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Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005

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Summary

On December 19, 2005, the House agreed to a conference report on S. 1932. However, the Senate amended the report, removing a few provisions as the result of a point of order raised associated with the "Byrd Rule." The amended agreement passed the Senate on December 21, 2005, and was returned to the House for further action. It is expected that the agreement will be taken up in the early part of the session.

This report provides a comparison of Medicare, Medicaid and State Child Health Insurance Program provisions contained in the Deficit Reduction Act of 2005 (S. 1932) as amended and passed by the Senate. The report compares the bill's provisions with current law.

This report will be updated.

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On December 19, 2005, the House agreed to a conference report on S. 1932. However, the Senate amended the report, removing a few provisions as the result of a point of order raised associated with the "Byrd Rule." [1] The amended agreement passed the Senate on December 21, 2005, and was returned to the House for further action. Among the many provisions in the act, Title V proposes changes in the Medicare program, and Title VI proposes changes in the Medicaid and State Child Health Insurance Program (SCHIP) and provides some fiscal relief for Katrina victims using Social Security Act section 1115 waiver authority. The House is slated to act on the bill when it returns in 2006.

This report provides a side-by-side comparison of the provisions contained in the Senate-passed version of the bill with current law. Additional information on provisions in the House and Senate versions of the bill can be found in CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Child Health Insurance Program (SCHIP) Provisions*.

This report will be updated.

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

Title V. Medicare

Provision	Current Law	Conference Agreement as passed by the Senate
Medicare's update factor to increase operating payments to acute-care hospitals as affected by submission of quality data.	Medicare's annual increase in its operating payments to hospitals is determined in part by the projected annual change in the hospital market basket (MB), a measure that estimates price inflation affecting hospitals. Congress establishes this update for Medicare's inpatient prospective payment system (IPPS) often several years in advance. Currently, through FY2007, the IPPS operating update has been established as the MB for hospitals that submit specific quality information and as the MB minus 0.4 percentage points for hospitals that do not provide such information. The required data are those 10 quality indicators established as of November 1, 2003. Starting in FY2008, the IPPS update will be the hospital MB. Any MB reduction does not apply when computing the applicable percentage increase in subsequent years	**Section 5001(a).** Hospitals that do not submit the required data in FY2007 and each subsequent year will have the applicable MB percentage increase reduced by two percentage points. Each IPPS hospital is required to submit data on measures selected by the Secretary in the established form, manner, and specified time. Any reduction applies only to the fiscal year in question and does not affect subsequent fiscal years. The conference agreement establishes that the Secretary will expand the number of quality indicators required from acute care hospitals. Beginning October 1, 2006 the Secretary will begin to adopt the baseline set of performance measures set forth in the November 2005 Institute of Medicine report that was required by Section 238(b) of MMA. Beginning October 1, 2007, the Secretary will add other measures that reflect consensus among the affected parties. Quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to inpatient services are to be reported on the CMS website.
Value-based purchasing for acute care hospitals.	No current law.	**Section 5001 (b).** The Secretary is required to develop a plan to implement a value-based purchasing program for IPPS payments to acute care hospitals beginning with FY2009. The plan is required to consider specified factors such as (1) the development, selection, and modification process for quality measures (2) data

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		reporting, collection, and validation; (3) the structure of value-based payment adjustments and sources of its funding; and (4) the disclosure of information on hospital performance. The Secretary will consult with relevant affected parties and consider experience with applicable demonstration programs.
DRG Adjustment for Certain Hospital Acquired Infections.	Medicare discharges are classified into diagnosis related groups (DRGs) primarily on the basis of the diagnosis and procedure code information included on the beneficiary's claim. The information includes the principal diagnosis (or main problem requiring inpatient care), up to eight secondary diagnoses codes as well as up to six procedures performed during the stay. Medicare pays for inpatient hospital services using per discharge rates that will vary by the DRG (and its calculated weight) to which a patient's stay is assigned. Each DRG weight represents the average resources required to provide care for cases in that specific DRG relative to the average resources used to treat cases in all DRGs. Under the DRG classification system, certain secondary diagnoses are considered to be complications or comorbidities (CC). When present as a secondary condition (with a specific principal diagnosis), these diagnosis codes are considered to increase the length of stay by least one day in at least 75% of the patients. In FY2006, 524 DRGs are used for Medicare payment purposes; 121 paired DRGs are split into higher and lower paid DRGs on the presence or the absence of a CC. CMS has added and deleted codes from the standard list of CCs, but has never conducted a comprehensive review of the	**Section 5001(c).** Starting for discharges on October 1, 2007, hospitals are required to report any secondary diagnosis codes applicable to patients at their admission in order to be paid. By October 1, 2007, the Secretary is required to identify at least two high cost or high volume (or both high cost and high volume) diagnoses codes with a DRG assignment that has a higher payment weight when present as a secondary diagnosis. These codes represent conditions, including certain hospital acquired infections, that could reasonably have been prevented through the use of evidence-based guidelines. Starting for discharges on October 1, 2008, the DRG assigned to a discharge with the identified diagnosis codes will be the lower paid DRG. The assignment of the lower paid DRG applies to discharges, where, at the time of the patient's admission, the beneficiary had none of the identified diagnosis codes. Adjustments to the relative weight that occur because of this action are not budget neutral. The list of diagnoses may be revised from time to time as long as there are at least two diagnosis codes selected for discharges occurring during any fiscal year. The Secretary is required to consult with the Centers for Disease Control and Prevention and other appropriate entities when

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	list. It is planning systematic review of the CC list for FY2007 Medicare payments.	selecting and revising the identified diagnosis codes. The list of diagnosis codes and DRGs are not subject to judicial review.
Clarification of Inclusion of Medicaid Patient Days in Medicare's Computation of its Disproportionate Share Hospital (DSH) Adjustment .	Hospitals that serve a certain number of low income Medicare and Medicaid beneficiaries will receive a DSH adjustment that increases their Medicare IPPS payments. Most hospitals receive the additional payments based on their DSH patient percentage which is calculated using proportion of the hospital's total days provided to Medicaid recipients added to the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who are eligible for Part A and receive Supplemental Security Income.) After a minimum threshold of 15% is met, a hospital's DSH adjustment will vary by the hospital's bed size or urban or rural location. The policy of whether inpatient days provided to a patient covered under a demonstration projects established by Section 1115 waivers could be included in the Medicare DSH calculation has changed over time. Starting January 20, 2000, hospitals were allowed to include the inpatient hospital days attributable to patients made eligible for Medicaid pursuant to a state's Social Security Act Section 1115 waiver. Previously, hospitals could include days for populations under the Section 1115 waiver who were or could have been made eligible under a state Medicaid plan. Starting for discharges on October 1, 2003, hospital days attributed to patients who do not receive coverage for inpatient benefits under Section 1115 demonstration projects cannot be	**Section 5002.** The Secretary can include inpatient hospital days of patients eligible for medical assistance under a Section 1115 demonstration waiver in the Medicare DSH calculation. These days will be counted as if they were provided to patients who were eligible for medical assistance under an approved Medicaid state plan. The existing regulations and their effective date are ratified. No hospital cost reports that are closed on the enactment date will be reopened to implement this provision

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	counted in the Medicare DSH calculation. These policies were established by regulation in January 2000 and August 2003.	
Improvements to the Medicare-Dependent Hospital (MDH) Program.	Certain small 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) attributed to Medicare patients qualify for special treatment as MDHs. MDH hospitals are paid at national standardized rate or, if higher, 50% of their adjusted FY1982 or FY1987 hospital-specific costs. This special treatment will lapse for discharges starting on October 1, 2006. Certain hospitals that serve a high proportion of Medicaid patients or poor Medicare beneficiaries qualify for a DSH adjustment to their inpatient payments. Small urban and most rural hospitals (except for rural referral centers) have their DSH adjustment capped at 12%.	**Section 5003.** 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 50% of its FY2002 hospital-specific costs if that would result in higher Medicare payments. MDH's payments would be based on 75% of their adjusted hospital-specific costs starting for discharges on October 1, 2006. MDH's that qualify for a disproportionate share hospital (DSH) adjustment would not have the adjustment capped at 12%.
Reduction in Payments to Skilled Nursing Facilities (SNFs) for Bad Debt.	Medicare pays the costs of certain items on a reasonable cost basis (outside of the applicable prospective payment system) including the unpaid debt for beneficiaries' coinsurance and deductible amounts. CMS has reimbursed certain providers for 100% of the debt. Effective for cost reports starting in FY2001, Medicare began reimbursing acute care hospitals for 70% of the reasonable costs associated with beneficiaries' allowable bad debt. SNFs are still reimbursed 100% for this bad debt.	**Section 5004.** Medicare payments to SNFS for allowable bad debts would be reduced to 70% for beneficiaries who are not eligible for both Medicare and Medicare. Medicare's payments for allowable bad debts attributed to dual eligible beneficiaries would remain at 100%.

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Extend Phase-in of the Inpatient Rehabilitation Facility (IRF) Compliance Thresholds.	IRFs are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's IPPS used to pay acute care hospitals. The Medicare statute gives the Secretary discretion to establish the criteria that facilities must meet in order to be considered an IRF. Recently issued regulations by CMS require that a facility must 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.	**Section 5005.** The compliance threshold for IRFs is established at 60% during the 12-month period beginning on July 1, 2006; at 65% during the 12-month period beginning on July 1, 2007; and at 75% beginning on July 1, 2008 and subsequently.
Development of a Strategic Plan Regarding Physician Investment in Specialty Hospitals.	Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. This prohibition does not extend to patient referrals to hospitals where physicians have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Section 507 of MMA established that the exception for physician investment and self-referral would not extend to specialty hospitals for a period of 18-months from enactment (or until June 8, 2004). This moratorium has been extended administratively by CMS which has not issued provider numbers to new specialty hospitals while it examines the criteria used to award such numbers. Generally, a specialty hospital is primarily or exclusively engaged in	**Section 5006.** The Secretary is required to develop a strategic and implementing plan regarding physician investment in specialty hospitals. The plan will address the proportionality of investment return, bona fide investments, annual disclosure of investment income, the provision of care to Medicaid patients and to charity care patients by specialty hospitals, and appropriate enforcement. An interim report is due within three months and the final report is due no later than six months after the date of enactment. The Secretary will continue to suspend the enrollment of new specialty hospitals until the earlier of the date of submission of the report or six months after the date of enactment. If the Secretary does not submit the final report within the six month time period, then the enrollment suspension will be extended

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	the care and treatment of cardiac or orthopedic patients, but does not include those that are in operation or under development as of November 18, 2003 (with the same number of physician investors as of such date that meets other specified requirements). For instance, an increase in the number of beds could only occur on the main campus of the hospital and could not exceed the greater of 50% of the number of beds in the hospital as of November 18, 2003, or five beds. The Secretary was directed to consider certain factors in determining whether a hospital is under development, such as the completion of architectural plans, and the status of funding, zoning requirements, and necessary approvals from State agencies.	an additional two months. The Secretary will also provide an appropriate certification of the failure to congressional committees of jurisdiction. The Secretary may waive certain requirements of the Administrative Procedures Act when developing the strategic and implementing plan. Two million dollars from the Treasury is appropriated in FY2006 for this strategic plan.
Gainsharing Demonstration Project.	Anti-kickback and patient referral laws are intended to discourage physicians and other health care providers from improperly profiting from referrals of Medicare and Medicaid patients. Exceptions to those laws permit certain physician-facility arrangements under specific circumstances. In 2004, a federal district court stopped CMS from implementing an eight hospital gainsharing demonstration project because of civil monetary penalty concerns. In March 2005, MedPAC recommended that Congress grant the Secretary the authority to allow regulated gainsharing arrangements between physicians and hospitals.	**Section 5007.** The Secretary will establish a gainsharing demonstration project to evaluate arrangements between IPPS hospitals and physicians and practitioners. Up to six projects (with at least two in rural areas) will be approved by November 1, 2006 and operational no later than January 1, 2007. The Secretary will solicit applications 90 days after enactment. The projects will end on December 31, 2009. The projects must meet certain requirements for maintaining or improving quality while achieving cost savings. Certain existing restrictions concerning incentive payments will be waived. The Secretary will meet the following reporting requirements: (1) a report to Congress on the number of projects will be due no later than December 1, 2006; (2) a project update will be due no later than December 1, 2007; (3) a report on quality improvement and savings will be due no later

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		than December 1, 2008; and (4) a final report will be due no later than May 1, 2010. Six million dollars will be appropriated from the Treasury in FY2006 to carry out the projects and will remain available for expenditure through FY2010.
Post-acute Care Payment Reform Demonstration Program.	No provision.	**Section 5008.** The Secretary is required to establish a three-year demonstration program to assess the costs and outcomes across different post-acute care sites by January 1, 2008. Under this demonstration, an individual provided treatment for specific diagnoses will receive a comprehensive assessment at discharge to determine the appropriate post-acute care placement for the patient. A standardized patient assessment instrument will be used across all post-acute care sites to measure the patients' functional status and other factors. Participants are required to provide information on the fixed and variable cost for each patient and provide an additional comprehensive assessment at the end of the person's episode of care. The demonstration program is required to consist of sufficient numbers to determine statistically reliable results. The Secretary is required to submit a report to Congress no less than six months from the end of the project. Six million dollars will be transferred from Medicare's Hospital Insurance Trust Fund for the costs of carrying out the demonstration program.

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Beneficiary ownership of certain DME and Oxygen equipment.	Medicare Part B pays for certain items of durable medical equipment such as hospital beds, nebulizers and power-driven wheelchairs under the capped rental category. Most items in this category are provided on a rental basis for a period that can not exceed 15 months. After using the equipment for 10 months, beneficiaries must be given the option of purchasing it effective 13 months after the start of the rental period. If they choose the purchase option, the title to the equipment is transferred to beneficiaries. If the purchase option is not chosen, the supplier retains ownership of the equipment. Beneficiaries can continue to use it, but Medicare rental payments to the supplier are terminated. In the case of a power-driven wheelchair, the supplier must offer the beneficiary the option of purchasing the equipment when it is first furnished. Medicare payments to suppliers for maintenance and servicing differ based on whether the beneficiary has purchased the equipment or whether the supplier continues to own it. In the case of a purchase agreement, payment for repairs and maintenance recommended by the manufacturer is covered. When the equipment remains in the ownership of the supplier and continues to be used by the beneficiary after the 15-month rental period, Medicare makes a payment to the supplier every six months for servicing and maintenance regardless of whether any maintenance and servicing is performed.	**Section 5101.** The conference agreement would require the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a 13-month rental period. The option for a 15-month rental period with the supplier retaining ownership of the item would be eliminated. The option for beneficiaries to purchase power-driven wheelchairs when initially furnished would be retained. Automatic payment to the suppliers every six months for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier's or manufacturer's warranty) would only be made if the Secretary determined them to be reasonable and necessary. This amendment would apply to items for which the first rental month occurred on or after January 1, 2006. The agreement further provides that rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after a 36-month rental period. After transfer of the title, monthly payments for oxygen contents (in the case of gaseous and liquid oxygen) will continue to be made, as provided for under current law, for the period of medical need. Payments for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) will be made if the Secretary

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		determines them to be reasonable and necessary. The agreement specifies that the provision takes effect on January 1, 2006. In the case of an individual receiving oxygen equipment as of December 31, 2005, the 36 month period begins January 1, 2006.
Adjustments in Payments for Imaging Services.	Medicare has a long-standing policy of reducing payment for multiple surgical procedures performed by the same physician, on the same patient on the same day. Full payment is made for the highest priced procedure, with any subsequent procedure paid at 50%. In 1995, the policy was extended to certain nuclear medicine diagnostic procedures. Under the physician fee schedule, diagnostic imaging procedures are priced as follows: (1) the professional component (PC) represents the physician work, that is the interpretation; (2) the technical component (TC) represents practice expenses including clinical staff, supplies, and equipment; and (3) the global service which represents both the PC and TC. Diagnostic imaging services, even those performed on contiguous body parts, are generally paid at 100% for each procedure. On November 21, 2005, CMS issued its final physician fee schedule regulation for 2006 (*Federal Register*, vol. 70, pp. 70116-70476). This regulation provided for a reduction in the TC for the subsequent imaging procedure performed on contiguous body parts. The multiple procedure reduction is not applied to PC	**Section 5102.** The conference agreement specifies that, effective for fee schedules established beginning with 2007, the reduced expenditures attributable to the multiple procedure payment reduction for imaging (under the final rule published November 21, 2005) will not be taken into account for purposes of the budget neutrality calculation for fee schedules for 2006 and 2007. The agreement further provides that for specified imaging services furnished on or after January 1, 2007, the technical component (including the technical component of the global fee) for a service will be reduced if it exceeds (without regard to the geographic wage adjustment factor) the outpatient department (OPD) fee schedule amount for the service established under the prospective payment system for hospital outpatient departments. In such cases, the Secretary will provide for the use of that OPD amount, adjusted by the geographic adjustment factor under the physician fee schedule. The services this policy applies to are: imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and

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	services. When a global service code is billed, the TC portion, but not the PC portion, is reduced. CMS identified 11 families of imaging procedures by imaging modality. The multiple procedure TC payment reduction is to be applied only to procedures involving contiguous body parts within a family of codes, not across families. The payment reduction is to be phased-in with a 25% reduction in 2006 and a 50% reduction in 2007. Further, the budget neutrality adjustment is to be applied only to practice expense relative value units rather than to both work and practice expense relative value units.	fluoroscopy. Not included are diagnostic and screening mammography. This change is not to be taken into account for purposes of the budget neutrality calculation beginning in 2007.
Limitation on Medicare Payments for Procedures in Ambulatory Care Surgical Centers (ASCs).	Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ASC. The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. CMS maintains a list of approved ASC procedures which is required to be updated every two years. The approved ASC procedures are categorized into one of nine payment groups that comprise the ASC facility fee schedule. The nine payment rates reflect the national median cost of procedures in that group adjusted to reflect geographic price variation. Payments are also adjusted when multiple surgical procedures are performed at the same time. The Secretary is required to implement a new ASC payment system no later than January 2008. Medicare reimbursement for hospital outpatient department (OPD) services is based on a fee schedule established by a separate prospective payment system (OPPS). Under OPPS, the unit of payment is the individual service or	**Section 5103.** Starting for surgical procedures on January 1, 2007, when the ASC facility payment (without application of any geographic price differences) is greater than the Medicare OPD fee schedule amount established under OPPS (without application of any geographic adjustment) for the same service, the ASC will be paid the OPD fee schedule amount. This adjustment applies to ASC payments until the revised ASC payment system is implemented. Total payments to ASCs under the revised payment system can be no more than those under the existing ASC payment system, including the reduced expenditures that result from the application of this provision.

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	procedure as assigned to a ambulatory payment classification (APC). The payment rate for each service is determined by multiplying the relative weight for the service's APC by the conversion factor.	
Update for Physicians' Services for 2006.	Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor 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. In no case can the adjustment factor be less than minus 7% or more than plus 3%.	**Section 5104.** The conference agreement overrides application of the formula for 2006 by setting the update at zero. In effect, this means that the 2006 conversion factor is the same as the 2005 conversion factor. The agreement also requires the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress by March 1, 2007 on mechanisms that could be used to replace the sustainable growth rate system. The report is to: (1) identify and examine alternative methods for assessing volume growth; (2) review options to control the volume of physicians services under Medicare while maintaining access for beneficiaries; (3) examine the application of volume controls under the fee schedule; (4) identify levels of application of volume controls such as group practice, hospital medical staff, type of service, geographic area, and outliers; (5) examine the administrative feasibility of implementing options under (2), including the availability of data and time lags; (6) examine the extent to which the alternative methods identified and examined under (1) should be specified; and (7) identify the appropriate levels of discretion for the Secretary of HHS to change payment rates under the fee schedule or to otherwise take steps that affect physician behavior. The report is to include recommendations on

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	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. Under the formula, a negative 4.4 % update goes into effect in 2006.	alternative mechanisms to replace the SGR. The section appropriates $550,000 from the Treasury, out of amounts not otherwise appropriated, to MedPAC to carry out the study.

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Three Year Hold Harmless Transition for Small Rural Hospitals Into the Outpatient Prospective Payment System (OPPS).	The OPPS 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 MMA, rural hospitals with no more than 100 beds and sole community hospitals (SCH) located in rural areas are paid no less under OPPS than they would have received under the prior reimbursement system for covered OPD services provided until January 1, 2006. Under its administrative authority, starting for services on January 1, 2006, CMS has increased OPPS payments to rural SCHs by 7.1%.	**Section 5105.** Certain small rural hospitals (with no more than 100 beds that are not SCHs) can receive additional Medicare payments if their outpatient payments under OPPS are less than under the old payment system. For calendar year (CY) 2006, these hospitals will receive 95% of any difference. The hospitals will receive 90% of the difference in CY2007 and 85% of the difference in CY2008.
Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services.	The 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.	**Section 5106.** The conference agreement increases the composite rate component of the basic case-mix adjusted system by 1.6% for services beginning January 1, 2006.

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Revisions to Payments for Therapy Services.	The Balanced Budget Act of 1997 (BBA 97) 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 go into effect again beginning January 1, 2006. In the November 2005, final physician fee schedule regulation	**Section 5107.** The conference agreement does not extend the moratorium. However, the Secretary is required to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on behalf of the enrollee, may request an exception from the physical therapy and occupational therapy caps. The individual may obtain such exception if the provision of services is determined medically necessary. If the Secretary does not make a decision on a request within 10 business days of receipt, the Secretary is deemed to have found the services medically necessary. The Secretary is required to waive such provisions of law and regulations (including those related to the Paperwork Reduction Act) as are necessary to implement these amendments on a timely basis. The amendments may be implemented by program instruction or otherwise. The agreement specifies that there can be no administrative or judicial review of the exceptions process (including establishment of the process). The agreement also requires the Secretary, by July 1, 2006, to implement clinically appropriate code edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments. The edits are to include edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

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	for 2006 CMS announced that the cap would be $1,740 in 2006.	
Accelerated Implementation of Income-Related Reduction in Part B Premium Subsidy.	Since the inception of Medicare, all Part B enrollees have paid the same Part B premium, regardless of their income level. MMA increased the Part B premiums for higher income enrollees beginning in 2007. In 2007, individuals whose modified adjusted gross income (AGI) exceeds $80,000 and couples whose modified AGI exceeds $160,000 will be subject to higher premium amounts. The increase is to be phased-in over five years. During the first year, higher income enrollees will pay premiums ranging from 27% to 36% of the value of Part B. When fully phased-in, higher income individuals will pay premiums ranging from 35% to 80% of the value of Part B. The term modified AGI means adjusted gross income as defined under the Internal Revenue Code (determined without regard to specified exclusions), increased by tax-exempt interest. In general, the taxable year to be used is that beginning in the second calendar year preceding the year involved. Under certain circumstances, an individual may request to have the determination made for a more recent year. The current law provision which specifies that a beneficiary's check can not go down from one year to the next as a result of the Part B premium increase will not apply to persons subject to an income-related increase in their Part B premiums.	**Section 5111.** The agreement accelerates the phase-in period from five years to three years, with the provision fully effective in 2009. In 2007, higher income enrollees will pay total premiums ranging from 28.3% to 43.15% of the total value of Part B. In 2010, enrollees will pay total premiums ranging from 31.7% to 61.85% of the total value of Part B. When fully phased-in in 2009, higher income individuals will pay total premiums ranging from 35% to 80% of the total value of Part B.
Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms.	Medicare provides coverage for services which are reasonable and necessary for the diagnosis or treatment of	**Section 5112.** The agreement authorizes Medicare coverage of ultrasound screening for abdominal aortic

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	illness or injury or to improve the functioning of a malformed body member. In addition, Medicare covers certain preventive services specified in law.	aneurysms for individuals who: (1) receive referrals for such screenings as a result of an initial preventive physical exam performed for new Medicare enrollees; (2) who have not previously had such a test covered by Medicare; and (3) who have a family history of abdominal aortic aneurysm or who manifest risk factors included in a beneficiary category identified by the United States Preventive Services Task Force. An ultrasound screening for abdominal aortic aneurysm is defined as a procedure using sound waves provided for the early detection of abdominal aortic aneurysm. The Secretary could specify other procedures using alternative technologies which are of commensurate accuracy and cost. The term includes the physician's interpretation of the results of the procedure. Ultrasound screening for abdominal aortic aneurysm is to be included in the package of services provided in the initial preventive service exam offered to new Medicare enrollees. Payments are made under the physician fee schedule for screenings performed on or after January 1, 2007. The Part B deductible does not apply to these services.

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Improving Patient Access to, and Utilization of, Colorectal Cancer Screening Under Medicare.	Medicare covers certain colorectal cancer screening tests, subject to coverage limitations based on the type of test and the individual's level of risk. Covered tests are fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy, and barium enema. Payments for services are made under the physician fee schedule, subject to the Part B deductible and coinsurance.	**Section 5113.** The agreement provides that the Part B deductible does not apply to colorectal cancer screening tests, effective January 1, 2007
Delivery of Services at Federally Qualified Health Centers (FQHC).	According to statute, an FQHC is required to provide certain primary care services by physicians and appropriate mid-level practitioners as well as other preventive health services including those required under certain sections of the Public Health Service (PHS) Act (specifically Sections 329, 330, and 340 of the PHS). Prior to the enactment of MMA, FQHC services were covered by a skilled nursing facility's (SNF) consolidated billing requirement. FQHC services were bundled into the SNF's comprehensive per diem payment for the covered stay and not separately billable. MMA specified that a SNF Part A resident who receives FQHC services from a physician or appropriate practitioner would be excluded from SNF consolidated billing and be paid separately.	**Section 5114.** Medicare covered diabetes self-management training and medical nutrition therapy services (provided by registered dietitian or nutrition professional) are added as FQHC services. Services furnished by a health care professional who is under contract with a FQHC would be made directly to the FQHC.
Waiver of Part B Late Enrollment Penalty for Certain International Volunteers .	Medicare Part B is a voluntary program. People generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of the surcharge that may apply. Further,	**Section 5115.** The agreement permits certain individuals to delay enrollment in Part B without a delayed enrollment penalty. Those individuals permitted to delay enrollment would be those who volunteered outside of the United States for at least 12 months through a program sponsored by a tax-exempt organization defined under Section 501(c)(3) of the Internal Revenue Code. The

Provision	Current Law	Conference Agreement as passed by the Senate
	the penalty continues to apply for the entire time the individual is enrolled in Part B. The law establishes certain exceptions to the delayed enrollment penalty. One exception applies to the "working aged." Delayed enrollment is also permitted for certain disabled persons who have group health insurance coverage based on their own or a family member's current employment with a large group health plan. Individuals who are permitted to delay enrollment have their own special enrollment periods. A special enrollment period begins when current employment ends or when coverage under the plan ends. The special enrollment period ends eight months later. Individuals who fail to enroll in this period are considered to have delayed enrollment and could become subject to the penalty.	individuals must demonstrate they had health insurance coverage while serving in the international program. Individuals permitted to delay enrollment will have a special Part B enrollment period which will be the six-month period beginning on the first day of the month the individual is no longer in the program. Coverage will begin the month after the individual enrolls. This section applies to months and special enrollment periods beginning January 2007.
Home health payments.	The Medicare home health prospective payment system, which was implemented on October 1, 2000, provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. Each year Medicare's payment to home health agencies is updated by the projected annual change in the home health market basket (HHMB), with specified reductions in some years. For the last three calendar quarters of 2004-2006,	**Section 5201.** The conference agreement eliminates the update for home health payments in 2006. It also extends the 5% additional payment for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007. Starting in 2007, the conference agreement directs home health agencies to submit to the Secretary health care quality data in a form, manner, and time period specified by the Secretary. In 2007 and subsequent years, a home health agency that does not submit the required quality data will receive an update of the market basket minus

Provision	Current Law	Conference Agreement as passed by the Senate
	the home health update is the HHMB minus 0.8 percentage points. In 2007 and subsequent years, the payment update for home health agencies is equal to the full HHMB. The Medicare Prescription Drug Improvement and Modernization Act of 2003 provided for a one-year 5% additional payment for home health services furnished in rural areas. The temporary payment began for episodes and visits ending on or after April 1, 2004 and before April 1, 2005. It was made without regard to certain budget neutrality provisions and was not included in the base for determination of payment updates.	two percentage points. This reduction would only apply to the fiscal year in question. The conference agreement directs the Secretary to design procedures for making the data available to the public. The conference agreement directs the Medicare Payment Advisory Commission to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services. The report is to include recommendations on the structure of the program, determining thresholds, the size of value-based payments, sources of funds, and the relationship of payments and improvements in health care quality. The conference agreement directs $550,000 to be appropriate to the Medicare Payment Advisory Commission to write this report.
Revision of period for providing payment for claims that are submitted electronically.	Mandatory electronic claims submission went into effect on July 1, 2005 for all providers, with a few exceptions. The exceptions include (1) small providers with fewer than 25 full-time equivalent (FTEs) employees and physicians, practitioners, or suppliers with fewer than 10 FTEs, (2) dentists, and (3) other providers as specified by the Centers for Medicare and Medicaid Services (CMS). Medicare contractors must pay 95% of all "clean" paper claims within 27-30 days of receipt.	**Section 5202.** The Conference agreement directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors are directed to pay 95% of all "clean" claims within 29-30 days of receipt for paper claims.
Time frame for part A and B payments.	Medicare contractors accept, process, and pay claims submitted by providers for Medicare-covered services. Medicare contractors must pay interest on claims that are	**Section 5203.** The Conference agreement delays Medicare Part A and B payments by nine days. Claims that would otherwise be paid on September 22, 2006,

Provision	Current Law	Conference Agreement as passed by the Senate
	not paid promptly. The contractors must pay 95% of all "clean" claims within 14-30 days of receipt for electronically submitted claims, and within 27-30 days of receipt for paper claims. If the payment is not made within that time, interest begins accruing on the day after the required payment date and ends on the date on which the payment is made. The interest rate is set at the higher of the "private consumer rate", or the "current value of funds."	through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individual for any delay in a payment during the period.
Increase in Medicare Integrity Program (MIP) Funding.	As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress acted to increase and stabilize federal funding for anti-fraud activities. As required by Section 1817(k) of the Medicare law, an expenditure account was established within the Federal Hospital Insurance Trust Fund (the HCFAC account). Certain amounts were appropriated from the Trust Fund for specific activities, including the Medicare Integrity Program (MIP). These amounts have been established as not less than $710 million and not more than $720 million for FY2002 and subsequently.	**Section 5204.** MIP funding is increased by $100 million for FY2006.
Phase-out of risk adjustment budget neutrality in determining the amount of payments to Medicare Advantage organizations.	Medicare Advantage payment rates are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. Rates are adjusted by demographic and health status indicators. 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	**Section 5301.** Beginning in 2007, this section (1) would change the way MA area-specific non-drug monthly benchmarks (or MA benchmarks) are calculated, and (2) would specify an adjustment to the benchmarks to phase-out overall increases in MA rates that are the result of the budget neutral implementation of risk adjustment.

Provision	Current Law	Conference Agreement as passed by the Senate
	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 studies that show a difference in the reported health status of Medicare Advantage enrollees compared to the reported health status of beneficiaries in traditional Medicare.	***Changes to the benchmark:*** In 2007, if the Secretary does not rebase rates to 100% of per capita fee-for-service costs, the MA benchmarks would be equal to the 2006 rates as announced by the Secretary on April 4, 2005, with four adjustments — (1) exclusion of any national adjustments for coding intensity, (2) exclusion of risk adjustment budget neutrality, (3) increase based on the national per capita MA growth percentage, and (4) omission of any adjustments to account for errors in previous years' projections of the national per capita MA growth percentage. If the Secretary does rebase the rates in 2007, the MA benchmark would 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 would be the previous year's benchmark (prior to the application of the phase-out percentage discussed below) 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 would be equal to the greater of either the rate calculated above, or 100% of per capita fee-for-service spending. ***Phasing out Budget Neutrality for Risk Adjustmen***t: The new benchmarks described above would be free of the budget neutral risk adjustment. However, the new benchmarks would be adjusted so that budget neutrality would be phased-out over four years. The applicable

Provision	Current Law	Conference Agreement as passed by the Senate
		phase-out factors would be equal to .55 in 2007, .40 in 2008, .25 in 2009 and .05 in 2010. This means that in 2007, 55% of the payment to plans would be based on the budget neutral risk adjustment, and 45% of the payment to plans would be based on a rate without the budget neutral adjustment. Additionally, the benchmark would be multiplied by a complex formula that equals the Secretary's estimate of the total amount of payments that would have been made to plans with budget neutrality, divided by the Secretary's estimate of the total amount of payments that would be made without budget neutrality. When making this calculation, the Secretary would (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, and (c) adjust the risk scores for differences in coding patterns under Medicare Part A and B compared to MA plans to the extent the Secretary has identified differences and (d) as necessary, adjust for late data submissions, lagged cohorts, and changes in MA enrollment. The Secretary could take into account estimated health risk of enrollees in preferred provider organizations (including MA regional plans) for the year. The Secretary would be required to conduct a study of the difference between treatment and coding patterns between MA plans and providers under Parts A and B of Medicare using data starting in 2004. The findings would be incorporated into calculations of MA benchmarks in 2008, 2009, and 2010. No adjustments would be made if

Provision	Current Law	Conference Agreement as passed by the Senate
		payments increased relative to current law. The Secretary could 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 would not be limited by these changes.
Establishment of PACE Provider Grant Program.	PACE is a program providing comprehensive Medicare and Medicaid services under a managed care arrangement to individuals over age 55 who are eligible for a nursing home level of care. PACE organizations, which are public or private non-profit entities, receive a fixed monthly Medicare and Medicaid payment to cover a comprehensive set of services for PACE participants. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.	**Section 5302.** This provision creates site development grants, provides technical assistance to established rural PACE providers, and establishes an outlier fund for rural PACE providers. A rural area would be a county that is not part of a Metropolitan Statistical Areas (as defined by the Office of Management and Budget) as established for Medicare IPPS payments to acute care hospitals. The Secretary will establish a procedures to award site development grants to up to 15 qualified PACE providers that serve a rural area. These providers are rural PACE pilot sites. The PACE grants would not exceed $750,000. The Secretary is appropriated $7.5 million in FY2006 out of the Treasury for these development grants and remain available for expenditure until FY2008. The Secretary will establish a technical assistance program to provide (1) outreach and education to specified entities interested in starting rural PACE programs, and (2) technical assistance necessary to support rural PACE pilot sites. An outlier fund for inpatient and related physician and ancillary costs incurred for an eligible participant within a given 12-month period is required. Outlier costs are those inpatient and other costs in excess of $50,000 incurred

Provision	Current Law	Conference Agreement as passed by the Senate
		within a given 12-month period for an eligible participant who resides in a rural area. For the first three years of its operation, a rural PACE site will receive 80% of the outlier costs in excess of $50,000 for that period. Total outlier payments for an eligible participant could not exceed $100,000 for the 12 month period used to calculate the payment. No site may receive more than $500,000 in total outlier expense payments in a period. A rural PACE pilot site is required to access and exhaust risk reserves held or arranged for the provider and any working capital amounts prior to receiving any payment from the outlier fund. The Secretary is appropriated $10 million for FY2006 for the outlier fund which are available for expenditure through FY2010. The Secretary is required to submit a report to Congress on the evaluation of the rural PACE pilot sites no later than 60 months from the date of enactment. Any amount paid under this authority would be in addition to Medicare PACE funds paid under Section 1894 of the Social Security Act or Medicaid PACE funds paid for under Section 1934 of the same act.

Title VI. Medicaid and SCHIP

Subtitle A. MedicaidChapter 1. Payment for Prescription Drugs

Provision	Current Law	Conference Agreement as passed by the Senate
Modification of Federal Upper Payment Limit for Multiple Source Drugs; Definition of Multiple Source Drugs.	States set the amounts to pay pharmacies for outpatient prescription drugs provided to Medicaid enrollees. States pay those amounts to pharmacies and then seek reimbursement of the federal share of those payments. Federal reimbursements to states for state spending for certain outpatient prescription drugs are subject to ceilings called federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs — those that have at least three therapeutically equivalent drug versions. The Centers for Medicare and Medicaid Services (CMS) calculates the FUL 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. Brand name drugs are subject to an upper limit equal to the amount that pharmacists must pay to acquire the drug (the acquisition cost) as estimated by the states. Pharmaceutical manufacturers whose drugs are available to Medicaid beneficiaries must provide state Medicaid programs with rebates. 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	**Section 6001.(a).** The conference agreement applies FULs to multiple source drugs for which the FDA has rated two or more products to be therapeutically and pharmaceutically equivalent. For those drugs, the FUL would be equal to 250% of the average manufacturer price computed without regard to prompt pay discounts. Effective January 1, 2007. The agreement modifies the definition of multiple source drug so that a drug qualifies as a multiple source drug if there is at least one other drug sold and marketed during the period that is rated as therapeutically equivalent and bioequivalent to it.

Provision	Current Law	Conference Agreement as passed by the Senate
	manufacturers sell 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. Sales at prices that are "nominal" in amount are excluded from the computation of best price. CMS defines nominal prices to be those that are below 10% of the AMP.	
Disclosure of Price Information to States and the Public.	AMP and best price data are required to be reported by manufacturers to CMS no later than 30 days after the date of entering into a rebate agreement and then no later than 30 days after the last day of each rebate period. Those prices are required to be kept confidential except for the purpose of carrying out the requirements of Medicaid rebates, or to permit the Comptroller General and the Director of the Congressional Budget Office to review the information.	**Section 6001(b)**. The conference agreement would increase the required reporting of AMP and best prices. AMP would be reported and calculated on a monthly basis. In addition, the agreement allows states to have access to reported AMP data for multiple source drugs for the purpose of carrying out the Medicaid programs and would require the Secretary to disclose such information through a website accessible to the public. In addition, the provision requires the Secretary to provide AMPs to states on a monthly basis and to update information posted to the website on at least a quarterly basis.
Definition of Average Manufacturer Price.	The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. CMS instructs manufacturers to exclude certain federal drug purchases as well as free goods from the computation of AMP. Sales at nominal prices are excluded from the best price computation. Manufacturers are required to report, for each rebate period, the AMP for all Medicaid covered outpatient drug products and the best price for single source and innovator multiple source drugs to CMS.	**Section 6001(c).** The conference agreement amends the definition of AMP to exclude customary prompt pay discounts extended to wholesalers from those amounts. In addition, the agreement modifies the price reporting requirements so that manufacturers would be required to submit, not later than 30 days after the last day of each rebate period, the customary prompt pay discounts extended to wholesalers in addition to the AMP and best price reporting required under current law.

Provision	Current Law	Conference Agreement as passed by the Senate
		The conference agreement requires the Inspector General of the Department of Health and Human Services (HHS) to, no later than June 1, 2006, review the requirements for, and the manner in which AMP is determined and to submit to the Secretary and Congress any recommendations for changes as determined to be appropriate. The agreement also requires the Secretary of HHS to promulgate a regulation clarifying the requirements for and the manner in which AMPs are to be determined, taking into consideration the recommendations of the Inspector General.
Exclusion of Sales at a Nominal Price from Determination of Best Price.	In addition to the AMP, 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 from best price reporting. Nominal prices are defined by CMS to be those that are below 10% of the average manufacturer's price.	**Section 6001 (d).** The conference agreement modifies the manufacturer price reporting requirements so that for calendar quarters beginning on or after January 1, 2007, manufacturers would be required to report information on sales of Medicaid covered drugs that are made at a nominal price. In addition, the agreement defines the sales that are to be considered nominal for the purpose of reporting nominal price sales and for computing and reporting the best price. (The agreement does not amend the AMP vis-a-vis nominal prices.) Nominal sales are those made by a manufacturer of covered drugs at nominal prices to (a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; (b)

Provision	Current Law	Conference Agreement as passed by the Senate
		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. The nominal price limitations do not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule.
Retail Survey Prices; State Payment and Utilization Rates; and Performance Rankings.	No provision.	**Section 6001(e)**. The agreement allows the Secretary to contract for services for the determination of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates. Such a contract would be awarded for a term of two years. The Secretary would be required to competitively bid for an outside vendor with a demonstrated history in surveying and determining on a representative nationwide basis, retail prices for ingredient costs of prescription drugs; working with retail pharmacies, commercial payers, and states in obtaining and disseminating price information; and collecting and reporting price information on at least a monthly basis. The contract would include the terms and conditions specified by the Secretary and would include a requirement that the vendor monitor the marketplace and report to the Secretary each

Provision	Current Law	Conference Agreement as passed by the Senate
		time there is a new covered outpatient drug available nationwide; and update the Secretary no less often than monthly on the retail survey prices for multiple source drugs and on the computed upper payment limit for those drugs. Information on the retail survey prices obtained through this process, including information on single source drugs would be required to be provided to states on an ongoing and timely basis. The Secretary would be required to devise and implement a means for providing access to each state Medicaid agency of collected price information and to provide information on retail survey prices, including information on single source drugs, to states at least monthly. The agreement allows such a contract to include notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available. If the Secretary were to be notified that such a product has become generally available, the Secretary would be required to make a determination within seven days as to whether the drug meets the definition of a multiple source drug subject to the application of the FUL. The agreement allows the Secretary to waive those provisions the Secretary determines are appropriate to waive, of the Federal Acquisition Regulation, for the efficient implementation of the contract. The agreement requires an annual report from each state agency. States are required to provide to the

Provision	Current Law	Conference Agreement as passed by the Senate
		Secretary, the payment rates for all covered drugs, dispensing fees and utilization of multiple source drugs under the state Medicaid plan. The Secretary is required to compare, on an annual basis, for the 50 most widely prescribed drugs, the national retail sales price data for each state. In addition, the Secretary is required to submit full information regarding the annual rankings to Congress. The provision becomes effective on January 1, 2007.
Miscellaneous Amendments.	States are required to have in place a program of prospective drug review wherein before each prescription is filled, the use of the prescription is screened for potential drug therapy problems. The requirement includes language clarifying that nothing in the provision is intended to require a pharmacist to provide this consultation when a beneficiary refuses such a consultation.	**Section 6001(f).** The conference agreement clarifies that the requirement to provide prospective drug reviews is not intended to require verifications that consultations were offered or refused. Effective on the date of enactment.
Effective Date for Prescription Drug Provisions.	No provision.	**Section 6001(g)**. Unless otherwise specified, the provisions in Section 6001 take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.
Collection and Submission of Utilization Data for Certain Physician Administered Drugs.	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	**Section 6002.** For administered drugs administered on or after January 1, 2006, states are required to provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered. For drugs administered on or after January 1, 2008, states are required to provide for the

Provision	Current Law	Conference Agreement as passed by the Senate
	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.	collection and submission of utilization and coding information for each Medicaid multiple source drug that is physician administered. Submissions from states will be based on National Drug Codes unless the Secretary specified an alternative coding system. All other provisions are identical to the House bill.
Collection and Submission of Utilization Data for Certain Physician Administered Drugs.	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	**Section 6002.** For administered drugs administered on or after January 1, 2006, states are required to provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered. For drugs administered on or after January 1, 2008, states are required to provide for the collection and submission of utilization and coding information for each Medicaid multiple source drug that is physician administered. Submissions from states will

Provision	Current Law	Conference Agreement as passed by the Senate
	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.	be based on National Drug Codes unless the Secretary specified an alternative coding system. All other provisions are identical to the House bill.
Children's Hospital Participation in Drug Discount Program.	Section 340(B) of the Public Health Service Act allows certain health care providers, including community health centers and disproportionate share hospitals, access to prescription drug prices that are similar to the prices paid by Medicaid agencies after being reduced by manufacturer rebates.	**Section 6004.** The conference agreement includes a provision adding Children's Hospitals to the list of providers that may have access to 340(B) discounted prices. The provision would become effective for drugs purchased on or after the date of enactment.

Chapter 2. Asset Transfers

Subchapter A — Reform of Asset Transfer Rules

Provision	Current Law	Conference Agreement, as Passed by the Senate
Lengthening Look-Back Period.	Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts. Ineligibility for Medicaid coverage is limited to only certain long-term care services, not all services covered under the program. The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations. States may choose to apply this ineligibility period to other state plan long-term care services. (They also currently apply to home and community care for functionally disabled elderly individuals	**Section 6011(a).** The Conference agreement would amend section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to five years, or 60 months, for all income and assets disposed of by the individual after enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	under Section 1929 of the act. This is an optional coverage group which operates only in Texas.) In general, states do not extend the penalty to Medicaid's acute care services.	
Change in Beginning Date for Period of Ineligibility.	The period of ineligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.	**Section 6011(b)**. The Conference agreement amends Section 1917(c)(1)(D) of the Social Security Act by changing the start date of the ineligibility period for all transfers made on or after the date of enactment, to begin on the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy. For transfers made prior to this act's enactment, current law applies.
Effective Date Section 6011.	Currently effective.	**Section 6011(c)**. The Conference agreement makes the provisions in this section effective on or after the date of enactment.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Availability of Hardship Waivers; Additional Provisions on Hardship Waivers.	To protect beneficiaries from unintended consequences as a result of 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.	**Sections 6011(d) and (e).** The Conference agreement amends Section 1917(c)(2(D)) of the Social Security Act by adding requirements that states approve undue hardship requests when the asset transfer penalty would deprive the individual of (A) medical care such that the individual's health or life would be endangered; or (b) food, clothing, shelter, or other necessities of life. States are required to provide for: (1) notice to recipients that an undue hardship exception exists; a (2) a timely process for determining whether an undue hardship waiver will be granted for the individual; and (3) a process under which an adverse determination can be appealed. The Conference agreement also amends Section 1917(c)(2) of the Social Security Act to permit facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or that of the personal representative. If the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.
Disclosure and Treatment of Annuities.	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	**Section 6012**. The Conference agreement amends Section 1917 of the Social Security Act and requires individuals applying for Medicaid-covered LTC services,

Provision	Current Law	Conference Agreement, as Passed by the Senate
	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.	upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form includes a statement naming the state as the remainder beneficiary. In the case of disclosure concerning an annuity, the state notifies the annuity's issuer of the state's right as a preferred remainder beneficiary for Medicaid assistance furnished to the individual. Issuers may notify persons with any other remainder interest of the state's remainder interest. States may require an issuer to notify the state when there is a change in the amount of income or principal withdrawn from the amount withdrawn at the point of Medicaid application or recertification. States take this information into account when determining the amount of the state's financial share of costs or in the individual's eligibility for Medicaid. The Secretary may provide guidance to states on categories of transactions that may be treated as a transfer of asset for less than fair market value. States may deny eligibility for medical assistance for an individual based on the income or resources derived from an annuity.

Provision	Current Law	Conference Agreement, as Passed by the Senate
		The Conference agreement also amends Section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity be treated as a 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 in the second position after the community spouse or minor or disabled child and such spouse or a representative of the such child does not dispose of any such remainder for less than fair market value. Includes annuities purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services in the definition of annuities that are subject to asset transfer rules. The Conference agreement excludes from the definition of an asset, those that are described in subsection (b) and (q) of Section 408 of the Internal Revenue Code (IRC) of 1986, or purchased with proceeds from: (1) an account or trust described in subsections (a), (c), and (p) of Section 408 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),

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		and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments. The Conference agreement amends 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 is issued by a financial institution or other business that sells annuities in the state as part of its regular business. The amendments apply to transactions, including the purchase of annuity, occurring on or after the date of this act's enactment.
Application of "Income-First" Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse.	Regarding income, current law exempts all income (e.g., pension or Social Security) of the community spouse (the spouse of a Medicaid beneficiary receiving institutional, or at state option, home and community-based long-term care services) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, Section 1924(d) of the Social Security Act provides for the establishment of a minimum monthly maintenance needs allowance for each community spouse to try to ensure that the community spouse has sufficient income to meet his or her basic monthly needs. (The community spouse's minimum monthly maintenance needs allowance is set at a level that is higher than the official federal poverty level.) Once income is attributed to each of the spouses according to their ownership interest, the	**Section 6013.** The Conference agreement amends Section 1924(d), and therein sections (c) and (e), of the Social Security Act to require states to consider that all income of the institutionalized spouse that could be made available to the community spouse, in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing, has been made before states allocate to the community spouse resources from the institutionalized spouse to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse. These amendments apply to transfers and allocations made on or after the date of this act's enactment by individuals who become institutionalized spouses on or after such date.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	community spouse's monthly income is compared against the minimum monthly maintenance needs allowance. Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. This amount is referred to as the community spouse resource allowance (CSRA). Federal requirements specify that this amount may be no greater than $95,100 and no less than $19,020 in total countable assets in 2005. When determining eligibility, all assets of the couple are combined, counted, and split in half, regardless of ownership. If the community spouse's share of the assets is less than the state-specified maximum, then the Medicaid beneficiary must transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid. If the community spouse's monthly income amount is less than the minimum monthly maintenance needs allowance, the institutionalized spouse may choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e., the difference between the community spouse's monthly income and the state-specified minimum monthly maintenance needs allowance). This transfer allows more income to be available to the community spouse, while Medicaid pays a larger share of the institutionalized spouse's care costs. Within federal limits, states set the maximum monthly income level that community spouses may retain. Federal requirements specify that this amount may be no	

Provision	Current Law	Conference Agreement, as Passed by the Senate
	greater than $2,377.50 per month, and no less than $1,561.25 per month in 2005.	
	The Medicaid beneficiary or community spouse is entitled to a fair hearing if either is dissatisfied with: (1) a determination of the community spouse monthly income allowance; (2) the amount of monthly income otherwise available; (3) the computation or attribution of the spousal share of resources; or (4) the determination of the community spouse resource allowance. If either spouse establishes that the community spouse needs income above the amounts provided by the minimum monthly needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted for the minimum monthly maintenance needs allowance amounts adequate to provide additional necessary income. Federal law allows either income or resources from the spouse receiving Medicaid to be transferred to the community spouse to meet this need.	
Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity.	Within federal law, states set asset standards that applicants must meet to qualify for Medicaid coverage. Among other things, these standards specify a limit on the amount of countable assets a person may have to qualify, as well as define which types of assets are counted and not counted. In general, countable assets cannot exceed $2,000 for an individual applicant. States generally follow SSI rules for computing both countable and non-countable assets. Current Medicaid and SSI asset counting practices generally exclude the entire value of an applicant's home. A home is	**Section 6014.** The Conference agreement amends Section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than $500,000. A state may elect, without regard to Medicaid's requirements concerning statewideness and comparability, to substitute an amount that exceed $500,000 but does not exceed $750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all

Provision	Current Law	Conference Agreement, as Passed by the Senate
	defined as any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. However, if an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.	urban consumers (all items, United States city average), rounded to the nearest $1,000. The Secretary establishes a process for waiving this provision in the case of a demonstrated hardship. Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the Section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home. The Conference agreement would apply to individuals who are determined eligible for Medicaid nursing facility or other long-term care services based on an application filed on or after January 1, 2006.
Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts.	Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay entrance fees and who often reside in such CCRCs throughout their older years. The services generally offered include meals, transportation, emergency response systems, and on-site nursing and physician services. Many also offer home care, maid services and laundry. CCRCs were developed, in large part, in response to an interest	**Section 6015.** The Conference agreement amends Section 1919(c)(5) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for community spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	among many elderly persons to age-in-place. CCRCs can be either for-profit or not-for-profits. They are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Although the majority of CCRC residents do not meet the financial criteria for Medicaid, some do.	For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered in the computation of the spousal share available to Medicaid. The Conference agreement amends Section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination to the extent that: (A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for care; (B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and (C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Requirement to Impose Partial Months of Ineligibility.	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.	**Section 6016(a).** The Conference agreement amends 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 with respect to the disposal of assets.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	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.	
Authority for States to Accumulate Multiple Transfers into One Penalty Period.	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	**Section 6016(b)** The Conference agreement amends Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple fractional assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	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.	
Inclusion of Transfer of Certain Notes and Loans Assets.	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, 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.	**Section 6016(c)**. The Conference agreement amends 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.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	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.	
Inclusion of Transfers to Purchase Life Estates.	Current law does not specify whether life estates should be treated as countable or noncountable 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.	**Section 6016(d).** The Conference agreement amends Section 1917(c)(1) of the Social Security Act by adding 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.
Effective Date for Section 6016.	No provision.	**Section 6016(f)**. This provision applies 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 do not

Provision	Current Law	Conference Agreement, as Passed by the Senate
		apply to Medicaid assistance provided for services before the date of enactment, assets disposed of on or before the date of enactment, or 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. This amendment applies to provision under Section 6016 of the Conference agreement.

Subchapter B — Expanded Access to Certain Benefits

Provision	Current Law	Conference Agreement, as Passed by the Senate
Expansion of State Long-Term Care Partnership Program.	Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at (1) the time of application to Medicaid; 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. Under Section 1902 of the Social Security Act, a state may request the Secretary's permission to amend its Medicaid state plans to allow certain applicants to retain greater amounts of countable assets than other applicants and still qualify for Medicaid. Specifically, states that obtain the Secretary's approval may disregard some or all of the assets of persons applying for Medicaid who have purchased long-term care insurance policies. Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-	**Section 6021.** The conference agreement amends Section 1917(b)(1)(C)(ii) of the Social Security Act to: (1) require that existing partnership programs not allow consumer protection standards to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a LTC policy (including a certificate issued under a group insurance contract), if the following requirements are met: (I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a LTC insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged; (II) The policy is a qualified LTC insurance policy (meeting specifications defined in Section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment; (III) The policy meets the following requirements specified

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	66) allows only those 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 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 benefits paid 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). Federal oversight of LTC insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA established new rules regarding the	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). Model Regulations relating to: - Guaranteed renewal or noncancellability (including some sections of the Model Act); - Prohibitions on limitations and exclusions; - Extension of benefits; - Continuation or conversion of coverage; - Discontinuance and replacement of policies; - Unintentional lapse; - Disclosure; - 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; - Suitability; - Prohibition against preexisting conditions and probationary periods in replacement policies or certificates; - Contingent nonforfeiture benefits if the policyholder

Provision	Current Law	Conference Agreement, as Passed by the Senate
	tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy. 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.	declines the offer of a nonforfeiture provision; - Standard format outline of coverage; and - Delivery of shopper's guide.
	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. HIPPA also includes requirements that tax-qualified policies comply with consumer protections regarding the	Model Act relating to: - Preexisting conditions; - Prior hospitalization; - Contingent nonforfeiture benefits; - Right of return; - Outline of coverage; - Requirements for certificates under group plans; - Policy summary; - Monthly reports on accelerated death benefits; and Incontestability period. These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act are treated as including any other provision the Regulation or Act necessary to implement the provision. Long-term care insurance policies issued in a state shall be deemed as meeting the requirements of the model regulation or the Model Act if the state plan amendment provides that the state

Provision	Current Law	Conference Agreement, as Passed by the Senate
	delivery of policies, information on denials of claims, and disclosure. 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.	insurance commissioner for the state certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements. (IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection.
	National Clearinghouse for Long-Term Care. No provision in current law requires the establishment of a LTC consumer clearinghouse. In related activities, DHHS has funded some states to establish state-based consumer-friendly access to information about LTC services. In FY2003 and FY2004, the Centers for Medicare and Medicaid (CMS) and AoA awarded approximately $19 million in grants to states for the purpose of assisting their efforts to create a single, coordinated system of information and access for all persons seeking long term care to minimize confusion, enhance individual choice, and support informed decision-making. In FY2005, $15 million was awarded. A total of 43 states have received grants for this purpose. Some of the common activities under this grants program include information and referral, outreach, counseling about public benefits and LTC options, and case management. States' methods for implementing the grant may vary; some states have	(V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a LTC insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of LTC; (VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (after consultation with the National Association of Insurance Commissioners, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the type and format of the data and

Provision	Current Law	Conference Agreement, as Passed by the Senate
	established an actual physical location, and other states have established a statewide clearinghouse through a toll-free number or a web-based information site. In addition, CMS has made available to the public, via its website, a comparison of Medicare and Medicaid-certified nursing homes and home health agencies. The information provides detailed facility and agency information and characteristics, and contains several measures of quality (e.g., improvement in mobility). This website does not cover assisted living facilities, group homes and other residential facilities that are not nursing facilities; nor does it cover non-medical, non-certified, home and community-based LTC services.	information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved;
		(VII) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on LTC insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership. In consultation with other appropriate federal agencies, issuers of LTC insurance, and the National Association of Insurance Commissioners, state insurance commissioners, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies, the Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of LTC insurance policies under qualified state LTC insurance

Provision	Current Law	Conference Agreement, as Passed by the Senate
		partnerships to a secure, centralized electronic query and report generating mechanism that state, the Secretary, and other federal agencies can access. Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update or other modification of a model regulation or model act provision listed above or substantially related those listed above, the Secretary reviews these changes, determines whether incorporating such changes into the corresponding provision would improve qualified state LTC insurance partnerships, and, if so, incorporate the changes into the provision. States may require issuers of LTC insurance policies sold in that state (regardless of whether the policy is issued under a qualified state LTC insurance partnership) to report additional information or data to the state. Out of any fund in the Treasury not otherwise appropriated, there is appropriated to the Secretary $1 million for the period of FYs2006-2010. To permit portability in LTC insurance policies purchased under state LTC insurance partnerships, the Secretary develops no later than January 1, 2007, in consultation with the National Association of Insurance Commissioners, states with experience with LTC insurance partnership plans, other state, and representatives of consumers of LTC insurance policies, standards for uniform reciprocal recognition of such policies among states with qualified state LTC insurance

Provision	Current Law	Conference Agreement, as Passed by the Senate
		partnerships which have benefits paid under such policies will be treated the same by all such states, and states with such partnerships shall be subject to such standards unless the state notifies the Secretary of the State's election to be exempt from such standards. The Secretary annually reports to Congress on the LTC insurance partnerships. Such reports would include analyses of the extent to which partnership programs expand or limit access of individuals to LTC and the impact of such partnerships on federal and state expenditures under Medicare and Medicaid. Nothing in this provision shall require the Secretary to conduct an independent review of each LTC insurance policy offered under or in connection with a state partnership program. A state plan amendment that provides for a qualified state LTC insurance partnership may provide that the amendment be effective for LTC insurance policies issued on or after a date that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

Provision	Current Law	Conference Agreement, as Passed by the Senate
		National Clearinghouse for LTC. The Secretary establishes a National Clearinghouse for LTC Information (this may be done through a contract or interagency agreement). The National Clearinghouse for LTC: (1) educates consumers with respect to the availability and limitations of Medicaid LTC coverage (and provides contact information for obtaining specific state information on LTC coverage), including state Medicaid eligibility and estate recovery requirements; (2) provides objective information to assist consumers with the decision-making process for determining whether to purchase LTC insurance or to pursue other private market alternatives for purchasing LTC and provide contact information for additional objective resources on planning for LTC needs; and (3) maintain a list of states with state LTC insurance partnerships. In providing information to consumers on LTC, the National Clearinghouse for LTC Information shall not advocate in favor of a specific LTC insurance provider or a specific LTC insurance policy. Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out for the National Clearinghouse for LTC $3 million for each of FY2006-2010.

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

Provision	Current Law	Conference Agreement, as Passed by the Senate
Encouraging the Enactment of State False Claims Acts.	Under the federal False Claims Act, anyone who knowingly submits a false claim to the federal government is liable for damages up to three times the amount of the government's damages plus mandatory penalties 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%, 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.	**Section 6031.** Under the conference agreement, if a state has in effect a law relating to false or fraudulent claims that meets requirements specified in the bill, the FMAP, with respect to any amounts recovered under a state action brought under such a law, is decreased by 10 percentage points. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.
Employee Education About False Claims Recovery.	No provision.	**Section 6032.** Under the conference agreement, a state is required to provide that any entity that receives annual Medicaid payments of at least $5 million, as a condition of receiving such payments, must: (1) establish written policies for all employees (and any contractor or agent) of the entity that provide detailed information on state

Provision	Current Law	Conference Agreement, as Passed by the Senate
		and federal false claims laws and whistle-blower protections under such laws, (2) include in such written polices detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. The provision is effective January 1, 2007, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.
Prohibition on Restocking and Double Billing of Prescription Drugs.	No provision.	**Section 6033.** The conference agreement would prohibit federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable re-stocking fee). It would become effective on the first day of the first fiscal quarter beginning after enactment.
Medicaid Integrity Program.	States and the federal government share in the responsibility for safeguarding Medicaid program integrity. States must comply with federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare and Medicaid Services (CMS) is the primary federal agency responsible for providing oversight of states' activities and facilitating their program integrity efforts. The HHS Office of Inspector General (OIG) also plays a role in Medicaid fraud and abuse	**Section 6034.** The conference agreement establishes a Medicaid Integrity Program, under which the Secretary of HHS shall enter into contracts with eligible entities to carry out its activities, including review of the actions of individuals or entities, audit of claims for payment, identification of overpayments, and education with respect to payment integrity and quality of care. Appropriations for the program total $5 million in FY2006, $50 million in each of FY2007 and FY2008,

Provision	Current Law	Conference Agreement, as Passed by the Senate
	detection and prevention efforts through its investigations, audits, evaluations, issuances of program recommendations, and other activities. As part of its program integrity activities, CMS operates a Medicare-Medicaid (Medi-Medi) data match project that analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation (e.g., providers submitting claims to both programs for procedures that add up to an excessive number of hours of patient care in a single day). The Medi-Medi project began with one state in 2001, and was subsequently expanded to include eight others. It is primarily supported by "wedge" funds from the Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (Medicare Part A) trust fund. HCFAC wedge funds are divided between the Department of Justice, the HHS Office of Inspector General, CMS, and other HHS agencies. The HCFAC account also funds the Medicare Integrity Program and activities of the Federal Bureau of Investigation related to health care fraud. Annual minimum and maximum HCFAC appropriations are specified in statute.	and $75 million in each fiscal year thereafter (with a mandated increase of 100 employees whose duties consist solely of protecting the integrity of the Medicaid program). States are required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program. In each of FY2006-2010, $25 million is 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). The conference agreement also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program. In addition to HCFAC appropriations for the Medicare Integrity Program, the Medi-Medi Program is appropriated $12 million in FY2006, $24 million in FY2007, $36 million in FY2008, $48 million in FY2009, and $60 million in FY2010 and each fiscal year thereafter.
Enhancing Third Party Identification and Payment.	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	**Section 6035**. The conference agreement substitutes the term "managed care organization" for "health maintenance organization" and amends the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include

Provision	Current Law	Conference Agreement, as Passed by the Senate
	claims before the Medicaid program pays for the care of an individual. 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. 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.	self-insured plans, pharmacy benefit managers, and other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It also amends that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual. In addition, it requires a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring third parties to provide, upon request of the state, information to determine health insurance coverage (in a manner prescribed by the Secretary) and to cooperate with payment and recovery efforts by Medicaid. The provision is effective January 1, 2006, except in the case of a state which the Secretary of HHS determines that state legislation is required for compliance.
Improved Enforcement of Documentation Requirements.	To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien (e.g., a legal permanent resident, refugee, alien granted asylum or related relief) who meets all other Medicaid program eligibility criteria.	**Section 6036.** Under the conference agreement, states are prohibited from receiving federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. Such evidence includes one of the following

Provision	Current Law	Conference Agreement, as Passed by the Senate
	Non-qualified aliens (e.g., those who are unauthorized or illegally present, non-immigrants admitted for a temporary purpose) who would otherwise be eligible for Medicaid except for their immigration status may only receive Medicaid care and services that are necessary for the treatment of an emergency medical condition and are not related to an organ transplant procedure. As a condition of an individual's eligibility for Medicaid benefits, Section 1137(d) of the Social Security Act requires a state to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. If an individual declares that he or she *is* a citizen or national, the state is not required to obtain additional documentary evidence but may choose to do so. If an individual declares that he or she *is not* a citizen or national, the individual must declare that he or she is a qualified alien and present Department of Homeland Security United States Citizenship and Immigration Services Bureau (DHS/USCIS, formerly the Immigration and Naturalization Service) or other documentation determined by the state to constitute reasonable evidence of satisfactory immigration status. If an individual presents DHS/USCIS documentation, the state must verify immigration status with DHS/USCIS through the automated Systematic Alien Verification for Entitlements (SAVE) system, or through an alternative system approved by the Secretary of HHS.	documents: (1) a U.S. passport; (2) Certificate of Naturalization; (3) Certificate of U.S. Citizenship; (4) a valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the state issuing the license or document requires proof of U.S. citizenship or a verified Social Security number before issuance; (5) such other document specified in regulation by the Secretary that provides reliable documentation of identity and proof of U.S. citizenship or nationality. Satisfactory evidence also includes a document from each of the following lists: (1) a certificate of birth in the U.S; (2) Certificate of Birth Abroad; (3) U.S. Citizen Identification Card; (4) Report of Birth Abroad of a Citizen of the U.S.; or (5) such other document specified by the Secretary that provides proof of U.S. citizenship or nationality; AND (1) any identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act; or (2) any other document specified in regulation by the Secretary that provides reliable documentation of identity. The requirements do not apply to aliens who are entitled to or enrolled for Medicare benefits, receiving Supplemental Security Income (SSI) benefits, or eligible for Medicaid on such other basis as the Secretary may specify that satisfactory evidence had been previously presented. The provision would apply to initial

Provision	Current Law	Conference Agreement, as Passed by the Senate
		determinations and to redeterminations of eligibility for Medicaid made on or after July 1, 2006.

Chapter 4. Flexibility in Cost Sharing and Benefits

Provision	Current Law	Conference Agreement, as Amended by the Senate
State Option for Alternative Premiums and Cost Sharing.	With some exceptions, premiums and enrollment fees are generally prohibited under Medicaid. When applicable, nominal amounts for such charges are between $1 and $19 per month depending on family income. States are allowed to establish nominal service-related cost-sharing requirements that are generally between $0.50 and $3, depending on the cost of the service provided. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules.	**Section 6041(a)**. The conference agreement allows states to impose premiums and cost-sharing for any group of individuals for any type of service (except prescribed drugs which are treated separately; see below), through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service. Premiums and cost-sharing provisions in current law for workers with disabilities are not affected.
General Limitations.	See above.	In general, for individuals in families with income between 100 and 150% FPL: (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state. For individuals

Provision	Current Law	Conference Agreement, as Amended by the Senate
		in families with income above 150% FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or service cannot exceed 20% of the cost of the item or service.
Specified Groups Exempt from Premiums.	Under certain circumstances, families qualifying for transitional Medicaid, pregnant women and infants with income over 150% FPL, medically needy groups, and workers with disabilities may be charged premiums for Medicaid coverage. Otherwise, in the absence of a waiver, premiums may not be charged for other individuals and groups.	Premiums are not permitted for: (1) mandatory groups of children under 18, including individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) pregnant women; (3) terminally ill persons receiving Medicaid hospice care; (4) individuals in medical institutions who are required to pay for costs of care all but a minimal amount of their income for personal needs, and (5) women who qualify for Medicaid under the breast and cervical cancer eligibility group. States may exempt additional groups from premiums.
Specified Groups and Services Exempt from Service-Related Cost Sharing.	All service-related cost-sharing is prohibited for: (1) children under 18 years of age; (2) pregnant women for any services that relate to the pregnancy or to any other medical condition which may complicate pregnancy; (3) services furnished to individuals who are inpatients in a hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care; (4) services furnished to individuals receiving	Service related cost-sharing is not permitted for: (1) services provided to mandatory groups of children under 18, including individuals in foster care receiving aid or assistance under Part B of Title IV and persons receiving adoption or foster care assistance under Title IV-E, regardless of age; (2) preventive services provided to children under 18 regardless of family income; (3) services provided to pregnant women that relate to

Provision	Current Law	Conference Agreement, as Amended by the Senate
	hospice care; (5) emergency services; and (6) family planning services and supplies. For most other beneficiaries and services, states may impose nominal service-related cost-sharing (described above). For workers with disabilities, service-related cost-sharing may be required that exceeds nominal amounts as long as they are set on a sliding scale based on income.	pregnancy or to other medical conditions that may complicate pregnancy; (4) services provided to terminally ill individuals receiving Medicaid hospice services; (5) services provided to individuals in medical institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs; (6) emergency services; (7) family planning services and supplies, and (8) services to women who qualify for Medicaid under the breast and cervical cancer eligibility group. States may exempt additional individuals or services from service-related cost-sharing.
Construction.	No provision.	The agreement further specifies that these provisions would not prevent states from further limiting premiums and cost sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect related waivers in effect before the date of enactment.
Beneficiary Conditions For Continued Medicaid Enrollment and Receipt of Services.	Under the state Medicaid plan, providers must not deny care or services to Medicaid beneficiaries due to the individual's inability to pay a cost-sharing charge. However, this requirement does not eliminate the beneficiary's liability for payment of such charges. For certain groups of pregnant women and infants for which monthly premiums may be charged, states must not require prepayment and must not terminate Medicaid eligibility for failure to pay such premiums until such failure continues for at least 60 days. States may waive those premiums when such payments would cause undue hardship.	The agreement allows states to condition the provision of medical assistance on the payment of premiums, and to terminate Medicaid eligibility on the basis of failure to pay a premium if that failure continues for at least 60 days. States may apply this provision to some or all groups of beneficiaries, and may waive premium payments in cases where such payments would be an undue hardship. In addition, the provision would allow states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition of receiving care or services. Providers would also be allowed to reduce or waive

Provision	Current Law	Conference Agreement, as Amended by the Senate
		cost-sharing amounts on a case-by-case basis.
Indexing Nominal Cost Sharing and Conforming Amendment.	The regulations that specify nominal premium and service-related cost-sharing amounts were published and amended in the late 1970s and the early 1980s. These amounts are not adjusted by any factor.	**Section 6041(b)**. Beginning with 2006, the Secretary is required to increase nominal amounts for service-related cost-sharing by the annual percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an appropriate manner. These changes apply to premium and cost-sharing provisions involving nominal amounts in existing statute (Section 1916) as well as to the new cost-sharing provisions specific to prescription drugs and non-emergency care provided in an emergency room (described below).
Effective Date.	No provision.	**Section 6041(c)** These provisions apply to cost-sharing for items and services furnished on or after March 31, 2006.
Special Rules for Cost Sharing for Prescription Drugs.	States are allowed to establish nominal service-related cost-sharing requirements (defined in regulation) that are generally between $0.50 and $3, depending on the cost of the service provided. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules. As with other Medicaid benefits, nominal cost-sharing may be imposed on prescribed drugs, and states may vary nominal cost-sharing amounts for preferred and non-preferred drugs. States may also implement prior authorization for prescribed drugs.	**Section 6042.** Under the conference agreement, states may impose higher cost-sharing amounts for state-identified non-preferred drugs within a class; waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class; and must not apply such cost-sharing for preferred drugs to persons exempt from cost-sharing (identified above). Within these parameters, states identify the group(s) of beneficiaries for which these special cost-sharing rules will apply.

Provision	Current Law	Conference Agreement, as Amended by the Senate
Limitations on cost-sharing for non-preferred drugs.	See above.	Cost-sharing for non-preferred drugs may not exceed: (1) nominal amounts for individuals in families with income below or equal to 150% FPL, and (2) 20% of the cost of the drug for individuals in families with income above 150% FPL. For persons generally exempt from cost-sharing (identified above), cost-sharing for non-preferred drugs may be applied. Such cost-sharing may not exceed nominal amounts, and aggregate caps on cost-sharing (identified above) would still apply.
Special conditions and applicable cost-sharing.	No provision.	In cases in which a prescribing physician determines that the preferred drug would not be effective or would have adverse health effects or both, the state may impose the cost-sharing amount for preferred drugs on the prescribed non-preferred product.
Flexibility regarding drugs excluded from cost sharing provisions.	No provision.	The agreement does not prevent states from excluding specified drugs or classes of drugs from these special cost-sharing rules.
Effective Date.	No provision.	These provisions are effective for cost-sharing imposed for items and services furnished on or after March 31, 2006.
Emergency Room Co-Payments for Non-Emergency Care.	Waivers may be used to allow states to impose up to twice the otherwise applicable nominal cost-sharing amounts for non-emergency services provided in a hospital emergency room (ER). States may impose these higher amounts if they have established that Medicaid beneficiaries have available and accessible alternative sources of non-emergency,	**Section 6043**. The conference agreement would allow states, through a state plan amendment, to impose increased cost-sharing on state-specified groups for non-emergency services provided in an ER, when certain conditions are met. First, alternative non-emergency providers must be available and accessible to the person

Provision	Current Law	Conference Agreement, as Amended by the Senate
	outpatient services.	seeking care. Second, after a medical screening for emergency medical conditions (as defined in Medicare law) and a determination that such an emergency does not exist, but before the non-emergency care is provided at the ER, the beneficiary must be told: (1) the hospital can require a copayment, (2) the name and location of an alternative non-emergency provider who is actually available and accessible and that such a provider may not impose the same cost-sharing, and (3) the hospital can provide a referral. When these conditions are met, states can apply or waive cost-sharing for services delivered by the alternative non-emergency provider.
Limitations.	See above.	For persons with income between 100-150% FPL, cost-sharing for non-emergency services in an ER can not exceed twice the nominal amounts. Individuals exempt from premiums or service-related cost-sharing under other provisions of this agreement may be subject to nominal copayments for non-emergency services in an ER, only when no cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers in the area served by the hospital ER. Aggregate caps on cost-sharing (described above) still apply.
Provider Obligations Regarding Emergency Services.	Contracts with managed care plans must provide for coverage of emergency services without regard to whether the emergency care provider has a contractual relationship with the plan or prior authorization. An emergency medical condition is one manifesting itself by acute symptoms of	These provisions have no impact on a hospital's obligations with respect to screening and stabilizing an emergency medical condition, nor do they modify the application of the prudent-layperson standard with respect to payment or coverage of emergency services by

Provision	Current Law	Conference Agreement, as Amended by the Senate
	sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy (and in the case of a pregnant woman, her health or that of her unborn child), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.	any managed care organization.
Provider Liability.	No provision. (In general, state laws govern provider liability.)	In addition, no hospital or physician that imposes cost-sharing for non-emergency care in an ER is liable in any civil action or proceeding, absent a finding by clear and convincing evidence of gross negligence. Liabilities related to the provision of emergency care or other applicable state laws regarding delivery of care are not affected by these provisions. On December 21, 2005, the Senate passed an amended conference agreement that, through a point of order, struck this provision.
Definitions.	No provision.	"Non-emergency services" means any care or services furnished in an ER that the physician determines does not constitute an appropriate medical screening examination or stabilizing examination and treatment screening required for hospitals under Medicare law (regarding examination and treatment for emergency medical conditions and women in labor). "Alternative non-emergency services provider" means a Medicaid-participating health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health

Provision	Current Law	Conference Agreement, as Amended by the Senate
		care provider that provides clinically appropriate services for the diagnosis or treatment of the condition contemporaneously with the provision of non-emergency services that would otherwise be provided in the ER.
Grants to Establish Alternative Non-Emergency Provider Networks.	No provision.	The Secretary is required to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. The conference agreement also authorizes and appropriates $50 million for paying such providers for the four-year period beginning with 2006. The Secretary is required to give a preference to states that establish or provide for alternate non-emergency services providers (or networks) that serve rural or underserved areas where beneficiaries may have limited access to primary care providers, or in partnership with local community hospitals. To access these funds, states are required to file an application meeting requirements set by the Secretary.
Effective Date.	No provision.	These amendments apply to non-emergency services furnished on or after January 1, 2007.
Use of Benchmark Packages.	Categorically needy (CN) eligibility groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. Some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital	**Section 6044**. The agreement gives states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage (described below). States can only exercise this option for eligibility groups that were established under the state plan on or before the date of enactment of this option. States may choose to provide other

Provision	Current Law	Conference Agreement, as Amended by the Senate
	care, lab and x-ray services, physician services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.	wrap-around and additional benefits (see below).
Full Benefit Eligible Individuals.	See above.	Enrollment in benchmark and benchmark-equivalent coverage can be required for "full benefit eligible individuals," including persons eligible for all services covered for the CN, or any other category of eligibility for all covered services under the state Medicaid plan as determined by the Secretary. Certain individuals would be excluded from the definition of a full-benefit eligible, including (1) the MN; (2) CN individuals in certain states who are required to pay for medical expenses from their income until their remaining net income meets SSI financial standards in effect in 1972; and (3) other individuals who qualify for Medicaid when costs incurred for medical expenses or other remedial care are subtracted from income to meet financial eligibility requirements (also known as spend-down populations).

Provision	Current Law	Conference Agreement, as Amended by the Senate
Exempted Groups.	No provision.	Specific groups are exempted from mandatory enrollment in the benefit package option, including (1) mandatory pregnant women; (2) individuals who qualify for Medicaid under the state plan on the basis of being blind or disabled regardless of their eligibility for SSI on such basis, including children that meet SSI disability standards who require institutional care, but for whom care is delivered outside the institution, and the cost of that care does not exceed institutional care (also known as Katie Beckett or TEFRA children); (3) dual eligibles; (4) terminally ill hospice patients; (5) individuals in medical institutions who are required to pay for costs of medical services except for a minimal amount retained from their income for personal needs; (6) individuals who are medically frail or who have special medical needs, as identified in accordance with regulations of the Secretary; (7) individuals who qualify for Medicaid long-term care services (i.e., nursing facility or equivalent level of care, home and community-based waiver services, home health, home and community care for functionally disabled elderly, personal care, and other optional long-term care offered by the state); (8) children in foster care receiving child welfare services (under Title IV-B) and children receiving foster care or adoption assistance under Title IV-E regardless of age; (9) individuals who qualify for Medicaid on the basis of receiving assistance under TANF (as in effect on or after the welfare reform effective date applicable to the state); (10) women in the breast and cervical cancer eligibility

Provision	Current Law	Conference Agreement, as Amended by the Senate
		group; and (11) other "limited services beneficiaries," including certain tuberculosis-infected individuals, and legal and undocumented non-citizens who meet the financial and categorical requirements for Medicaid eligibility without regard to time in the U.S. and are eligible only for emergency medical services.
Standard Benefits.	As described above, some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, FQHC services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.	Benchmark and benchmark-equivalent packages would be nearly identical to those offered under SCHIP, with some additions. Benchmark coverage would include (1) the standard Blue Cross/Blue Shield preferred provider plan under FEHBP; (2) health coverage for state employees; (3) health coverage offered by the largest commercial HMO; and (4) secretary approved coverage which may include any other health benefits coverage that the Secretary determines will provide appropriate coverage for the population targeted to receive such coverage. Benchmark-equivalent coverage would have the same actuarial value as one of the benchmark plans. Such coverage includes (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) well child care, including immunizations, and (5) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for: (1) prescribed drugs, (2) mental health services, (3) vision care, and (4) hearing services. Determination of actuarial value would follow generally accepted actuarial principles and methodologies and would be conducted by a member of

Provision	Current Law	Conference Agreement, as Amended by the Senate
		the American Academy of Actuaries.
Wrap-Around Benefits for Children Only.	Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid children under age 21 in CN groups receive comprehensive screening services and preventive care, and are guaranteed access to all federally coverable services necessary to treat a problem or condition. EPSDT may be offered to MN children.	For any child under age 19 in one of the major mandatory and optional eligibility groups (defined in Section 1902(a)(10)(A)) under the state Medicaid plan, wrap-around benefits to the benchmark or benchmark-equivalent coverage includes ESPDT as defined in current Medicaid law.
Treatment of Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).	Both the services provided by RHCs and FQHCs are required benefits for CN groups under Medicaid. Among other mandatory benefits for MN groups, states must offer ambulatory services for persons under 21 and those entitled to institutional services. Such ambulatory services may include RHC and FQHC services at state option. In general, RHCs and FQHCs are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services.	States can only enroll eligible beneficiaries in benchmark and benchmark-equivalent coverage if such persons have access to services provided by RHCs and FQHCs, and the Medicaid prospective payment system for both types of providers remains in effect.
Effective Date.	No provision.	These provisions are effective on March 31, 2006.

Chapter 5. State Financing

Provision	Current Law	Conference Agreement, as Passed by the Senate
Managed Care Organization Provider Tax.	States' ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be "broad-based." A broad-based tax is a tax that is uniformly applied to all providers or services within the provider class. The federal statute identifies each of the classes of providers or services for the purpose of determining whether a tax is broad-based. Medicaid managed care organizations (MCOs) are identified as a separate class of providers for the purposes of determining if a tax is broad-based. This class is unlike all of the other classes of providers or services because it is limited to only Medicaid providers. Other classes of providers or services identified in statute, such as inpatient hospital services, outpatient hospital services, physicians — are not restricted to Medicaid providers or Medicaid services.	**Section 6051**. The conference agreement would expand the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. This would make the MCO provider class more consistent with the other provider classes for purposes of determining if a provider tax is broad-based. The provision becomes effective upon enactment except in states with taxes based on the current law Medicaid MCO provider class in place as of December 8, 2005. In those states, the provision becomes effective on October 1, 2009.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Reforms of Case Management and Targeted Case Management (TCM).	Case management is an optional Medicaid benefit designed to help Medicaid beneficiaries access needed medical, social, educational, and other services. States that cover case management do not have to offer the benefit statewide and can limit the service to specific groups of Medicaid beneficiaries which is referred to as "targeted case management" (TCM). Several states extend case management services to individuals who may also be receiving certain case management services as part of another state and/or federal program (e.g., foster care, juvenile justice).	**Section 6052**. The conference agreement clarifies the activities that can be considered case management or targeted case management, and those activities (primarily foster care-related activities) that may not be reimbursed as case management services or TCM.
Additional FMAP Adjustments.	The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under the State Children's Health Insurance Program (SCHIP), subject to the availability of funds from a state's SCHIP allotment. When state FMAPs are calculated by HHS for an upcoming fiscal year, the state and U.S. amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate	**Section 6053.** Under the conference agreement, if Alaska's FY2006 or FY2007 FMAP for Medicaid or SCHIP is less than its FY2005 FMAP, the FY2005 FMAP shall apply. In addition, in computing Medicaid and SCHIP FMAPs for any year after 2006 for a state that the Secretary of HHS determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary shall disregard such evacuees and their incomes.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	revised Census Bureau population figures and newly available source data. It also undertakes a comprehensive data revision — reflecting methodological and other changes — every few years. P.L. 106-554 (Consolidated Appropriations Act, 2001), provided that for FY2001-2005, Medicaid and SCHIP FMAPs for Alaska would be calculated using the state's per capita income divided by 1.05. Dividing by 1.05 lowered the state's per capita income, thereby increasing its FMAP.	
DSH Allotment for the District of Columbia.	States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under broad federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment.	**Section 6054.** The conference agreement would raise the allotments for the District of Columbia for FY2000, 2001, and 2002 from $ 32 million to $ 49 million. The higher allotments would be used to calculate DSH allotments beginning with FY2005 amounts. The provision would take effect as if enacted on October 1, 2005 and would apply to expenditures made on or after that date
Increase In Medicaid Payments to the Insular Areas.	In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. For FY1999 and subsequent fiscal years, these caps are	**Section 6055**. For each of FY2006-2007, the Conference Agreement increases the federal Medicaid funding caps in the insular areas. For Puerto Rico, the federal Medicaid cap is increased by $12 million in each of FY2006 and FY2007. For the Virgin Islands and Guam, the federal Medicaid caps is increased by $2.5

Provision	Current Law	Conference Agreement, as Passed by the Senate
	increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics). The federal Medicaid matching rate, which determines the share if Medicaid expenditures paid for by the federal government, is statutorily set at 50% of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps.	million in FY2006, and by $5.0 million in FY2007. For the Northern Marianas, the federal Medicaid cap is increased by $1.0 million in FY2006, and by $2.0 million in FY2007. For American Samoa, the federal Medicaid cap is increased by $2.0 million in FY2006, and by $4.0 million in FY2007. For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in the insular areas is calculated by increasing the FY2007 ceiling for inflation. The Conference Agreement is effective upon enactment of this act

Chapter 6. Other Provisions
Subchapter A — Family Opportunity Act.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children.	For children with disabilities, there are a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. For some of these groups, disability status or medical need is directly related to Medicaid eligibility (e.g., children receiving Supplemental Security Income or SSI with family income below 75% FPL). There are other pathways through which such children may also qualify for Medicaid coverage for which disability status and/or medical need are irrelevant (e.g., children under age 6 with family income below 133% FPL). All of the Medicaid eligibility pathways for children require income levels that are generally below 300% of the federal poverty level (FPL) with some state-specific exceptions.	**Section 6062(a)(1).** The agreement creates a new optional Medicaid eligibility group for children with disabilities under age 19 who meet the severity of disability required under SSI without regard to any income or asset eligibility requirements applicable under SSI for children, and whose family income does not exceed 300% FPL. (States can exceed 300% FPL, without federal matching funds for such coverage.) Medicaid coverage will be phased in by age group, beginning with children through age six in the second through fourth quarters of FY2007, then covering children through age 12 beginning in FY2008, and finally, covering children through age 18 during FY2009 and thereafter.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Interaction with Employer-Sponsored Family Coverage.	States may require Medicaid beneficiaries to apply for coverage in certain employer-sponsored group health plans (in which such persons are eligible) when it is cost-effective to do so (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. 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.	**Section 6062(a)(2)**. Under the agreement, states must require certain parents of children eligible for Medicaid under the new optional coverage group to enroll in, and pay premiums for, family coverage through employer-sponsored insurance if certain conditions are met. When the employer offers family coverage, the parent is eligible for such coverage, and the employer contributes at least 50% of the total cost of annual premiums for such coverage, states must require participation in such coverage as a condition of continuing Medicaid eligibility for the child. States can pay any portion of required premiums on behalf of eligible children under such employer plans. Medicaid would be the secondary payer to these employer plans. Benefits offered by Medicaid but not offered by the employer plans would be covered under Medicaid. Also, if such employer coverage is obtained, states must reduce income-related premiums for Medicaid coverage (permitted under Section 6062(b); see below) by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability.
State Option to Impose Income-Related Premiums.	For certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. States are specifically prohibited from requiring payment of deductions, cost-sharing or similar charges for services furnished to children under 18 (up to age 21, or reasonable subcategories, at state option). Also, in certain circumstances, states may impose monthly	**Section 6062(b)**. States are permitted, within certain limits, to require families with children that qualify for Medicaid under the new optional eligibility category to pay monthly premiums on a sliding scale based on income, but only if specific caps on aggregate payments for cost-sharing, including premiums for employer-sponsored family coverage if applicable, and other charges are met. These caps specify

Provision	Current Law	Conference Agreement, as Passed by the Senate
	premiums for Medicaid. For example, states may require certain workers with disabilities to pay premiums and cost-sharing set on a sliding scale based on income. For one of these groups, states may require those with income between 250% and 450% FPL to pay the full premium. But 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 may also waive premiums when such payments would cause undue hardship.	that cost-sharing cannot exceed 5% of income for families with income up to 200% FPL, and cannot exceed 7.5% of income for families with income between 200% and 300% FPL. States cannot require prepayment of premiums, nor can states terminate eligibility of an enrolled child for failure to pay premiums unless lack of payment continues for a minimum of 60 days beyond the due date. States can waive payment of premiums when such payment would cause undue hardship.
Conforming Amendments.	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 allotments. 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 personal income, compared to	**Section 6062(c)**. The agreement permits the upper 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. This section 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 higher SCHIP E-FMAP, applies for determining the federal share of Medicaid expenditures for the new optional coverage group. In addition, federal payments will be drawn from the open-ended Medicaid account and not the capped SCHIP account.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	the national average.	
Effective Date.	No provision.	**Section 6062(d)**. These provisions are effective for items and services furnished on or after January 1, 2007.
Demonstration Projects Regarding Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children.	Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allows states to provide a broad range of home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation (ICF-MR). The HCBS waiver does not allow states to provide these types of programs as an alternative to a psychiatric residential treatment facility for children with psychiatric disabilities.	**Section 6063.** The conference agreement establishes a five-year demonstration project in which up to 10 states could provide a broad range of home- and community-based services to children who would otherwise require services in a psychiatric residential treatment facility. The demonstration would test the effectiveness of improving or maintaining the child's functional level, and the cost-effectiveness of providing these types of services as an alternative to psychiatric residential treatment services.
State Demonstration.	No provision	The state demonstration projects may provide a variety of home and community-based services as an alternative to psychiatric residential treatment facilities. The projects must follow the existing requirements of the HCBS waiver, and be budget neutral. The state must also provide for an interim and final evaluations that must be conducted by an independent third party. Following the demonstration, a state may continue to provide home and community-based services to those children who are enrolled in the demonstration project as of the project's termination date.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Federal Evaluation and Report.	No provision.	The Secretary is required to complete evaluations of the project and report the findings to the President and Congress within 12 months of completing the evaluations. Of the amount appropriated for the demonstration, the Secretary may use $1 million each year in the FY2007-FY2011 period for this purpose.
Appropriation.	No provision.	The conference agreement appropriates $218 million for FY2007-FY2011 to carry out the demonstration. The funds available for this demonstration total: $21 million in FY2007; $37 million in FY2008; $49 million in FY2009, $53 million in FY2010; and $57 million in FY2011.
Family-to-Family Health Information Centers.	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	**Section 6064.** The conference agreement increases 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. It appropriates an additional $3 million for FY2007, $4 million for FY2008, and $5 million for FY2009 for this new purpose. For each of FYs 2010 and 2011, the conference agreement authorizes $5 million for this purpose. Funds would remain available until expended. The purpose of the family-to-family health information centers is to: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health

Provision	Current Law	Conference Agreement, as Passed by the Senate
	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.	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 is required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.
Restoration of Medicaid Eligibility for Certain SSI Beneficiaries.	SSI and Medicaid eligibility is effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date that the individual is determined eligible.	**Section 6065.** The agreement extends Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application is filed, or (2) the date SSI eligibility is granted. This provision is effective one year after the date of enactment.

Subchapter B — Money Follows the Person Rebalancing Demonstration.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Money Follows the Person Demonstration.	States can provide a variety of home and community-based services to Medicaid beneficiaries who need long-term care. Some of these services may be offered statewide as part of the Medicaid state plan (e.g., home health services and personal care services). Other services may be offered through a home and community-based services (HCBS) waiver under Section 1915(c) of the Social Security Act. The HCBS waivers allow states to provide a broad range of home and community-based services (e.g., respite, adult day care) to individuals who would otherwise require the level of care provided in certain types of institutions (i.e., a hospital, nursing facility or intermediate care facility for individuals with mental retardation (ICF-MR)). As part of the HCBS waiver, states have the ability to define the covered services and specify a target population (e.g., elderly individuals). States may also limit the number of waiver participants. Medicaid beneficiaries who are residents of an institution (such as a nursing home) and who would like to leave that institution would be entitled to receive those Medicaid services covered by the Medicaid state plan. However, individuals may not be able to access the broader range of services under an HCBS waiver because many states have waiting lists.	**Section 6071(a).** The conference agreement authorizes the Secretary to conduct a demonstration project in states to (1) increase the use of home and community-based care instead of institutions by relocating individuals from institutions into the community, (2) expand the state's capacity to provide home and community-based long-term care services for individuals who choose to transition into the community; and (3) to ensure that procedures are in place to provide quality assurance and continuous quality improvement, that is at least comparable to other Medicaid home and community-based services.

Provision	Current Law	Conference Agreement, as Passed by the Senate
State Demonstrations.	No provision	States awarded a demonstration would receive additional federal funding for the costs of home and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant's transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community-based long-term care program.
Eligible Individuals.	No provision.	Individuals may participate in the demonstration if they meet the following criteria: (1) they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); (2) they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); (3) they are receiving Medicaid benefits for the services in this facility; (4) they will continue to require the level of care of the facility but for the provision of HCBS services. After relocating into the community, the individual must reside in one of the following: a home owned or leased by the individual or his/her family; an apartment with an individual lease in which the individual (or family) has domain and control over the space; or a community-based residential setting where no more than four unrelated individuals reside.

Provision	Current Law	Conference Agreement, as Passed by the Senate
State Application.	No provision.	**Section 6071(c)**. The state's application for a demonstration project is required to include, at a minimum, the following information: (1) assurance that the project was developed and will be operated through a public input process; (2) assurance that the project will operate in conjunction with an existing Medicaid home and community-based program; (3) the duration of the project, which must be for at least two consecutive fiscal years in a five-year period starting in FY2007; (4) the service area, which may be statewide or less-than-statewide; (5) the target groups and the projected number to be enrolled and the estimated total expenditures for each fiscal year; (6) assurance that the project defers to individual choice and that the state will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible; (7) information on recent Medicaid expenditures for long-term care and home and community-based services the year preceding the demonstration, and proposed methods to increase the state's investment in home and community-based services; (8) methods the state will use to eliminate barriers to paying for long-term care services for participants in the setting(s) of their choice; (9) assurance that the state will meet a maintenance of effort for Medicaid HCBS expenditures and will continue to operate a HCBS waiver that meets the statutory requirements for cost-neutrality. A state is also required to identify any requested waivers of Medicaid law; describe a plan for quality assurance and improvement of HCBS services under Medicaid; if

Provision	Current Law	Conference Agreement, as Passed by the Senate
		applicable, the process for participants to self-direct his or her own services (meeting standards described below); and compliance with reports and evaluation, as required by the Secretary.
Requirements for Self-Directed Services.	No provision.	If a state allows demonstration participants to self-direct their home and community-based long-term care services, the state must include the following: (1) an assessment of the individual's needs, capabilities and preferences; (2) a service plan that is developed jointly with the individual (or an authorized representative). If a state allows for an individualized budget which is the value of the self-directed services, the state must describe the method used to set the budget, define a process to adjust the budget to reflect changes in individuals assessment and service plans, and evaluate expenditures under the budget.
Secretary's Award of Competitive Grants and Waivers.	No provision.	**Section 6071(d).** In addition to evaluating the merits of a state's application, in selecting demonstration projects, the Secretary is required to consider a national balance of target groups and geographic distribution and to give a preference to states that cover multiple groups or offer project participants the opportunity to self-direct their services. The Secretary is also authorized to waive certain sections of Medicaid law to achieve the demonstration's purpose.
Conditional Approval of Out-Year Grants.	No provision	To qualify for grant awards after year one, states will be required to meet numerical benchmarks measuring the

Provision	Current Law	Conference Agreement, as Passed by the Senate
		increased investment in services under this proposal and the number of individuals transitioned into the community. States will also be required to demonstrate that they are assuring the health and welfare of project participants. For states that do not meet these requirements, the Secretary will be required to rescind the grant award for future grant periods and will be allowed to re-award unused funding.
Payments to States/ Carryover of Unused Grant Amounts.	Medicaid expenditures for services (including the Medicaid state plan and HCBS waiver) are generally shared between the federal and state governments. The specific federal share of a state is based on the state's federal medical assistance percentage (FMAP) rate which can range from 50% to 83%.	**Section 6071 (e).** Those states awarded a demonstration would receive an enhanced FMAP rate (referred to as the `MFP-enhanced FMAP') equal to the current FMAP rate for the state increased by a number of percentage points equal to 50% of the difference between 100% and the normal FMAP rate. However, in no case can the FMAP rate exceed 90% for a state. The state will receive the MFP-enhanced FMAP for the costs of home and community-based, long-term care services for 12 months following a demonstration participant's transition from an institution into the community. Payments for home and community-based long-term care services under the demonstration project would be in lieu of payment for expenditures that could otherwise be paid for by Medicaid. However, if a state exhausts its grant funding in a particular year, the state is not prevented from using Medicaid to pay for home and community-based long-term care services. Finally, a state that does not use all of its funding in a given fiscal year will continue to have access to that funding for four subsequent fiscal years.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Quality Assurance and Improvement; Technical Assistance and Oversight.	No provision.	**Section 6071 (f**). The Secretary is required to provide for technical assistance and oversight of states to improve the quality assurance and quality improvement systems under Medicaid home and community-based waivers. The Secretary may use up to $2.4 million of the amounts appropriated in the portion of FY2007 that begins on January 1, 2007, and ends on September 30, 2007, and for FY2008, to carry out these activities during the period beginning on January 1, 2007, and ending on September 30, 2011.
Research and Evaluation.	No provision.	**Section 6071 (g).** The conference agreement requires the Secretary to provide for research on, and conduct a national evaluation of, the demonstration project. The Secretary must make a final report to the President and Congress no later than September 30, 2011, and may use up to $1.1 million each year from FY2008-FY2011, to carry out these activities.
Appropriations.	No provision.	**Section 6071(h)**. The conference agreement appropriates $250 million for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; $300 million in FY2008; $350 million in FY2OO9; $400 million in FY2010; and $450 million in FY2011 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years, through September 30, 2011.

Subchapter C — Miscellaneous.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Medicaid Transformation Grants.	Section 1903(a) of the Social Security Act describes the level of federal reimbursement available to states for various Medicaid program functions. 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.	**Section 6081**. Under the House bill, in addition to the normal federal Medicaid reimbursement received by states under Section 1903(a), the Secretary of HHS shall provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in Medicaid. Examples of innovative methods for which funds may be used include (1) methods for reducing patient error rates through the implementation and use of electronic systems, (2) methods for improving rates of Medicaid collection from estates, (3) methods for reducing waste, fraud, and abuse, (4) implementation of a medication risk management program, (5) methods for reducing outpatient drug expenditures by increasing the utilization of generics, and (6) methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems. Total payments will equal and not exceed $75 million in each of FY2007 and FY2008. The Secretary shall specify a method for allocating funds among states, providing preference for states targeting health providers that treat significant numbers of Medicaid beneficiaries and allocating at least 25% of the funds among states

Provision	Current Law	Conference Agreement, as Passed by the Senate
		whose populations as of July 1, 2004 were more than 105% of their populations as of April 1, 2000.
Health Opportunity Accounts.	Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income families, children, pregnant women, and individuals who are aged or disabled. Each state designs and administers its own program under broad federal guidelines. Variation exists among states in eligibility, covered services, and the delivery of, and reimbursement for services. States that wish to experiment with new approaches for providing health care coverage that promote the objectives of the Medicaid program may seek approval for Section 1115 demonstration waivers. While the demonstration programs described in the conference agreement have some of the elements of a Section 1115 demonstration waiver, "Health Opportunity Accounts", as defined by the provision are not explicitly authorized under current law.	**Section 6082**. The conference agreement requires the Secretary of HHS to establish no more then 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2007. If successful (based on cost-effectiveness, quality of care and other Secretary-specified criteria) during the initial five-year test period, such demonstrations may be extended or made permanent, and other demonstrations may be approved. HOAs will be used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Among other things, state demonstration programs are required to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.
Eligibility Rules for Demonstration Participants.	To qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. The specific income and resource limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions.	**Section 6082 (b).** Eligibility for HOAs is determined by the state, though individuals age 65 or older, or who are blind or disabled regardless of whether the individual is eligible for SSI on such basis, who are pregnant, who have been eligible for medical assistance for a continuos period of less than three months, or who are receiving terminal care or long-term care, are among those who are

Provision	Current Law	Conference Agreement, as Passed by the Senate
		precluded from participating. Other excluded groups include (1) dual eligibles, (2) terminally ill hospice patients, (3) children with disabilities that meet SSI disability standards who require institutional care, but for whom care is delivered outside the institution, and the cost of that care does not exceed the otherwise applicable institutional care (also known as Katie Beckett or TEFRA children); (4) medically frail and special medical needs individuals (as determined in accordance with regulations of the Secretary); (5)children in foster care receiving child welfare services (under Part B of Title IV) and who are children receiving foster care or adoption assistance under Part E of Title IV without regard to age; (6) individuals who qualify for Medicaid under the family coverage provision (Section 1931) or on the basis of receiving assistance under TANF (as in effect on or after the welfare reform effective date); (7) women in the breast and cervical cancer eligibility group; and (8) other "limited services beneficiaries," including certain tuberculosis-infected individuals, and legal and undocumented non-citizens who meet the financial and categorical requirements for Medicaid eligibility without regard to time in the U.S. and are eligible only for emergency medical services. The conference agreement adds a one-year moratorium for reenrollment, whereby eligible individuals disenrolled from the state demonstration programs are not permitted to reenroll for a full year from such individual's disenrollment date.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Benefits for Demonstration Participants.	Medicaid's basic benefits rules require all states to provide certain "mandatory" services as listed in Medicaid statute. Federal matching payments are also available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each service to be provided under that plan within broad federal guidelines including (1) Amount, duration, and scope. Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose, (2) Comparability. With certain exceptions, services available to any categorically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state. Similarly, services available to any medically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other medically needy beneficiary in the state, (3) Statewideness. State plan services must be covered throughout an entire state, and (4) Freedom of choice. With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers or managed care entities participating in Medicaid.	The conference agreement requires demonstration participants have both an HOA and coverage for medical items and services that, after an annual deductible is met, are available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations as permitted under current law. Including federal shares, state contributions generally may not exceed $2,500 for each adult and $1,000 for each child. Once account holders are no longer eligible for Medicaid they may continue to make HOA withdrawals under state-specified conditions for a period of three years, though no additional account contributions will be made and the account balances will be reduced by 25%. For ineligible individuals who participated in the demonstration program for at least one year, accounts could then also be used to pay for health insurance or, at state option, for additional expenditures such as job training or education.
Cost Sharing for Demonstration Participants.	States may generally impose nominal cost-sharing on beneficiaries, with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, services provided to nursing facility residents who are required to spend all of their income for medical care except for a personal needs allowance, and services furnished to individuals receiving hospice care. States may require nominal copayments,	The conference agreement requires demonstration participants to meet an annual deductible before they are permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible must be at least 100%, but no more than 110%, of the annual state contributions to the HOA without regard to state-specified limits on the HOA balance. Both the

Provision	Current Law	Conference Agreement, as Passed by the Senate
	coinsurance, or deductibles within federal limits from other beneficiaries or for other services. Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts.	deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.
Provider Payments.	For the most part, states establish their own rates to pay Medicaid providers for services. By regulation these rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. All providers are required to accept payments under the program as payment in full for covered services except where states require nominal cost-sharing by beneficiaries.	The conference agreement requires demonstration participants to be able to obtain services from Medicaid providers, or Medicaid managed care organizations at the same payment rates that are applicable if the coverage deductible did not apply, or from any other provider or managed care organization at payment rates not exceeding 125% of such Medicaid provider payment rates. The conference agreement requires that the payment rates for Medicaid providers or managed care organizations be computed without regard to any cost sharing that are otherwise applicable under current law (as modified by the conference agreement).
Demonstration evaluation.	No provision.	Not later than three months prior to the end of the initial five-year test period, the conference agreement requires the Comptroller General of the Unites States to submit to Congress an evaluation of the demonstration programs and, out of funds in the Treasury not otherwise appropriated, the conference agreement appropriates $550,000 for the period FY2007-FY2010 to the Controller General of the United States to carry out such an evaluation.

Provision	Current Law	Conference Agreement, as Passed by the Senate
Effective Date.	No provision.	The agreement is effective upon enactment of this act.
State Option to Establish Non-Emergency Medical Transportation Program.	Federal regulations require states to ensure necessary transportation for beneficiaries to and from providers. When states offer transportation as an optional benefit, federal reimbursement uses FMAP which varies by state and ranges from 50% to 83%. FMAP reimbursement is only available if transportation is furnished by a provider to whom a direct payment can be made. Beneficiaries must have freedom of choice among transportation providers and such services must be equal in amount, duration and scope for all beneficiaries classified as CN. This comparability requirement also applies among MN groups. Services must also be available statewide. Other arrangements, such as payments to a broker who manages and pays transportation vendors, must be claimed as an administrative expense rather than as a benefit. Such costs are reimbursed by the federal government at 50% for all states, and fewer federal requirements must be met.	**Section 6083**. The agreement allows states to establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care but have no other means of transportation. States are not required to provide such services on a statewide basis, comparable services for all Medicaid enrollees, nor freedom of choice among providers. The program includes wheelchair van, taxi, stretcher car, bus passes and tickets, and other transportation methods deemed appropriate by the Secretary, and can be conducted under contract with a broker who: (1) is selected through a competitive bidding process that assesses the broker's experience, references, qualifications, resources and costs; (2) has oversight procedures to monitor beneficiary access and complaints and to ensure that transport personnel are licensed, qualified, competent and courteous; (3) is subject to regular auditing by the state to ensure quality of services and adequacy of beneficiary access to medical care; and (4) complies with requirements related to prohibitions on referrals and conflict of interest established by the Secretary. This provision takes effect on the date of enactment of this act.
Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program.	States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). States are	**Section 6084.** The conference agreement extends TMA under Section 1925 of the Social Security Act through December 31, 2006.

Provision	Current Law	Conference Agreement, as Passed by the Senate
	currently required to provide TMA to families losing eligibility for Medicaid under two scenarios. First, under Section 1931(c) of the Social Security Act, states must provide four months of TMA coverage to families losing Medicaid eligibility due to increased child or spousal support. This is a permanent provision of law with no sunset date. Second, states are required to provide TMA to families losing Medicaid eligibility for work-related reasons. While Section 1902(e)(1) of the Social Security Act permanently requires states to provide four months of TMA to families losing Medicaid eligibility due to an increase in hours of work or income from employment, the Family Support Act (FSA) of 1988 expanded state TMA requirements under Section 1925 of the Social Security Act. As a result, states are currently required to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards have the effect of increasing the income level at which a family may qualify for Medicaid). FSA originally authorized Section 1925 to replace the four-month TMA requirement in Section 1902(e)(1) through FY1998. However, the sunset date for Section 1925 has been extended a number of times, most recently through December 31, 2005.	
Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Enrollees.	Medicaid law provides certain protections for beneficiaries enrolled in managed care, including assuring coverage of emergency services under each managed care contract awarded by the state.	**Section 6085(a).** A Medicaid provider that does not have a contract with a Medicaid managed care entity (MCE) that furnishes emergency care to a beneficiary enrolled with that MCO must accept as payment in full

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		no more than the amount otherwise applicable outside of managed care (e.g., in the fee-for-service setting) minus any payments for indirect costs of medical education and direct costs of graduate medical education. Also, in a state where rates paid to hospitals under the state Medicaid plan are negotiated by contract and not publicly released, the payment amount applicable under this provision must be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under the plan for tertiary hospitals. This provision is effective on January 1, 2007.
Expansion of home and community-based services.	Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. HCBS waiver services can include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state and approved by the Secretary. As part of the waiver, states may define the services that will be offered, target a specific population (e.g., individuals with developmental disabilities) or a specific geographic region, and limit the number of waiver participants (resulting in a waiting list for services in many states). Approval for a HCBS waiver is contingent on a state documenting	**Section 6086.** The conference agreement establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve, and would not include an individual's room and board. The state may provide this option to individuals without determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR.

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	the cost-neutrality of the waiver. Cost-neutrality is met if, on average, the per person cost under the HCBS waiver is no higher than the cost if the person were residing in one of the three types of institutions identified in Medicaid law, (hospital, nursing facility or ICF-MR). The state determines which type of institution(s) it will use to make the cost-neutrality calculation. A HCBS waiver is generally approved for a three- or five-year time period and is subject to additional oversight from the Centers for Medicare and Medicaid Services (CMS).	
Establishment of Needs-Based Criteria.	No provision	States that offer this new benefit must establish needs-based criteria to determine an individual's eligibility for HCBS services, and the specific HCBS the individual will receive. The state must also establish needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision. The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state

Provision	Current Law	Conference Agreement, as Passed by the Senate
Projected Number of Enrollees in the Benefit and Modification of Needs-Based Criteria.	No provision.	A state may limit the number of individuals who can participate in this benefit and establish waiting lists. The state must submit to the Secretary the projected number of individuals who will receive HCBS services under this option. If the enrollment in the HCBS option exceeds the projected enrollment, a state may modify the needs-based criteria. The state is not required to seek prior approval of the Secretary if the state wishes to modify the needs-based criteria, but must give the Secretary and the public at least 60 days notice of the proposed modification. If a state modifies the needs-based criteria, existing recipients of the HCBS optional state plan services will continue to be eligible to receive those services for at least 12 months beginning on the date the individual first received medical assistance for HCBS services. After such a modification, the state, at a minimum, must apply the level of care determination for hospitals, nursing facilities, and ICF-MRs that were in effect prior to the application of more stringent criteria.
Independent Evaluation of Eligibility.	No provision.	A state is required to use an independent evaluation for determining an individual's eligibility for the HCBS option. The independent evaluation must include an assessment of the needs of the individual to: (1) determine a necessary level of services and supports consistent with the individual's physical and mental

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		capacity; (2) prevent unnecessary or inappropriate care, and (3) establish an individualized care plan for the individual.
Independent Assessment Process.	No provision.	A state is required under the HCBS option to conduct an independent assessment of the individual. This independent assessment must include (1) an objective evaluation of an individual's inability or need for significant assistance to perform two or more activities of daily living as defined in the Internal Revenue Service code; (2) a face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for HCBS; (3) where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual; (4) consultation with all treating and consulting health and support professionals caring for the individual; (5) an examination of the individual's relevant history and medical records, and care and support needs guided by best practices and research on effective strategies that result in improved health and quality of life outcomes. The assessment must also evaluate the ability of the individual or individual's representative to self-direct the purchase and control of HCBS if he/she elects this option, and if such an option is covered by the state.
Individualized Care Plan.	No provision.	The state must establish a written individualized care plan for all individual participating in the HCBS option. The care plan must be developed in consultation with the

Provision	Current Law	Conference Agreement, as Passed by the Senate
		individual, the individual's physician and other health care and support professionals, and where appropriate the individual's family or representative. The service plan must take into account existing family or other supports, identify necessary home and community-based services to be provided, and be reviewed at least annually.
State Option to Offer Self-Directed Services.	No provision.	For this new benefit, a state may allow an individual or the individual's representative to receive self-directed home and community-based services. If the state permits self-direction, there must be an assessment of the needs, capabilities and preferences of the individual. There must also be a service plan developed jointly with the individual that is approved by the state. The service plan must specify the services to be self-directed, identify the method of self-direction, specify the roles of various parties, and, if offered by the state, an individualized budget for the value of the services and supports to be self-directed.
Quality Assurance and Conflict of Interest Standards.	No provision.	The state must ensure that the provision of home and community-based services meets state and federal guidelines for quality assurance. The state must also establish standards for the conduct of the independent evaluation and assessment to safeguard against conflict of interest.
Redeterminations and Appeals.	No provision.	At least annually, the state must redetermine eligibility for this benefit according to the frequency and method

Provision	Current Law	Conference Agreement, as Passed by the Senate
		used for redeterminations and appeals under the Medicaid state plan.
Presumptive Eligibility.		The state may provide presumptive eligibility, for up to 60 days, for individuals who the state believes may be eligible for home and community-based services. An individual may only receive home and community-based services while the evaluation and assessment for determining eligibility for the HCBS benefit is carried out.
No Effect on Other Waiver Authority.		This provision does not affect a state's option to offer home and community-based services under waivers of Sections 1915(c) or (d), or Section 1115 of the Social Security Act
Continued Federal Medicaid Funding for Certain Individuals.		Federal Medicaid funding continues to be available for Medicaid beneficiaries who are residing in an institution, or receiving home and community-based services under a waiver of Section 1915(c), (d) or Section 1115 of this act as of the effective date of a state plan amendment that adds this HCBS benefit, without regard to whether the individual satisfies the more stringent eligibility criteria established by this option. The federal Medicaid funding will be available until the individual is discharged from the institution or waiver program, or no longer requires such level of care
Quality of care measures.		The provision requires the Secretary acting through the Director of the Agency for Healthcare Research and

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		Quality, to consult with consumers and health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction regarding HCBS offered under Medicaid. The Secretary is required to use the indicators and measures to assess HCBS and outcomes, particularly with respect to a recipient's health and welfare, and the overall system for RCBS under Medicaid. The Secretary is also required to make best practices and comparative analyses of system features available to the public. The conference agreement appropriates $1 million for the period of FY2006-FY2010 for the Secretary to carry out these activities. This section would be effective for home and community-based services furnished on or after January 1, 2007.
Optional Choice of Self-Directed Personal Assistance Services (Cash and Counseling).	Traditionally, Medicaid personal care services have been provided to individuals through local public or private agencies. However, in the last decade, Medicaid beneficiaries with disabilities or chronic conditions and federal and state policymakers have been increasing the discretion that beneficiaries have over key elements of the service (e.g., what time a personal care worker comes to the home to help the beneficiary, who provides the service, etc.) These types of programs are broadly known as `self-directed' or `consumer-directed' programs. The specific elements that a	**Section 6087.** This proposal would allow a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self-

Provision	Current Law	Conference Agreement, as Passed by the Senate
	Medicaid beneficiary can control vary widely depending upon the state and the type of service covered. Currently, Medicaid law allows certain types of self directed programs to be implemented through the normal Medicaid state plan and HCBS waiver process. Other types of self-directed programs require a research and demonstration waiver under Section 1115 of the Social Security Act. Generally, CMS policy has been that payments for personal care (or similar) services delivered by legally responsible individuals (e.g., the parent of a minor child or a spouse) are not eligible for federal Medicaid matching funds. However, CMS has recently amended its policy so that under a HCBS waiver (though not the Medicaid personal care benefit), states have the option of paying legally responsible relatives in extraordinary circumstances when the provision of personal care services is determined to be necessary to ensure the health and welfare of the waiver participant and so long as the parent or spouse meets the Medicaid provider requirements established by the state.	directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.
State Requirements.		The state must ensure that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and to assure financial accountability for funds expended for these services. The state must also evaluate the need for personal care under the Medicaid state plan or personal services under a HCBS waiver for individuals who (1) are entitled to Medicaid personal care under the state plan or receive

Provision	Current Law	Conference Agreement, as Passed by the Senate
		HCBS waiver services; (2) may require self-directed personal assistance services; and (3) may be eligible for self-directed personal assistance services. If covered by the state and at the choice of the individual, those who are likely to require personal care or HCBS waiver services must be informed of the feasible alternatives in the provision of Medicaid personal care services or personal assistance services under a HCBS waiver. The state must provide a support system that ensures participants in the program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.
Reports and Evaluation.		States that elect this option must submit an annual report to the Secretary which includes the number of individuals served and total expenditures on their behalf, in the aggregate. The state must also provide an evaluation of overall impact on the health and welfare of participants compared to non-participants every three years.
Limits to the Availability of Self-Directed Services.		A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section

Provision	Current Law	Conference Agreement, as Passed by the Senate
		1902(a)(10)(B) of the Social Security Act).
Scope of Self-Directed Personal Assistance Services.		The term `self-directed personal assistance services' means personal care and related services, or HCBS waiver services that are provided to an eligible participant. Individuals participating in such services would be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services. At the election of the state, a participant is be allowed to (1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and (2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.
Self-Directed Services Plan.		The approved self-directed services plan developed under option must meet the following requirements: (1) The participant (or his/her guardian or authorized representative if appropriate) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider and location of service provision; (2) There is an assessment of the needs, strengths, and preferences of the participants for such service; (3) An individual's plan for self-directed

Provision	Current Law	Conference Agreement, as Passed by the Senate
		services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant's capacity to engage in activities that promote community life; respects the participant's preferences, choices and abilities; and involves families, and professionals in the planning or delivery of services or supports as desired or required by the participant.
Self-Directed Services Budget.		The budget for self-directed services and supports must be developed and approved by the state based on the assessment and plan, and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the state but not included in the budget.
Application of Quality Assurance and Risk Management.		In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual's resources and capabilities.

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Financial Management Entity.		A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity is reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50 %, though certain activities may be eligible for 75 % reimbursement).
Effective date.		This provision becomes effective on January 1, 2007.

Subtitle B — State Children's Health Insurance Program

Provision	Current Law	Conference Agreement, as Passed by the Senate
Additional allotments to eliminate FY2006 funding shortfalls.		**Section 6101**. Out of money not otherwise available in the Treasury, the Conference Agreement authorizes and appropriates $283,000,000 for the purpose of providing additional SCHIP allotments to shortfall states and territories in FY2006. The Conference Agreement defines shortfall states as those with an approved SCHIP plan for which (based on the most recent SCHIP data as of December 31, 2005) the Secretary estimates that such state's FY2006 projected expenditures exceed the sum of all funds available for expenditure by that state in FY2006 including (1) the amount, if any, that is redistributed to such state from unspent FY2003 original allotments during FY2006; (2) the amount of such state's FY2004 and FY2005 original allotments that will not be expended in FY2005 and that remain available for expenditure in FY2006; and (3) the amount of such state's newly available FY2006 original allotment. From the additional FY2006 SCHIP appropriation, after a 1.05% set aside for distribution among the territories, each FY2006 shortfall state would receive an allotment to cover its projected shortfall. Such additional SCHIP allotments are available for one year only. On October 1, 2006, any remaining unspent additional allotments will not be subject to redistribution, but will instead revert to the Treasury. The Conference Agreement is silent on how the

Provision	Current Law	Conference Agreement, as Passed by the Senate
		Secretary will distribute the additional appropriated funds if such funds are inadequate to cover the FY2006 projected shortfalls.
Use of Additional FY2006 Appropriation for Child Health Assistance for Targeted Low-Income Children.	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. The federal government contributes more toward the coverage of individuals in SCHIP than it does for those covered under Medicaid. All SCHIP assistance for targeted low-income children, including claims submitted and approved by CMS for expenditures under the Section 1115 waiver authority, are matched at the enhanced federal medical assistance percentage (enhanced- FMAP). Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for 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.	The Conference Agreement limits the types of payments that may be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the additional FY2006 appropriation available to shortfall states to include child health assistance payments made on behalf of targeted low-income children. The amendments made by this section of the Conference Agreement apply to items and services furnished on or after October 1, 2005, without regard to wether or not regulations implementing such amendments have been issued.
Prohibition against covering nonpregnant adults with SCHIP funds.	Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under	**Section 6102**. The Conference Agreement limits the Secretary of Health and Human Services' Section 1115 waiver authority by prohibiting the approval of new

Provision	Current Law	Conference Agreement, as Passed by the Senate
	Section 1115, the Secretary may waive requirements in Section 1902 (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 regarding treatment of adults. While this Administration was supportive of using the 1115 authority to expand SCHIP to parents of Medicaid or SCHIP-eligible children, as well as to certain pregnant women, it opposed coverage of childless adults. Under the Bush Administration, the Health Insurance Flexibility and Accountability (HIFA) Initiative was implemented using the 1115 waiver authority. The initiative was created to encourage states to increase the number of individuals with health insurance coverage (including childless adults) within current program resources	waiver, experimental, pilot, or demonstration projects (approved on or after October 1, 2005) that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The Conference Agreement allows 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 1931of Medicaid statue), and to pregnant adults. Finally, the Conference Agreement allows the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to such projects) affecting federal SCHIP funds that were approved under the Section 1115 waiver authority before the date of enactment of this act. The Conference Agreement is effective as if enacted on October 1, 2005, and shall apply to any waiver, experimental, pilot, or demonstration project that is approved on or after that date.
Continued authority for qualifying states to use certain funds for Medicaid expenditures.	Current law permits qualifying states (i.e., states 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 also apply to states with statewide waivers under Section 1115 of the Social Security Act) to receive the SCHIP enhanced federal matching rate for the coverage of certain children enrolled in regular Medicaid. Specifically, for services delivered to Medicaid beneficiaries under the age of 19 who are not	**Section 6103.** The Conference Agreement continues the authority for qualifying states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the Conference Agreement allows qualifying states to use any available FY2004 and FY2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds, as the case may be) for such Medicaid

Provision	Current Law	Conference Agreement, as Passed by the Senate
	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 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. No 20% spending will be permitted in FY2006 or any fiscal year thereafter.	services made on or after October 1, 2005 under the 20% allowance. The Conference Agreement is effective on or after October 1, 2005.

Subtitle C — Katrina Relief

Provision	Current Law	Conference Agreement, as Passed by the Senate
Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations.	The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under SCHIP, subject to the availability of funds from a state's SCHIP allotment.	**Section 6201.** The conference agreement appropriates $2 billion (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those who have provided care to affected individuals or evacuees under a Section 1115 project) for: (1) the non-federal (i.e., state) share of expenditures for health care provided to affected individuals (those who resided in a county or parish designated for individual assistance pursuant to the Stafford Act as a result of Hurricane Katrina and continue to reside in the same state) and evacuees (affected individuals displaced to another state) under approved multi-state Section 1115 demonstration projects; (2) reasonable administrative costs related to such projects; (3) only with respect to affected counties and parishes, the non-federal share of expenditures for medical assistance provided to individuals under existing Medicaid and SCHIP state plans; and (4) other purposes, if approved by the Secretary, to restore access to health care in impacted communities.
	Using an application template developed by the Centers for Medicare and Medicaid Services (CMS) within HHS, a number of states (17 as of December 15, 2005) have been granted waivers under Section 1115 of the Social Security Act to provide	The non-federal share paid to eligible states shall not be regarded as federal funds for purposes of Medicaid matching requirements. No payment obligations may be incurred under approved multi-state Section 1115 projects

Provision	Current Law	Conference Agreement, as Passed by the Senate
	Medicaid and SCHIP services to certain individuals affected by Hurricane Katrina (these waivers are referred to as being part of a multi-state demonstration project). All of the waivers granted thus far create a temporary eligibility period, not to exceed five months, during which certain Hurricane Katrina evacuees will be granted access to Medicaid and SCHIP services in the host state (i.e., the state that has been granted a Section 1115 waiver) based on simplified eligibility criteria. In addition, waivers for some states also create an uncompensated care pool that may be used through January 31, 2006, to augment Medicaid and SCHIP services for evacuees and to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP.	for: (1) costs of health care provided as Medicaid or SCHIP medical assistance incurred after June 30, 2006, (2) uncompensated care costs incurred after January 31, 2006, (3) uncompensated care costs for an item or service received by an evacuee or an affected individual from an individual or organization as part of a public or private hurricane relief effort.