary of HHS 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 income.

Conference Agreement, as Passed by the Senate

On December 19, 2005, the House agreed to a conference report on S. 1932. However, the Senate amended the report, removing a few provisions as the result of a point of order raised associated with the "Byrd Rule."[6] The amended agreement passed the Senate on December 21, 2006, and was returned to the House for further

[6] See CRS Report RL33132, *Budget Reconciliation Legislation in 2005*, by Robert Keith.

action. It is expected that the agreement will be taken up in the early part of the session.

Title V and Title VI of the Deficit Reduction Act of 2005 contain provisions dealing with Medicare (Title V) and Medicaid, SCHIP and Hurricane Katrina relief (Title VI). Preliminary estimates from the Congressional Budget Office indicate $3.4 billion in Medicare savings in direct spending for FY2006, and $8.3 billion in Medicare savings in direct spending from FY2006-FY2010. Preliminary Medicaid savings estimates show a $1 billion increase in Medicaid spending for FY2006, and over the five-year period, FY2006-FY2010, savings of $6.9 billion. The SCHIP provisions are estimated to cost $170 million in FY2006 and $20 million over the FY2006-FY2010 period. Finally, the conference agreement provides for $2.0 billion in funding for Katrina-related health care costs in FY2006. Over the five-year period, estimated costs of the Katrina provisions would equal $2.1 billion.

Medicare

Medicare's Update Factor to Increase Operating Payments to Acute-care Hospitals. Medicare's annual increase in its operating payments to hospitals is determined in part by the projected annual change in the hospital market basket (MB), a measure that estimates price inflation affecting hospitals. Congress establishes this update for Medicare's inpatient prospective payment system (IPPS), often several years in advance. Currently, through FY2007, the IPPS operating update has been established as the MB for hospitals that submit specific quality information and as the MB minus 0.4 percentage points for hospitals that do not provide such information.

Under the 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 two percentage points. 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 from acute care hospitals.

Value-based Purchasing for Acute-Care Hospitals. Under the conference agreement, the DHHS Secretary is required to develop a plan to implement a value-based purchasing program for inpatient payments to acute care hospitals beginning with FY2009. The plan is required to consider specified factors such as (1) the development, selection, and modification process for quality measures; (2) data reporting, collection, and validation; (3) the structure of value-based payment adjustments and sources of its funding; and (4) the disclosure of information on hospital performance.

DRG Adjustment for Certain Hospital Acquired Infections. 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). When present as a secondary condition (with a specific principal diagnosis), these diagnosis codes are considered to increase the length of stay by least one day in at least 75% of the patients. Paired DRGs are split into higher- and lower-paid DRGs on the presence or the absence of a CC. CMS has added and deleted codes from the standard list of CCs, but has never conducted a comprehensive review of the list. It is planning to systematic review of the CC list for FY2007 Medicare payments.

Under the conference agreement, starting for discharges on October 1, 2007, hospitals are required to report any secondary diagnosis codes applicable to patients at their admission in order to be paid. By October 1, 2007, the Secretary is required to identify at least two high-cost or high-volume (or both high-cost and high-volume) diagnosis codes with a DRG assignment that has a higher payment weight when present as a secondary diagnosis. These codes represent conditions, including certain hospital-acquired infections, that could reasonably have been prevented through the use of evidence-based guidelines. Starting for discharges on October 1, 2008, the DRG assigned to a discharge with the identified diagnosis codes will be the lower-paid DRG.

Clarification of Inclusion of Medicaid Patient Days in Medicare's Computation of its Disproportionate Share Hospital (DSH) Adjustment. Hospitals that serve a certain number of low-income Medicare and Medicaid beneficiaries will receive a DSH adjustment that increases their Medicare IPPS payments. Most hospitals receive the additional payments based on their DSH patient percentage, which is calculated using proportion of the hospital's total days provided to Medicaid recipients added to the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries. The policy of whether inpatient days provided to a patient covered under demonstration projects established by Section 1115 waivers could be included in the Medicare DSH calculation has changed over time. Policies on these issues were established through regulation.

Under the conference agreement, the Secretary can 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 provision ratifies existing regulations.

Improvements to the Medicare-Dependent Hospital (MDH) Program. Under current law, special reimbursement for facilities with Medicare dependent hospital (MDH) status will lapse in 2006. Certain rural hospitals with 100 beds or less that have at least 60% of their discharges or inpatient days attributable to Medicare patients in two of the last three years are classified as MDH hospitals. Under the conference agreement, their MDH status would be extended for discharges occurring before October 1, 2011. Starting for discharges on October 1, 2006, an MDH would be able to elect payments based on 50% of its FY2002 hospital-specific costs if that would result in higher Medicare payments. MDH's payments would be based on 75% of their adjusted hospital-specific costs starting for discharges on October 1, 2006. MDH's that qualify for a disproportionate share hospital (DSH) adjustment would not have the adjustment capped at 12%.

Reduction in Payments to Skilled Nursing Facilities (SNFs) for Bad Debt. Medicare pays the costs of certain items on a reasonable cost basis (outside of the applicable prospective payment system), including the unpaid debt for beneficiaries' coinsurance and deductible amounts. Historically, CMS has reimbursed certain providers (e.g., SNFs) for 100% of the debt. Effective for cost reports starting in FY2001, Medicare began reimbursing acute care hospitals for 70% of the reasonable costs associated with beneficiaries' allowable bad debt. Under the conference agreement, Medicare payments to SNFS for allowable bad debts would be reduced to 70% for beneficiaries who are not eligible for both Medicare and Medicare. Medicare's payments for allowable bad debts attributed to dual eligible beneficiaries would remain at 100%.

Extend Phase-in of the Inpatient Rehabilitation Facility (IRF) Compliance Thresholds. CMS requires that a facility treat a certain proportion of patients with specified medical conditions in order to qualify as an inpatient rehabilitation facility (IRF) and receive higher Medicare payments. The "75% rule" established in regulation requires IRFs to meet a compliance threshold of 60% from July 1, 2005 and before July 1, 2006, 65% from July 1, 2006 and before July 1, 2007 and 75% thereafter. Under the conference agreement, the compliance threshold for IRFs is established 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.

Development of a Strategic Plan Regarding Physician Investment in Specialty Hospitals. Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. This prohibition does not extend to patient referrals to hospitals where physicians have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Section 507 of MMA established that the exception for physician investment and self-referral would not extend to specialty hospitals for a period of 18 months from enactment (or until June 8, 2004). This moratorium has been extended administratively by CMS, which has not issued provider numbers to new specialty hospitals while it examines the criteria used to award such numbers. Under the conference agreement, the Secretary is required to develop a strategic and implementing plan regarding physician investment in specialty hospitals. An interim report is due within three months, and the final report is due no later than six months after the date of enactment. The Secretary will continue to suspend enrollment of new specialty hospitals until the earlier date of either the submission of the report or six months after the date of enactment. If the Secretary does not submit the final report within the six-month time period, then the enrollment suspension will be extended an additional two months. The Secretary will also provide an appropriate certification of the failure to Congressional committees of jurisdiction.

Gainsharing Demonstration Project. In 2004, a federal district court stopped CMS from implementing an eight-hospital gainsharing demonstration project because of civil monetary penalty concerns. Under the conference agreement, the Secretary will establish a gainsharing demonstration project to evaluate arrangements between IPPS hospitals and physicians and practitioners. Up to six projects (with at least two in rural areas) will be approved by November 1, 2006, and operational no

later than January 1, 2007. The sum of $6 million will be appropriated from the Treasury in FY2006 to carry out the projects and will remain available for expenditure through FY2010.

Post-Acute Care Payment Reform Demonstration Program. Under the conference agreement, the DHHS Secretary is required to establish a three-year demonstration program to assess the costs and outcomes across different post-acute care sites by January 1, 2008. Six million dollars will be transferred from Medicare's Hospital Insurance Trust Fund for the costs of carrying out the demonstration program.

Beneficiary Ownership of Certain DME and Oxygen Equipment. Medicare Part B pays for certain items of durable medical equipment such as hospital beds, nebulizers and power-driven wheelchairs under the capped rental category. Most items in this category are provided on a rental basis for a period that can not exceed 15 months. After using the equipment for 10 months, beneficiaries must be given the option of purchasing it effective 13 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. 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. Oxygen equipment rentals continue for the entire period of medical need and are not subject to a maximum number of months.

The conference agreement would require the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a 13-month rental period. The option for a 15-month rental period with the supplier retaining ownership of the item would be eliminated. Automatic payment for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier's or manufacturer's warranty) would only be made if the Secretary determined them to be reasonable and necessary. Rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after a 36-month rental period. After transfer of the title, monthly payments for oxygen contents will continue to be made. Payments for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) will be made if the Secretary determines them to be reasonable and necessary.

Adjustments in Payments for Imaging Services. Medicare has a long-standing policy of reducing payment for multiple surgical procedures performed by the same physician on the same patient on the same day. Full payment is made for the highest priced procedure, with any subsequent procedure paid at 50%. In 1995, the policy was extended to certain nuclear medicine diagnostic procedures. On November 21, 2005, CMS issued its final physician fee schedule regulation for 2006. This regulation provided for a reduction in the a component of payments (the technical component) for the subsequent imaging procedure performed on contiguous body parts. The conference agreement specifies that, effective for fee schedules established beginning with 2007, the reduced expenditures attributable to the multiple procedure payment reduction for imaging (under the final rule published

November 21, 2005) will not be taken into account for purposes of the budget neutrality calculation for fee schedules for 2006 and 2007. The agreement further provides that for specified imaging services furnished on or after January 1, 2007, the technical component for a service will be reduced if it exceeds (without regard to the geographic wage adjustment factor) the outpatient department (OPD) fee schedule amount for the service established under the prospective payment system for hospital outpatient departments.

Limitation on Medicare Payments for Procedures in Ambulatory Care Surgical Centers (ASCs). Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ASC. The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. The Secretary is required to implement a new ASC payment system no later than January 2008. Medicare reimbursement for hospital outpatient department (OPD) services is based on a fee schedule established by a separate prospective payment system (OPPS). Under OPPS, the unit of payment is the individual service or procedure as assigned to an ambulatory payment classification (APC). The payment rate for each service is determined by multiplying the relative weight for the service's APC by the conversion factor. Under the conference agreement, starting for surgical procedures on January 1, 2007, when the ASC facility payment (without application of any geographic price differences) is greater than the Medicare OPD fee schedule amount established under OPPS (without application of any geographic adjustment) for the same service, the ASC will be paid the OPD fee schedule amount. This adjustment applies to ASC payments until the revised ASC payment system is implemented. Total payments to ASCs under the revised payment system can be no more than those under the existing ASC payment system, including the reduced expenditures that result from the application of this provision.

Update for Physicians' Services for 2006. 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. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor is the same for all services. It is updated each year according to a formula specified in law. Under the formula, a negative 4.4% update goes into effect in 2006. The conference agreement overrides application of the formula for 2006 by setting the update at zero. In effect, this means that the 2006 conversion factor is the same as the 2005 conversion factor. The agreement also requires the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress by March 1, 2007 on mechanisms that could be used to replace the sustainable growth rate system (SGR). The sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period).

Three Year Hold Harmless Transition for Small Rural Hospitals Into the Outpatient Prospective Payment System (OPPS). Rural hospitals with no more than 100 beds and sole community hospitals (SCH) located in rural areas are paid no less under OPPS than they would have received under the prior reimbursement system for covered outpatient department services provided until

January 1, 2006. Under its administrative authority, starting for services on January 1, 2006, CMS has increased OPPS payments to rural SCHs by 7.1%. Under the conference agreement, certain small rural hospitals (with no more than 100 beds that are not SCHs) can receive additional Medicare payments if their outpatient payments under OPPS are less than under the old payment system. For calendar year (CY) 2006, these hospitals will receive 95% of any difference. The hospitals will receive 90% of the difference in CY2007 and 85% of the difference in CY2008.

Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services. The basic case-mix adjusted reimbursement system for dialysis 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. The basic case-mix adjusted payment amounts are to be updated 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. The conference agreement increases the composite rate component of the basic case-miz adjusted system by 1.6% for services beginning January 1, 2006.

Revisions to Payments for Therapy Services. The Balanced Budget Act of 1997 established annual per beneficiary payment limits on all outpatient therapy services provided by non-hospital providers beginning in 1999. Subsequent legislation suspended application of the limits beginning in 2000. A moratorium has been in place since then, except for a brief period in 2003. Under current law, the caps are again slated to go into effect in 2006. The conference agreement does not extend the moratorium. However, the Secretary is required to implement an exceptions process for expenses incurred in 2006. The agreement also requires the Secretary, by July 1, 2006, to implement clinically appropriate code edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments.

Accelerated Implementation of Income-Related Reduction in Part B Premium Subsidy. Since the inception of Medicare, all Part B enrollees have paid the same Part B premium, regardless of their income level. MMA increased the Part B premiums for higher income enrollees beginning in 2007. The increase is to be phased-in over five years. The agreement accelerates the phase-in period from five years to three years, with the provision fully effective in 2009.

Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms. The conference agreement would authorize Medicare coverage of ultrasound screening for abdominal aortic aneurysms for individuals who (1) received referrals for such screenings as a result of an initial preventive physical exam performed for new Medicare enrollees; (2) had not previously had such a test covered by Medicare; and (3) had a family history of abdominal aortic aneurysm or manifested risk factors included in a beneficiary category (not related to age) identified by the United States Preventive Services Task Force. The Part B deductible would not apply to these services.

Improving Patient Access to, and Utilization of, Colorectal Cancer Screening Under Medicare. The conference agreement provides that the Part B deductible does not apply to colorectal cancer screening tests, effective January 1, 2007.

Expansion and Payment for Services Provided by Federally Qualified Health Centers (FQHC). Medicare pays FQHCs to provide primary and other preventative services. MMA specified that a SNF Part A resident who receives FQHC services from a physician or appropriate practitioner would be excluded from SNF consolidated billing and receive separate Medicare payments. Under the conference agreement, FQHCs may provide diabetes self-management training and nutrition therapy benefits, as covered under Medicare, and be paid under the all-inclusive per visit payment. FQHCs would receive direct payment for any FQHC service provided by a health care professional under contract to the center.

Waiver of Part B Late Enrollment Penalty for Certain International Volunteers. The conference agreement permits certain individuals to delay enrollment in Part B without a delayed enrollment penalty. Those individuals permitted to delay enrollment would be those who volunteered outside of the United States for at least 12 months through a program sponsored by a tax-exempt organization defined under Section 501(c)(3) of the Internal Revenue Code. The individuals must demonstrate they had health insurance coverage while serving in the international program. Individuals permitted to delay enrollment will have a special Part B enrollment period.

Home Health Payments. The Medicare home health prospective payment system, which was implemented on October 1, 2000, provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. Each year Medicare's payment to home health agencies is updated by the projected annual change in the home health market basket (HHMB), with specified reductions in some years. The Medicare Prescription Drug Improvement and Modernization Act of 2003 provided for a one-year 5% additional payment for home health services furnished in rural areas. The temporary payment began for episodes and visits ending on or after April 1, 2004 and before April 1, 2005.

The conference agreement eliminates the update for home health payments in 2006. It also extends the 5% additional payment for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007. Starting in 2007, the conference agreement directs home health agencies to submit to the Secretary health care quality data in a form, manner, and time period specified by the Secretary. In 2007 and subsequent years, a home health agency that does not submit the required quality data will receive an update of the market basket minus two percentage points. The conference agreement directs the Medicare Payment Advisory Commission to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services.

Delay of Medicare Payments. The conference agreement delays Medicare Part A and B payments by nine days at the end of the FY2006. Claims that would

otherwise be paid on September 22, 2006 through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid for any delay in a payment during the period.

Increase in Medicare Integrity Program (MIP) Funding. Certain Hospital Insurance Trust Fund amounts were appropriated for specific activities, including the Medicare Integrity Program (MIP) that focuses on anti-fraud activities. Under the conference agreement, MIP funding is increased by $100 million for FY2006.

Phase-out of Risk Adjustment Budget Neutrality in Determining the Amount of Payments to Medicare Advantage Organizations. Beginning in 2007, this section (1) would change the way MA area-specific non-drug monthly benchmarks (or MA benchmarks) are calculated, and (2) would specify an adjustment to the benchmarks to phase-out overall increases in MA rates that are the result of the budget neutral implementation of risk adjustment.

Establishment of PACE Provider Grant Program. The Program for All-Inclusive Care for the Elderly (PACE) makes available all services covered under Medicare and Medicaid without amount, duration or scope limitations, and without application to any deductibles, copayments or other cost-sharing. Under the program, certain low-income individuals age 55 and older, who would otherwise require nursing home care, receive all health, medical, and social services in a community setting through a capitated managed care program. The conference agreement establishes a grant program for no more than 15 pilot PACE providers in rural areas. For FY2006, $7.5 million is appropriated to the Secretary for a grant distribution in amounts of no greater than $750,000 per pilot site (for specified purposes) to remain available through FY2008. Technical assistance programs are also created to help establish and support rural PACE pilot sites. The conference agreement also establishes an outlier reimbursement fund for recognized outlier costs (as defined in the provision). Under this fund, the Secretary makes payments equal to 80% of costs greater than $50,000 for an eligible outlier participant, with total outlier payments per eligible individual not exceeding $100,000 for a 12-month period. Total payments, for all outlier eligibles at a particular site, may not exceed $500,000 in a 12-month period. For this purpose, $10 million is appropriated to remain available through FY2010. The Secretary conducts an evaluation of rural PACE pilot sites no later than 60 months after enactment.

Medicaid

Outpatient Prescription Drugs

Modification of Federal Upper Payment Limit (FUL) for Multiple Source Drugs; Definition of Multiple Source Drugs. The conference agreement applies FULs to multiple source drugs for which the FDA has rated two or more products to be therapeutically and pharmaceutically equivalent. For those drugs, starting in CY2007, the FUL would be equal to 250% of the average manufacturer price. In addition, the definition of AMP is altered to exclude

customary prompt pay discounts extended to wholesalers from those amounts. The price reporting requirements are also modified such that manufacturers would be required to submit, not later than 30 days after the last day of each rebate period, the customary prompt pay discounts extended to wholesalers in addition to the AMP and best price reporting required under current law. The agreement contains additional provisions on reporting including provisions on sales of Medicaid covered drugs that are made at a nominal prices; and that AMP would be reported and calculated on a monthly basis. In addition, the agreement allows states to have access to reported AMP data for multiple source drugs for the purpose of carrying out the Medicaid programs and would require the Secretary to disclose such information through a website accessible to the public. Additionally, the conference agreement allows 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, net of all discounts and rebates. Funds are made available beginning in 2006 for this purpose.

Collection and Submission of Utilization Data for Certain Physician Administered Drugs. Certain drugs administered by physicians in their offices or in another outpatient setting, such as chemotherapy, have often been excluded from the drug rebate program although there is no specific statutory exclusion. This is because providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectible prescription drugs, including cancer drugs. The HCPCS J-codes do not, however, provide states with the specific manufacturer information necessary to enable them to seek rebates. The conference agreement requires that states provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered.

Improved Regulation of Drugs Sold Under a New Drug Application Approved Under Section 505(c) of the Federal Food, Drug, and Cosmetic Act. The conference agreement modifies the existing drug price reporting requirements to include, for single source drugs, innovator multiple source drugs, and any other drugs sold under a new drug application approved (under Section 505c of the Federal Food, Drug and Cosmetic Act, FFDCA) by FDA, both the average manufacturer's price and the manufacturer's best price for such drugs.

The definition of AMP would be modified to include, in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA to be inclusive of the average price paid for such drugs.

In addition, the definition of best price would be modified so that it is inclusive, in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under Section 505(c) of the FFDCA, of the lowest price for an authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the U.S.

Children's Hospital Participation in Drug Discount Program. Section 340(B) of the Public Health Service Act allows certain health care providers, including 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. The conference agreement includes a provision adding Children's Hospitals to the list of providers that may have access to 340(B) discounted prices.

Asset Transfers

Lengthening Look-Back Period. Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value. the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts. The conference agreement would lengthen the look-back period to five years, for all income and assets disposed of by the individual after enactment.

Change in Beginning Date for Period of Ineligibility. The period of ineligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred. The conference agreement would change the start date of the ineligibility period for all transfers made on or after the date of enactment, to begin on 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 Medicaid and would otherwise be receiving institutional level care.

Availability of Hardship Waivers; Additional Provisions on Hardship Waivers. The conference agreement adds requirements that states approve undue hardship requests when the asset transfer penalty would deprive the individual of (a) medical care such that the individual's health or life would be endangered; or (b) food, clothing, shelter, or other necessities of life. States are required to provide notice to recipients about the hardship waivers; a timely processing of the waivers; and, an appeals process. Institutions may file hardship applications on behalf of residents. States may pay nursing facilities to hold beds of residents while applications are pending.

Disclosure and Treatment of Annuities. The conference agreement requires individuals applying for Medicaid-covered LTC services, upon Medicaid application and recertification of eligibility, to disclose to the state a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. The purchase of an annuity is treated as an improper transfer unless the state would be named as a remainder beneficiary to the asset for amounts up to certain Medicaid expenditures. The conference agreement also makes certain annuities subject to estate recovery.

Application of "Income-First" Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse. Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules. The law allows community spouses with more limited income to retain at least a state specified amount set within federal guidelines. If the community spouse's monthly income amount is less than this amount, the institutionalized spouse may choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e., the difference between the community spouse's monthly income and the state-specified minimum monthly maintenance needs allowance). The conference agreement requires states to consider that all income of the institutionalized spouse that could be made available to the community spouse, in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing, has been made before states allocate to the community spouse resources from the institutionalized spouse to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.

Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity. The conference agreement would exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. A state may elect to substitute an amount that exceeds $500,000 but does not exceed $750,000. Beginning in 2011, these dollar amounts are increased,, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average) rounded to the nearest $1,000. Individuals whose spouse, child under age 21, or child who is blind or disabled who lawfully resides in the home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts. The conference agreement would allow state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRC) or a life care 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), declared for the purposes of admission, on their care before they apply for Medicaid. It would also allow certain entrance fees for CCRCs or life care communities to be considered by states to be countable resources for purposes of the Medicaid eligibility determination.

Requirement to Impose Partial Months of Ineligibility. The conference agreement requires that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the penatly period (or ineligibility period) with respect to the disposal of assets.

Authority for States to Accumulate Multiple Transfers into One Penalty Period. Under the conference agreement, for an individual or an individual's spouse who disposes of multiple fractional assets in more than one month for less than fair market value on or after the applicable look-back date, states 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.

Inclusion of Transfer of Certain Notes and Loans Assets. The conference agreement would make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would 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 nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender.

Inclusion of Transfers to Purchase Life Estates. The conference agreement would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to make the purchase of a life estate interest in another individual's home subject to asset transfer penalties unless the purchaser resides in the home for at least one year after the date of purchase.

Expanded Access to Certain Benefits

Expansion of State Long-Term Care Partnership Program. Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) 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-eligible individuals. 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. Under current law, these provisions are limited to selected states.

The conference agreement: (1) requires that existing partnership programs not allow consumer protection standards to be less stringent than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a LTC policy, if the program meets NAIC LTC model regulations and other requirements. In addition, the DHHS Secretary is to develop recommendations for Congress to fund a minimum electronic data set of the LTC insurance partnerships and reciprocal recognition of the policies among states.

Fraud, Waste and Abuse

Encouraging the Enactment of State False Claims Acts. 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. Under the conference agreement, if a state has in effect a law relating to false or fraudulent claims that meets requirements specified in the bill, the FMAP, with respect to any amounts recovered under a state action brought under such a law, is decreased by 10 percentage points.

Employee Education About False Claims Recovery. Under the conference agreement, a state is required to provide that any entity that receives annual Medicaid payments of at least $5 million, as a condition of receiving such payments, must: (1) establish written policies for all employees (and any contractor or agent) of the entity that provide detailed information on state and federal false claims laws and whistle-blower protections under such laws, (2) include in such written polices 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 whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Prohibition on Restocking and Double Billing of Prescription Drugs. The conference agreement would prohibit 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).

Medicaid Integrity Program. The conference agreement establishes a Medicaid Integrity Program, under which the Secretary of HHS shall enter into contracts with eligible entities to carry out its activities, including review of the actions of individuals or entities, audit of claims for payment, identification of overpayments, and education with respect to payment integrity and quality of care. Appropriations for the program total $5 million in FY2006, $50 million in FY2007-FY2008, and $75 million each year thereafter. In each year of FY2006-FY2010, $25 million is appropriated for Medicaid actitivities of the HHS Office of Inspector General. The conference agreement also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program.

Enhancing Third Party Identification and Payment. With certain exceptions, Medicaid is a payer of last resort in cases where another party is legally liable to pay for a beneficiary's care. The conference agreement amends the list of third parties for which states must take all reasonable measures to ascertain legal liability to include self-insured plans, pharmacy benefit managers, and 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 requires a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring third parties to provide, upon request of the state, information to determine health insurance coverage and to cooperate with payment and recovery efforts by Medicaid.

Improved Enforcement of Documentation Requirements. Under the conference agreement, states are prohibited from receiving federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. The agreement provides a listing of acceptable documentation. The requirements do not apply to aliens who are entitled to or enrolled for Medicare benefits, receiving Supplemental Security Income (SSI) benefits, or eligible for Medicaid on such other basis as the Secretary may specify that satisfactory evidence had been previously presented.

Flexibility in Cost Sharing and Benefits

State Option for Alternative Premiums and Cost Sharing. The conference agreement allows states to impose premiums and cost-sharing for any group of individuals for any type of service (except prescribed drugs which are treated separately; see below), through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing provisions in current law for workers with disabilities are not affected.

In general, for individuals in families with income between 100 and 150% FPL: (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state. For individuals in families with income above 150% FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or service cannot exceed 20% of the cost of the item or service.

Certain groups are exempt from paying premiums under this option. There are additional limitations on service-related cost sharing and certain groups and services are exempt from these provisions. Such cost-sharing provisions would be indexed over time.

The agreement allows states to condition the provision of medical assistance on the payment of premiums, and to terminate Medicaid eligibility on the basis of failure to pay a premium if that failure continues for at least 60 days. Providers can also deny care for failure to pay service-related co-payments.

Special Rules for Cost Sharing for Prescription Drugs. Under the conference agreement, states may impose higher cost-sharing amounts for state-identified non-preferred drugs within a class; waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class; and must not apply such

cost-sharing for preferred drugs to persons exempt from cost-sharing. Cost-sharing limits for non-preferred drugs are associated with income classes. In cases in which a prescribing physician determines that the preferred drug would not be effective or would have adverse health effects or both, the state may impose the cost-sharing amount for preferred drugs on the prescribed non-preferred product.

Emergency Room Co-Payments for Non-Emergency Care. The conference agreement would allow states, through a state plan amendment, to impose increased cost-sharing on state-specified groups for non-emergency services provided in an ER, when certain conditions are met. The agreement also provides for limitations on the cost-sharing. The Secretary is required to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers.

Use of Benchmark Benefit Packages. The conference agreement gives states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage. States can only exercise this option for eligibility groups that were established under the state plan on or before the date of enactment of this option. States may choose to provide other wrap-around and additional benefits. Specific groups are exempted from mandatory enrollment in the benefit package option. Benchmark and benchmark-equivalent packages would be nearly identical to those offered under SCHIP, with some additions. For any child under age 19 in one of the major mandatory and optional eligibility groups, wrap-around benefits to the benchmark or benchmark-equivalent coverage includes ESPDT.

State Financing Under Medicaid

Managed Care Organization (MCO) Provider Tax. States' ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets specific rules. One of these rules stipulates that the tax must be broad-based. To meet the broad base requirement under current law an MCO tax must apply to all Medicaid MCOs. The conference agreement would expand 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.

Reforms of Case Management and Targeted Case Management (TCM). The conference agreement clarifies the activities that can be considered case management or targeted case management, and those activities (primarily foster care-related activities) that may not be reimbursed as case management services or TCM.

Additional FMAP Adjustments. Under the conference agreement, if Alaska's FY2006 or FY2007 FMAP for Medicaid or SCHIP is less than its FY2005 FMAP, the FY2005 FMAP shall apply. In addition, in computing Medicaid and SCHIP FMAPs for any year after 2006 for a state that the Secretary of HHS 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 shall disregard such evacuees and their incomes.

DSH Allotment for the District of Columbia. 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. DSH payments are made to each qualifying hospital. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment. The conference agreement would raise the allotments for the District of Columbia for FY2000, 2001, and 2002 from $ 32 million to $ 49 million. The higher allotments would be used to calculate DSH allotments beginning with FY2005 amounts.

Increase In Medicaid Payments to the Insular Areas. For each of FYs 2006 and 2007, the conference Agreement increases the federal Medicaid funding caps in the insular areas. For Puerto Rico, the federal Medicaid cap is increased by $12 million in each of FY2006 and FY2007. For the Virgin Islands and Guam, the federal Medicaid caps is increased by $2.5 million in FY2006, and by $5.0 million in FY2007. For the Northern Marianas, the federal Medicaid cap is increased by $1.0 million in FY2006, and by $2.0 million in FY2007. For American Samoa, the federal Medicaid cap is increased by $2.0 million in FY2006, and by $4.0 million in FY2007. Caps in subsequent years will be indexed.

Other Provisions

Family Opportunity Act

Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children. This provision would create a new optional Medicaid eligibility group for children with disabilities up to age 18 who meet the severity of disability required under the Supplemental Security Income (SSI) program, but whose family income is above the financial standards for SSI but below 300% of the federal poverty level (FPL). Under current law, children with disabilities have generally had to qualify for Medicaid using an income standard that is lower than 300% of FPL. Medicaid coverage for this optional group would be initially effective January 1, 2008 and would be fully phased in starting in FY2010. Within certain limits, states would be permitted to charge monthly premiums (based on income) for Medicaid coverage provided to this new group. Finally, under this option, states must require the parents of Medicaid beneficiaries to enroll in any available employer-sponsored private insurance meeting certain criteria.

Demonstration Projects Regarding Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children. The conference agreement establishes a five-year demonstration project in which up to 10 states could provide a broad range of home- and community-based services to children who would otherwise require services in a psychiatric residential treatment facility.

Development and Support of Family-to-Family Health Information Centers. The conference agreement increases funding for the development and support of new family-to-family health information centers. The purpose of the

family-to-family health information centers is to: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health delivery models; (4) develop a model for collaboration between families of such children and health professionals; (5) provide training and guidance with regard to the care of such children; and (6) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals.

Restoration of Medicaid Eligibility for Certain SSI Beneficiaries. The agreement extends 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 is filed, or (2) the date SSI eligibility is granted.

Money Follows the Person Rebalancing Demonstration

Money Follows the Person Rebalancing Demonstration. The conference agreement authorizes the Secretary to conduct a demonstration project in states to (1) increase the use of home and community-based care instead of institutions by relocating individuals from institutions into the community, (2) expand the state's capacity to provide home and community-based long-term care services for individuals who choose to transition into the community; and (3) to ensure that procedures are in place to provide quality assurance and continuous quality improvement, that is at least comparable to other Medicaid home and community-based services.

State demonstrations would receive additional federal funding for 12 months for home and community based services following an individual's relocation from institutions to the community. The amount of additional funding would be based on a Money Follows the Person enhanced federal matching percentage. State demonstrations must operate for at least two years in a five-year period starting in FY2007, and services for individuals must continue following the demonstration, so long as the person remains eligible for these services. States must also take steps to eliminate barriers to using Medicaid funding to provide long-term care services in the setting of a person's choosing, and meet maintenance of effort requirements. The Secretary would be required to provide technical assistance and oversight to state grantees and conduct and report the findings of a national evaluation. The conference agreement appropriates $250 million for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; $300 million in FY2008; $350 million in FY2009; $400 million in FY2010; and $450 million in FY2011 to carry out the demonstration project.

Miscellaneous

Medicaid Transformation Grants. The conference agreement requires that the Secretary of HHS shall provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in Medicaid.

Examples of innovative methods for which funds may be used include (1) methods for reducing patient error rates through the implementation and use of electronic systems, (2) methods for improving rates of Medicaid collection from estates, (3) methods for reducing waste, fraud, and abuse, (4) implementation of a medication risk management program, (5) methods for reducing outpatient drug expenditures by increasing the utilization of generics, and (6) methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems. Total payments will equal and not exceed $75 million in each of FY2007 and FY2008.

Health Opportunity Accounts. The conference agreement requires the Secretary to establish demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2006. No more than 10 state programs could be established the first five years, though afterwards other programs would be allowed if the earlier ones were not unsuccessful. Among other things, state programs would have to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care. Eligibility for HOAs would be determined by the state, though individuals who are disabled, pregnant, or receiving terminal care or long-term care, would be among those who could not participate.

Participants would have both an HOA and coverage for medical items and services that, after an annual deductible is met, were available under the existing Medicaid state plan and waiver authorities. The deductible would have to be at least 100%, but no more than 110%, of the annual state contributions to the HOA. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

HOAs would be used to pay health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Withdrawals would be made by electronic transfer. Once account holders were no longer eligible for Medicaid they could continue to make withdrawals under these conditions, though accounts could then also be used to pay for health insurance or, at state option, for job training or education. Participants generally would be able to obtain services from Medicaid providers or managed care organizations at the same payment rates that would be applicable if the coverage deductible did not apply, or from any provider for payment rates not exceeding 125% of those rates.

HOA contributions could be made by the state or by other persons or entities, including charitable organizations. Including federal shares, state contributions generally could not exceed $2,500 for each adult and $1,000 for each child.

State Option to Establish Non-Emergency Medical Transportation Program. The agreement allows 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. States are not required to provide such services on a statewide basis, comparable services for all Medicaid enrollees, nor freedom of choice among providers.

Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program. 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). The conference agreement extends a provision of law that requires states to provide up to 12 months of TMA coverage through December 31, 2006.

Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Enrollees. 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. A Medicaid provider that does not have a contract with a Medicaid managed care entity (MCE) that furnishes emergency care to a beneficiary enrolled with that MCO must accept as payment in full no more than the amount otherwise applicable outside of managed care (e.g., in the fee-for-service setting) minus any payments for indirect costs of medical education and direct costs of graduate medical education. In a state where rates paid to hospitals under the state Medicaid plan are negotiated by contract and not publicly released, the payment amount applicable under this provision must be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under the plan for tertiary hospitals.

Expansion of Home and Community-Based Services. Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need institutional care. The conference agreement establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. States that offer this new benefit must establish needs-based criteria to determine an individual's eligibility for HCBS services, and the specific HCBS the individual will receive. The individual does not have to meet an institutional level of care to qualify for services. A state may limit the number of individuals who can participate in this benefit and establish waiting lists. A state is required to use an independent evaluation for determining an individual's eligibility for the HCBS option. The state must establish a written individualized care plan for all individual participating in the HCBS option. For this new benefit, a state may also allow an individual or the individual's representative to receive self-directed home and community-based services.

Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling). Medicaid beneficiaries with disabilities or chronic conditions and federal and state policymakers have been increasing the discretion that beneficiaries have over key elements of the service (e.g., what time a personal care worker comes to the home to help the beneficiary, who provides the service, etc.) These types of programs are broadly known as `self-directed' or `consumer-directed' programs. The conference agreement would allow a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care.

State Children's Health Insurance Program (SCHIP)

Additional Allotments to Eliminate Fiscal Year 2006 Funding Shortfalls. The conference agreement authorizes and appropriates $283, million for the purpose of providing additional SCHIP allotments to shortfall states and territories in FY2006. From the additional FY2006 SCHIP appropriation, after a 1.05% set aside for distribution among the territories, each FY2006 shortfall state would receive an allotment to cover its projected shortfall. Such additional SCHIP allotments are available for one year only. The conference agreement limits the types of payments that may be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the additional FY2006 appropriation available to shortfall states to include child health assistance payments made on behalf of targeted low-income children.

Prohibition Against Covering Nonpregnant Adults with Schip Funds. The conference agreement limits the Secretary of Health and Human Services' Section 1115 waiver authority by prohibiting the approval of new waiver, experimental, pilot, or demonstration projects (approved on or after October 1, 2005) that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The Secretary can continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible children and to pregnant adults. It also allows the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to such projects) approved under the Section 1115 waiver authority before the date of enactment of this act.

Continued Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures. Current law permits qualifying states to receive the SCHIP enhanced federal matching rate for the coverage of certain children enrolled in regular Medicaid. The maximum amount that qualifying states may claim under this allowance is the lesser of the following two amounts: (1) 20% of the state's available FY1998-FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998-FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% spending. Under current law, no 20% spending will be permitted in FY2006 or any fiscal year thereafter. The conference agreement continues the authority for states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid. Tthe conference agreement allows 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, as the case may be) for such Medicaid services made on or after October 1, 2005 under the 20% allowance.

Katrina Relief

Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations. 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: (1) the non-federal (i.e., state) share of expenditures for health care provided to affected individuals (those who resided in a county or parish designated for individual assistance pursuant to the Stafford Act as a result of Hurricane Katrina and continue to reside in the same state) and evacuees (affected individuals displaced to another state) under approved multi-state Section 1115 demonstration projects; (2) reasonable administrative costs related to such projects; (3) only with respect to affected counties and parishes, the non-federal share of expenditures for medical assistance provided to individuals under existing Medicaid and SCHIP state plans; and (4) other purposes, if approved by the Secretary, to restore access to health care in impacted communities