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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 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 largely result from temporary federal medical assistance percentage (FMAP) increases targeted to help Medicaid recipients from selected Louisiana parishes and counties in Alabama and Mississippi devastated by Hurricane Katrina, and also from the limiting of any FY2006-FY2007 FMAP decrease to Alaska. The proposal includes a number of Medicaid demonstration projects and some benefit and eligibility expansions. The proposal would alter the method for redistribution of SCHIP funds to the states. Medicare savings would result from changes in Medicare's Part C (Medicare Advantage) and the establishment of variations in provider payments that reflect quality differences (value-based purchasing, or "pay for performance"). The proposal would also provide for a 1% Medicare payment update for physicians in 2006.

The House Energy and Commerce Committee limited its major proposals to changes in the Medicaid program. The House Committee achieves its largest savings with cost-sharing and benefit changes. The recommendations also foresee savings in changes in prescription drug reimbursement and asset transfer rules. Increased spending provisions are focused on long-term care services, the establishment of health opportunity account demonstrations, and Hurricane Katrina health program relief.

This report will be updated to reflect legislative activity.

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

The Senate Committee on Finance was instructed to meet a budget reconciliation target of \$10 billion in mandatory spending savings over the five-year period. On October 25, 2005, the Senate Finance Committee reported its reconciliation proposal to the Senate Budget Committee, which subsequently incorporated the proposal into S. 1932, The Deficit Reduction Omnibus Reconciliation Act of 2005. The Finance Committee met its reconciliation instruction by making changes in Medicaid, Medicare, and the State Children's Health Insurance program (SCHIP). In the House, the Committee on Energy and Commerce had budget reconciliation instructions specifying a mandatory savings target of \$14.734 billion between FY2006 and FY2010. The Energy and Commerce Committee mark-up took place on October 27, 2005. In the health care area, its recommendations resulted in changes in Medicaid. The Committee's recommendations will be incorporated into the House Budget Committee bill slated for consideration on November 3, 2005.

Senate Bill

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

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

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

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

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.

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

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. The bill would also define weighted AMP for the purpose of calculating FULs for multiple source drugs, and would establish that dispensing fees for multiple source drugs may be higher than those for single source drugs.

Rebates. Under current law, prescription drug manufacturers that participate in the Medicaid program are required to pay rebates to states. 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.²

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

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

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

Fraud, Waste, and Abuse

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

Medicaid Integrity Program. Under current law, states and the federal government — acting primarily through CMS and the Office of Inspector General within the Department of Health and Human Services (HHS) — share in the responsibility for safeguarding Medicaid program integrity. The Senate bill would establish a Medicaid Integrity program, under which entities that meet certain contracting requirements (modeled after the Medicare Integrity program) would review the actions of Medicaid providers, audit claims for payment, identify and recover overpayments, and provide education on payment integrity and benefit quality assurance issues. Appropriations for the Medicaid Integrity program would 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, whistle-blower protections, and policies and procedures for detecting fraud, waste, and abuse; and prohibit states from billing Medicaid twice for the same drugs.

State Financing and Medicaid

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

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

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

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

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

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

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

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 (SNF).

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

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

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

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

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

Durable Medical Equipment Rentals. This provision would eliminate the semi-annual maintenance payment currently allowed for capped rental equipment and pay only for repairs when needed. The Secretary would determine the amount of payments for maintenance and service, which would only be made if deemed reasonable and necessary. 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 (FQHC) to provide diabetes outpatient self management training services and medical nutrition therapy services provided by a registered dietician or nutritional professional. It would modify the definition of FQHC services so that only the primary preventative required services would be retained. Services would include those furnished to an outpatient of an FQHC that are provided by a health care professional under contract with the center, and payments would be made directly to the FQHC.

Delay of Medicare Payments. Medicare Parts A and B payments for services made by fiscal intermediaries and carriers would be delayed for 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.

House Energy and Commerce Committee Proposal

Under the budget resolution instructions, the House Energy and Commerce Committee was required to obtain \$2 million in savings in FY2006 and \$14.734 billion over the five-year budget period, FY2006-FY2010. The total House Energy and Commerce proposal, which includes changes in areas outside of health, is estimated to reduce federal outlays by \$17.1 billion over the five-year budget window.³ Proposed changes to the Medicaid program would result in an \$11.9 billion reduction in spending over the five-year period. Katrina health care and energy relief would increase spending by \$3.6 billion. Additional savings would result from Digital Television transition. This report summarizes provisions dealing only with Medicaid and SCHIP.⁴

Subtitle A of the Committee proposal reduces federal Medicaid spending by \$11.9 billion over the FY2006-FY2010 five year budget period. Changes in outpatient prescription drug payments would result in \$2.1 billion in savings over the period. Changes in Medicaid cost-sharing and benefits would result in \$6.5 billion in savings over the period. Changes in asset transfer rules would reduce Medicaid spending by an additional \$2.5 billion over the five year period. Changes in other provisions (e.g., changes in the treatment of state taxes on health care providers, and changes aimed at reducing Medicaid overpayment when a Medicaid recipient also has private insurance) would reduce Medicaid spending by an additional \$1.8 billion over the five year period. Benefit expansions would add \$1 billion in Medicaid

³ Congressional Budget Office. Cost Estimate. Reconciliation Recommendations of the House Committee on Energy and Commerce, as approved by the House Committee on Energy and Commerce on October 28, 2005.

⁴ Specifically, this report does not discuss provisions that alter the Public Health Services Act (PHSA). These provisions are in sections 3202, 3203, and 3204. In addition, the report does not discuss subtitle C, Katrina and Rita Energy Relief, and subtitle D, Digital Television Transition.

spending. These expansions would include changes in benefits for individuals with long-term care needs in the community, and the establishment of health opportunity account demonstration programs (Medicaid-funded savings accounts that beneficiaries would use to pay for certain health care services). Under subtitle B, federal government spending for Medicaid and SCHIP would be temporarily increased for Medicaid-eligible individuals who lived or currently live in parts of Alabama, Louisiana, and Mississippi affected by Hurricane Katrina. The overall effect of this subtitle's changes would result in an increase in spending over the FY2006- FY2010 period of \$2.5 billion. In total, the two health subtitles in the House Energy and Commerce proposal is estimated by CBO to result in net Medicaid and SCHIP savings of \$9.3 billion over the five year budget period.

Medicaid

Medicaid Outpatient Prescription Drugs

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

Federal Upper Limits. The House Energy and Committee recommendation would also replace the current FUL requirement so that state payments for single source drugs would qualify for federal reimbursement up to 106% of the RAMP, defined as the average price paid to a manufacturer by wholesalers as reported to CMS by the manufacturers. FULs for multiple source drugs would be equal to 120% of the volume weighted average RAMP for all drug products in the same multiple source drug billing and payment code. The provision would provide the Secretary with the authority to enter into contracts and engage the services of vendors to determine RAMP.

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

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

provided physician administered multiple source drugs. This would improve the ability of CMS to ensure manufacturers pay rebates for those drugs.

Children’s Hospitals and Access to Discounted Drug Products. The Energy and Commerce recommendation includes a provision allowing Children’s Hospitals access to the discounted outpatient prescription drugs prices negotiated under Section 340(B) of the Public Health Service Act. Section 340(B) allows certain health care providers, including many community health centers and disproportionate share hospitals, access to prescription drug prices that are similar to the prices paid by Medicaid agencies after being reduced by manufacturer rebates.

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

Reform of Asset Transfer Rules

Lengthening Look-back Period for all Disposals to five years. Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual’s spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a “look-back date.” The “look-back date” is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts. The penalty, or period of ineligibility, begins with the first month during which the assets were transferred. The Committee recommendation would lengthen the look-back date to five years, or 60 months, for all income and assets disposed of by the individual. It would also change the start date of the ineligibility period for all transfers to the first day of a month during or before which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the state plan and would be receiving certain long-term care services if it were not for the penalty, whichever is later.

Availability and Provisions Concerning Hardship Waivers. To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary of DHHS, can show that a penalty would impose an undue hardship. The Committee recommendation would add to existing law criteria for approving or disapproving applications for undue hardship waivers. It would also require states to provide applicants with notice about the availability of undue hardship waivers; to review applications under a timely process; and to establish an appeal process for beneficiaries who receive an adverse

determination. The recommendation would also permit facilities to apply for waivers on behalf of, and with the consent of, institutionalized individuals. In addition, if the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Disclosure and Treatment of Annuities and of Large Transactions.

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

Subject to certain requirements, the recommendation would also require the state to be made the remainder beneficiary under such annuities or similar financial instruments. The recommendation would also give the Secretary authority to provide guidance to states on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as an asset transfer for fair market value.

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

Disqualification for Long-term Care Assistance for Individuals with Substantial Home Equity. Under current law, states set asset standards, within federal parameters, that applicants must meet to qualify for coverage. These standards specify a limit on the amount of countable assets a person may have to qualify, as well as define which assets are not counted. In general, countable assets cannot exceed \$2,000 for an individual. States generally follow SSI rules for computing both countable and non-countable assets. Current Medicaid and SSI asset counting practices exclude the entire value of an applicant's home. The Committee recommendation would exclude from Medicaid eligibility for nursing facility or other long-term care services, those individuals with an equity interest in their home of greater than \$500,000. (The Secretary of DHHS would establish a process to waive application of this provision for demonstrated cases of hardship.) This amount would be increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest \$1,000. Individuals whose spouse, child under age 21, or child who is blind or disabled resides in the individual's home would *not* be excluded from eligibility.

Enforceability of Continuing Care Retirement Communities and Life Care Community Admission Contracts. The Committee recommendation would allow state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRC) or a life care community to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources and income allowances for community spouses), declared for the purposes of admission, on their care before they apply for Medicaid. It would also allow certain entrance fees for CCRCs or life care communities to be considered by states to be countable resources for purposes of the Medicaid eligibility determination.

Flexibility in Cost Sharing and Benefits

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

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

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

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

GAO would be required to conduct a study of the impact of premiums and cost-sharing under Medicaid on access to and utilization of services, with a report of findings due to Congress no later than January 1, 2008. All provisions would be effective for cost-sharing imposed on items and services furnished on or after January 1, 2006.

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

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

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

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

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

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

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

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

Use of Benchmark Benefit Packages. Medicaid benefits may differ for what are called categorically needy (CN) versus medically needy (MN) groups. In general, CN groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. These financial criteria are tied to rules under two federal cash assistance programs — the former AFDC program for poor families with children or the SSI program for the poor elderly and persons with disabilities. Some groups of the elderly, pregnant women, and children must meet financial standards tied to specified percentages of the FPL instead. MN groups include the same types of

individuals, but different, typically higher financial standards apply. Medical expenses (if any) may be subtracted from income in determining financial eligibility for the MN. For nearly all CN groups, medical expenses are not considered in determining Medicaid eligibility.

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

The Committee recommendation would give states the option to provide Medicaid to state-specified groups of beneficiaries through enrollment in benchmark and benchmark-equivalent coverage (described below). States could implement this option through a Medicaid state plan amendment rather than a waiver as would be required under current law. States could require “full-benefit eligible individuals” to enroll in such coverage. A full-benefit eligible would be a person eligible for all services covered for the CN, or under any other category of eligibility for full services as defined by the Secretary. Some individuals would be excluded from the definition of a full-benefit eligible (e.g., the MN, persons who spend-down their income for medical care to meet the financial requirements for Medicaid coverage). Several other specific groups would also be exempted from this option (e.g., mandatory pregnant women and children, dual eligibles, hospice patients, persons with special medical needs, individuals who qualify for Medicaid long-term care services). States could only apply this option to eligibility categories established before the date of enactment of this provision.

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

for each of the benefits in the “additional service category,” including (1) prescription drugs, (2) mental health services, (3) vision services, and (4) hearing services.

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

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

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

If a state chooses to provide transportation as an optional Medicaid service, costs are reimbursed by the federal government using the federal medical assistance percentage (FMAP), which varies by state and has a statutory floor of 50% and ceiling of 83%. Under this option, states must meet a number of federal requirements that apply to all Medicaid services (e.g., enrollees must have freedom to choose among qualified providers) unless they have an approved waiver. Costs are only allowable for FMAP reimbursement if the transportation is furnished by a provider to whom a direct payment can be made. Other arrangements (e.g., payment to a broker who manages and pays transportation providers) must be claimed as an administrative expense. If a state chooses to claim transportation as an administrative expense, costs are reimbursed by the federal government at a rate of 50%, which is lower than the FMAP in many states, but there are fewer federal requirements that must be met.

Under the Committee recommendation, a state would have the option to establish a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for Medicaid enrollees who need access to medical care or services and have no other means of transportation. Under the program, the state would not be required to provide comparable services for all Medicaid enrollees or freedom to choose among providers. The program could include wheelchair van, taxi, stretcher car, bus passes and tickets, and other transportation methods deemed appropriate by the Secretary, and could be conducted under contract with a broker who: (1) is selected through a competitive bidding process, (2) meets oversight requirements, (3) is subject to regular auditing by the state, and (4) complies with requirements related to prohibitions on referrals and conflict of interest established by the Secretary.

Exempting Women Covered under Breast or Cervical Cancer Program. Under current law, states may offer Medicaid to certain uninsured women who are under age 65, and are in need of treatment for breast or cervical cancer based on screening services provided under an early detection program run by the CDC. This group has access to the same Medicaid services offered to the CN in a given state, and are subject to Medicaid's nominal cost sharing rules.

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

Benefit Expansions

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

This proposal would allow states to cover these types of home and community-based services under the Medicaid state plan *without* requiring the state to seek a waiver or document the waiver's cost-neutrality. To cover this option, a state's existing waiver must have expired. Similar to rules governing the current waiver program, states would be able to: 1) define which services will be covered (room and board may not be paid for); 2) offer the waiver on a less-than-statewide basis; 3) limit the number of individuals who are eligible for services; and 4) establish a waiting list for services. This section would be effective for home and community-based services furnished on or after October 1, 2006.

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

Expansion of State Long-term Care Partnership Program. Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at (1) the time of application to Medicaid (allowed with Secretary's approval, without changes to current law); and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied. Current law allows states with an approved state plan amendment *as of* May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. Except for Iowa, all of these states have implemented partnership programs.

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

Health Opportunity Accounts. The recommendation would require the Secretary to establish demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2006. No more than ten state programs could be established the first five years, though afterwards other programs would be allowed if the earlier ones were not unsuccessful. Among other things, state programs would have to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care. Eligibility for HOAs would be determined by the state, though individuals under 18 years of age or 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, would be among those who could not participate.

Participants would have both an HOA and coverage for medical items and services that, after an annual deductible is met, were available under the existing Medicaid state plan and waiver authorities. The deductible would have to be at least 100%, but no more than 110%, of the annual state contributions to the HOA. Both

the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

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

HOA contributions could be made by the state or by other persons or entities, including charitable organizations. Including federal shares, state contributions generally could not exceed \$2,500 for each adult and \$1,000 for each child. However, states could contribute more to some accounts as long as its aggregate contributions did not increase.

Other Medicaid Provisions

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

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

Reforms of Targeted Case Management Benefit. Targeted case management (TCM) is an optional benefit under the Medicaid state plan that is designed to help Medicaid beneficiaries access needed medical, social, educational, and other services. States that cover the TCM service do not have to offer the benefit

statewide and can limit the service to specific groups of Medicaid beneficiaries (e.g., those with chronic mental illness). Several states extend the TCM services to individuals who may also be receiving certain case management services as part of another state and/or federal program (e.g., foster care, juvenile justice).

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

Increase in Payments to Insular Areas. In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. These spending caps were set in FY1998 and adjusted for inflation in subsequent years. For each of fiscal years 2006 and 2007, the provision would increase the total annual cap on federal funding for the Medicaid programs in each of Puerto Rico, the Virgin Islands, Guam, the Northern Marianas, and American Samoa. For Puerto Rico the total annual Medicaid cap would be increased by \$12 million; for the Virgin Islands and Guam, the FY2006 total annual Medicaid caps would be increased by \$2.5 million and the FY2007 caps would be increased by \$5.0 million. For the Northern Marianas, the FY2006 total annual Medicaid cap would be increased by \$1.0 million and the FY2007 cap would be increased by \$2.0 million. For American Samoa, the FY2006 total annual Medicaid cap would be increased by \$2.0 million and the FY2007 cap would be increased by \$4.0 million. For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in each of Puerto Rico, the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be calculated by increasing the FY2007 ceiling for inflation.

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

Citizenship Documentation. As a condition of an individual's eligibility for Medicaid benefits, Section 1137(d) of the Social Security Act requires a state to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. Under current law, if an individual declares that he or she is not a citizen or national, the individual must declare that he

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

FMAP Computation for Employer Pension Contributions. When state FMAPs are calculated by HHS for an upcoming fiscal year (usually in the preceding November), the state and U.S. per capita personal income amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). The definition of personal income used by BEA is comprised of many parts, including supplements to wages and salaries such as employer contributions for employee pension and insurance funds. When BEA undertakes a comprehensive revision of its income data every few years, there may be upward and downward revisions to each of these parts, the sum of which has a net effect on overall personal income. For example, in describing its most recent comprehensive revision, BEA reported that upward revisions to employer contributions for pensions beginning with 1989 were the result of methodological improvements and more complete source data. However, BEA reported upward and downward revisions to other parts of personal income as well (e.g., wages and salaries). Under the House proposal, for purposes of computing states FMAPs beginning with FY2006, employer contributions toward pensions that exceed a specified threshold would be excluded from the per capita income of a state.

Katrina Health Care Relief

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

FMAP Hold Harmless. When state FMAPs are calculated by HHS for an upcoming fiscal year (usually in the preceding November), the state and U.S. per capita personal income amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from

the Department of Commerce's Bureau of Economic Analysis (BEA). For example, to calculate FY2006 FMAPs, HHS used per capita personal income data for 2001, 2002, and 2003 that became available from BEA in October 2004. Under the Committee recommendation, for any year after 2006 for a state that the Secretary of HHS determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary would disregard such evacuees and their income for purposes of calculating state FMAPs for Medicaid and SCHIP.