CHAIRMAN'S MARK

TO ACHIEVE THE COMMITTEE'S BUDGET RECONCILIATION INSTRUCTIONS

TO REDUCE THE GROWTH OF OUTLAYS

AS CONTAINED IN H. CON. RES. 95

TABLE OF CONTENTS

TITLE VI - FINANCE

Section 6000. Amendments to Social Security Act; Table of Contents of Title

Current Law

No provisions.

Explanation of Provision

The provision specifies the title of the Act and includes a table of contents.

Subtitle A - Medicaid

CHAPTER 1 - PAYMENT FOR PRESCRIPTION DRUGS UNDER MEDICAID

Section 6001. Pharmacy Reimbursement

(a) Definition of Average Manufacturer Price

Current Law

Medicaid is a health benefits program administered by the states under broad federal guidelines. Its costs are shared by the states and the federal government based on a formula that takes each state's average per capita personal income relative to the national average into account. Federal statute defines certain groups of individuals as mandatory for inclusion in states' programs and other groups that are optional for states. The same is true of benefits covered — federal law defines a number of health care items and services required to be provided under state Medicaid programs, others are optional. Coverage of prescription drugs under Medicaid is an optional service, although all states presently include such coverage.

States have a great deal of flexibility in setting the payment amounts for pharmacies that provide prescription drugs to Medicaid enrollees. The total cost of prescription drugs paid under the Medicaid program, however, is intended to be kept as low as possible through two policies laid out in federal Medicaid law. Total federal reimbursement for state prescription drug

spending is subject to a ceiling called the federal upper limit (FUL), and manufacturers that enter into agreements to have their drugs available to Medicaid beneficiaries must pay states rebates.

Pharmaceutical manufacturers that wish to have their products available to Medicaid beneficiaries enter into "rebate agreements" under which they agree to provide state Medicaid programs with the rebates. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs. In return for entering into agreements with the Secretary, state Medicaid programs are required to cover all of the drugs marketed by those manufacturers (with possible exceptions of 10 categories of drugs that states are allowed to exclude from coverage). Rebate requirements do not apply to drugs dispensed by Medicaid managed care organizations when the drugs are paid as part of the MCOs capitation rate, and to drugs provided in hospitals, and sometimes in physicians' or dentists' offices, or similar settings. Rebate requirements, on the other hand, do apply to prescription drugs provided on a fee-for-service basis as well as to nonprescription items, such as aspirin, when they are prescribed for a Medicaid beneficiary and covered under the state's Medicaid plan.

The rebates are calculated based on the average manufacturer's price (AMP) of each product, and for certain other products, the best price at which the manufacturers sells the drug. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation.

Pharmaceutical manufacturers are required to report to the Secretary of HHS the "best price" at which the manufacturer sells each of its drug products to certain purchasers for the purpose of calculating the rebate amounts. Prices that are nominal in amount are excluded. Nominal prices are defined by CMS to be those that are below 10% of the average manufacturer's price. Based on explanatory material of the Senate Finance committee for OBRA 1990, this exclusion appears to have been intended to allow manufacturers to sell drugs at deeply discounted prices to charitable organizations. The purpose of the nominal price exclusion, however, was never codified nor formalized in regulation.

Explanation of Provision

The provision would modify the definition of AMP to specify that sales exempted from inclusion in the determination of best price, nominal sales, and bona fide service fees would be exempted from the computation of the AMP. The provision further specifies that the computation of AMP would include cash and volume discounts; free goods and nominal price sales that are contingent on purchase requirements or agreements; chargebacks or rebates to a pharmacy (excluding pharmacy benefit managers), or any other direct or indirect discounts; and any other price concessions which may be based on recommendations of the Inspector General of HHS.

The provision would establish a new definition of the *weighted* AMP. The *weighted* AMP would be defined, with respect to the rebate period, as the average manufacturer price for the

form of the drug, weighted by the total number of units sold relative to the sum of all units for all forms of the drug that are therapeutically equivalent and bioequivalent.

For the purposes of computing the AMP, sales by a manufacturer of covered outpatient drugs that are single source, innovator multiple source drugs, or are authorized generics that are made available at nominal prices to the listed entities are to be excluded. Sales to a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area are eligible for sales at the nominal price. The nominal price limitations would not, on the other hand, apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule.

For the purpose of computing the AMP, bona fide user fees are defined as expenses for a service actually performed by an entity for a manufacturer that would have generally been paid for by the manufacturer at the same rate had these services been performed by another entity.

Manufacturers' drug price reporting requirements under Medicaid would be modified to include the total number of units sold for each covered drug for the rebate period, and information and data on any sales made during the reporting period at a nominal price. Such reports would include, for each nominal price sale, the purchaser, the name of the product, the amount or number of units of product sold at the nominal price, and the nominal price paid.

The amendments made by this subsection would become effective as if enacted on January 1, 2006 except for the provisions related to the exclusion of nominal prices from AMP. Those provisions would become effective on the later of the expiration date of a contract in effect on the date of enactment or October 1, 2006 and would apply to sales made and rebate periods beginning on or after that date.

(b) Upper Payment Limit for Ingredient Cost of Covered Outpatient Drugs

Current law

The FUL, the ceiling up to which federal reimbursements for outpatient prescription drug are available, applies to multiple source drugs — those that have at least three therapeutically equivalent drug versions sold by at least three suppliers. The FUL is calculated by the Centers for Medicare and Medicaid Services (CMS) to be equal to 150% of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating the FULs are the lowest of the average wholesale prices (AWP) for each group of drug equivalents. The FUL amounts are calculated and published in regulations by CMS. CMS periodically updates the FUL list and re-publishes those amounts. A state's aggregate payment for all Medicaid prescription drugs with a FUL must not exceed, in the aggregate, the payment levels established by the FUL program. The aggregate cap allows states to increase or decrease

the cost of individual prescription drugs in accordance with state or local markets while maintaining the overall savings created by the FUL program. States may exceed the FUL price for individual prescription drugs as long as their aggregate expenditures do not exceed the amounts that would have otherwise been spent by applying the FUL limit plus a reasonable dispensing fee.

Explanation of Provision

The provision would replace the current FUL requirement with a new FUL formula. The FUL for a single source drug would be equal to 105% of the AMP for the drug. The FUL for a multiple source drug would be equal to 115% of the *weighted* AMP.

For those drugs sold during an initial sales period in which data on sales for the drug are not sufficiently available from the manufacturer to compute the AMP or the *weighted* AMP, the provision would establish a transitional upper payment limit to apply only during such period. During the initial sales period, not to exceed 2 calendar quarters, the upper limit for single source drugs would be calculated to be equal to the wholesale acquisition cost (WAC) for the drug. For first innovator multiple source drugs, the upper limit during the transition period would be calculated to be equal to the AMP for the single source drug rated as therapeutically equivalent minus 10%. For subsequent non-innovator multiple source drugs, one of two rules would apply. First, if the Secretary has sufficient data to determine the weighted AMP for the drug, the upper limit must be the weighted AMP determined for the therapeutically equivalent and bioequivalent form of the drug. Second, if the Secretary does not have sufficient data to determine the weighted AMP for the drug, the upper limit must be the AMP for the single source drug that is rated as therapeutically equivalent and bioequivalent to the drug minus 10%.

The provisions would define wholesale acquisition cost (WAC) to be the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

In the case of an innovator multiple source drug that a prescribing health care provider determines is necessary for treatment of a condition and that a non-innovator multiple source drug would not be as effective for the individual or would have adverse effects for the individual or both, and for which the provider obtains prior authorization in accordance with the states' program, the upper payment limit for the innovator multiple source drug shall be equal to 105% of the AMP for such drug.

The Secretary would be required to update the upper payment limits on a quarterly basis, taking into account the most recent data collected for purposes of determining such limits and the Food and Drug Administration's (FDA) most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations." Beginning on January 1, 2006, the Secretary would be required to collect data with respect to the AMP and volume of sales of covered outpatient drugs or, in the case of covered outpatient drugs that are first marketed after that date, beginning with the first quarter during which the drugs are first marketed.

If there is a lag in the reporting of information on rebates and chargebacks so that adequate data are not available on a timely basis to update the *weighted* AMP for a multiple source drug, the manufacturer would estimate those amounts by applying a methodology based on a 12-month rolling average. For years after 2006, the Secretary would be required to establish a uniform methodology for this purpose. Beginning with the first quarter of FY 2006 for which data are available, and for each fiscal year quarter thereafter, the Secretary would be required to make available to States the most recently reported AMP for single source drugs and the *weighted* AMP for multiple source drugs.

The provision would provide the Secretary with the authority to enter into contracts with appropriate entities to determine AMP, volume and other data necessary to calculate the upper payment limit for a covered outpatient drug and to calculate such limit.

The provision would require the Secretary to devise and implement a means for electronic distribution of the most recently calculated *weighted* AMP and AMP for all covered outpatient drugs to each State Medicaid agency. States would be permitted to use such data in establishing payment rates for covered outpatient drugs under state Medicaid programs.

The provision would require states to pay a dispensing fee for each covered outpatient drug. The dispensing fees for a non-innovator multiple source drug (generally referred to as generics) must be greater than the dispensing fee for an innovator multiple source drug that is rated as therapeutically equivalent and bioequivalent to that drug. States would be required to take into consideration, in setting those fees, such requirements as the Secretary establishes. Those requirements would be required to include: (a) any reasonable costs associated with a pharmacist's time in checking for information about an individual's coverage or performing quality assuring activities, and (b) costs associated with: the measurement or mixing of a covered drug or filling the container, physically providing the prescription to the Medicaid beneficiary, delivery, special packaging, overhead relating to facility maintenance, equipment and staff salaries; and geographic factors that impact operational costs; patient counseling; and the dispensing of drugs requiring specialty pharmacy care management services.

Not later than 15 months after the date of enactment of this Act, the Secretary must establish a list of covered outpatient drugs that require specialty pharmacy care management services, and must update this list on a quarterly basis. This list would include only those drugs, as determined by the Secretary, for which access would be seriously impaired without the provision of specialty pharmacy care management services. The term "specialty pharmacy care management services" means services provided in connection with dispensing or administration of a covered outpatient drug that requires: (1) significant caregiver and provider contact and education regarding relevant disease state, prevention, treatment, drug indications, benefits, risks, complications, use, pharmacy counseling, and explanation of existing provider guidelines; (2) patient compliance services, including coordination of provider visits with drug delivery, compliance with a drug dosing regimen, mailing or telephone call reminders, compiling compliance data, and assisting providers in developing compliance programs; or (3) tracking services, including developing referral processes with providers, screening referrals, and tracking patient weight and dosing requirements.

Provisions in Subsection (b) would become effective on the later of January 1, 2007 or six months after the close of the first regular session of the State legislature that begins after the date of enactment.

(c) Interim Upper Payment Limit

During the period January 1, 2006 through the effective date as defined above, the Secretary would apply the FUL as under current law and regulations except that instead of limiting federal matching at 150% of AWP, it would be 125% of AWP. In the case of covered outpatient drugs that are marketed as of July 1, 2005, the Secretary would be required to use the AWPs, direct prices, and WACs in those determinations. For new drugs that are first marketed between July 1, 2005 and January 1, 2007, the federal matching would be limited to 125% of AWP.

Section 6002. Increase in Rebates for Covered Outpatient Drugs

Current Law

Since December 31, 1995, basic Medicaid rebates for single source and innovator multiple source drugs are equal to the greater of 15.1% of the AMP or the difference between the reported AMP and best price for each drug. Since December 31, 1993, the basic rebate for all other multiple source drugs is equal to 11% of the AMP.

Explanation of Provision

The provision would modify the formulas for prescription drug rebates under the Medicaid program. Beginning on January 1, 2006, rebates for single source and innovator multiple source drugs would be equal to the greater of 17% of the AMP or the difference between the reported AMP and the best price for each drug.

Changes to the rebate formula would begin on January 1, 2006.

Section 6003. Improved Regulation of Authorized Generic Drugs

Current Law

Under the Medicaid drug rebate program, rebate amounts are calculated separately for brand name drug products provided to Medicaid beneficiaries and for generics. The rebate for brand name drugs, referred to as single source and innovator multiple source drugs, is equal to the greater of 15.1% of the average manufacturer's price (AMP) or the AMP minus the best price available from the manufacturer. The rebates for generics, referred to as multiple source drugs, is equal to 11% of the AMP.

Prescription drug manufacturers participating in the Medicaid program are required to report to the Secretary of HHS data on the AMP for each pharmaceutical product offered under Medicaid and, for each brand name drug product, the best price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or governmental entity. The term 'best price' is defined in the Medicaid statute but only with respect to brand name drugs since the best price is part of the rebate computation for only those drugs.

Drug price reporting is based on each drug product's unique "national drug code" (NDC). For each product for which pricing has been reported, HHS calculates the rebate amount. The NDC code numbers are assigned to each drug product by the Food and Drug Administration (FDA) together with the manufacturers.

Sometimes manufacturers produce both a brand name version of a prescription drug and also sell or license a second manufacturer (or a subsidiary) to produce some of the same product to be sold or re-labeled as a generic. These generics, called "authorized generics," are usually distributed by a second manufacturer and are provided with a separate NDC code. The rebate is calculated for each manufacturer's product and, for brand name products, takes into account the best price reported for each drug. Such price often does not include the price of the product sold as the authorized generic both because it is considered a separate product (with its own unique NDC number) and is sold by a separate manufacturer.

Explanation of Provision

The provision would modify the current law definition of AMP 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 manufacturer price paid for such drugs.

The current law definition of best price would be changed to apply not only to each single source drug and innovator multiple source drug, but also to each authorized generic drug, or any other drug of a manufacturer that is sold under a new drug application (NDA) approved by (under Section 505c of FFDCA) FDA. In addition, the definition would be modified so that the best price, 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, is inclusive of the lowest price such authorized generic or other drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity except for those entities excluded under current law.

The provision would modify the current law definition of AMP 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 manufacturer price paid for such drugs.

Finally, the provision would add a definition of authorized generic drug to the definitions section of the outpatient prescription drug provisions of Medicaid law. An authorized generic drug would be defined as a drug listed (as the term is used in Section 505j of FFDCA) that has

been approved by the FDA under Section 505(c) of such Act and is marketed, sold or distributed directly or indirectly to the retail class of trade under a different labeling, packaging (other than repackaging the listed drug for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.

The provision would become effective on October 1, 2005.

Section 6004. Collection and Submission of Rebates for Certain Physician-Administered Drugs

Current Law

Manufacturers are required to provide rebates to states for all outpatient prescription drugs with some exceptions. Outpatient prescription drugs provided through managed care organizations are explicitly exempted from the rebate requirement. In addition, outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs are exempt from the rebate requirement. 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 NDC number is necessary for the state to bill manufacturers for rebates. CMS has requested that states identify Medicaid drugs, specifically those using HCPCS J-codes, by their NDC codes so that rebates can be collected for these drugs (Letter to State Medicaid Director, SMDL #03-002, dated March 14, 2003). CMS has concluded that because of this coding, many state Medicaid programs have not collected rebates on these drugs, resulting in millions of dollars in uncollected rebates.

Explanation of Provision

As a condition of receiving Medicaid payment, states would be required to submit to the Secretary of HHS, utilization data and coding information for physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required. The reporting would include J-codes and National Drug Code numbers. The purpose of the reporting would be to allow the Secretary to secure rebates for such drugs.

Effective upon enactment.

CHAPTER 2 - LONG-TERM CARE UNDER MEDICAID

Section 6011. Reform of Medicaid Asset Transfer Rules

(a) Requirement to Impose Partial Months of Ineligibility

Current Law

Current law requires states to 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, the rules require states to 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.

The length of the delay 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. For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

When calculating the length of the penalty period when assets are transferred for less than fair market value, current law allows states to "round down," or not include in the ineligibility period the quotient amounts (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month. For example, in a state with an average private stay in a nursing home of $4,100, an ineligibility period for an improper transfer of $53,000 could be 12.92 months (i.e. $53,000/$4,100=12.92). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31 day month), other states may round down the quotient to an ineligibility period of 12 months only.

Explanation of the Provision

This provision would amend Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period.

(b) Authority for States to Accumulate Multiple Transfers into One Penalty Period

Current Law

Current law and additional CMS guidance provides that when a number of assets are transferred for less than fair market value on or after the look-back date during the *same* month, the penalty period is calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or individual's spouse) divided 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. When a number of assets are transferred during *different* months, then the rules vary based upon whether the penalty periods overlap. If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

Explanation of Provision

This provision would amend Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, 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.

(c) Inclusion of Transfer of Certain Notes and Loans Assets

Current Law

Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets.

Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Under Medicaid and SSI rules, non-countable assets include an

individual's primary place of residence, one automobile, household goods and personal effects,[1] property essential to income-producing activity, up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500, and miscellaneous other items.

Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

Explanation of Provision

This provision would amend Section 1917(c)(1) of the Social Security Act to 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.

In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

(d) Treatment of Annuities

(1) Inclusions of Transfers to Purchase Balloon Annuities

Current Law

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 State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound.

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1 Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, no. 24, Feb. 7, 2005.

States and courts interpret this guidance differently. In *Mertz v. Houston*, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. In a recent case in Ohio, a state court ruled that it was proper to look at the intent of asset transfers, even if the annuity was actuarially sound. (*Bateson v. Ohio Dept. of Job and Family* (Ohio Ct. Appl., 12th, No. CA2003-09-093, Nov. 22, 2004).

Explanation of Provision

This provision would amend section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

(2) Requirement for State to be Names as a Remainder Beneficiary

Current Law

No provision.

Explanation of Provision

This provision would amend section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

(3) Inclusion of Certain Annuities in an Estate

Current Law

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 to only 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.

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state *probate* law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. Thus assets such as living trusts, life insurance policies, certain annuities, which may pass to heirs outside of probate, would be subject to Medicaid recovery only if a state expanded its definition of "estate."

Explanation of Provision

This provision would amend Section 1917(b)(4) of the Social Security Act to include an annuity in the definition of estate that is subject to estate recovery unless the annuity was purchased from a financial institution or other business that sells annuities in the state as part of its regular business.

(e) Inclusion of Transfers to Purchase Life Estates

Current Law

Current law does not specify whether life estates should be treated as countable or non-countable assets for purposes of applying the Medicaid asset transfer rules. In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets. The guidance also explains that a transfer for less than fair market value occurs whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate. According to CMS, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

Explanation of Provision

This provision would amend Section 1917(c)(1) of the Social Security Act to add a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

(f) Protection Against Undue Hardship

Current Law

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

CMS guidance requires that state procedures, at a minimum, provide for and discuss (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Explanation of Provision

This provision would amend Section 1917(c) of the Social Security Act by adding a requirement that states establish undue hardship procedures (in accordance with standards specified by the Secretary) that would provide for: (1) a notice that an undue hardship exception exists before the imposition of a penalty period to an applicant for Medicaid who would be subject to such a penalty; (2) a timely process before the imposition of a penalty for determining whether an undue hardship waiver will be granted for the individual; (3) a process under which an adverse determination can be appealed; and (4) an application of criteria that specifies that undue hardship exists when application of the ineligibility period or counting of trusts would deprive the individual of medical care so that the individual's health or life would be endangered or when it would deprive the individual of food, clothing, shelter, or other necessities of life.

(g) Effective Dates

Current Law

No provision.

Explanation of Provision

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act's enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act. In the case of a state that has a two-year legislative session, each year of the session would be considered to be a separate regular session of the state legislature.

Section 6012. State long-term care partnerships

Current Law

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; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.

In general, states allow individuals to retain no more than $2,000 in countable assets and exempt certain non-countable assets such as an individual's primary place of residence, one automobile, household goods and personal effects.

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. All of these states, except Iowa, have implemented programs, known as Long-Term Care Partnership programs. .

The four partnership states with active programs have different models for determining the amount of assets that an eligible participant may protect. Connecticut and California use a *dollar-for-dollar* model, in which the amount of the assets protected is equivalent to the value of the benefit package paid by the policy purchased (e.g., $100,000 of nursing home or assisted living coverage enables that individual to retain up to $100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a *total asset protection* model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policies, LTC insurance products are

largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners
(NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including the following:

Model Regulations:
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Requirements to deliver shopper's guide.

Model Act:
- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary;
- Accelerated death benefits; and
- Incontestability period.

While many state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards. As a result, there is significant variation in regulatory practices across states.

Explanation of Provision

This provision would amend section 1917(b)(1)(C)(ii) of the Social Security Act to exempt two groups of persons with certain long-term care insurance plans from Medicaid estate recovery. They would include individuals who received Medicaid: (1) under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below and (2) under a current LTC insurance partnership program in one of the 5 state (in which the state received approval for state plan amendments as of May 14, 1993 allowing for the disregard of any assets or resources to the extent that payments are made under a *LTC insurance policy* or because an individual has received (or is entitled to receive) benefits under a *LTC insurance policy)* and the Medicaid state plan satisfies requirements B through G described below as long as the LTC insurance policy was sold on or after 2 years after enactment.

This provision would define *LTC insurance policies* as including, but not limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term "Qualified State LTC Insurance Partnership," would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another state's Qualified LTC Insurance Partnership" or a long-term care insurance policy in 2 above, the same as the state treats benefits paid under such a policy under the state's plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed $250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest $100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold;

(F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and

(G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective.

LTC insurance policies would be required to meet the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). The requirements include the following topics described below.

Model Regulations:

Guaranteed renewal or noncancellability with the exception of paragraph (5) and the requirements of section 6B of the Model Act relating to such section 6A

Prohibitions on limitations and exclusions with the exception of paragraph (7);
Extension of benefits;
Continuation or conversion of coverage;
Discontinuance and replacement of policies;
Unintentional lapse;
Disclosure with the exception of section 8F, 8G, 8II, and 8I
Required disclosure of rating practices to consumer;
Prohibitions against post-claims underwriting;
Minimum standards;
Application forms and replacement coverage;
Reporting requirements;
Filing requirements for marketing;
Standards for marketing, including inaccurate completion of medical histories with the exception of paragraphs (1), (6), and (9) of section 23C;
Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
Standard format outline of coverage; and
Deliver shopper's guide.

Model Act:

Preexisting conditions;
Prior hospitalization;
Contingent nonforfeiture benefits;
Right to return;
Outline of coverage;
Requirements for certificates under group plans;
Policy summary; and
Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act would be treated as including any other provision the Regulation or Act necessary to implement the provision. The determination of whether any requirement under the Model Act or Regulation have been met would be made by the Secretary.

These amendments would become effective on October 1, 2007 and apply to long-term care insurance policies sold on or after that date.

No later than one year after enactment, the Secretary, in consultation with the NAIC, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies would be required to develop uniform standards for:

Reciprocity. These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such LTC insurance partnerships;

Minimum reporting requirements. These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;

Suitability. These standards would be for determining whether a long-term care insurance policy is appropriate for the needs of an applicant (based on guidance of the NAIC regarding suitability).

The Secretary, in consultation with those listed above, would also be required to submit recommendations to Congress with respect to the following:

Incontestability. Recommendations regarding whether the requirements relating to incontestability for LTC insurance policies sold under a state LTC insurance partnership program should be modified based on guidance of the NAIC regarding incontestability;

Nonforfeiture. Recommendations regarding whether requirements relating to nonforfeiture for issuers of LTC insurance policies under a state LTC insurance partnership program should be modified to reflect changes in an insured's financial circumstances;

Independent certification for benefits assessment. Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be conducted by independent entities should be established for issuers of LTC insurance policies under such a state partnership program, and if so, what such standards should be;

Rating requirements. Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for LTC insurance policies sold under such a state partnership program should be established and if so, what such standards should be; and

Dispute Resolution. Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under LTC insurance policies sold under such a state partnership program and the delivery of the benefits promised under such policies.

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures.

CHAPTER 3 - ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID

Section 6021. Enhancing Third Party Recovery

Current Law

Third-party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. In general, federal law requires Medicaid to be the payor of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered medical support (including health insurance) from noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (with certain exceptions, such as the Indian Health Service).

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. To this end, they must: (1) collect health insurance information from individuals at the time of initial application for Medicaid and during any subsequent redeterminations of eligibility, (2) match data provided by Medicaid applicants and recipients to certain files maintained by government agencies (e.g., state wage and income, Social Security Administration wage and earnings, state workers' compensation, state motor vehicle accident reports), (3) identify claims with diagnosis codes that would indicate trauma-related injury for which a third party may be liable for payment, and (4) follow up on TPL leads identified through these information-gathering activities.

If the state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

As a condition of eligibility for Medicaid, individuals are required to assign to the state Medicaid agency their rights to medical support and payment for medical care from any third party. This assignment of rights facilitates TPL recovery by allowing the state to collect, on behalf of Medicaid enrollees, amounts owed by third parties for claims paid by Medicaid.

Explanation of Provision

(a) Clarification of Right of Recovery Against Any Third Party Legally Responsible for Payment of a Claim for a Health Care Item or Service

This subsection would amend the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include: (1) self-insured plans, (2) pharmacy benefit managers, and (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It would also amend 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.

(b) Requirement for Third Parties to Provide the State with Coverage Eligibility and Claims Data

A state would be required to provide assurances satisfactory to the Secretary that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state, to: (1) provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid, (2) accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the state, (3) respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided, and (4) agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim.

(c) Effective Date

The provision would be effective January 1, 2006 (except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance).

Section 6022. Limitation on Use of Contingency Fee Arrangements

Current Law

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or human resources umbrella agency, will often contract with other public or private entities (e.g., other state agencies or departments, consulting firms) to perform various administrative functions. In some cases, contingency fee arrangements are used to pay contractors based on Medicaid dollars saved, recovered, or otherwise obtained for the state (e.g.,

a fee equal to 10% of third party liability collections). The federal reimbursement rate for most Medicaid administrative costs is 50%.

In determining the amount of administrative costs — including contingency fees — that may be eligible for federal reimbursement, states must comply with a number of federal statutes and regulations. In general, federal Medicaid law requires states to use methods of administration that are found by the Secretary of HHS to be necessary for the proper and efficient operation of their Medicaid programs. With regard to contingency fee contracts, guidance issued by the Centers for Medicare and Medicaid Services to its regional offices in 2002 notes that in order to be eligible for federal reimbursement, contingency fees must: (1) be based on Medicaid cost avoidance savings or recoveries in which the federal government shares, (2) be intended to produce Medicaid program savings, not additional expenditures reported for federal reimbursement, and (3) not be contingent upon recoveries from the federal government. CMS guidance also notes that states may not claim federal reimbursement for contingency fee payments made to another government unit for Medicaid administrative activities.

Additional federal guidance is contained in Office of Management Budget (OMB) Circular A-87, which establishes principles and standards for determining allowable costs for states (and other governmental units) under federal grant programs such as Medicaid. The circular specifies that the cost of professional and consultant services are allowable when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the federal government (meaning that the state may not claim federal reimbursement for payments made to a contractor whose fees are dependent on obtaining additional federal dollars for the state).

Explanation of Provision

(a) In General

States would not be eligible for federal reimbursement of amounts expended in connection with a contract or agreement (other than a Medicaid managed care contract) between the state Medicaid agency (or any state or local agency that administers a portion of the Medicaid program) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet standards established by the Inspector General of HHS.

(b) Contingency Fee Arrangement Standards

The Inspector General of HHS would issue standards for the terms of compensation of consultants and other individuals or entities contracting with state agencies (or their designees) administering state Medicaid programs. The standards would be designed to ensure prudent purchasing and program integrity with respect to federal funds. The Inspector General would annually review the standards and revise them as necessary to promptly address new compensation arrangements that may present a risk to Medicaid program integrity.

The standards would be issued no later than six months after enactment of this provision.

(c) Effective Date

The requirements in subsection (a) would be effective January 1, 2007 (except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance).

Section 6023. Encouraging the Enactment of State False Claims Acts

Current Law

Under the federal False Claims Act, anyone who knowingly submits a false claim (whether directly or indirectly) to the federal government is liable for damages up to three times the amount of the government's damages plus mandatory penalties of $5,500 to $11,000 for each false claim submitted. Under *qui tam* (whistleblower) provisions of the act, private citizens with knowledge of potential violations ("relators") may file suit on behalf of the government and are entitled to receive a share of the proceeds of the action or settlement of the claim (ranging from 15 to 30 percent, depending on whether or not the government elects to participate in the case).

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.

Explanation of Provision

(a) In General

If a state has in effect a law relating to false or fraudulent claims that meets certain requirements (described below), the federal medical assistance percentage, with respect to any amounts recovered under a state action brought under such a law, shall be decreased by 10 percentage points.

The state law relating to false and fraudulent claims must be determined by the Inspector General of HHS, in consultation with the Attorney General, to:(1) establish liability to the state for false or fraudulent claims described in the federal False Claims Act, with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal False Claims Act, (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act, (5) contain provisions that are designed to prevent a windfall recovery for a *qui tam* relator that files a federal and state action for the same false or fraudulent claim.

(b) Effective Date

The provision would be effective January 1, 2007.

Section 6024. Employee Education about False Claims Recovery

Current Law

No provision.

Explanation of Provision

(a) In General

A state would be required to provide that any entity that receives annual Medicaid payments of at least $1 million, as a condition of receiving such payments, must: (1) establish written policies, procedures, and protocols for training of all employees of the entity, and of any contractor or agent of the entity, that includes a detailed discussion of the federal False Claims Act, federal administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, (2) include in such written materials detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, (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, and (4) require mandatory training for all employees of the entity and of any contractor or agent of the entity, at the time of hiring, with respect to such laws and the entity's policies and procedures for detecting fraud, waste, and abuse.

(b) Effective Date

The requirement would be effective January 1, 2007 (except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance).

Section 6025. Prohibition on Restocking and Double Billing of Prescription Drugs

Current Law

In the case U.S. ex rel. Quinn v. Omnicare, Inc., 382 F. 3d 432 (3rd Cir. 2004), the Third Circuit held that the Medicaid statute does not explicitly prevent pharmacists from billing the Medicaid program twice for selling the same drugs. The practice, referred to as "restocking," occurs when a pharmacy resells drugs returned by hospitals or nursing homes. The medications

often were for patients who had died and for whom the state had already been billed. The restocked drugs are then re-dispensed and Medicaid is billed a second time.

Explanation of Provision

Provision would prohibit federal matching payments for the cost of a covered outpatient drug claim if the claim has already been submitted and for which the pharmacy has already received payment.

Would become effective on the first day of the first fiscal quarter beginning after enactment.

Section 6026. Medicaid Integrity Program

Current Law

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

Explanation of Provision

(a) Establishment of Medicaid Integrity Program; Medicaid CFO; Medicaid Program Integrity Oversight Board

A Medicaid Integrity Program would be established under title XIX. The Secretary of HHS would enter into contracts with eligible entities to carry out the program's activities, which would include: (1) review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, (2) audit of claims for payment for items or services furnished or for administrative services rendered, (3) identification and recovery of overpayments to individuals or entities receiving federal funds under Medicaid, (4) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

An entity would be eligible to enter into a contract to carry out Medicaid Integrity Program activities if it meets eligibility and contracting requirements similar to those under the Medicare Integrity Program. Beginning in FY2006 and every five years, the Secretary — in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of HHS, and state officials with

responsibility for controlling provider fraud and abuse under Medicaid — would establish a comprehensive plan for ensuring Medicaid program integrity by combating fraud, waste, and abuse. Appropriations for the Medicaid Integrity Program would total $50 million in FY2006, $50 million in FY2007, $50 million in FY2008 and $75 million in each fiscal year after FY2008. No later than 180 days after the end of each fiscal year (beginning with FY2006), the Secretary would submit a report to Congress that identifies the use and effectiveness of the use of funds appropriated for the program.

A Medicaid Chief Financial Officer (CFO) and Medicaid Program Integrity Oversight Board would also be established under title XIX. The Medicaid CFO would be appointed by and would report directly to the Administrator of the Centers for Medicare and Medicaid Services. The duties and authority of the Medicaid CFO would be comparable to those of other CFOs with respect to the management and expenditure of federal funds under federal health care programs. A Medicaid Program Integrity Oversight Board would also be established by the Secretary. The duties and authority of the board would be comparable to those of the Medicare Contractor Oversight Board, and would include responsibility for identifying vulnerabilities and developing strategies for minimizing integrity risks to state Medicaid programs.

(b) State Requirement to Cooperate with Integrity Program Efforts

States would be required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program, or the duties of the Medicaid CFO and the Medicaid Program Integrity Oversight Board.

(c) Increased Funding for Medicaid Fraud and Abuse Control Activities

In each of fiscal years 2006 through 2010, $25 million would be appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended).

(d) Increase in CMS Staffing Devoted to Ensuring Medicaid Program Integrity.

The Secretary would significantly increase the number of full-time equivalent employees whose duties consist solely of ensuring the integrity of the Medicaid program by providing states with support and assistance to combat provider fraud and abuse.

(e) Delayed Effective Date

In the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance with the Medicaid state plan requirements of this chapter, the plan would not be regarded as failing to comply solely on the basis of its failure to meet the

requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this act.

CHAPTER 4 — STATE FINANCING

Section 6031. Targeted Case Management

Current Law

Under current Medicaid law (Section 1915(g)(2) of the Social Security Act), targeted case management is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. Targeted case management services are an optional benefit under the Medicaid state plan. The term "targeted case management" (TCM) refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of Medicaid eligible individuals as defined by the state (e.g., those with chronic mental illness), or persons who reside in a specific area.

Several states extend the Medicaid TCM benefit to individuals who may also be receiving case management services as a component of another state and/or federal program. For example, a state may provide TCM services for Medicaid beneficiaries in foster care – defined in the Medicaid state plan as "children in the state's custody and who are placed in foster homes." As part of the foster care program, children receive certain case management services regardless of whether or not they are a Medicaid beneficiary.

In addition, the existing federal guidance is conflicting with respect to the process states should follow to claim Medicaid reimbursement for TCM services when another program also covers case management services for the same beneficiary. The State Medicaid Manual (Section 4302.2) states that claims for targeted case management services must be fully documented for a specific Medicaid beneficiary in order to receive payment. In addition, documentation that includes time studies and cost allocation plans "are not acceptable as a basis for Federal participation in the costs of Medicaid services." Cost allocation plans are a narrative description of the procedures that a state agency uses in identifying, measuring, and allocating the state agency's administrative costs incurred for supervising or operating programs. Per federal regulations (45 CFR 95.505), the cost allocation plan does not include payments for services and goods provided directly to program recipients. However, a State Medicaid Director's (SMD) letter dated January 19, 2001, which discusses targeted case management services for children in foster care under the federal Title IV-E program, requires states to "properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program." Thus, this letter extended the application of cost allocation plans to claim reimbursement for case management services when a child is receiving these services under both the Title IV-E (foster care) and Medicaid programs.

Explanation of Provision

This proposal would further define the Medicaid TCM benefit under Section 1915(g)(2) of the Social Security Act, and would codify the ability of states to use an approved cost

allocation plan (as outlined under OMB Circular A-87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.

Specifically, the proposal would clarify that the TCM benefit includes the following: 1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; 2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; 3) referral and related activities to help an individual obtain needed services; and 4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The proposal would also specify certain activities that are not reimbursable as TCM services. First, the TCM benefit would *not* include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. In addition, with respect to the direct delivery of foster care services, the TCM benefit would *not* cover: research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the *eligible* individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.

Finally, consistent with existing Medicaid law, this proposal would also specify that federal 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.

Section 6032. Temporary Federal Matching Payments for Medical Assistance

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal reimbursement rate for Medicaid administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive enhanced (usually 75%) reimbursement.

SCHIP service expenditures are reimbursed at an enhanced FMAP that varies by state and may range from 65% to 85%, subject to the availability of funds from a state's federal SCHIP allotment. SCHIP administrative expenditures are reimbursed using the enhanced FMAP that applies to SCHIP services; however, federal reimbursement for SCHIP administrative expenditures is capped at 10% of the state's SCHIP allotment.

P.L. 106-554 (Consolidated Appropriations Act of 2001), provided that for fiscal years 2001 through 2005, the FMAP for Alaska would be calculated using the Alaska per capita personal income divided by 1.05, instead of the Alaska per capita personal income. Dividing the per capita personal income by 1.05 lowers the per capita personal income and serves to increase the FMAP.

Explanation of Provision

(a) Temporary Federal Matching Payments for Medical Assistance.

For items and services furnished during the period that begins on August 28, 2005, and ends on May 31, 2006, the FMAP would be 100% for providing medical assistance under a Medicaid state plan to any specified individual (described in subsection (b)). Costs directly attributable to all administrative activities that relate to the provision of such medical assistance would also be reimbursed at 100%. In addition, the federal reimbursement rate for providing child health assistance under an SCHIP state plan to any specified individual, as well as for costs directly attributable to all related administrative activities, would be 100% during the period.

(b) Specified Individual defined.

The provision would define a specified individual as any individual who had a primary residence in a parish or county during the week preceding August 28, 2005.

In Louisiana, the parishes of Acadia, Ascension, Assumption, Calcasieu, Cameron, East Baton Rouge, East Feliciana, Iberia, Iberville, Jefferson, Jefferson Davis, Lafayette, Lafourche, Livingston, Orleans, Pointe Coupee, Plaquemines, St. Bernard, St. Charles, St. Helena, St. James, St. John, St. Mary, St. Martin, St. Tammany, Tangipahoa, Terrebonne, Vermilion, Washington, West Baton Rouge, and West Feliciana.

In Mississippi, the counties of Adams, Amite, Attala, Claiborne, Choctaw, Clarke, Copiah, Covington, Forrest, Franklin, George, Greene, Hancock, Harrison, Hinds, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lamar, Lauderdale, Lawrence, Leake, Lincoln, Lowndes, Madison, Marion, Neshoba, Newton, Noxubee, Oktibbeha, Pearl River, Perry, Pike, Rankin, Scott, Simpson, Smith, Stone, Walthall, Warren, Wayne, Wilkinson, Winston, and Yazoo.

In Alabama, the counties of Baldwin, Choctaw, Clarke, Marengo, Mobile, Pickens, Greene, Hale, Sumter, Tuscaloosa, and Washington.

(c) Temporary Provision Relating to Alaska.

Provides that for fiscal years 2006 and 2007, if the Alaska FMAP calculated under the formula is less than the fiscal year 2005 Alaska FMAP (57.58), then the Alaska FMAP for that fiscal year would be 57.58 (the fiscal year 2005 Alaska FMAP).

CHAPTER 5 - IMPROVING THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

Subchapter A - Family Opportunity Act

Section 6041. Short Title of Subchapter

Current Law

No provision.

Explanation of Provision

The provision specifies the subchapter of the Act.

Section 6042. Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children

(a)(1) State Option to Allow Families of Disabled Children to Purchase Medicaid Coverage for Such Children

Current Law

For children with disabilities, there are a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. Generally, when a child lives with a parent, that parent's income and resources are counted when determining a child's financial eligibility for Medicaid.

There are four main coverage groups for which disability status or medical need is directly related to eligibility. First, states are required to cover children receiving Supplemental Security Income (SSI) for which the income threshold is about 75% FPL nationwide. SSI is a federal cash assistance program for certain persons with disabilities. (Under the 209(b)

provision, some states apply more restrictive financial standards and/or methodologies for determining Medicaid eligibility than the standards under SSI.) Second, states may offer medically needy coverage under Medicaid. The medically needy (MN) are persons who fall into one of the categories of eligibility (e.g., dependent children) and whose income is no higher than 133 and 1/3% of the state's former Aid to Families with Dependent Children (AFDC) payment standard in effect on July 16, 1996. These standards are typically lower than the current FPL. Individuals can meet these financial criteria by having income that falls below the MN standard, or by incurring medical expenses that when subtracted from income, result in an amount that is lower than the MN standard. Third, states may extend Medicaid to certain children with disabilities under 18 who are living at home and who would be eligible for Medicaid via the SSI pathway if they were in a hospital, nursing facility, or intermediate care facility for the mentally retarded, as long as the cost of care at home is no more than institutional care. (This group is also called the Katie Beckett or TEFRA category.) The law allows states to consider only the child's finances when determining eligibility for this group. Fourth, states have an option to cover persons needing home and community based services, if these persons would otherwise require institutional care covered by Medicaid. These services are provided under waiver programs authorized under Section 1915(c) of Medicaid law. States may ignore parents' income in determining a child's eligibility for waiver services. Unlike the Katie Beckett option which requires that all qualified children with disabilities within a state be covered, waiver programs may be limited to specific geographic areas, and/or may target specific groups. States may also cap the number of people who can receive waiver services.

Children with disabilities can also qualify for Medicaid via other eligibility pathways for which disability status and medical need are irrelevant. For example, parents and children in families with income that meets AFDC financial standards (typically below the FPL) must be covered under Medicaid. Additional pathways cover children at higher income levels than those applicable to most of the disability-related eligibility categories. States are required to provide Medicaid coverage to children under age 6 (and pregnant women) in families with incomes below 133% FPL, and for children between ages 6 and 18 in families with income below 100% FPL. States may cover infants under age 1 (and pregnant women) in families with income between 133% and 185% FPL. Similarly, under the State Children's Health Insurance Program (SCHIP), states may extend Medicaid coverage to children under age 19 in families with income above the applicable Medicaid standard but less than 200% FPL, or in states that already exceed the 200% FPL level for Medicaid children, within 50 percentage points over that existing level.

Explanation of Provision

A new optional eligibility group for certain children with disabilities would be added to Medicaid statute. In general, the new group would include children up to 18 who meet the disability definition for children under the SSI program, and whose family income is above the financial standards for SSI but not more than 300% FPL. States would be permitted to exceed 300% FPL, but federal financial participation would not be available above that level. Medicaid coverage would be phased in depending on a child's age, beginning with qualifying children with disabilities: up to age 6 beginning January 1, 2008; up to age 12 in FY2009, and up to age 18 in FY2010 forward. This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.

(a)(2) Interaction with Employer-Sponsored Family Coverage

Current Law

States may require Medicaid eligibles to apply for coverage in certain employer-sponsored group health plans (in which such persons are eligible) when it is cost-effective to do so (defined below). This requirement may be imposed as a condition of continuing Medicaid eligibility, except that failure of a parent to enroll a child must not affect the child's continuing eligibility for Medicaid. If all members of the family are not eligible for Medicaid, and the group health plan requires enrollment of the entire family, Medicaid will pay associated premiums for full family coverage if doing so is cost-effective. However, Medicaid will not pay deductibles, coinsurance or other cost-sharing for family members ineligible for Medicaid. Third party liability rules apply to coverage in a group health plan. That is, such plans, not Medicaid, must pay for all covered services under the plan.

"Cost-effectiveness" means that the reduction in Medicaid expenditures for Medicaid beneficiaries enrolled in a group health plan is likely to be greater than the additional costs for premiums and cost-sharing required under the group health plan.

"Group health plan" means a plan of (or contributed to by) an employer or employee organization to provide health care (directly or otherwise) for employees and their families.

Explanation of Provision

When certain conditions, described below, are met, states must require parents of children eligible for the newly defined coverage group to enroll in employer-sponsored family coverage. Specifically, when the employer of such a parent offers family coverage under a group health plan, the parent is eligible for such coverage, and the employer contributes at least 50% of the annual premium costs, states must require participation in such employer-sponsored family coverage plan as a condition of continuing Medicaid eligibility for the child. Also, if such coverage is obtained, states must reduce premiums by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability. States may pay any portion of a required premium for family coverage under an employer-sponsored plan; for families with income that does not exceed 300% FPL, the federal government would share in the cost of these payments. These employer-sponsored plans, not Medicaid, must pay for all covered services under the plan, as is the case with all other third party liability situations. This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.

(b) State Option to Impose Income-Related Premiums

Current Law

Generally, for certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. Further, states are specifically prohibited from requiring payment

of deductions, cost-sharing or similar charges for services furnished to persons under 18 years of age (up to age 21, or any reasonable subcategory of such persons between 18 and 21 years of age, at state option).

In certain circumstances, states may impose monthly premiums for enrollment in Medicaid. For example, states may require certain working individuals with disabilities (who but for earnings would be eligible for SSI) to pay premiums and other cost-sharing charges set on a sliding scale based on income. For one of these eligibility groups, states may require such persons with income between 250% to 450% FPL to pay the full premium. However, the sum of such payments may not exceed 7.5% of income.

For other groups, states may not require prepayment of premiums and may not terminate eligibility due to failure to pay premiums, unless such failure continues for at least 60 days. States can also waive premiums when such payments would cause undue hardship.

Explanation of Provision

The provision would add a new section to Medicaid law governing premiums applicable to the new optional eligibility group. It would allow states to require families with children with disabilities who would be eligible for Medicaid under the new optional eligibility group to pay monthly premiums for enrollment in Medicaid on a sliding scale, based on family income.

Such a premium requirement could *only* be applied if specific caps on aggregate payments for cost-sharing (premiums plus other charges) for employer-sponsored family coverage are met. These caps specify that cost-sharing may not exceed 5% of income for families with income up to 200% FPL, and may not exceed 7.5% for families with income between 200% and 300% FPL. (*Note: under Title XXI of the Social Security Act states have the option to impose certain cost sharing provisions, but these provisions may not exceed 5% of a family's yearly income.*)

States must not require prepayment of premiums, nor are states allowed to terminate eligibility of an enrolled child for failure to pay premiums, unless lack of payment continues for a minimum of 60 days beyond the payment due date. States may waive payment of premiums when such payment would cause undue hardship. The provision would not change current law with respect to other cost-sharing by beneficiaries (e.g., deductibles, co-insurance, co-payments) which is not permitted for children under 18 years of age.

This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.

(c) Conforming amendments

Current Law

Unless otherwise specified for a given coverage group, Medicaid eligibility for children is limited to those in families with income up to 133 and 1/3% of the applicable AFDC payment standard in place as of July 16, 1996. In addition, targeted low-income children under SCHIP statute are defined as those who would not qualify for Medicaid under the state plan in effect on March 31, 1997.

Payments for services provided to children who receive Medicaid benefits through an expansion of eligibility under SCHIP authority are reimbursed by the federal government at the enhanced federal medical assistance percentage (E-FMAP) rate, and funds based on this rate are drawn from annual SCHIP appropriations. The SCHIP E-FMAP builds on the Medicaid FMAP. The FMAP formula is designed to provide a higher federal matching rate for states with lower average per capita income levels, compared to the national average. As of FY2005, the Medicaid FMAP ranged from 50% (statutory floor) to 77.08% compared to the SCHIP E-FMAP ranging from 65% (statutory floor) to 83.96%. The Medicaid FMAP and the SCHIP E-FMAP are subject to ceilings of 83% and 85%, respectively.

Explanation of Provision

This provision permits the income level for the new optional coverage group (set at 300% FPL) to exceed the otherwise applicable AFDC-related income standard for children under Medicaid. It also stipulates that children with disabilities made eligible for Medicaid through the new optional coverage group would not be considered to be targeted low-income children as defined under SCHIP. Thus, the regular Medicaid FMAP, rather than the SCHIP E-FMAP would apply for determining the federal share of Medicaid expenditures for the new optional coverage group. In additional, federal payments would be drawn from the open-ended Medicaid account and not the capped SCHIP account. This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.

Section 6043. Demonstration Projects Regarding Home and Community-based Alternative to Psychiatric Residential Treatment Facilities for Children

Current Law

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

hospital, nursing home, or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

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

Explanation of Provision

The Secretary would be authorized during the period from FY2007 through FY2011 to conduct demonstration projects in up to 10 states to test the effectiveness of improving or maintaining the child's functional level, and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment, for children enrolled in Medicaid. These demonstration projects will develop home and community-based services as an alternative to a psychiatric residential treatment facility. However, these projects must also follow the requirements of the HCBS waiver program. Specifically, demonstration participants would be required to meet the level of care of a psychiatric residential treatment facility, and the average, per-person project expenditures may not exceed the average, per-person cost of a psychiatric residential treatment facility.

The demonstration states would be selected through a competitive bidding process. At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project.

As part of the demonstration, the following conditions would apply: (1)projects must meet the same terms and conditions that apply to all HCBS waivers; (2) the Secretary must ensure that the projects are budget neutral; that is, total Medicaid expenditures under the demonstration projects will not be allowed to exceed the amount that the Secretary estimates would have been paid in the absence of the demonstration projects; and (3) applications for a demonstration project must include an assurance to conduct an interim and final evaluation by an independent third party and any reports that the Secretary may require.

This proposal would appropriate $218 million for FY2007 through FY2011 for the state demonstration projects and the federal evaluations and report. Total expenditures for state demonstration projects would not be allowed to exceed $21 million in FY2007, $37 million in FY2008, $49 million in FY2009, $53 million in FY2010, and $57 million in FY2011. Funds not expended in a given fiscal year would continue to be available in subsequent fiscal years. An additional $1 million would be available to the Secretary to complete a *required* interim and final

evaluation of the project and report the conclusions of the evaluations to the President and Congress within 12 months of completing these evaluations.

Section 6044. Development and Support of Family-to-family Health Information Centers

Current Law

Family-to-family health centers provide information and assistance to help families of children with special health care needs navigate the system of care and make decisions about the needs and available supports for their child. No provision in current law specifically authorizes a dedicated amount of funds for these family-to-family health information centers. However, since 2002, the Department of Health and Human Services (HHS) has awarded approximately $6.9 million to develop these information centers in 36 states under various program authorities including: (1) Special Projects of Regional and National Significance Program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) operated by the Health Resources Services Administration (HRSA); (2) the Real Choice Systems Change grant program operated by the Centers for Medicare and Medicaid Services (CMS); and (3) a one-year direct Congressional appropriation to an organization in Iowa. Federal funding for these projects is time-limited. Except for the one-year direct appropriation, state projects have generally been funded for a three or four-year period. HRSA intends to fund additional family-to-family health information centers awarding up to $2.4 million to six projects for a four-year period starting in FY2006.

Explanation of Provision

This proposal would increase funding under the SPRANS program of Title V of the Social Security Act for the development and support of new family-to-family health information centers (described below). This proposal would appropriate an additional $3 million for FY2007, $4 million for FY2008, and $5 million for FY2009 for this new purpose. For each of fiscal years 2010 and 2011, the bill would authorize to be appropriated to the Secretary $5 million for this purpose. Funds would remain available until expended.

The family-to-family health information centers would: (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. The family-to-family health information center would be staffed by families who have expertise in public and private health care systems and by health professionals.

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.

Section 6045. Restoration of Medicaid Eligibility for Certain SSI Beneficiaries

Current Law

States are required to provide Medicaid benefits to elderly individuals and certain persons with disabilities who receive Supplemental Security Income (SSI). (Under the 209(b) provision, states may apply more restrictive income and resources standards and/or methodologies for determining Medicaid eligibility than the standards under SSI.) For disability purposes, two groups of disabled children exist: those under the age of 18 and those age 18 through 21 (if a full time student). Eligibility for SSI is effective on the later of: (1) the first day of the month following the date the application was filed, or (2) the first day of the month following the date that the individual was determined eligible.

Explanation of Provision

The provision would confer 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. It would apply to medical assistance for items and services furnished on or after the date that is one year after the date of enactment of this Act.

Subchapter B — State Children's Health Insurance Program

Section 6051. Rules for Availability, Redistribution, and Extended Availability of Allotments for Fiscal Years 2003, 2004, and 2005

(a). In General

Current Law

Funds for the State Children's Health Insurance Program (SCHIP) are authorized to be appropriated for FY1998 through FY2007. From each year's appropriation, each state is allotted an amount determined by a formula set in law. Federal funds not drawn from a state's original allotment by the end of each fiscal year continue to be available to that state for two additional fiscal years (for example, FY2005 allotments are available through FY2007).

At the end of the three-year period, the unspent funds from the original allotment are reallocated in ways that vary depending on the fiscal year. The original SCHIP law, the Balanced Budget Act of 1997 (BBA97, P.L. 105-33), specifies that only those states that spend all of their original allotment by the applicable three-year deadline would receive redistributed funds from the other states' unspent allotments, based on a process determined by the Secretary of Health and Human Services (HHS); these redistributed funds would be available for one year only. However, later laws (the Medicare, Medicaid, and SCHIP Benefits Improvement and

Protection Act of 2000 (BIPA, P.L. 106-554) and the State Children's Health Insurance Program Allotments Extension Act (P.L. 108-74)) overrode how the reallocation of unspent FY1998 to FY2001 original allotments would occur.

States that fully expended their FY1998 or FY1999 original allotment within the applicable three-year period (i.e., redistribution states) received a redistribution equal to their excess spending (i.e., the difference between the state's spending during the three years of availability and the amount of the applicable original allotment). The remaining unused funds (after a set-aside of 1.05% of the total unspent funds for the territories that fully exhausted their original allotments) were then divided among those states that did *not* spend their original allotments by the applicable three-year deadline (i.e., retention states) in proportion to their contribution to the total pool of unspent funds. Reallocated funds from the unspent FY1998 and FY1999 original allotments were available until the end of FY2004.

For the unspent FY2000 and FY2001 original allotments, a set-aside of 1.05% of the total unspent funds was made for territories that fully exhausted their original allotments. Retention states kept one-half of their unused funds. The remaining unspent funds were then distributed among redistribution states in proportion to their contribution to the total pool of excess spending. Reallocated funds from the unspent FY2000 and FY2001 original allotments are available until the end of FY2004 and FY2005, respectively.

The redistribution of unspent FY2002 SCHIP original allotments was determined by the Secretary of HHS in accordance with the default redistribution provision in BBA97 and published in the January 19, 2005, *Federal Register*. On September 29, 2005, the final notice was released announcing the revised amounts redistribution states would receive based on states' SCHIP spending estimates from August 2005 rather than from November 2004. States that were projected to exhaust their available federal SCHIP funds in FY2005, based on their estimated FY2005 expenditures, received access to FY2002 redistribution money equal to their estimated shortfall. The remaining balance of unspent FY2002 funds (after a set-aside of 1.05% of the total unspent funds for the territories that fully exhausted their original allotments) was then divided among the redistribution states, including the five shortfall states, in proportion to their contribution to the total pool of excess spending. Redistributed funds from the unspent FY2002 original allotments are available until the end of FY2005.

Under current law, unspent original allotments from FY2003 forward are also to be redistributed according to the original 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.

Explanation of Provision

The provision would reduce the period of availability of the FY2004 and FY2005 original allotments from three years to two, 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.

In FY2006, the unspent FY2003 original allotments remaining at the end of FY2005 (after a set-aside of 1.05% of the total unspent FY2003 funds for the territories) would be redistributed to states with an initial projected FY2006 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures in FY2006 would exceed the amounts available from the state's FY2005 and FY2006 original allotments. Each state with an initial projected shortfall would receive a portion of the available unspent FY2003 original allotments in proportion to its contribution to the total pool of such shortfalls. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2003 original allotments for the territories.

Also in FY2006, the territories would receive a set-aside of 1.05% of the total unspent FY2004 original allotments available at the end of FY2005.

"Described states" would be permitted to extend the use of their unspent FY2004 original allotments in an amount equal to the shortfall still remaining after receiving redistributed FY2003 funds. Described states would be defined as states that (1) spent all FY2003 original allotments by the end of FY2005, (2) did *not* spend all of their FY2004 original allotment by the end of FY2005, and (3) reported an initial projected FY2006 shortfall. After the set-aside for the territories as well as the reduction of FY2004 extended funds for the described states, the remaining unspent FY2004 funds would be available to states with a *net* projected FY2006 shortfall, defined as each state's initial projected shortfall reduced by the redistributed FY2003 funds it received and by the extended FY2004 funds if it is a described state. Each state with a net projected shortfall would receive a redistribution of FY2004 funds to cover its net projected shortfall. Any remaining FY2004 unspent original allotments would then be extended proportionally to states that did not spend their FY2004 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2004 original allotments for the territories. The FY2004 reallocation pot for states and territories would be available until the end of FY2006.

In FY2007, the territories would receive a set-aside of 1.05% of the total unspent FY2005 original allotments available at the end of FY2006. Described states would be permitted to extend the use of their unspent FY2005 original allotments in an amount equal to their initial projected FY2007 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures for FY2007 exceeds the amount available from the state's FY2006 and FY2007 original allotments. Described states would be defined as states that (1) did *not* spend all of their FY2005 original allotment by the end of FY2006, and (2) reported an initial projected FY2007 shortfall. After the set-aside for the territories as well as the reduction of FY2005 extended funds for the described states, the remaining unspent FY2005 funds would be available to states with a *net* projected FY2007 shortfall, described as each state's initial projected shortfall reduced by the extended FY2005 funds for the described states. Each state with a net projected shortfall would receive a redistribution of FY2005 funds to cover its net projected shortfall or, if the remaining funds are inadequate to cover the FY2007 projected

shortfalls, a portion of the available unspent FY2005 original allotments in proportion to the state's contribution to the total shortfall pool. If any FY2005 unspent original allotments remain, they would then be extended proportionally to states that did not spend their FY2005 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2005 original allotments for the territories. The FY2005 reallocation pot for states and territories would be available until the end of FY2007.

To calculate the amounts available for redistribution and retention in each formula described above, the Secretary would use expenditures reported by states not later than November 30, 2005, for the FY2003 and FY2004 redistributions, and November 30, 2006, for the FY2005 redistribution. To calculate states with projected shortfalls in each formula described above, the Secretary would use projected expenditures reported by the states not later than September 30, 2005, for the FY2003 and FY2004 redistributions, and not later than September 30, 2006, for the FY2005 redistribution.

This provision would be effective upon enactment of this Act.

(b). Use of Redistributed Funds for Child Health Assistance for Targeted Low-Income Children

Current Law

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. A state's share of program spending for Medicaid is equal to 100% minus the federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%. All SCHIP assistance for targeted low-income children, including coverage provided under Medicaid, is eligible for the enhanced FMAP. In addition, approved SCHIP Section 1115 waivers are deemed to be a part of a state's SCHIP state plan. Claims submitted to, and approved by CMS, for expenditures under the demonstration waiver are matched at the same enhanced matching rate as all other SCHIP claims. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83% and 85%, respectively.

Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

Explanation of Provision

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 provision would require the federal government to make matching payments at the SCHIP enhanced matching rate for child health assistance payments made on behalf of targeted low-income children. However, expenditures drawn against the FY2003, FY2004, and FY2005 redistributed SCHIP funds would occur at the regular Medicaid FMAP rate for all other approved SCHIP expenditures, consisting of the following: (1) benefit expenditures for adults (other than pregnant women) approved under the Section 1115 waiver authority; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

This provision would be effective upon enactment of this Act.

Section 6052. Authority to Use Up to 10% of Fiscal Year 2006 and 2007 Allotments for Outreach

Current Law

In general, Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate can be made for the following four specific health care activities: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

For a given fiscal year, payments for these four specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP insurance benefits and other specific health care activities combined.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) created a special rule for the redistribution of unspent FY1998 and FY1999 original allotments. Under BIPA, states that did not use all of their original allotments for the year were permitted to use up to 10% of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap, described above.

Explanation of Provision

The provision would allow states to use up to 10% of their FY2006 and FY2007 original allotments for expenditures on outreach activities incurred during FY2006 and FY2007 respectively. This allowance would be over and above spending for such activities under the

general administrative cap described above. Outreach activities would include: (1) activities to promote the coordination of the administration of SCHIP with other public and private health insurance programs; and (2) strategies to market the program to the target population and to simplify and expedite the eligibility determination and enrollment process.

This provision would be effective upon enactment of this Act.

Section 6053. Prohibition Against Covering Nonpregnant Childless Adults with SCHIP Funds

Current Law

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to conduct research and demonstration projects under six programs, including Medicaid and SCHIP. Under Section 1115 authority, the Secretary may waive certain statutory requirements for conducting these projects. Specifically, the Secretary may waive provisions in Section 1902 of Medicaid statute (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP.

With respect to SCHIP, the Clinton Administration issued a July 31, 2000, letter to state health officials regarding treatment of adults. While this Administration was supportive of using 1115 authority to expand the SCHIP program to parents of Medicaid or SCHIP-eligible children, as well as certain pregnant women, it opposed coverage of childless adults.

Under the Bush Administration, a new Health Insurance Flexibility and Accountability (HIFA) Initiative was implemented using 1115 waiver authority for both Medicaid and SCHIP. The goals of this initiative are to encourage new approaches that will increase the number of individuals with health insurance coverage within current program resources, with a particular emphasis on broad statewide strategies that maximize private health insurance coverage options and target individuals with income below 200% of the federal poverty level.

Explanation of Provision

The provision would limit the Secretary of Health and Human Services's Section 1115 waiver authority by prohibiting the approval of waiver, experimental, pilot, or demonstration projects that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The provision would allow the Secretary to continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible children (as defined under Section 1931 of Medicaid statue), and to pregnant adults.

Finally, the provision would allow for the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to such projects) affecting federal

SCHIP funds that had been approved under the Section 1115 waiver authority before the date of enactment of this Act. However, nothing in the provision would imply congressional approval of any waiver, experimental pilot, or demonstration project affecting SCHIP funds that has been approved prior to the date of enactment of this Act.

This provision would be effective upon the enactment of this Act.

Section 6054. Continued Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures

Current Law

For specific Medicaid expenditures occurring after August 15, 2003, current law permits certain states to receive the federal SCHIP matching rate for the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, for services delivered to Medicaid beneficiaries under the age of 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150% of the FPL, federal SCHIP funds can be used to pay the difference between the SCHIP enhanced federal matching rate and the regular Medicaid federal matching rate the state receives for these children. 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 through FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% spending.

Qualifying states include those that on or after April 15, 1997, had an income eligibility standard for children (other than infants) of at least 184% of the FPL. (Other qualifications apply to states with statewide waivers under Section 1115 of the Social Security Act.)

Under current law, no 20% spending will be permitted in FY2006 or any fiscal year thereafter.

Explanation of Provision

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

This provision would be effective on or after October 1, 2005.

CHAPTER 6 — OPTION FOR HURRICANE KATRINA DISASTER STATES TO DELAY APPLICATION

Sec. 6081. Option for Hurricane Katrina Disaster States to Delay Application

Current Law

The Robert T. Stafford Disaster Relief and Emergency Assistance Act authorizes the President to issue a major disaster declaration to speed a wide range of federal aid to states determined to be overwhelmed by hurricanes or other catastrophes. Section 401 of the Stafford Act describes the procedure for declaring a major disaster or emergency. The Federal Emergency Management Agency (FEMA) makes the decision as to when a major disaster or emergency is "closed out" for administrative purposes.

Explanation of Provision

Notwithstanding any provision of or amendment made by this bill subtitle, the state of Louisiana, Mississippi, or Alabama may elect to not have the provisions of or amendments made by the subtitle apply with respect to the state during any period for which a major disaster declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act with respect to a parish (in the case of Louisiana) or a county (in the case of Mississippi or Alabama) as a result of Hurricane Katrina is in effect.

Subtitle B - Medicare

Section 6101. Improvements to the Medicare-Dependent Hospital (MDH) Program

Current Law

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

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

Explanation of Provision

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

Section 6102. Reduction in Payments to Skilled Nursing Facilities for Bad Debt

Current Law

Medicare pays for the costs of certain items outside of the Prospective Payment System on a reasonable costs basis. Section 1861(v)(1)(A)(I) of the Social Security Act states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. Under this authority, the Secretary adopted a bad debt policy in 1966. Under this policy, Medicare reimburses certain providers for debt unpaid by beneficiaries for coinsurance and deductibles. Historically, CMS has reimbursed certain providers for 100% of this bad debt. SNFs are among the Medicare entities that are currently being reimbursed for 100% of beneficiary's bad debt.

Effective beginning with cost reports starting in FY2001, Medicare began reimbursing hospitals for 70% of the reasonable costs associated with beneficiaries' bad debt. In 2003, CMS issued a proposed rule (42 CFR Part 413, Medicare Program; Provider Bad Debt Payment) in which it described its intent to reduce reimbursement of bad debt for certain providers, including SNFs, by 30%. Within the rule, CMS explained that it believed that reducing the amount of Medicare debt reimbursement would encourage accountability and foster an incentive to be more efficient in bad debt collection efforts. It also stated that it believed that Medicare bad debt policy should be applied consistently and fairly among all providers eligible to receive bad debt reimbursement.

Explanation of Provision

The provision would amend Section 1861(v)(1) of the Social Security Act to reduce the payment for the allowable bad debts attributable to Medicare deductibles and coinsurance amounts by 30% for services furnished in SNFs on or after October 1, 2005.

Section 6103. Two-Year Extension of the 50 Percent Compliance Threshold Used to Determine Whether A Hospital or Unit of a Hospital is an Inpatient Rehabilitation Facility under the Medicare Program

Current Law

Inpatient rehabilitation facilities (IRFs) are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) used to pay short-term general hospitals. The Medicare statute gives the Secretary of Health and Human Services (the Secretary) discretion to establish the criteria that facilities must meet in order to be considered an IRF. Recently issued regulations by the Centers for Medicare and Medicaid Services (CMS) require that a facility treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. CMS adopted a transition period for the compliance threshold as follows: at 50% from July 1, 2004 and before July 1, 2005; at 60% from July 1, 2005 and before July 1, 2006; at 65 % from July 1, 2006 and before July 1, 2007; and at 75% from July 1, 2007 and thereafter.

Explanation of Provision

The compliance threshold would be established at 50% from July 1, 2005 though June 30, 2007. The Secretary would not be permitted to change the designation of an IRF that is in compliance with that threshold. The Secretary would be required to restore the status of a facility as an IRF from July 1, 2005 through the effective date of this provision because of not meeting the 60% threshold required as of July 1, 2005. The Secretary would be required to make appropriate payments to those facilities.

The provision would deem those IRFs that failed to meet the 50% compliance threshold as meeting the threshold while directing the Secretary to examine an additional 6 months of claims data. If after review of the new data the IRF is still not in compliance with the 50% threshold, then the deemed status of the IRF will be revoked retroactively to the beginning of the 6 month period. The Secretary will collect any overpayments made to the IRF.

The Inspector General would conduct a study that analyzes the types of patients treated at IRFs that have a compliance rate between 50% and 60%, and report to Congress and the Secretary by January 1, 2007 with its findings. A rehabilitation advisory council would be established by the Secretary to provide advice and recommendations concerning the coverage of rehabilitation services under the Medicare program.

Section 6104. Prohibition on Physician Self Referrals to Physician Owned Limited Service Hospitals

Current Law

Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. Physicians,

however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital).

Section 507 of MMA established that the exception for self-referral and physician investment in the whole hospital would not extend to specialty hospitals for a period of 18-months from enactment (or until June 8, 2005). In this instance, a specialty hospital is primarily or exclusively engaged in the care and treatment of patients with a cardiac condition, an orthopedic condition, those receiving a surgical procedure, or other specialized category of patient or cases that the Secretary designates as inconsistent with the purpose of permitting physician investment in a hospital. A specialty hospital does not include any hospital that is determined by the Secretary to be in operation or under development as of November 18, 2003 and which meets certain specified requirements, such as requiring the same number of physician investors, the same categories of services, and a limitation in the growth of beds as of November 18, 2003.

Explanation of Provision

The prohibition on Medicare and Medicaid referrals to specialty hospitals by physician investors would be effective on and after December 8, 2003. The exception to the definition of specialty hospital would be modified to include those: (1) where the percent investment by physician investors is no greater than the percentage on June 8, 2005; (2) where the percent investment by any physician investor is no greater than the percentage on June 8, 2005; and (3) where the number of operating rooms is not greater than the number on June 8, 2005; and (4) where the number of beds is not greater than the number on June 8, 2005. These amendments would be effective on June 8, 2005.

Section 6105. Minimum Update for Physicians' Services for 2006

Current Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule, in place since 1992, is intended to relate payments for a given service to the actual resources used in providing that service. 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 for 2005 is $37.8975.

The conversion factor is the same for all services. It is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians' services; and (3) the update

adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The technical calculation of the update adjustment factor is equal to the sum of the prior year adjustment component and a cumulative adjustment component. In no case can the adjustment factor be less than minus seven percent or more than plus three percent.

The law specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in fees; (2) estimated change in the average number of Part B enrollees (excluding Medicare Advantage beneficiaries); (3) estimated projected growth in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations. In order to even out large fluctuations, MMA changed the GDP calculation from an annual change to an annual average change over the preceding 10 years (a "10-year rolling average").

The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to occur in 2003 and 2004; however, legislation prevented this from occurring through 2005. A negative update of 4.4 percent is slated to occur in 2006.

Explanation of Provision

The provision would specify that the update to the conversion factor in 2006 could not be less than one percent. The provision would further specify that these amendments would not be considered as a change in law for purposes of calculating the SGR.

Section 6106. One-Year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals Under the Prospective Payment System For Hospital Outpatient Department Service

Current Law

The prospective payment system for services provided by hospital outpatient departments (OPD) was implemented in August 2000 for most acute care hospitals. Under hold harmless provisions, as modified by the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA), rural hospitals with no more than 100 beds and sole community hospitals (SCH) located in rural areas are paid no less under this payment system than they would have received under the prior reimbursement system for covered OPD services provided before January 1, 2006.

Explanation of Provision

The hold harmless provisions governing OPD reimbursement for small rural hospitals and rural SCH would be extended to January 1, 2007.

Section 6107. Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports.

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

Explanation of Provision

The provision would increase the composite rate component of the basic case-mix adjusted system by 1.6% for services beginning January 1, 2006.

Section 6108. One-Year Extension of Moratorium on Therapy Caps

Current Law

The Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient services provided by hospitals.

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

The Balanced Budget Refinement Act of 1999 (BBRA) suspended application of the limits for 2000 and 2001. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) extended the suspension through 2002. Implementation of the provision was delayed until September 2003. The caps were implemented from September 1, 2003 through December 7, 2003. MMA reinstated the moratorium from December 8, 2003 through December 31, 2005. The caps are slated to go into effect again beginning January 1, 2006. In the

August 2005 proposed physician fee schedule regulation for 2006 (*Federal Register*, vol 70, no. 151, 45851), CMS estimated that the cap would be $1,750 in 2006.

Explanation of Provision

The provision would extend the moratorium for an additional year, through 2006.

Section 6109. Transfer of Title of Certain DME to Patient after 13-Month Rental

Current Law

Medicare Part B pays for certain items of durable medical equipment such as hospital beds, and non-customized wheelchairs under the capped rental category. Under this category, most items are provided on a rental basis for a period that cannot exceed fifteen months. After using the equipment for ten months, beneficiaries must be given the option of purchasing the equipment effective thirteen months after the start of the rental period. If they choose the purchase option, Medicare continues to make rental payments for three additional rental months and then title to the equipment is transferred to beneficiaries after thirteen months of use. If the purchase option is not chosen, ownership of the equipment is retained by the supplier. Beneficiaries can continue to use the equipment, Medicare rental payments to the supplier will continue for up to five additional rental months, and cease after that. Rental cap payments are subject to beneficiary 20% coinsurance.

In the case of a power-driven wheelchair, the supplier must offer the beneficiary the option of purchasing the equipment when it is first furnished.

Medicare payments to suppliers for maintenance and servicing differ depending on whether the beneficiary has purchased the equipment or whether it continues to be owned by the supplier. In the case of purchased equipment, payment for necessary servicing and maintenance is covered. When the equipment remains in the ownership of the supplier and continues to be used by a beneficiary after the fifteen month rental period, Medicare makes a payment to the supplier every six months for servicing and maintenance regardless of whether the equipment was actually serviced by the supplier.

Explanation of Provision

The provision would implement the recommendation from a 2002 report by the Inspector General of the Department of Health and Human Services to "eliminate the semi-annual maintenance payment currently allowed for capped rental equipment and pay only for repairs when needed." Payments to suppliers for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) would be made if the Secretary determines they are reasonable and necessary. The Secretary would also determine the amount of payments for maintenance and servicing. For durable medical equipment in the capped rental category, after a 13 month rental period, the supplier would transfer the title for the item to the beneficiary. The option for a supplier to retain ownership of the item after a 15 month rental period would be

eliminated. The option for beneficiaries to purchase power wheelchairs at the time they are initially furnished would be moved to the tenth month as with other rental cap items. This amendment would apply to items for which the first rental month occurs on or after January 1, 2006.

Section 6110. Establishment of Medicare Value-Based Purchasing Programs

(a) In General

Current Law

No provision.

Explanation of Provision

The Medicare statute would be amended by redesignating the existing Section 1860E as Section 1860F and by adding a new Section 1860E which requires the Secretary to establish value-based purchasing systems for different providers.

Part E Value-Based Purchasing Programs

Quality Measurement Systems for Value-Based Purchasing Programs

1860E-1. (a) Establishment

Current Law

No provision.

Explanation of Provision

Specifically, Section 1860E-1 would require the Secretary to develop provider-specific quality measurement systems for making value-based payments to hospitals, physicians and practitioners, Medicare Advantage (MA) and Part D prescription drug plans, end stage renal disease providers and facilities, and home health agencies. Measures for each quality system would be required to (1) be evidence-based; (2) be easy to collect and report; (3) address process, structures, outcomes, beneficiary experience, efficiency, and overuse and under use of health care; and (4) include at least one measure of health information technology infrastructure during the first year of implementation. Additional measures would be added in subsequent years. Measures would include those that assess the quality of care furnished to older, frail individuals and those with multiple complex chronic conditions. By 2008, hospital quality systems would be required to include at least 5 measures that take into account the unique characteristics of small hospitals located in rural areas and frontier areas.

Before a measure would be used to determine whether a provider receives a value-based payment, data on the measure must have been collected for at least a twelve month period. Each

set of quality measures selected for specific categories of providers would be able to vary in their application to an individual or entity depending of the type, size, scope and volume of services provided by the individual or entity.

The Secretary would be required to establish risk adjustment procedures and to control for differences in beneficiaries' health status and characteristics and to assign weights to measures used by each quality system. If appropriate, the Secretary may weigh some types of measures more heavily than others. The Secretary would be required to revise the quality measurement system, but not more often than every twelve months. The revision would permit a comparison of data from one year to the next. The Secretary would be required to use the most recent quality data for a provider type. However, if the Secretary determines that there is insufficient data because of the low service volume, the Secretary would be able to aggregate data across more than one fiscal or calendar year.

In developing and updating each quality measurement system, the Secretary would be required to consult with provider-based groups and clinical specialty societies. The Secretary would also take into account quality measures developed by nationally recognized entities, existing quality measurement systems, reports by the Medicare Payment Advisory Commission (MedPAC) required by this Act, results of relevant demonstrations, and the report on Health Care Performance Measures being developed by the Institute of Medicine under section 238 (b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In implementing each quality measurement system, the Secretary would be required to consult with entities that have joined together to assess the feasibility of collecting and reporting quality measurements as well as a wide range of stakeholders.

By July 1, 2006, the Secretary would be required to have in place an arrangement with an entity that will provide the Secretary with advice and recommendations about the development and updating of the quality measurement systems established by this Act. This arrangement, with a private nonprofit entity, would meet a specific set of requirements. For FY2006 and FY2007, $3,000,000 is authorized for this purpose, with the amount in subsequent years increased by the Consumer Price Index for urban consumers.

1860E-2 PPS Hospital Value-Based Purchasing Program

Current Law

No current law

Explanation of Provision

The Medicare statute would be amended by adding a new Section 1860E-2 which establishes the hospital value-based purchasing program for inpatient hospital services, starting FY2007. The program would make value-based payments to hospitals based on data reported under the quality measurement system established by the Secretary. Hospitals paid under Medicare's prospective payment system (PPS) that have substantially improved the quality of

care over the prior year or exceeded an established quality threshold would receive a value-based payment as determined by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to hospitals that are receiving such payments for exceeding a quality threshold. Starting in FY2008, the percentage of fund for exceeding a threshold (rather than for quality improvement) in any fiscal year would be greater than the equivalent percentage paid in the previous year. Hospitals would be required to comply with all the quality data reporting requirements and attest to the accuracy of the data in order to be eligible for a value-based payment. The total amount of value-based payments in a fiscal year would equal the total amount of available funding for such payments for that year. The payments would be based on the methods determined by the Secretary and would be made to hospitals no later than the close of the following fiscal year. The Secretary would provide each hospital with a description of how its payments for a period determined appropriate by the Secretary would have been affected had the value-based payment program been in effect during that period.

Value-based payments in a fiscal year would be made from Medicare's Part A Trust fund and would equal specified reductions in those trust fund expenditures as established in Section 6113(b) of the bill.

1860E-3. Physician and practitioner value-based purchasing program

Current Law

No current law.

Explanation of Provision

This provision would direct the Secretary to establish a program under which value-based payments are provided each year to physicians and practitioners that demonstrate the provision of high quality health care to individuals enrolled under part B. In addition, MedPAC would be required to conduct five studies evaluating the new program.

The first study would examine how the Medicare value-based purchasing programs under this section will affect Medicare beneficiaries, Medicare providers, and Medicare financing, including the impact of these programs on the access of such beneficiaries to items and services, the volume and utilization of such items and services, and low-volume providers. The initial report would be due to Congress and the Secretary no later than March 1, 2008, and a final report due no later than June 1, 2012.

The second study would examine the advisability and feasibility of establishing a value-based purchasing program for critical access hospitals (CAHs). This report would be due to Congress and the Secretary no later than March 1, 2007.

The third study would address the advisability and feasibility of including pediatric renal dialysis facilities in the value-based purchasing program described in this section or establishing a separate value-based purchasing program for pediatric renal dialysis facilities under this title.

This report would be required to be submitted to Congress and the Secretary no later than June 1, 2007.

The fourth study would be a report on the feasibility of implementing an end-stage renal disease (ESRD) provider and facility value-based purchasing program for facilities paid under the bundled case-mix adjusted payment system established under Section 623(e) of MMA. This report would include issues for the Secretary to consider in operating the ESRD provider and facility value-based purchasing program under the bundled case-mix adjusted payment system as well as recommendations on such issues. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2008.

The fifth study, due to Congress and the Secretary by June 1, 2007, would report on the advisability and feasibility of establishing a value-based purchasing program for skilled nursing facilities (SNFs).

The value-based purchasing program would be established so that value-based payments will be made initially in 2009 and in each subsequent year. The definition of a physician would not be changed as a result of this section and would remain as given in current law (section 1861(r)). The term 'practitioner' would mean: (i) a practitioner defined under current law[2]; (ii) a physical therapist; (iii) an occupational therapist; and (iv) a qualified speech-language pathologist. The Secretary would be charged with establishing procedures for the identification of physicians and practitioners for payment purposes under this section, such as through physician or practitioner billing units, physician identifier number, unique physician identifier number, tax ID or national physician identifier.

The value-based payments would be based on either relative or absolute standards. The Secretary would be able to make a value-based payment to a physician or a practitioner if both the quality and efficiency of care to an individual enrolled under Part B has improved substantially or has exceeded an established threshold. In determining which physicians and practitioners would qualify for a value-based payment, the Secretary would be required to use both the quality measurement system developed for this section with respect to the quality of the care provided by the physician or practitioner and the comparative utilization system developed under this section with respect to the efficiency and appropriateness of such care.

In determining the amount of the award and the allocation of awards under the value-based purchasing program, the Secretary would determine the amount of a value-based payment provided to a physician or a practitioner with respect to physicians and practitioners that meet the quality threshold requirements described above.

The Secretary would ensure that a majority of the total amount available for value-based payments for any year is provided to physicians and practitioners who meet the threshold for receiving such payments. Additionally, the percentage of value-based payments would not be

2 Section1842(b)(18)(C) defines a practitioner as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or a registered dietitian or nutritional professional.

able to decrease. For every year beginning in 2010, the Secretary would be required to ensure that the percentage of the total amount available for value-based payments for any year that is used to make payments to physicians and practitioners is greater than the previous year's percentage.

In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner would be required to submit quality data with respect to that year, and provide the Secretary (under procedures established by the Secretary) with an attestation that the data submitted is complete and accurate.

The Secretary would be required to establish value-based payments such that the estimated total amount of the value-based payments is equal to the total amount of available funding for value-based payments for the year. The payment of value-based payments would be based on such a method as the Secretary determines appropriate, and the Secretary would ensure that value-based payments with respect to a year are made by not later than December 31 of the subsequent year.

The Secretary, in consultation with relevant stakeholders, would develop a comparative utilization system for purposes of providing value-based payments. The resulting comparative utilization system would measure the efficiency and appropriateness of the care provided by a physician or practitioner. Under this comparative utilization system, the Secretary would select the measures of efficiency and appropriateness and review the most recent claims data with respect to services furnished or ordered by physicians and practitioners to determine utilization patterns. The Secretary would establish risk adjustment procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics.

Beginning in 2007, the Secretary would provide physicians and practitioners with annual reports on the utilization of items and services under this title based upon the review of claims data. The 2007 and 2008 reports would be confidential and not be made available to the public. The Secretary would provide each physician and practitioner with a description of how its payments for a period determined appropriate by the Secretary would have been affected had the value-based payment program been in effect during that period.

Payments to physicians and practitioners under the value-based payment program would be made from the Federal Supplementary Medical Insurance (Part B) Trust Fund. The total amount available for value-based payments with respect to a year would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the amendments made by Section 6113(c)(2) of the bill, as estimated by the Secretary.

1860E-4. Plan Value-Based Purchasing Program

Current Law

No provision in current law.

Explanation of Provision

The Secretary would establish a program to award value-based payments to Medicare Advantage (MA) organizations that provide high quality health care. The quality payment pool would be established in 2009, and continue each year thereafter. The program would apply to both MA regional and local plans. It also would apply to reasonable cost contract plans.

The Secretary would make payments for each plan offered by an MA organization if the plan substantially improved over the prior year, or exceeded a minimum threshold. The Secretary would use measures of quality developed for the plan value-based payments system (Section 1860E-1) and ensure that awards are based on data from a full 12-months when making a comparison against a threshold, and 24-months when measuring improvement over a prior year.

The Secretary would determine the amount of the value-based payments, but must ensure that the majority of funds go to plans that receive a payment because their health measures exceeded a threshold. In 2010 and each subsequent year, the percentage of the total amount available is greater than the percentage in a previous year.

Value based payments may only be used to invest in quality improvement programs or to enhance beneficiary benefits.

To be eligible for value based payments, an MA plan or reasonable cost contract would be required have collected, analyzed and reported the required data for the two previous years. Also, an MA plan would be required to provide the Secretary with an attestation that the value based payment program including payment adjustments made by reason of Section 6113(d)(2)(A)) had no effect on the integrity and actuarial soundness of the plan's bid.

The Secretary would ensure that the total of value based payments is equal to the amount made available for those payments. Payments for a particular year would be required to be made not later than March 1 of the subsequent year, in a manner determined by the Secretary.

By March 1, 2009, the Secretary would provide each MA organization with an estimate of how plan payments would have been affected if the value based payment system had been in effect in 2008.

The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as a result of amendments to fund the value-based payment system, as estimated by the Secretary. Payments to MA organizations would be drawn from the two trust funds in proportion to the relative weight that part A and part B benefits represent of the total actuarial value of Medicare benefits.

1860E-5. ESRD Provider and Facility Value-Based Purchasing Program

Current Law

No provision.

Explanation of Provision

Beginning in 2007, the Secretary would establish a program under which value-based payments are provided each year to providers of services and renal dialysis facilities that provide services to ESRD individuals enrolled under part B and that demonstrate the provision of high quality health care. Facilities with at least 50% of their patients under the age of 18, as well as those providers and facilities currently participating in the bundled case-mix demonstration are excluded from this program.

Value-based payments would be made to a provider or facility, if the Secretary determines that the quality of care in that year has substantially improved over the prior year or exceeds a threshold established by the Secretary, using the quality measurement system.

The Secretary would determine the amount of a value-based payment and the allocation of the total amount available for all such payments, subject to certain requirements. The Secretary would ensure that the majority of the total amount available is awarded to those providers of services and renal dialysis facilities who provide high quality services. For 2007, the entire amount would be available for those who meet the requirements.

Beginning in 2007, each provider of services and renal dialysis facility would be required to submit data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the program. A provider or facility would be required to submit this data, in order to be eligible for a value-based payment for a year. The Secretary would establish procedures for making submitted data available to the public in a clear and understandable form and would ensure that a provider or facility first has the opportunity to review the data. The provider or facility would be required to provide an attestation that the data is complete and accurate.

The Secretary would establish payment amounts so that, as estimated by the Secretary, the total amount of value-based payments made in a year is equal to the total amount available. The payment of the awards would be based on a method as determined by the Secretary and must be paid no later than December 31 of the subsequent year. The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance (SMI) Trust Fund, as estimated by the Secretary. Payments to providers of services and renal dialysis facilities, under this section, would be made from the Federal SMI Trust Fund.

1860E-6. Home Health Agency Value-based Purchasing Program

Current Law

No current law.

Explanation of Provision

The Medicare statute would be amended by adding a new Section 1860E-6 which establishes the Home Health Agency Value-Based Purchasing Program. In 2008 and in subsequent years, the Secretary would make value-based payments to those home health agencies that, based on data submitted under the quality measurement system, have either substantially improved quality of care over the prior year, or exceed a threshold established by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to home health agencies that qualify for payments because they exceed a quality threshold. Starting in 2009 and in each subsequent year, the percentage of total value-based payments made to agencies that exceed the quality threshold would be greater than the percentage made in the previous year. To be eligible for a value-based payment, home health agencies would be required to submit the required quality data and attest that it is complete and accurate.

The total amount of value-based payments made in a year would equal the total funds available for such payments. The payments would be based on the methods determined by the Secretary and would be made to home health agencies no later than the close of the following calendar year. The Secretary would provide each home health agency with a description of how its payments for a period determined appropriate by the Secretary would have been affected had the value-based payment program been in effect during that period.

Value-based payments would be made from Part A and Part B in the same proportion as payments for home health services are made.

(b) Hospitals

(1) Voluntary Submission of Hospital Quality Data

Current Law

Each year, Medicare's operating payments to acute general hospitals are increased or updated by a factor that is determined, in part, by the projected annual change in the hospital market basket (MB). Congress establishes the update for Medicare's inpatient prospective payment system (IPPS) for operating costs, often several years in advance. An IPPS hospital will receive an operating update of the MB from FY2005 through FY2007 if it submits data on the 10 quality indicators established by the Secretary as of November 1, 2003. The Secretary will specify the form, manner, and time of the data submission. A hospital that does not submit data to the Secretary will receive an update of the MB minus 0.4 percentage points for the fiscal

year in question. The Secretary will not take into account this reduction when computing the applicable percentage increase in subsequent years. For FY2008 and subsequent fiscal years, hospitals will receive an update of the MB.

Explanation of Provision

In FY2007 and subsequent years, an IPPS hospital that does not submit the required quality data would receive an update of the MB minus two percentage points. This reduction would only apply to the fiscal year in question. In FY2007 and subsequently, an IPPS hospital receiving an update of the MB would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. Procedures for making the data available to the public would be established. These procedures would be required to provide the hospitals with an opportunity to review the data before it is released to the public.

(2) Reduction in Payments in order to Fund Program

Current law

Outlier payments are intended to protect IPPS hospitals from the risk of financial losses associated with patients with exceptionally high costs or unusually long stays. Medicare cases qualify for outlier payments if they exceed a threshold or fixed loss amount that is established each year. As directed by statute, the total amount of any outlier payments for any year should equal no less than 5% nor more than 6% of total projected operating diagnosis related group (DRG) payments. Outlier payments are financed by a reduction in the national average standardized amount, typically set at 5.1%.

Explanation of Provision

The Secretary would be directed to reduce the average standardized amount by certain percentages to fund outlier payments and the hospital value-based purchasing program. Outlier payments would be established as no less than 5% and no more than 6% for fiscal years prior to 2007. In FY2007, outlier payments would be established as no less than 4% and no more than 5%. In FY2008, outlier payments would be established as no less than 3.75% and no more than 4.75%. In FY2009, outlier payments would be established as no less than 3.5% and no more than 4.5%. In FY2010, outlier payments would be established as no less than 3.25% and no more than 4.25%. In FY2011 and in subsequent years, outlier payments would be established as no less than 3% and no more than 4%.

The reduction factor will be equal to a calculation where the numerator is the sum of the additional outlier payments (as discussed above) plus a specified percentage of total projected DRG prospective payment rates for the quality pool divided by the total projected DRG prospective payment rates. The specific percentages for the quality pool would be 0% for fiscal years prior to 2007, 1% in FY2007, 1.25% in FY2008, 1.5% in FY2009, 1.75% in FY2010, and 2% in FY2011 and in subsequent years.

(3) Value-Based Purchasing Demonstration Program for Critical Access Hospitals

Current Law

No current law.

Explanation of Provision

The Secretary, within six months from enactment, would be required to establish a two-year value-based payment demonstration program at six representative CAHs, using such funds as are necessary from the Part A trust fund. The Secretary would be required to report to Congress with recommendations within six months of completing the demonstration.

(c) Physicians and Practitioners

(1) Voluntary Submission of Physician and Practitioner Quality Data

Current law

No current law.

Explanation of Provision

In FY2007 and in subsequent years, physicians and providers who do not submit the required quality data would receive an update to the conversion factor minus two percentage points. This reduction would only apply to the fiscal year in question. In FY2007 and subsequently, physicians and practitioners would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. There will be a phased-in approach to the public reporting of data for physicians and practitioners. In the first phase, public reporting would identify physicians and practitioners who had reported data (without any information on what the data revealed). The next phase, public reporting would identify those physicians and practitioners who had been awarded value-based payments for high quality, efficient care and improvement. The last phase, public reporting would reveal the actual data being reported by physicians and practitioners on the quality measures. Procedures, established by the Secretary, would be required to provide the physicians and practitioners with an opportunity to review the data before it is released to the public. The Secretary would be allowed to make exceptions to the requirement for making data available to the public by taking into account the size and specialty representation of the practice involved when providing such exceptions.

(2) Reduction in Conversion Factor for Physicians and Practitioners that Submit Quality Data in order to Fund Program

Current law

Medicare payments under Part B are based on a fee schedule. The fee schedule reflects a set of weights that vary across the many procedures that encompass the range of activities and services that physicians and practitioners provide. These relative weights are converted to dollar amounts for payment under Medicare by applying a multiplicative conversion factor. The conversion factor is updated each year according to a formula that aims to place a restraint on overall increases in Medicare spending for Part B services.

Explanation of Provision

To fund the value-based purchasing program for physicians and practitioners, the conversion factor would be reduced as follows: 1.0% in 2009, 1.25% in 2010, 1.5% in 2011, 1.75% in 2012, and 2.0% in 2013 and subsequent years.

(d) Plans

(1) Submission of Quality Data

Current Law

Each Medicare Advantage (MA) organization has an ongoing quality improvement program. MA private fee-for-service plans, MSA plans and Medicare cost reimbursement plans are exempt from this requirement. Each MA organization collects, analyses and reports health outcomes and quality data. The quality improvement program for local preferred provider organizations only applies to providers that have contracts with the organization. The Secretary can collect only the types of data that were collected by the Secretary as of November 1, 2003. The Secretary can collect other types of data only after consulting with MA organizations and private accrediting bodies, and submitting a report to Congress.

Explanation of Provision

Beginning on or after January 1, 2006, the Secretary would also collect data necessary for the plan value-based purchasing program (Section 1860E-4). The Secretary would establish requirements for MA private fee-for-service plans and cost reimbursement plans with respect to the collection, analysis and reporting of data on health outcomes and quality. The Secretary would establish procedures for making health outcomes and quality data available to the public in a clear and understandable form. Prior to the data being made public, the Secretary would ensure that an MA organization has the opportunity to review the data for the plans it offers. The Secretary may change the type of data collected for the value-based purchasing program after complying with requirements for the development, update and implementation of the program.

The Secretary would take into account the data reporting requirements that plans must comply with under other federal and state programs and in the commercial market when establishing a time frame for data reporting requirements under the new program.

(2) Reduction in Payments to Organizations in order to Fund Program

Current Law

No provision.

Explanation of Provision

For those providers included in the value based program, including reasonable cost contracts, the monthly payment to plans would be reduced by 1% in 2009, 1.25% in 2010, 1.5% in 2011, 1.75% in 2012, and 2.0% for 2013 and each subsequent year. These reductions would not have any effect on determining whether the risk adjusted benchmark exceeds a plan's risk adjusted bid, or the amount of the difference.

(3) Requirements for Reporting on Use of Value-Based Payments

Current Law

No provision.

Explanation of Provision

Beginning on or after January 1, 2011, MA plans would submit information describing how the organization will use any value based payments received under the program. This information would be submitted by plans at the same time they submit plan bids. Beginning in 2010, not later than July 1 of each year, any reasonable cost reimbursement contract that received a value based payment would submit a report to the Secretary describing how the organization will use the value based payment.

(e) ESRD Providers and facilities

Current Law

No provision.

Explanation of Provision

No later than July 31, 2006, the Secretary would establish procedures for providers of services and renal dialysis facilities, who are paid based on the case-mix adjusted prospective payment system, to submit data that permits the measurement of health outcomes and other indices of quality.

In the case of any payment for an item or service furnished on or after January 1, 2007, the case-mix adjusted prospective payment amount would be reduced by the applicable percent, but only for those providers of services or renal facilities included in the value-based program. The applicable percent would be 1% for 2007, 1.25% for 2008, 1.5% for 2009, 1.75% for 2010, and 2% for each year thereafter.

Beginning January 1, 2007, the Secretary would implement a value-based purchasing program for providers and facilities participating in the bundled case-mix demonstration (as established under Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), in a manner similar to the value-based program established under Section 1860E-5 of this bill, including the funding of the program.

(f) Home Health Agencies

Current Law

No provision.

Explanation of Provision

In 2007 and subsequent years, a home health agency that does not submit to the Secretary the required quality data would receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. For 2007 and subsequently, each home health agency receiving an update of the MB would be required to submit data necessary for a value-based purchasing system in the form, manner, and time period specified by the Secretary. Procedures for making the data available to the public would be established. These procedures require that home health agencies be given an opportunity to review the data before it released to the public.

To fund the program, spending under the trust funds for home health services would be reduced by a percent applied to the standard prospective payment amount made to all agencies that comply with the data submission requirements. The percent reduction would be 1% in 2008, 1.25% in 2009, 1.5% in 2010, 1.75% in 2011, and 2% in 2012 and subsequent years.

(g) Skilled Nursing Facilities

(1) Requirement for Skilled Nursing Facilities to Report Functional Capacity of Medicare Residents Upon Admission and Discharge

Current Law

Medicare law requires nursing homes to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Under the law, this assessment must describe the resident's capability of performing daily life functions and significant

impairments in functional capacity and be based on a uniform minimum data set specified by the Secretary, or specified by the state with the Secretary's approval. If specified by a state, it must be consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

As a result, the Minimum Data Set (MDS), designed by the Secretary, consists of a core set of screening, clinical and functional status elements, including common definitions and coding categories which form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. MDS is designed to facilitate and standardize resident assessments, which are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. These resident assessments help identify social, medical and psychological problems and form the basis for individualized care planning. MDS is also used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement.

In general, MDS resident assessments are conducted on the 5^{th}, 14^{th}, 30^{th}, 60^{th}, and 90^{th} days of post-hospital SNF care. SNFs also conduct other assessments that may be needed to account for changes in patient care needs.

Explanation of Provision

This provision would amend section 1819(b) of the Social Security Act by adding a requirement that on or after October 1, 2006, a SNF would be required to submit a report to the Secretary on the functional capacity of each resident who is entitled to SNF benefits at the time of his or her admission and discharge. This report would be required to be submitted within 10 days of the admission or discharge as the case may be.

(2) Voluntary Submission of Skilled Nursing Facility Data

Current Law

As described above, the MDS submitted to CMS by states is intended to provide information on the quality of care provided to residents in SNFs. In recent years, CMS has attempted to make available additional quality measures. CMS posts data on nursing home's care records from complaint surveys, staffing levels, and number and types of residents, facility ownership and 15 quality measure scores on a website entitled Nursing Home Compare. This site is available to the public and is intended to assist individuals in choosing a Medicare- and Medicaid-certified nursing home by state, county, city, zip code, or by facility name. Additional research into the development of quality measures, staffing, and best practices is currently underway through CMS contracts with Quality Improvement Organizations (QIOs).

Explanation of Provision

This provision would require SNFs to submit quality data for the measurement of health outcomes and other indices of quality to the Secretary for FY 2008 and each subsequent fiscal year. Data required would be determined by the Secretary after conducting a study in consultation with certain nationally recognized quality measurement entities, researchers, health care provider organizations, and other appropriate groups and consult with, and take into account, recommendations of, the entity that the Secretary has an arrangement with based on criteria specified in section 6113(e) of this bill. The Secretary would also be required to consult with entities that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures and that involve representatives of health care providers, health plans, consumers, employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care. The Secretary would be required to establish procedures for making this data available to the public in a clear and understandable form. Such procedures would be required to ensure that a facility has the opportunity to review the data that is being made public with respect to the facility prior to such data being made public.

For FY 2009 and each subsequent year, a SNF that does not submit to the Secretary the required quality data would receive an update of the market basket percentage reduced by two percentage points. Such reductions would apply only with respect to the fiscal year involved.

Section 6111. Phase-out of Risk Adjustment Budget Neutrality in Determining the Amount of Payments to Medicare Advantage Organizations

Current Law

Medicare Advantage payment rates are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. In 2006, twenty-five percent of the rate will be adjusted by demographic factors and 75 percent will be adjusted for health status indicators. In 2007, 100 percent of the rates will be adjusted for health status indicators In the report language to the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Congress urged the Secretary to implement a more clinically-based risk adjustment methodology without reducing overall payments to plans. To keep payments from being reduced overall, the Secretary applied a budget neutrality adjustment to the risk adjusted rates. However, the Secretary has proposed to phase-out the budget neutrality adjustment citing data that show a difference in the reported health status of Medicare Advantage enrollees compared to the reported health status of beneficiaries in traditional Medicare. Specifically, these data show that Medicare Advantage plans are enrolling less healthy beneficiaries. The Administration has stated that as plans enroll less healthy beneficiaries, the need for a budget neutrality adjustment will decline.

Explanation of Provision

Beginning in 2007, this section (1) changes the way MA area-specific non-drug monthly benchmarks (or MA benchmarks) are calculated, and (2) specifies an adjustment to the benchmarks to phase-out overall increases in MA rates that result from the budget neutral implementation of risk adjustment. In 2007, if the Secretary does not rebase rates to 100% of per capita fee-for-service costs, the MA benchmarks will be equal to the 2006 rates as announced by the Secretary on April 4, 2005, with three adjustments that – (1) exclude any national adjustments for coding intensity, (2) exclude any risk adjustment budget neutrality factor, and (3) increase the benchmark based on the national per capita MA growth percentage calculated without adjusting for errors in the estimation of the growth percentage for a year before 2004.

If the Secretary does rebase the rates in 2007, the MA benchmark will be set at the greater of either the rate calculated above, or 100% of per capita fee-for-service spending in the area. After 2007, if the Secretary does not rebase rates, the MA benchmarks will be the previous year's benchmark increased by the national per capita MA growth percentage without adjusting for errors in the estimation of the growth percentage for a year before 2004. After 2007, if the Secretary rebases rates, the benchmark will be equal to the greater of either the rate calculated above, or 100% of per capita fee-for-service spending.

The Secretary can then adjust the benchmarks by an amount calculated by dividing the difference between payments had they been adjusted for demographic factors and payments specified in the above paragraph by payments specified in the above paragraph. This amount is then multiplied by an applicable percentage, which is equal to 55% in 2007, 40% in 2008, 25% in 2009, and 5% in 2010. When calculating the this amount, the Secretary will (a) use a complete set of the most recent and representative MA risk scores available, (b) adjust the risk scores to reflect changes in treatment and coding practices in fee-for-service, (c) adjust the risk scores for differences in coding patterns under Medicare Part A and B compared to Medicare Part C, to the extent the Secretary has identified differences, (d) as necessary, adjust risk scores for lagged cohorts, and (e) adjust risk scores for changes in enrollment in Medicare Advantage plans during the year. The Secretary shall conduct an analysis of differences in coding patterns for the purposes of making such adjustments. The Secretary may take into account estimated health risk of enrollees in preferred provider organizations (including MA regional plans) for the year.

The Secretary can not make any adjustments to MA benchmarks, other than those specified above. The Secretary's authority to risk adjust MA benchmarks based on 100% of per capita fee-for-service spending is not limited by these changes.

Section 6112. Elimination of the Medicare Advantage Regional Plan Stabilization Fund

Current Law

The Secretary will 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 will be available for expenditures from the Fund beginning on January 1, 2007 and ending on December 31, 2013. Additional funds will be available in an amount equal to 12.5% of average per capita monthly savings from regional plans that bid below the benchmark

Explanation of Provision

This section is repealed effective as of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.