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

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# Budget Reconciliation FY2006: Medicaid, Medicare, and SCHIP Provisions

## Summary

The House and Senate approved the conference report (H.Rept. 109-62) on H.Con.Res. 95, the Concurrent Resolution on the FY2006 Budget, on April 28 and April 29, 2005, respectively. The Senate Committee on Finance was instructed to meet a budget reconciliation target of \$10 billion in direct spending savings over a five-year period, FY2006-FY2010. On October 25, 2005, the Senate Finance Committee reported its reconciliation proposal to the Senate Budget Committee, which subsequently incorporated the proposal into S. 1932, The Deficit Reduction Omnibus Reconciliation Act of 2005. In the House, the Committee on Energy and Commerce had budget reconciliation instructions that specified a mandatory savings target of \$14.734 billion between FY2006 and FY2010. The Committee mark-up took place on October 27, 2005.

Like a number of Senate committees, the Senate Committee on Finance achieves its reconciliation instruction budget mark through recommended program changes that result in direct spending increases as well as decreases. The Committee proposal focused on changes to the Medicaid, the State Children's Health Insurance program (SCHIP), and Medicare. Based on Congressional Budget Office (CBO) estimates, the largest Medicaid savings amounts are the result of changes in the reimbursement of outpatient prescription drugs. The Senate proposal would change some asset transfer rules for Medicaid-eligible individuals applying for long-term care services also resulting in estimated program savings. Additional Medicaid savings are estimated to occur as a result of changes to the program designed to combat fraud, waste, and abuse. Increases in Medicaid spending would result from temporary federal medical assistance percentage (FMAP) increases targeted to help Medicaid recipients in selected Louisiana parishes and counties in Alabama and Mississippi devastated by Hurricane Katrina, and also from the limiting of any FY2006-FY2007 FMAP decrease to Alaska. The proposal includes a number of Medicaid demonstration projects and some benefit and eligibility expansions. The SCHIP proposal would alter the method for redistribution of funds to the states. Medicare savings would result from changes in Medicare's Part C (Medicare Advantage) and the establishment of variations in provider payments that reflect quality differences (value-based purchasing or "pay for performance"). The proposal would also provide for a 1% Medicare payment update for physicians in 2006. In addition, there are other Medicare and Medicaid provisions.

The House Energy and Commerce Committee limited its proposal to changes in the Medicaid program. The House Committee proposed reforms in the payment for prescription drugs, and asset transfer rules for long-term care Medicaid-eligible individuals. Other provisions in the House would alter Medicaid's cost-sharing requirements, allow for the use of actuarial-equivalent benchmark insurance packages, and would allow for Health Opportunity Account demonstration projects. The House recommendation also provides Katrina relief. This report will be updated to provide a summary of all the major provisions in the Committee's recommendations.

# Contents

FY2006 Budget Reconciliation Targets .....	1
Senate Bill .....	1
Medicaid .....	2
Medicaid Outpatient Prescription Drugs .....	2
Federal Upper Limits .....	3
Rebates .....	3
Authorized Generics and Physician-Administered Drugs .....	3
Long-Term Care Under Medicaid .....	4
Calculating the Length of the Penalty Period .....	4
Changing Non-Countable Assets to Countable Assets .....	4
Undue Hardship Waivers .....	4
Medicaid Estate Recovery .....	5
Long-Term Care Insurance Partnership Program .....	5
Fraud, Waste, and Abuse .....	6
Third-party Liability .....	6
Medicaid Integrity Program .....	6
Other Provisions .....	6
State Financing and Medicaid .....	7
Temporary FMAP Increases .....	7
Managed Care Organization Provider Tax Reform .....	7
Disproportionate Share Hospital Allotment for the District of Columbia .....	7
Changes to Medicaid Targeted Case Management Benefit .....	7
Inclusion of Podiatrists as Physicians .....	8
Demonstration Project Providing Medicaid Coverage for Institutions for Mental Disease to Stabilize Emergency Medical Conditions ..	8
Improving the Medicaid and State Children’s Health Insurance Programs ..	8
Family Opportunity Act .....	8
Demonstration Projects Regarding Home- and Community-Based Alternative to Psychiatric Residential Treatment Facilities for Children .....	8
Development and Support of Family-to-Family Health Information ..	9
Restoration of Medicaid Eligibility for Certain SSI Beneficiaries ....	9
Grants to Promote Innovative Outreach and Enrollment Under Medicaid and SCHIP .....	9
Money Follows the Person Rebalancing Demonstration .....	9
State Children’s Health Insurance Program (SCHIP) .....	10
Medicare .....	11
Physicians .....	11
Medicare Value-Based Purchasing Programs .....	11
Medicare Advantage .....	12
Phase-Out of Risk Adjustment Budget Neutrality .....	12
Elimination of Stabilization Fund .....	12

Other Medicare Provisions .....	12
Medicare Dependent Hospitals .....	13
Skilled Nursing Facility Bad Debt .....	13
Inpatient Rehabilitation Facilities .....	13
Physician Self Referrals .....	13
Hold Harmless Provision for Small Rural and Sole Community Hospitals .....	13
Composite Rate for Dialysis Services .....	13
Therapy Caps .....	14
Durable Medical Equipment Rentals .....	14
Rural Program of All-Inclusive Care for the Elderly (PACE) Provider Grant Program .....	14
Waiver of Part B Late Enrollment Penalty .....	14
Federally Qualified Health Centers .....	15
Delay of Medicare Payments .....	15

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

## **FY2006 Budget Reconciliation Targets**

The House and Senate approved the conference report (H.Rept. 109-62) on H.Con.Res. 95, the Concurrent Resolution on the FY2006 Budget, on April 28 and April 29, 2005, respectively. The annual concurrent resolution on the budget sets forth the congressional budget. When the federal deficit is expected to be large, budget resolutions often require reductions in mandatory spending. In such instances, the budget resolution includes reconciliation instructions that require authorizing committees to report changes to legislation to reduce spending on mandatory programs under their jurisdictions. The FY2006 budget resolution includes reconciliation instructions that direct authorizing committees to report legislation to reduce mandatory spending for the FY2006-FY2010 period. Subsequently, these proposals are to be combined in a single reconciliation bill by the budget committees.

The Senate Committee on Finance was instructed to meet a budget reconciliation target of \$10 billion in mandatory spending savings over the five-year period. On October 25, 2005, the Senate Finance Committee reported its reconciliation proposal to the Senate Budget Committee, which subsequently incorporated the proposal into S. 1932, The Deficit Reduction Omnibus Reconciliation Act of 2005. The Committee met its reconciliation instruction by making changes in Medicaid, Medicare, and the State Children's Health Insurance program (SCHIP). In the House, the Committee on Energy and Commerce had budget reconciliation instructions specifying a mandatory savings target of \$14.734 billion between FY2006 and FY2010. The Committee mark-up took place on October 27, 2005. The Committee's legislation focused on changes to the Medicaid program. When details of the House Committee mark-up become available, this report will be updated.

## **Senate Bill**

Like a number of Senate committees, the Senate Committee on Finance achieves its reconciliation instruction budget mark through recommended program changes that result in both direct spending increases and decreases. The Committee's Medicaid saving proposals include (a) changes in the payment methods for prescription drugs; (b) changes in eligibility and benefit rules for long-term care services; (c) changes in the program's approach to limit fraud; and, (d) changes in

some components of state Medicaid financing. The Committee also recommended a number of changes that would result in Medicaid spending increases. These proposals include (a) temporary financial relief for Medicaid costs of individuals who resided prior to Hurricane Katrina in selected parishes in Louisiana and counties in Alabama and Mississippi, and a provision not to allow Alaska's federal medical assistance percentage to fall below its FY2005 level; (b) an increase in the disproportionate share hospital payment allotment in the District of Columbia; and (c) a number of demonstrations and program expansions.

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

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

## Medicaid

### Medicaid Outpatient Prescription Drugs

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

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<sup>1</sup> Congressional Budget Office Cost Estimate, Reconciliation, *Recommendations of the Senate Committee on Finance*, as approved by the Senate Committee on Finance on Oct. 25, 2005.

**Federal Upper Limits.** Under current law, state Medicaid programs set the prices paid to pharmacies for Medicaid outpatient drugs. Federal reimbursements for those drugs, however, are limited to a federal upper limit (FUL). The FUL that applies to drugs available from multiple sources (generic drugs, for the most part) is calculated by the Centers for Medicare and Medicaid Services (CMS) to be equal to 150% of the lowest published average wholesale price (AWP) for the least costly therapeutic equivalent. The upper limit that applies to brand-name and other drugs is equal to the acquisition cost as estimated by the states. The Senate bill would replace the current FUL requirement so that state payments for single-source drugs would qualify for federal reimbursement of up to 105% of the average manufacturer price (AMP) as reported to CMS by the manufacturers. FULs for multiple-source drugs would be equal to 115% of the weighted AMP for those drugs. In addition, the bill includes interim upper payment limits that would apply during calendar year 2006, before the new FULs become effective.

This section of the bill would modify the definitions of the prices that manufacturers are currently required to provide to CMS. The definition of AMP, an important price point for calculating Medicaid drug rebates and for the proposed FULs, would become more specified than under current law. For example, one of the new specifications would direct manufacturers to include cash and volume discounts in the computation of AMP. In addition, the bill would add a definition of weighted AMP for the purpose of calculating FULs for multiple-source drugs.

**Rebates.** Under current law, prescription drug manufacturers that participate in the Medicaid program are required to pay rebates to states. The rebates are calculated based on a formula in statute. For single-source and “innovator” multiple-source drugs (those drugs that had formerly been sold under a patent, but are now off patent), basic rebates are equal to the greater of 15.1% of the AMP or the difference between the reported AMP and the best price for each drug. The rebate for all other multiple-source drugs is equal to 11% of the AMP. The Senate bill would increase basic rebates for all drugs. The basic rebate for single-source and innovator multiple-source drugs would be raised to the greater of 17% of the AMP or the difference between the reported AMP and the best price for each drug. The rebate for all other multiple-source drugs would be raised to 17% of the AMP.

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

## Long-Term Care Under Medicaid

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

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

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

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



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

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

**Long-Term Care Insurance Partnership Program.** Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid-eligible individuals. For these individuals, means-testing requirements are relaxed at (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied. Under current law, these provisions are limited to selected states.<sup>2</sup>

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

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

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

## **Fraud, Waste, and Abuse**

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

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

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

## State Financing and Medicaid

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

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

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

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

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

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

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

## **Improving the Medicaid and State Children’s Health Insurance Programs**

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

**Demonstration Projects Regarding Home- and Community-Based Alternative to Psychiatric Residential Treatment Facilities for Children.** This proposal would establish a five-year demonstration project in which up to 10 states could provide a broad range of home- and community-based services to children who would otherwise require services in a psychiatric residential treatment facility. Though these types of home- and community-based services are often allowed for other types of disability groups (e.g., children with developmental disabilities) under Section 1915(c) waivers of the Social Security Act, the waiver requirements prohibit states from developing home- and community-based services as an alternative to a psychiatric residential treatment facility. The demonstration would test the effectiveness of improving or maintaining the child’s functional level, and the cost-effectiveness of providing these types of services as an alternative to

psychiatric residential treatment services. These projects must also follow the existing requirements of the Section 1915(c) waiver. The demonstration project must be budget neutral and there must be an assurance that an interim and final evaluations will be conducted by an independent third party. The Secretary will also be required to complete evaluations of the project and report the findings to Congress. This proposal would authorize a total of \$218 million for FY2007-FY2011 to carry out the demonstration.

**Development and Support of Family-to-Family Health Information.**

This proposal would increase funding under the Special Projects of Regional and National Significance program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) for the development and support of new family-to-family health information centers. These family-to-family health information centers would assist families of children with disabilities to make informed decisions about health care options and available resources. The proposal would appropriate a total of \$12 million for FY2007-FY2009, and would authorize an additional \$5 million, each year, for FY2010 and FY2011. The Secretary would be required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.

**Restoration of Medicaid Eligibility for Certain SSI Beneficiaries.** The provision would extend Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application was filed, or (2) the date SSI eligibility was granted. Currently, SSI and Medicaid eligibility is effective on the first day of the month *following* the dates specified above. This provision would be effective one year after the date of enactment.

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

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

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

## **State Children's Health Insurance Program (SCHIP)**

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

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

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

## Medicare

### Physicians

Physicians are paid under the fee schedule which assigns relative values to services based on physician work, practice expense costs and malpractice costs. The relative values are then adjusted for geographic variations in costs. These adjusted relative values are converted into dollar payment amounts by a conversion factor. The conversion factor is updated annually according to a complex formula specified in the law. The scheduled update for 2006 is estimated at a *negative* 4.3%. The bill would override the formula by setting a minimum update for 2006 at a *positive* 1%.

### Medicare Value-Based Purchasing Programs

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

- The value-based purchasing programs would begin collecting data on quality measures in the initial year of establishment, with incentive payments disbursed in subsequent years. Data from the initial year would be used to inform providers what their payments would have been for the year had the value-based purchasing program already been in place.
- Each value-based purchasing program would create an incentive pool funded by withholding up to 2% of total payments to that category of provider. The percentage of funds that goes towards the incentive pool would not decrease over time, and all funds collected for the year must be paid to providers as incentive payments under the program for that year.
- Participation in the value-based purchasing program would be voluntary, but providers would be required to report quality data in order to be eligible for incentive payments.
- Incentive payments would be paid to providers who meet certain thresholds for quality measurement. These thresholds would be based on either relative or absolute standards.
- The quality measures would be specific to each category of providers and would be revised over time, but the measures would

be required to be evidence-based, easy to collect and report, address process, structure, outcomes, beneficiary experience, efficiency, over- and underuse of health care. In the initial year, the measures would include at least one measure of health information technology infrastructure.

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

## **Medicare Advantage**

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

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

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

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

## **Other Medicare Provisions**

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



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

**Skilled Nursing Facility Bad Debt.** Beginning October 1, 2005, the amount of bad debts otherwise treated as allowed costs, which are attributable to deductible and coinsurance amounts, would be reduced by 30% for services furnished in skilled nursing facilities (SNFs).

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

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

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

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

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

**Durable Medical Equipment Rentals.** This provision would eliminate the semi-annual maintenance payment currently allowed for capped rental equipment and pay only for repairs when needed. The Secretary would determine the amount of payments for maintenance and service, which would only be made if deemed reasonable and necessary. For durable medical equipment in the capped rental category, after a 13-month rental period, the supplier would transfer the title to the Medicare beneficiary. The option for beneficiaries to purchase power wheelchairs when initially furnished would be moved to be the same time as other rental cap items.

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

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

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

the Internal Revenue Code). Upon return to the United States, they would have a special enrollment period.

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

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