DIVISION B – MEDICARE AND OTHER HEALTH PROVISIONS

Section 1. Short title of division.

Current Law

No Provision

Explanation of Provision

This division may be cited as the "Medicare Improvements and Expansion Act of 2006".

Title I — Medicare Improved Quality and Provider Payments

Section 101. Physician payment and quality improvement.

Current Law

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2006 is $37.8975.

The conversion factor is the same for all services. It is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include: (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians services; and (3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. In no case can the adjustment factor be less than minus seven percent or more than plus three percent.

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

The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to in subsequent years; however, legislation kept this from occurring. Most recently, the Deficit Reduction Act froze the 2006 conversion factor at the 2005 level. A negative 5% percent update is slated to occur in 2007.

Explanation of Provision

The conversion factor for 2007 would be the conversion factor otherwise applicable for 2007 divided by the product of:: (i) 1 plus the Secretary's estimate of the percentage increase in the MEI for 2007(divided by 100), and (ii) 1 plus the Secretary's estimate of the update adjustment factor for 2007. These changes would not be considered in the computation of the conversion factor for 2008.

The provision would also implement a voluntary quality reporting system for Medicare payments for covered professional services tied to the reporting of claims data. Physicians and other eligible professionals (including physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutritional professionals as defined under current law, physical therapists, occupational therapists, and qualified speech-language pathologists) who report the quality information would be eligible for a bonus incentive payment for services. For 2008, the Secretary would address a mechanism whereby an eligible professional could provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) as identified by the Secretary.

For covered professional services furnished beginning July 1, 2007 and ending December 31, 2007, the quality reporting measures are those identified as physician quality measures under the CMS Physician Voluntary Reporting Program (PVRP) as published on the CMS public website as of the date of enactment of this provision. The Secretary may modify these quality measures if changes are based on the results of a consensus-process meeting in January of 2007 and if such changes are published on the CMS website by April 1, 2007. The Secretary may subsequently refine the quality measures (without notice or opportunity for public comment) up until July 1, 2007 by publishing modifications or refinements to previously published quality measures but may not change the quality measures.

Eligible professionals who (1) furnish services for which there are established quality measures as determined by this provision and (2) satisfactorily submit quality measures would be paid a single additional bonus payment amount equal to 1.5% of the allowed charges for covered professional services furnished during the reporting period. The bonus incentive payments would be paid from the Supplemental Medical Insurance Trust Fund (Part B). These bonus incentive payments would not be taken into account in the calculations and determination of payments for providers in health professional

shortage areas or Physician Scarcity Areas, nor would these bonus payments be taken into account in computing allowable charges under this subsection.

The Secretary would presume that if an eligible professional submits data for a measure, then the measure is applicable to the professional. However, the Secretary may validate (by sampling or other means as the Secretary determines to be appropriate) to determine if an eligible professional reports measures applicable to such professional services. If the Secretary determines that an eligible professional has not successfully reported applicable measures, the Secretary would not pay that professional the bonus.

Satisfactory reporting of data determines whether the provider is eligible for the bonus payment. If there are no more than 3 quality measures that are applicable to the professional services furnished, the provider must report each measure for at least 80% of the cases to meet the criteria. If there are 4 or more quality measures that are applicable, the provider must report at least 3 of the quality measures for at least 80% of the cases.

The provision also places a limit on bonus payments. No provider would receive payments in excess of the product of the total number of quality measures for which data are submitted and three times the average per measure payment amount. The average per measure payment amount would be estimated by the Secretary and would equal the total amount of allowed charges under Medicare part B for all covered professional services furnished during the reporting period on claims for which quality measures are reported divided by the total number of quality measure for which data are reported during the reporting period under the physician reporting system.

The Secretary would provide for education and outreach to eligible professionals regarding these changes. The Secretary would implement these provisions acting through the Administrator of the Centers for Medicare and Medicaid services.

This provision would allow no administrative or judicial review, under the existing Medicare appeals process or through a Provider Reimbursement Review Board as currently codified in statute, of the determination of measures, satisfactory reporting, payment limitation, or bonus incentive payment. A determination under the provisions of this section would not be treated as a determination under current appeals processes for Medicare.

For 2008, the quality measures would be selected from measures adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA, originally known as the Ambulatory Care Quality Alliance) that includes measures that have been submitted by a physician specialty developed through a consensus-based process as identified by the Secretary. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology. The CMS administrator would publish a proposed set of quality measures for 2008 in the Federal Register no later than August 15, 2007 with a public comment period. The final set of measures appropriate for eligible professionals to use to submit quality data in 2008 would be published no later than November 15, 2007.

The Secretary would be required to establish a Physician Assistance and Quality Initiative Fund which would be available to the Secretary for physician payment and quality improvement initiatives. Such initiatives may include application of an adjustment to the update to the conversion factor. The amount available to the Fund would be $1.35 billion for 2008 The Secretary would be required to provide for expenditures from the Fund for the obligation of the entire amount (to the maximum extent feasible) for payment for physicians services furnished in 2008. The specified amount available to the Fund would be made to the Fund from the Part B trust fund as expenditures are made from the Fund. The amounts in the Fund are to be available in advance of appropriations, but only if the total amount obligated to the Fund does not exceed the amount available to it. The Secretary may obligate funds from the Fund only if the Secretary determines (and the CMS Chief actuary and the appropriate budget officer certifies) that there sufficient amounts available in the Fund. If the expenditures from the fund affect the conversion factor for a year, this would not affect the computation of the conversion factor for a subsequent year.

The Secretary would be required to transfer $60 million from the Part B trust fund to the CMS Program Management Account for the period of FY 2007, FY 2008, and FY 2009 for the purposes of implementing this section.

Section 102. Extension of floor on Medicare work geographic adjustment

Current Law

Medicare's physician fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to a national average. An area with costs above the national average would have an index greater than 1.00 while an area with costs below the average would have an index below 1.00. The physician work geographic adjustment factor is based on a sample of median hourly earnings in six professional specialty occupational categories. Unlike the other geographic adjustments, the work adjustment factor reflects only one-quarter of the cost differences in an area. The practice expense adjustment factor is based on employee wages, office rents, medical equipment and supplies. The malpractice adjustment factor reflects differences in malpractice insurance costs. The Secretary is required to periodically review and adjust the geographic indices.

MMA required the Secretary to increase the value of any work geographic index that was below 1.00 to 1.00 for services furnished on or after January 1, 2004 and before January 1, 2007.

Explanation of Provision

The requirement is extended for an additional year, for services provided before January 1, 2008.

Section 103. Update of the composite rate component of the basic case-mix adjusted prospective payment system for dialysis services.

Current Law

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

The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate. The DRA increased the composite rate component of the basic case-mix adjusted system for services beginning January 1, 2006 by 1.6%, over the amount paid in 2005. For 2006, the base composite rate is $130.40 for independent ESRD facilities and $134.53 for hospital-based ESRD facilities. The total drug add-on adjustment, with inflation, is 14.5%.

Explanation of Provision

The composite rate component of the basic case-mix adjusted system shall by increased by 1.6 percent above the 2005 rate, for services furnished on or after January 1, 2006 and before April 1, 2007. For services furnished on or after April 1, 2007, the composite rate component of the basic case-mix adjusted system shall by increased by 1.6 percent, above the amount of such rate for services furnished on March 31, 2007.

Not later than January 1, 2009, GAO shall submit a report to Congress on the costs for home hemodialysis treatment and patient training for both home hemodialysis and peritoneal dialysis. The report shall include recommendations for a payment methodology that measures, and is based on, the cost of providing such services and takes into account the case mix of patients.

Section 104. Extension of Treatment of certain physician pathology services under Medicare

Current Law

In general, independent laboratories cannot directly bill for the technical component of pathology services provided to Medicare beneficiaries who are inpatients or outpatients of acute care hospitals. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permitted independent laboratories with existing arrangements with acute care hospitals to bill Medicare separately for the technical component of pathology services provided to inpatients and outpatients. The arrangement between the hospital and the independent laboratory had to be in effect as of July 22, 1999. The direct payments for these services applied to services furnished during 2001 and 2002. MMA applied the provision to services furnished during 2005 and 2006.

Explanation of Provision

The provision is extended through 2007.

Section 105. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas

Current Law

Generally, hospitals that provide clinical diagnostic laboratory tests under Part B are reimbursed under a fee schedule. MMA specified that hospitals with under 50 beds in qualified rural areas (low density population rural areas) would receive 100% reasonable cost reimbursement for clinical diagnostic tests covered under Part B that are provided as outpatient services. The provision applied to services furnished during a cost-reporting period beginning during the 2-year period starting July, 1, 2004.

Explanation of Provision

The provision is modified to apply to services furnished during a cost-reporting period beginning during the 3-year period starting July, 1, 2004. The provision is effective as if included in the enactment of MMA.

Section 106. Hospital Medicare reports and clarifications

(a) Correction of Mid-Year Reclassification Expiration.

Current Law

Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established a one-time-only appeals procedure to provide relief for

certain hospitals that could not meet the existing reclassification criteria used by the Medicare Geographic Classification Review Board (MGCRB). The Section 508 reclassifications appeals were heard by the MGCRB and were not subject to further administrative or judicial review. The Section 508 reclassifications are effective for 3 years, beginning on April 1, 2004 and ending on March 31, 2007. Congress allocated $900 million over three years to fund this provision. Generally speaking, unless otherwise specified by law, the MGCRB's classification decisions are required to have a budget neutral effect in the inpatient prospective payment system (IPPS).

Explanation of Provision

The provision would extend wage index reclassifications that expire on March 31, 2007 until September 30, 2007. This provision would not be implemented in a budget neutral fashion.

(b) Revision of the Medicare Wage Index Classification System.

Current Law

As directed by Medicare statute, the amount of a hospital's operating and capital payments will vary according to the relative level of hospital wages in its geographic area compared to the national average. The geographic areas or hospital labor markets that have been used by Medicare are urban areas as established by the Office of Management and Budget (OMB). Essentially, a hospital's payment will depend upon whether it is in an urban area (and if so, which one) and the wage data reported by the hospitals in that area. Counties that are not in an urban area are grouped into one statewide rural labor market. Also, with modifications, the hospital wage data are used to adjust for geographic cost differences in Medicare's payment systems for other services, such as inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), home health agency (HHA), skilled nursing facility (SNF), and hospice care. Unlike these other providers, IPPS hospitals have an administrative process, through appeals to the Board (the Board), to reclassify to different geographic areas. Other statutory provisions affecting hospital's geographic designation also have been established.

Explanation of Provision

The Medicare Payment Advisory Commission (MedPAC) would be required to submit a report to Congress no later than June 30, 2007 on the wage index classification system used in Medicare's prospective payment systems, including IPPS. This report would include recommendations for alternatives to the current methods used to compute the wage index. $2 million in funds in the Treasury would be appropriated to MedPAC for FY2007 for these activities. The Secretary would be required to include in the proposed rule making process for FY2009 one or more proposals to revise the IPPS wage adjustment, after taking into account MedPAC's recommendations. The proposals would consider problems associated with labor market definitions; modification or elimination of geographic reclassifications and other adjustments; the use of Bureau of Labor

Statistics data to calculate relative wages; minimizing variations in wage index adjustments between and within metropolitan statistical areas and rural areas; the feasibility of applying all components of the proposal to other settings, including HHAs and SNFs; methods to minimize the volatility of wage index adjustments while maintaining the budget neutrality; the effect on health care providers and on each region of the country; implementation of proposal, including the transition methods; and occupational mix issues such as staffing practices, effect on quality of care and alternative recommendations.

(c) Elimination of Unnecessary Report.

The Secretary is required to submit a report to Congress that includes an initial estimate of the percentage update (change factor) in the per discharge payment amounts. The Secretary's estimate is required to take into consideration the recommendations of MedPAC and may vary for hospitals in different geographic areas

Explanation of Provision

This provision would eliminate the requirement that the Secretary include recommendations with respect to the update factors no later than March 1 before the beginning of the fiscal year.

Section 107. Extension of payment rule for brachytherapy

Current Law

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established that brachytherapy devices consisting of radioactive sources (or seeds) would be paid on the basis of a hospital's cost for such device (computed by reducing a hospital's charges to costs) for services furnished starting January 1, 2004 until January 1, 2007. The Secretary was directed to create additional groups of covered OPD services that classify such devices separately from other services (or group of services) in a manner that reflects the number, isotope, and radioactive intensity, including separate groups for palladium-103 and iodine-125 devices. Starting January 1, 2007, CMS will continue to pay separately for brachytherapy sources, but will base payment on the source-specific median costs. CMS declined to create new brachytherapy source codes to differentiate stranded from unstranded brachytherapy sources.

Explanation of Provision

This provision would extend payment for brachytherapy sources on the basis of a hospital's charges adjusted to cost until January 1, 2008. The provision also directs the Secretary to create additional groups of covered OPD services for stranded and non-stranded brachytherapy devices furnished on or after July 1, 2007. These provisions may be implemented by program instruction or otherwise.

Section 108. Payment process under the competitive acquisition program (CAP)

Current Law

MMA revised the way Medicare pays for Part B drugs. Beginning in 2005, payments for these drugs are based on an average sales price (ASP) payment methodology, which sets payments at the weighted average ASP plus 6%; the Secretary has the authority to reduce the ASP payment amount if the widely available market price is significantly below the ASP. Alternatively, beginning in 2006, drugs can be provided through a newly established competitive acquisition program (CAP). The intent of the program is to enable physicians to acquire certain drugs from an approved CAP vendor thereby enabling them to reduce the time they spend buying and billing for drugs.

Explanation of Provision

The provision deletes the requirement that payments to CAP contractors are conditioned upon the administration of the drugs and biologicals. The provision specifies that payment may only be made to the contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary. Further, the Secretary is required to establish a post-payment review process to assure that payment is made for a drug or biological only if it has been administered. The process of post-payment review may be established by program instruction or otherwise and may include the use of statistical sampling. The Secretary is required to recoup, offset or collect any overpayments determined by the Secretary under this process.

The section further clarifies that nothing in this provision is to be construed as requiring any additional competition by entities under the CAP program. Further the provision is not to be construed as requiring any additional process for elections by physicians under the program or additional selection by a selecting physician of a CAP contractor. The provision applies to payments for drugs and biologicals supplied on or after April 1, 2007. Additionally, the provision applies on or after July 1, 2006 and before April 1, 2007, for claims that are paid before April 1, 2007.

Section 109. Quality reporting for hospital outpatient services and ambulatory surgical center services

(a) Outpatient Hospital Services.

Current Law

Each year the hospital outpatient department (OPD) fee schedule is increased by a factor that is generally based on the hospital market basket (MB) percentage increase. In certain years, the MB has been reduced by percentage points as specified by statute.

Explanation of Provision

Starting in 2009 and for each subsequent year, a hospital paid under the inpatient prospective payment system (IPPS) that does not submit required measures will receive an OPD fee schedule increase of the MB minus 2.0 percentage points. A reduction under this provision would only apply to payments for the year involved and would not be taken into account when computing the OPD fee schedule increase in a subsequent year.

Each IPPS hospital is required to submit data on measures under this section in the form, manner, and timing specified by the Secretary. The Secretary would be required to develop appropriate measures for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties. To the extent feasible and practicable, the measures shall include those set forth by one or more national consensus building entitles. Nothing would prevent the Secretary from selecting the IPPS quality measures or a subset of such measures. The Secretary would be able to replace any measures as appropriate, such as where all hospitals are effectively in compliance or the measures have subsequently been shown not to represent the best clinical practice.

The Secretary would be required to establish procedures for making the submitted data available to the public. These procedures would ensure that a hospital has the opportunity to review data prior to being made available to the public. The Secretary would be required to report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care on the Internet website of the Centers for Medicare and Medicaid Services. Other conforming amendments would also be established.

(b) Application to Ambulatory Surgical Centers.

Current Law

Presently, Medicare pays for surgery-related facility services in an ambulatory surgical center (ASC) based on a fee schedule. The Medicare Prescription Drug, Improvement, and Modernization Act of 2006 (MMA) required the Secretary to implement a revised payment system for ASCs no later than January 1, 2008, taking into account recommendations issued by a required report from the Government Accountability Office (GAO). The GAO report, which has just been issued, was required to examine the relative costs of ASC services to those in hospital outpatient departments. GAO was also required to recommend whether CMS should use the outpatient prospective payment system as the basis for the revised ASC system. Total payments under the new system should be equal to total projected payments under the old system.

Explanation of Provision

In the revised payment system, the Secretary would be able to provide for a reduction in any annual update of 2.0 percentage points for failure to report required quality measures. A reduction under this provision would only apply to payments for the year involved and would not be taken into account when computing any annual increase

factor in subsequent years**.** Except as otherwise provided by the Secretary, the provisions of subparagraphs (B), (C), (D), and (E) of the newly established Section 1833(t)(17) concerning the form and submission of data, the development of outpatient measures, the replacement of measures, and the availability of quality measures in a hospital outpatient setting would apply to ASC services.

(c) Effective Date.

Current Law

No provision.

Explanation of Provision

The amendments made by the section would apply to payment for services furnished starting January 1, 2009.

Section 110. Reporting of anemia quality indicators for Medicare part B cancer anti-anemia drugs.

Current Law

Medicare Part B covers certain drugs used as anticancer chemotherapeutic agents, and certain oral anti-emetic drugs and biologicals used as part of an anticancer chemotherapeutic regimen. Medicare also covers certain drugs and biologicals to counter anemia for chronic kidney disease and cancer patients. At present, Medicare Part B requires hemoglobin or hematocrit levels to be reported only for certain chronic kidney disease (dialysis) patients, but not for cancer patients. MedPAC has recommended that the hemoglobin or hematocrit levels be reported for patients receiving anti-anemia drugs.

Explanation of Provision

The provision requires that all Part B claims submitted for drugs for treatment of anemia in connection with cancer chemotherapy include the hemoglobin or hematocrit levels for the individual. The information is to be submitted in the form and manner specified by the Secretary after full notice-and-comment rulemaking as part of the physician fee schedule update rule in 2007. The provision applies to drugs and biologicals furnished on or after January 1, 2008.

Section 111. Clarification of hospice satellite designation.

Current Law

Section 1814(i)(2)(A) of the Social Security Act limits total Medicare payment amounts to individual hospice providers by an absolute dollar amount, or "cap amount." This amount is based on the number of Medicare patients the agency serves and is

calculated by dividing total payments to a hospice per year by the total number of beneficiaries served to get the per beneficiary payment amount. If the per beneficiary payment amount does not exceed the cap amount, the hospice may retain all payments. If the result exceeds the cap amount, the hospice must repay excess funds to the Medicare program. For purposes of calculating whether or not a hospice exceeds the cap amount, increasing the number of beneficiaries a hospice serves reduces the per beneficiary payment amount. A lower per beneficiary payment amount reduces the likelihood that a hospice will exceed the annual hospice cap and be required to repay excess funds to the Medicare program.

Explanation of Provision

For purposes of calculating the hospice cap for 2004, 2005 and 2006 and for hospice care provided after November 1, 2003 and before December 27, 2005, this provision would designate hospice with provider number 290-1511 as a multiple location of hospice with provider number 29-1500.

Title II—Medicare Beneficiary Protections

Section 201. Extension of exceptions process for Medicare therapy caps

Current Law

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

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

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

The caps went into effect again beginning January 1, 2006. The 2006 caps are each $1,740. However, DRA required the Secretary to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on

behalf of the enrollee, can request an exception from the physical therapy and occupational therapy caps. The individual may obtain such exception if the provision of services is determined medically necessary. The exceptions process only applies for 2006.

Explanation of Provision

The provision extends the exceptions process through 2007.

Section 202. Payment for administration of part D vaccines

Current Law

Medicare Part B covers pneumoccoccal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration when furnished to a high or intermediate risk individual. Medicare Part D covers other vaccines licensed under the Public Health Service Act.

Explanation of Provision

The provision specifies that during 2007, the administration costs for a vaccine paid under Part D are to be paid under Part B as if it were the administration of a hepatitis B drug covered under Part B. Beginning in 2008, Part D coverage will include the administration costs.

Section 203. OIG study of never events.

Current Law

No provision.

Explanation of Provision

The Office of the Inspector General (OIG) in the Department of Health and Human Services would be required to conduct a study on the incidence of never events for Medicare beneficiaries, including types of such events and payments by any party, including beneficiaries, of such events. This study would also include the extent to which Medicare paid, denied or recouped payment for such services as well as the administrative processes of the Centers for Medicare and Medicaid Services (CMS) to identify such events and to deny or recoup associated payments. The OIG would be required to audit a representative sample of claims and medical records of the events; would be able to request access to claims and records from any Medicare contractor; and would not be able to release individually identifiable or facility specific information. The OIG would be required to submit a report to Congress no later than two years from enactment. This report would include recommendations for legislative or administrative

action on the processes to identify, deny or recoup payments for never events. The report will also provide a recommendation on a potential process for public disclosure of never events that ensures patient privacy and permits the use of disclosed information for root cause analysis. $3 million of funds in the Treasury will be appropriated which will be available until January 1, 2010. Never events are those that are listed and endorsed as "serious reportable events" by the National Quality Forum as of November 16, 2006.

Section 204. Medicare medical home demonstration project.

Current Law

No provision.

Explanation of Provision

The Secretary is required to establish a medical home demonstration project in Medicare law for the purpose of redesigning the healthcare delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations (i.e., those with multiple chronic illnesses that require regular monitoring, advising, or treatment).

Under the project, case management fees would be paid to personal physicians, and incentive payments would be paid to physicians participating in practices that provide "medical home" services. Medical homes are physician practices in charge of targeting beneficiaries for project participation. They are responsible for: (1) providing safe and secure technology to promote patient access to personal health information; (2) developing a health assessment tool for the targeted individuals; and (3) providing training for personnel involved in the coordination of care.

The project is to operate for three years in urban, rural, and underserved areas in up to 8 states and would include physician practices with fewer than three full-time equivalent physicians, as well as larger practices, particularly in rural and underserved areas.

In addition to meeting Medicare requirements for physicians, personal physicians who provide first contact and continuous care for their patients must be board certified. Personal physicians must also have staff and resources to manage the comprehensive and coordinated health care of each of their patients. Participating physicians may be specialists or subspecialists for patients requiring ongoing care for specific conditions, multiple chronic conditions (e.g., severe asthma, complex diabetes, cardiovascular disease, and rheumatologic disorder), or for those with a prolonged illness.

Personal physicians must perform (or provide for the performance of): (1) advocates for and provides ongoing support, oversight, and guidance to implement a plan of care; that provides an integrated, coherent, cross discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing

care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies); (2) uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care (based on patient-specific factors); (3) uses health information technology that may include remote monitoring and patient registries; and (4) encourages patients to engage in management of their own health through education and support systems.

Payments for care management to personal physicians are to be provided under a care management fee under Section 1848 of the Social Security Act. The Secretary would be required to develop a care management fee code and a value for these payments using the relative value scale update committee (RUC) process.

Payments for a medical home shall be based on the payment methodology applied to physician group practices under section 1866A of the Social Security Act. Under this methodology, 80% of Medicare reductions (determined by using assumptions with respect to the reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions) resulting from the medical home participation (as reduced by the total project-related care management fees), would be paid to the medical home. Project payments are to be paid from Part B.

The Secretary would be required to provide a yearly project evaluation and submit it to Congress on a date specified by the Secretary. In addition, the Secretary would be required to submit to Congress a project evaluation no later than one year after project completion.

Section 205. Medicare DRA technical corrections.

(a) PACE Clarification

Current Law

The Secretary appropriated $10 million for FY2006 for the outlier funds for rural PACE providers. Outlier costs are those inpatient and other costs in excess of $50,000 incurred within a given 12-month period by a PACE provider for an eligible participant who resides in a rural area. These appropriated funds would remain available for expenditure through FY2010.

Explanation of Provision

The amendment clarifies that the appropriated $10 million would be applied to fiscal years 2006 through 2010, rather than only for FY2006. It also specifies that the funds would remain available for obligation, rather than for expenditure, through FY2010.

(b) Miscellaneous technical corrections

(1) Correction of Margin (Section 5001)

Current Law

No provision.

Explanation of provision.

Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 5001(a) of the Deficit Reduction Act of 2005 (Public Law 109–171), is amended by moving clause (viii) (including subclauses (I) through (VII) of such clause) 6 ems to the left.

(2) Reference Correction (Section 5114)

Current Law

This P.L. 109-171 provision modified the first sentence of Section 1842(b)(6)(F) of the Social Security Act to add a new paragraph H to1842(b)(6) so that a federally qualified health center (FQHC) would be paid directly for FQHC services provided by a health care professional under contract with that FQHC.

Explanation of Provision

Instead of modifying Section 1842(b)(6)(F) to add paragraph H, the amendment would modify Section 1842(b)(6) of the Social Security Act.

(c) Effective Date

These amendments would become effective as if they had been included in DRA 2005, enacted on February 8, 2006.

Sec. 206 Continuous Open Enrollment into Certain Medicare Advantage Plans.

Current Law

Individuals entitled to Medicare Part A or enrolled in Part B can choose to receive Medicare benefits by enrolling in a Medicare Advantage plan. Individuals enrolled in a Medicare Advantage (MA) plan who also want to receive Medicare prescription drug coverage may obtain prescription drug coverage through that MA plan. MA enrollees may not also enroll in a stand-alone prescription drug plan under Part D, except for: (1) enrollees in private fee-for-service MA plans that do not offer qualified prescription drug coverage or (2) enrollees in Medical Savings Accounts MA plans.

In general, individuals can make a coverage election during the annual election period, which in 2006 and beyond, begins on November 15 and ends on December 31. During this time, beneficiaries can elect to receive benefits through original Medicare fee-for-service (FFS) program or an MA plan. Individuals also can elect to enroll in a stand-alone prescription drug plan or an MA plan that offers drug coverage. Under certain circumstances, an individual may be afforded a special election period outside of the annual election period, during which time they can change their coverage election.

Beginning in 2007, individuals can change their coverage elections one time between January 1 and March 31. Permissible election changes during this period include: FFS to an MA plan; MA plan to FFS; MA plan to a different MA plan; FFS with stand-alone prescription drug coverage to an MA-PD; MA-PD to a different MA-PD; and MA-PD to FFS with a stand-alone prescription drug plan. With respect to PFFS plans, the permissible election changes include FFS with a stand-alone PDP to a PFFS or MSA plan with the same stand-alone PDP or FFS with a stand-alone PDP to a PFFS-PD. Individuals who did not elect prescription drug coverage during the annual election period cannot elect prescription drug coverage during this one-time change period.

Explanation of Provision

For 2007 and 2008, the provision modifies current law such that an unenrolled fee-for-service individual can make a one-time change to their coverage election on any date during the year. An unenrolled individual is defined as an individual who is receiving benefits under original Medicare FFS, is not enrolled in an MA plan on such date; and as of such date is not otherwise eligible to elect to enroll in an MA plan. Permissible coverage election changes for an unenrolled individual include: (1) FFS to an MA plan with no drug coverage and (2) FFS with a stand-alone prescription drug plan to an MA plan with the same stand-alone prescription drug plan. As such, this provision effectively permits only MA plans with no drug coverage to enroll individuals throughout the year. MA plans that integrate prescription drug coverage into their benefit packages would be kept under the current law provision that is they would not be allowed to enroll individuals throughout the year.

Title III – Medicare Program Integrity Efforts

Section 301. Offsetting adjustment in Medicare Advantage Stabilization Fund

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a stabilization fund to provide incentives for plans to enter into and to remain in the Medicare Advantage regional program. Money in the fund is available to the Secretary for expenditures from January 1, 2007 to December 31, 2013. Initially $10

billion is to be provided to the stabilization fund and additional amounts are to be added to the fund from a portion of any average per capita monthly savings amounts. The secretary is responsible for determining the amounts that may be given to MA plans from this fund, based on statutory requirements. For example, the national bonus payment will be available to an MA organization that offers an MA regional plan in every MA region in the year, but only if there was no national plan in the previous year.

Explanation of Provision

This provision would delay the initial availability of the stabilization fund until January 1, 2012, and reduce the amount of the fund to $3.5 billion.

Section 302. Extension and expansion of recovery audit contractor program under the Medicare Integrity Program.

(a) Use of Recovery Audit Contractors

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-73) authorized a 3-year demonstration project using recovery audit contractors to identify both under and overpayments made to Part A & B Medicare providers and recoup overpayments in the Medicare program. The demonstration is being conducted as part of the Medicare Integrity Program, created by Section 1893 of the Social Security Act, which enables the Secretary to enter into contracts with entities to carry out a range of activities designed to prevent health care fraud and abuse in Parts A & B of the Medicare program. The Medicare Integrity Program was established by the Health Insurance Portability and Accountability Act of 1996 along with the Health Care Fraud and Abuse Control Program. The program is financed via the Federal Hospital Insurance Trust Fund.

Explanation of Provision

Section 302 would allow the Centers for Medicare and Medicaid Services (CMS) to continue using recovery audit contractors to identify both under and overpayments made under Medicare Parts A & B and recoup any overpayments made to providers. To pay the contractors, the Secretary would be required to use only those funds recovered by the contractors. From these recoveries, the bill would require the Secretary to pay the contractors in two ways: 1) on a contingent basis for collecting overpayments; and 2) in amounts that the Secretary may specify for identifying underpayments. A portion of the recovered funds would be available to the CMS program management account for activities conducted under the recovery audit contractor program. Any remaining recovered amounts – those recoveries that are not paid to the contractors or applied to the CMS program management account – would be used to reduce expenditures under Medicare Parts A & B. It is also expected that CMS will rectify any identified underpayments. Each contract would be required to provide that audit and recovery activities be conducted during the fiscal year and retrospectively for not more than 4

fiscal years. The Secretary would be allowed to waive Medicare statutory provisions to pay for the services of the recovery audit contractors.

By January 1, 2010, the Secretary would be required to contract with enough recovery audit contractors to cover Medicare activities in all states. When awarding contracts, the Secretary would be required to contract only with recovery audit contractors that have the staff with the appropriate clinical knowledge of and experience with Medicare payment rules and regulations, or recovery audit contractors that will contract with another entity that has the staff with the appropriate knowledge of and experience with Medicare payment rules and regulations. The Secretary shall give preference to entities with more than three years direct management experience and a demonstrated proficiency in audits with private insurers, health care providers, health plans, state Medicaid programs or Medicare. Recovery audit contractors cannot be fiscal intermediaries, carriers, or Medicare Administrative Contractors, and the recovery of overpayments by these contractors would not prohibit the Secretary or the Attorney General from prosecuting allegations of fraud and abuse arising from these overpayments.

Finally, the Secretary would be required to submit a report to Congress annually on the use of these recovery audit contractors. Specifically the report would include information on the performance of these contractors as it relates to identifying over and underpayments and in collecting overpayments. The report would also be required to include an evaluation of the comparative performance of these contractors and any Medicare savings that have accrued as a result of their activities.

(b) Access to Coordination of Benefits Contractor Database

Current Law

The Coordination of Benefits (COB) Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits.

Explanation of Provision

For the purpose of carrying out their audit and recovery activities, the Secretary of HHS would provide recovery audit contractors with access to the database of the Coordination of Benefits Contractors of the Centers for Medicare and Medicaid Services during the current fiscal year and for a period of up to 4 fiscal years prior to the current fiscal year.

(c) Conforming Amendments to Current Demonstration Project

Current Law

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires that the Secretary's demonstration project using recovery audit contractors last for no longer than three years. After the completion of the program, the Secretary shall submit to Congress a report on the project and its impact on savings to the Medicare program.

Explanation of Provision

The provision would continue the use of recovery audit contractors under the demonstration until all contracts could be entered into. The provision would also eliminate the requirement that the Secretary submit to Congress a report not later than 6 months after the project's completion on the impact of recovery audit contractors' activities on Medicare savings.

Section 303. Funding for the Health Care Fraud and Abuse Control Account.

(a) Departments of Health and Human Services and Justice

Current Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–91) established section 1128C of the Social Security Act, which authorized the creation of a national health care fraud and abuse control program headed by the Secretary of HHS and the Attorney General. In Section 1817(k) of the Social Security Act, HIPAA created an expenditure account within the Medicare Federal Hospital Insurance Trust Fund called the Health Care Fraud and Abuse Control (HCFAC) Account. Within the HFCFAC account, the legislation appropriated funds to HHS and DOJ at an amount of $104 million in FY97 and for FY98 through FY03 at annual increases of 15% above the preceding year. For each fiscal year after 2003, the annual appropriation available to HHS and DOJ was to be capped at the FY2003 level of $240.6 million. The legislation also established a separate funding stream within the HCFAC account to support activities undertaken by the FBI. Funding for the FBI was increased from $47 million in FY97 to $114 million in FY03. The legislation capped FBI funding at the FY03 level for FY03 and beyond.

Explanation of Provision

Section 303 would extend appropriations for the Health Care Fraud and Abuse Control Program through FY06 and beyond. For FY98 through FY03, the annual appropriation to HHS and DOJ is the limit for the preceding fiscal year increased by 15%. For fiscal years 2007 through 2010, the annual appropriation would be the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers. For each fiscal year beyond 2010, the legislation would cap the appropriation at the FY10 level.

For the Office of the Inspector General of HHS, Section 303 would extend the annual appropriation of $160 million through FY06. For FY07, the bill would increase the FY06 appropriation to OIG by the percentage increase in the consumer price index. For fiscal years 2008, 2009, and 2010, the annual appropriation would increase by the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers. For each fiscal year after FY10, the legislation would cap the appropriation at the FY10 level.

(b) Federal Bureau of Investigations

Current Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–91) established section 1128C of the Social Security Act, which authorized the creation of a national health care fraud and abuse control program headed by the Secretary of HHS and the Attorney General. In Section 1817(k) of the Social Security Act, HIPAA created an expenditure account within the Medicare Federal Hospital Insurance Trust Fund called the Health Care Fraud and Abuse Control (HCFAC) Account. Within the HFCFAC account, the legislation appropriated funds to HHS and DOJ at an amount of $104 million in FY97 and for FY98 through FY03 at annual increases of 15% above the preceding year. For each fiscal year after 2003, the annual appropriation available to HHS and DOJ was to be capped at the FY2003 level of $240.6 million. The legislation also established a separate funding stream within the HCFAC account to support activities undertaken by the FBI. Funding for the FBI was increased from $47 million in FY97 to $114 million in FY03. The legislation capped FBI funding at the FY03 level for FY03 and beyond.

Explanation of Provision

Section 303 would extend the annual appropriation to the Federal Bureau of Investigations (FBI). For fiscal years 2007 through 2010, the annual appropriation would be the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers. For each fiscal year after 2010, the legislation would cap the appropriation at the FY2010 level.

Section 304. Implementation funding

Current Law

No current law.

Explanation of Provision

For implementation of provisions and amendments made by this title and titles I and II of this division, other than the section requiring the Inspector General in the Department of Health and Human Services to conduct a study of never events, the provision would require the Secretary of Health and Human Services to transfer $45,000,000 to the CMS Program Management Account for FY2007 and FY2008, from the Federal Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust, in appropriate proportions.

Title IV – Medicaid and Other Health Provisions

Section 401. Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program

Current Law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12, months. The sunset date for Section 1925 has been extended a number of times, most recently through December 31, 2006 by the Deficit Reduction Act of 2005.

Under Section 510 of the Social Security Act, federal law appropriated $50 million annually for each of the fiscal years 1998-2003 for matching grants to states to provide abstinence education and, at state option, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on groups that are most likely to bear children out-of-wedlock. Funds must be requested by states when they apply for Maternal and Child Health Services (MCH) Block Grant funds and must be used exclusively for the teaching of abstinence. States must match every $4 in federal funds with $3 in state funds.

A state's allotment of abstinence education block grant program funding is based on the proportion of low-income children in the state as compared to the national total. Funding for the abstinence education block grant has been extended a number of times, most recently through December 31, 2006 by the Deficit Reduction Act of 2005.

Explanation of Provision

The provision would extend TMA under Section 1925 of the Social Security Act through June 30, 2007. It would also fund the abstinence education block grant program through June 30, 2007 at the level provided through the third quarter of FY2006.

Section 402. Grants for research on vaccine against Valley Fever

Current Law

Under existing National Institutes of Health (NIH) authority, the National Institute on Allergy and Infectious Diseases has supported projects to study coccidioidomycosis, known as Valley Fever. Grants have included projects to study the organism that causes Valley Fever; to improve the ability to evaluate vaccine candidates; to support the clinical development of potential drug therapies; and to support acquisition of equipment and facilities for research on the disease, among others.

Explanation of Provision

The Secretary is required to conduct research on the development of a vaccine against coccidioidomycosis, known as Valley Fever. Grants may not be made on or after October 1, 2012. This does not have any legal effect on payments for grants for which amounts appropriated under this section were obligated prior to October 1, 2012.

To carry out this section, $40 million is authorized for fiscal years 2007-2012.

Section 403. Change in Threshold for Medicaid Indirect Hold Harmless Provision of Broad-Based Health Care Taxes

Current Law

Under federal law and regulations, a state's ability to use provider-specific taxes to fund their state share of Medicaid expenditures is limited. If states establish provider-specific taxes, those taxes cannot generally exceed 25% of the state (or non-federal) share of Medicaid expenditures and the state cannot provide a guarantee to the providers that the taxes will be returned to them. However, there is what is referred to as a "safe harbor." If the taxes returned to a provider are less than 6% of the provider's revenues, the prohibition on guaranteeing the return of tax funds is not violated. Those taxes do not have to undergo the process, defined in section 433.68 of Title 42 of the Code of Federal Regulations, of determining if a guarantee exists. The President's FY2006 budget proposes to phase the 6% "safe harbor" for provider taxes down to 3% although no new regulation has been issued on this subject to date.

Explanation of Provision

Beginning on the date of enactment, the provider tax "safe harbor" upper limit is codified at 6%. For the fiscal periods beginning on or after January 1, 2008 and ending before October 1, 2011, the "safe harbor" percentage will be reduced from 6% to 5.5%. After October 1, 2011, the provider tax "safe harbor" percentage will return to 6%.

Section 404. DSH allotments for fiscal year 2007 for Tennessee and Hawaii

(A) Tennessee

Current Law

Tennessee operates its Medicaid program under a comprehensive statewide waiver, the terms and conditions of which have been negotiated by the state and CMS. Medicaid demonstration waivers, authorized under Section 1115 of the Social Security Act, allow states a great deal of flexibility on how eligibility for Medicaid is determined, how Medicaid services are provided, and what those services are comprised of. States operating under a waiver are subject to a budget neutrality requirement intended to hold program spending under the waiver to estimates of amounts that would have been spent in the absence of the waiver. Because Tennessee receives its Medicaid funds under the provisions of the waiver, it does not receive federal matching for Medicaid payments to disproportionate share (DSH) hospitals nor do they receive an allotment for DSH payments (state by state allotments are calculated based on a formula in Medicaid law and represent a federal cap on the amount that the federal government will provide in DSH matching payments to any state.) DSH payments, however, continue to be counted as a component in Tennessee's budget neutrality calculation since, in the period prior to the waiver approval, the state was required to make DSH payments, and if the waiver had not been granted, the requirement to make those payments would continue to have applied.

Explanation of Provision

The provision would establish a DSH allotment for the state of Tennessee for fiscal year 2007 equal to the greater of the amount that is reflected in the budget neutrality provision for the TennCare demonstration year ending in 2006 and $280 million. Federal matching payments to the state for DSH hospitals for fiscal year 2007 would, however, be limited to one-third of the DSH allotment. Those amounts would be considered TennCare project expenditures and would be subtracted from TennCare demonstration payments for Essential Access Hospital supplemental pool payments. The sum of the DSH payments and the Essential Access Hospital supplemental pool payments would be prohibited from exceeding the allotment amount. The state would be permitted to submit a state plan amendment describing the methodology to be used to identify DSH hospitals and to make payments to such hospitals. However, the Secretary may not approve the plan amendment unless the methodology is consistent with the requirements under Section 1923 of the Medicaid Act for making payment adjustments for DSH hospitals.

(B) Hawaii

Current Law

Like Tennessee, Hawaii operates its Medicaid program under a statewide waiver, the terms and conditions of which have been negotiated by the state and CMS. The state does not make DSH payment under their waiver program and does not have a DSH allotment in Medicaid law.

Explanation of Provision

The provision would set a DSH allotment for Hawaii for fiscal year 2007 at $10 million. The Secretary shall permit Hawaii to submit an amendment to its State plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

Section 405. Certain Medicaid DRA technical corrections.

(a) Technical Corrections Relating to State Option for Alternative Premiums and Cost Sharing (Sections 6041 through 6043)

Current Law

P.L. 109-171 allows states to impose premiums and cost-sharing for any group of individuals for any type of service (except prescribed drugs which are treated separately), through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Preferred drugs are defined as those that are the least (or less) costly effective prescription drugs within a class of drugs (as defined by the state). Premium and cost-sharing rules for workers with disabilities were not changed in P.L. 109-171.

Individuals in families with income below 100% of the federal poverty line (FPL). Premiums and service-related cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service. Explicit rules are provided by income level for those with income between 100-150% FPL and for those with income over 150% FPL.

States are allowed to condition the provision of medical assistance on the payment of premiums, and to terminate Medicaid eligibility on the basis of failure to pay a premium if that failure continues for at least 60 days. States may apply this provision to some or all groups of beneficiaries, and may waive premium payments in cases where such payments would be an undue hardship. In addition, the provision allows states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition of receiving care or services. Providers may be allowed to reduce or waive cost-sharing amounts on a case-by-case basis.

For the purposes of cost-sharing, two income-related groups are identified: (1) individuals in families with income between 100 and 150% FPL, and (2) individuals in families with income over 150% FPL. For both groups, the total aggregate amount of all cost-sharing (including special cost sharing rules for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state.

Treatment of non-preferred drug cost-sharing. Special cost-sharing for prescribed drugs is subject to the general 5% aggregate cap on cost-sharing for individuals with income between 100-150% FPL and for individuals with income over 150% FPL who are not otherwise exempt from service-related cost-sharing.

Treatment of non-emergency cost-sharing. Individuals exempt from premiums or service-related cost-sharing under other provisions of P.L. 109-171 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. For non-exempt populations with income between 100-150% FPL, cost-sharing for non-emergency services in an ER cannot exceed twice the nominal amounts. For non-exempt populations with income exceeding 150% FPL, no cost-sharing limit is specified for non-emergency care in an ER. Aggregate caps on cost-sharing (described above) still apply.

Definition of non-emergency services. The term "non-emergency services" means any care or services furnished in an emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under Medicare law (Section 1867 of the Social Security Act).

Exemption from cost-sharing for newly eligible children with disabilities. Section 6062 of P.L. 109-171 created a new optional Medicaid eligibility group for children with disabilities under age 19 who meet the severity of disability required under the Supplemental Security Income program (SSI) without regard to any income or asset eligibility requirements applicable under SSI for children, and whose family income does not exceed 300% FPL. (States can exceed 300% FPL, without federal matching funds for such coverage.) Special premium and cost-sharing rules apply to this new group of eligibles.

Explanation of provision

The definition of preferred drugs would be amended to include those that are the most (or more) cost effective prescription drugs within a class of drugs (as defined by the state). In addition to separate cost-sharing provisions for prescribed drugs, the amendment would clarify that separate cost-sharing provisions also apply to non-emergency services provided in an emergency room.

Individuals in families with income below 100% of the federal poverty line (FPL). The provision would exempt from the general cost-sharing rules in new Section 1916A (a) all individuals in families with income below 100% of the federal poverty line (FPL). However, Section 1916 of Title XIX (nominal cost-sharing provisions) would still apply to this income group, as would the comparability rule regarding amount, duration and scope of available benefits (Section 1902(a)(10)(B)). States would still have the option to impose the special cost-sharing rules for prescribed drugs and non-emergency care provided in an emergency room to individuals in families with income below 100% FPL.

The provision would exempt individuals in families with income below 100% FPL from the provisions defining enforceability of premiums and other cost-sharing. Protections regarding payment of premiums and cost-sharing in Section 1916(c)(3) and Section 1916(e) would continue to apply to this income group.

The provision would apply the total aggregate cap of 5% of family income to individuals in families with income below 100% FPL for applicable cost-sharing with respect to nominal amounts (as defined in Section 1916), and prescribed drugs and emergency room copayments for non-emergency care (as defined in new Sections 1916A(c) and 1916A(e)).

Treatment of non-preferred drug cost-sharing. The definition of preferred drugs would be amended to include those that are the most (or more) cost effective prescription drugs within a class of drugs (as defined by the state). In addition to separate cost-sharing provisions for prescribed drugs, the provision would clarify that separate cost-sharing provisions also apply to non-emergency services provided in an emergency room. The provision would clarify that no cost-sharing for preferred drugs can be imposed on individuals exempt from service-related cost-sharing under the general cost-sharing provisions (identified in new Section 1916A(a)). It would also clarify that no more than nominal cost-sharing amounts may be imposed for non-preferred drugs on individuals exempt from services-related cost-sharing under the general cost-sharing provisions.

Treatment of non-emergency cost-sharing. The provision would clarify that for non-exempt persons with income between 100-150% FPL, cost-sharing for non-emergency care in an ER may not exceed twice the applicable nominal amount (up to the 5% aggregate cap). For persons with income below 100% FPL or who are exempt from service-related cost-sharing, cost-sharing for non-emergency care in an ER may not exceed the applicable nominal amount when no cost-sharing is imposed by the outpatient department or alternative providers. The 5% aggregate cap on all service-related cost-sharing for all income groups remains in effect.

Definition of non-emergency services. The provision would strike the phrase "the physician determines" from the definition of non-emergency services as provided in P.L. 109-171.

Exemption from cost-sharing for newly eligible children with disabilities. The provision would exempt this new optional eligibility group for children with disabilities established under P.L. 109-171 from the premium and service-related cost-sharing rules under new Section 1916A.

Correction of IV-B References. Among the groups explicitly exempted from the general cost-sharing provisions for premiums and cost-sharing, the provision would change references to Title IV-B to mean child welfare services made available under Title IV-B on the basis of being a child in foster care.

Effective Date. The provision specifies that all changes made are effective as if included in the affected sections and subsections of P.L. 109-171.

(b) Clarifying Treatment of Certain Annuities (Section 6012)

Current Law

Under Section 6012(b) of P.L. 109-171, the purchase of an annuity is treated as a disposal of an asset for less than fair market value unless certain criteria are met. One of these criteria is that the state be named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or be named in the second position after the community spouse or minor or disabled child and such spouse or a representative of such child does not dispose of any such remainder for less than fair market value.

Explanation of Provision

The provision would strike the term "annuitant" and replace it with "institutionalized individual." This change would become effective as if it had been included in DRA 2005, enacted on February 8, 2006.

(c) Additional Miscellaneous Technical Corrections

(1) Documentation (Section 6036)

Current Law

Under Section 6036 of P.L. 109-171, states are prohibited from receiving federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. Documents that provide satisfactory evidence are described in the law, as are exceptions to the documentation requirement.

Section 6036(a)(2) of the law specifies that the documentation requirements do not apply to an *alien* who is eligible for Medicaid:

- and is entitled to or enrolled for Medicare benefits;

- *on the basis of* receiving Supplemental Security Income (SSI) benefits; or
- on *such other basis* as the Secretary may specify that satisfactory documentary evidence *had* been previously presented.

The provision applies to initial determinations and to redeterminations of eligibility for Medicaid made on or after July 1, 2006.

Explanation of Provision

The provision would specify that the documentation requirements do not apply to an individual *declaring to be a citizen or national of the United States* who is eligible for Medicaid:

- and is entitled to or enrolled for Medicare benefits;
- *and is* receiving (1) Social Security benefits on the basis of a disability or (2) SSI benefits;
- and with respect to whom (1) child welfare services are made available under Title IV-B of the Social Security Act or (2) adoption or foster care assistance is made available under Title IV-E; or
- on *such basis* as the Secretary may specify that satisfactory documentary evidence *has* been previously presented.

The provision would also make reference corrections. These changes would be effective as if included in the Deficit Reduction Act of 2005.

In addition, effective 6 months after enactment, the provision would (1) require states to have procedures in effect for verifying the citizenship or immigration status of children in foster care under the responsibility of the state under Title IV-E or IV-B of the Social Security Act and (2) specify that in reviews of state programs under IV-E and IV-B, the requirements subject to review shall include determining whether the state program is in conformity with the requirement to verify citizenship or immigration status.

(2) Miscellaneous Technical Corrections

Current Law

Section 5114(a)(2). This P.L. 109-171 provision modified the first sentence of Section 1842(b)(6)(F) of the Social Security Act to add a new paragraph H to 1842(b)(6) so that a federally qualified health center (FQHC) would be paid directly for FQHC services provided by a health care professional under contract with that FQHC.

Section 6003(b)(2). This P.L. 109-171 provision modified Section 1927 of the Social Security Act by referencing subsection (k) relating to Section 505(c) drugs.

Section 6031(b), 6032(b), and 6035(c). These sections referenced Section 6035(e) of P.L. 109-171, which does not exist, to provide exceptions to effective dates.

Section 6034(b). Section 6034 of P.L. 109-171 establishes the Medicaid Integrity Program. It references modifications made to the Social Security Act by Section 6033(a).

Section 6036(b). Section 6036 of P.L. 109-171 deals with improved enforcement of documentation requirements. Section 6036(b) references Section 1903(z) of the Social Security Act. This section does not exist.

Section 6015(a)(1). Section 6015 of P.L. 109-171 pertains to continuing care retirement community admissions contracts. It makes reference to clause (v) of Section 1919(c)(5)(A)(i)(II) of the Social Security Act.

Explanation of provision

Section 5114(a)(2). Instead of modifying Section 1842(b)(6)(F) to add paragraph H, the amendment would modify Section 1842(b)(6) of the Social Security Act.

Section 6003(b)(2). Instead of referencing subsection (k) of Section 1927 of the Social Security Act, the amendment would reference subsection (k)(1).

Section 6031(b), 6032(b), and 6035(c). Instead of referencing Section 6035(e), the amendment would reference the effective date exception in Section 6034(e) of P.L. 109-171.

Section 6034(b). Instead of referencing modifications made by Section 6033(a) of P.L. 109-171, the amendment would reference Section 6032(a).

Section 6036(b). Instead of referencing Section 1903(z) of the Social Security Act, the amendment would reference Section 1903(x).

Section 6015(a)(1). Instead of referencing clause (v) of Section 1919(c)(5)(A)(i)(II) of the Social Security Act, the amendment would reference subparagraph (B)(v).