SUMMARY

The Chairman's proposal for Medicaid reform in the context of the 2006 Budget Reconciliation process achieves significant budget savings, slashes wasteful spending, and targets resources to preserve program integrity

SPENDING REDUCTIONS

MEDICAID

Prescription Drug Payment Reforms

- Redefines average manufacturer price (AMP) to reflect discounts and rebates available to retail pharmacies and then uses that definition for payments to pharmacies and for the calculation of the best price.
- Defines weighted average manufacturer price (WAMP) as the basis of a new payment system for these drugs and for a new federal upper limit for multiple source drugs.
- Clarifies nominal price definition to ensure that sales made at a nominal price are appropriately included in AMP calculations.
- Creates a new federal upper limit for payments to states for covered drugs that goes into effect January 1, 2007 (with a later transition for states without '06 legislative sessions) of AMP+5% for single source drugs and WAMP+15% for multi-source drugs.
- Includes language that requires states to provide appropriate dispensing fees to pharmacists and sets factors upon which they should be based.
- Creates an interim payment policy for 2006 capping the current federal upper limit at 125% of the July 1, 2005 AWP, WAC, or direct price levels.

-$4.595 billion / 5 years

Reform of Medicaid Asset Transfer Rules and Loopholes

- Closes loopholes in current Medicaid law concerning transfer of assets to limit the circumstances under which persons may intentionally shelter assets in order to qualify for Medicaid.
- This section includes the following provisions to close other loopholes that exist in current law:
    - Requires states to apply partial month penalties.
    - Requires states to accumulate transfers in computing the period of ineligibility.
    - Requires that annuities are treated the same as trusts under current law.

- Requires that certain notes and loans are considered countable.
- Requires private annuities be based on actuarial life expectancy.
- Limits transfers to purchase life estates.

- States would be required to provide a notice of the undue hardship waiver process to any individual applying for Medicaid who would be subject to a penalty period so they may request a waiver of the penalty period.
- States would be required to provide for a timely process for determining whether an undue hardship waiver will be granted, and a process for appeal of an adverse determination.

-$335 million / 5 years

Fraud, Waste and Abuse

- Enhancing third party recovery. The section creates useful new tools for existing third party recovery programs: (1) clarifies that PBMs must respond to claims; (2) clarifies that self-insured plans must turn over eligibility data; and (3) clarifies that states can recover claims for up to three years from the date of service.
- Limitation on use of contingent fee arrangements. The section gives the Secretary authority to implement standards for states in their use of contingent fee contracts.
- State False Claims Act. Creates an incentive for states to implement state False Claims Acts by providing them with an enhanced FMAP for any settlements reached through a state False Claims Act.
- False Claims Act employee education program as a condition of participation. Requires employers that do more than $1M business with Medicaid to have a False Claims Act education program for their employees.
- Prohibition on payments to States for prescriptions drug claims that have already been submitted and paid. This section clarifies in statute that pharmacists cannot bill Medicaid for drugs that have been paid for previously and restocked.

-$512 million / 5 years

State Financing of Medicaid

<u>MCO Provider Tax Reform</u>

- This provision would treat managed care organizations the same as other providers for purposes of applying current law on provider taxes. This section permits states that have a Medicaid-only managed care provider tax to keep it.

-$75 million / 5 years

Targeted Case Management Reforms

- The Targeted Case Management provision clarifies the definition of case management services. The provision specifies that "case management services" include: assessment activities, the development of a specific care plan, referral and related activities to help an individual obtain needed medical, social educational and other services, monitoring and follow up activities.
- Further clarifies that "case management services" do NOT include the direct delivery of medical, educational, social or other services, such as: research gathering, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, homes investigations, and transportation.

-$760 million / 5 years

Drug Rebate and Related Provisions

Close Authorized Generics Loophole

- Improved regulation of authorized generic drugs. This section requires CMS to include the best price of an authorized generic in the calculation of the best price for the branded drug.

-$180 million / 5 years

Increase Flat Rebate Amount to 17% in 2006

- Increase in rebates for covered outpatient drugs. This section increases the rebate paid by innovator drug manufacturers from 15.1% to 17% and on noninnovator drugs from 11% to 17%.

-$1.400 billion / 5 years

Physician Administered Drugs

- Requires the collection and submission of utilization data for certain physician administered drugs. This section requires states to begin collecting information on physician administered drugs for the purpose of insuring the state receives the proper rebate amount.

-$150 million / 5 years

Subtotal – Medicaid Spending Reductions: -$8.007 billion / 5 years

MEDICARE

PART A

Extend Medicare Bad Debt Policy to Skilled Nursing Facilities

- As proposed in the President's FY 2006 budget, this provision would reduce Medicare's reimbursement of skilled nursing facility bad debt (unpaid beneficiary co-pays and deductibles) from 100% to 70% of allowable costs.
- Medicare skilled nursing facility bad debt payments have increased 44% from 1996 to 2000.
- Congress provides a 30% reduction in Medicare bad debt payments to hospitals. This policy would equalize the SNF bad debt payment rate making it consistent with the bad debt payment rate for hospitals.

-$250 million / 5 years

Prohibit Physician Self-Referrals to Physician-Owned Limited Service Hospitals

- Prohibits new physician-owned limited service hospitals from having any ownership or investment interest by physicians who refer Medicare or Medicaid patients to the hospital. Confirms that the "whole hospital" exception would not apply to any new physician-owned limited service hospital effective June 8, 2005.
- Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they have a financial interest, unless they have an ownership or investment interest in the whole hospital and not merely a subdivision of the hospital.
- In 2003, Congress established that the "whole hospital" exception would not extend to physician-owned limited service hospitals (hospitals that are primarily engaged in cardiac, orthopedics or surgical care) for an 18-month period.
- Allows existing physician-owned limited service hospitals to continue operation with certain restrictions.

-$22 million / 5 years

PART B

DME Payment and Maintenance Fee Reforms

- Part B of Medicare pays for certain pieces of durable medical equipment (DME) under a capped rental method. Medicare currently pays 120% of the purchase price over 15 months.
- Suppliers can bill Medicare for maintenance and servicing (usually 10% of the purchase price) 6 months after the 15 month rental period ends and once every 6 months thereafter. *Suppliers are allowed to bill even if maintenance is not provided.*

- This provision would require DME rentals to be purchased after the 13th month, which would eliminate payments for 2 months and eliminate payments for maintenance and servicing unless otherwise necessary.
- This would reduce the price Medicare pays suppliers from 120% to 105% of the purchase price.

-$910 million / 5 years

PART C

Eliminate Budget-Neutrality Modification to Risk Adjusted Payments to Medicare Advantage Plans

- This provision would codify the Administration's proposed phase-out of its budget neutral modification that undermines the Medicare Advantage risk-adjusted payment system.
- Permits true comparisons based on health status of beneficiaries enrolled in Medicare Advantage to beneficiaries enrolled in fee-for-service Medicare.
- Ensures that underlying BBA-mandated health status based risk adjusted payment system will produce accurate payments for a beneficiary with a particular health status who enrolls in Medicare Advantage.
- This provision is consistent with a June 2005 MedPAC recommendation.

-$6.460 billion / 5 years

Eliminate Regional Medicare Advantage PPO Stabilization Fund

- Repeals fund established to promote plan entry and retention in Medicare Advantage program.
- In an August 2005 Fact Sheet on the Medicare Advantage program, the Centers for Medicare and Medicaid Services indicated that the program has "stabilized and flourished."
- As of January 1, 2006, regional Medicare Advantage plans will be available in 21 out of the 26 Medicare Advantage regions, indicating that plans are experiencing fewer than anticipated challenges in entering regions.
- Does not affect any other provisions to promote regional PPOs such as risk-corridors, local PPO moratorium, essential hospital fund, and network requirements.
- This provision is consistent with a June 2005 MedPAC recommendation.

-$5.440 billion / 5 years

OTHER MEDICARE

Pay for Performance

- Requires the Secretary of Health and Human Services to develop and implement value-based purchasing programs under Medicare for acute-care hospitals, physicians and practitioners, Medicare Advantage plans, end-stage renal disease (ESRD) providers, home health agencies, and to take initial steps toward value-based purchasing for skilled nursing facilities.
- Outlines the process and requirements for the development, implementation, and updating of a Quality Measurement System that will guide reporting and value-based purchasing programs.
- Principles for Medicare value-based purchasing include:
    - Building upon existing system and involving all relevant stakeholders.
    - A two-phased implementation that first ties Medicare reimbursement updates to the reporting of quality measures, and then creates a quality pool to reward providers for meeting certain thresholds of quality improvement and quality attainment.
    - The amount of Medicare payments in the quality pool will start at 1% of provider payments scaling up to 2% over a 5-year period.
    - Increased transparency and mandatory reporting of quality data to ensure that beneficiaries and the public have access to information to help them make informed health care decisions.

-$4.510 billion / 5 years

Subtotal – Medicare Spending Reductions: -$18.637 billion / 5 years

SUBTOTAL – GROSS SPENDING REDUCTIONS: -$26.644 BILLION / 5 YEARS

PROGRAM IMPROVEMENTS

MEDICAID AND SCHIP

IMPROVED FRAUD AND ABUSE OVERSIGHT

Health Care Fraud and Abuse Control Program / Medicaid Integrity Fund

- Under current law, funds from the Health Care Fraud and Abuse Control (HCFAC) account are used by federal agencies in their efforts to control fraud and abuse in health care programs. Funds go to the HHS OIG and to the Department of Justice. The additional funding provided would be used to continue efforts to find erroneous and fraudulent uses of Medicaid and SCHIP funding and provide an increase in audits and evaluations of state Medicaid programs.

$403 million / 5 years

PRESERVING AND IMPROVING ACCESS TO HEALTH CARE

Family Opportunity Act

- Under current law, parents of severely disabled children who work lose Medicaid eligibility for their disabled children if they have income and resources above the poverty level.
- The Family Opportunity Act, which has broad bipartisan support, would allow these parents to go to work and earn above-poverty wages while maintaining health care for their disabled children.
- Key Provisions:
    - Medicaid "buy-in" for disabled children whose family income or resources are at or below 300% of the poverty level ($58,050.00 for a family of four).
    - Funds for demonstration projects in 10 states to provide services to Medicaid enrolled children with psychiatric disabilities at home, instead of in an institution.
    - Funds for information and outreach centers to serve families with disabled children.
    - Immediate access to Medicaid coverage for those children who are "presumed eligible" for Supplemental Security Income (SSI).

$872 million / 5 years

Addressing SCHIP Shortfalls

- Under current law, CMS projects that as many as 23 states are projected to experience funding shortfalls in their SCHIP programs over the next 2 years.
- Consistent with the SCHIP proposal in the President's budget, this provision addresses SCHIP shortfalls by redistributing a portion of these balances from states that have SCHIP surpluses to states that have SCHIP shortfalls.

- Permits states to use up to 10% of their 2006 and 2007 allotments for outreach activities.
- Prohibits future SCHIP waivers for non-pregnant adults. Provides that redistributed funds for shortfall states must be spent on targeted low-income children in order to receive the enhanced SCHIP-match. States that wish to use the redistributed funds for individuals other than targeted low-income children may do so but at their regular FMAP matching rate.
- Continues authority for certain "qualifying states" to use funds for Medicaid expenses. Qualifying states include: *Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin*. Public Laws #108-74 and 108-27 allowed qualifying states to use up to 20% of the state's 1998-2001 allotments to pay for Medicaid eligible children above 150% FPL that were part of a state's Medicaid expansion prior to enactment of SCHIP. The 1998-2000 allotments "expired" in 2004. The 2001 allotments "expired" at the end of the FY 2005. Therefore, currently, no spending under these provisions is permitted.
- "Covering Kids" which provides $25 million for fiscal year 2006 for grants to eligible entities to conduct outreach and enrollment efforts designed to increase enrollment and participation of eligible children under Medicaid and SCHIP and promote understanding of the importance of health insurance coverage for prenatal care and children.

$205 million / 5 years

Money Follows the Person Demonstration

- Provides for demonstration projects to encourage community based services to individuals with disabilities rather than institutional long-term care services.
- This provision offers states a financial incentive to expand the number of individuals who can receive home and community-based services by providing an enhanced federal match rate for the cost of service expenditures for one year for individuals who are relocating from an institution into the community.
- Authorizes grants by HHS to states for the following purposes:
    - To increase the use of home and community based services, rather than institutional services.
    - Eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable individuals to receive support for appropriate and necessary long term services in the settings of their choice.
    - To increase the ability of the State Medicaid program to assure home and community based long term care services to eligible individuals, who choose to transition from an institution to a community setting.
    - Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community based long term care services and to provide for continuous quality improvement in such services.

$105 million / 5 years

IMPROVED LONG TERM CARE OPTIONS

Expand Long-Term Care Partnership Program

- Encourages the purchase of private long term care insurance by providing persons who have exhausted the benefits of a private long-term care insurance policy to access Medicaid under different means-testing requirements. This proposal is designed to result in savings to the Medicaid program by delaying the need for Medicaid coverage of long term care expenses.
- Repeals the federal legislative ban on new long-term care partnership programs to allow any state in the nation the option of implementing a long term care insurance partnership program.
- Establishes consumer-protections consistent with National Association of Insurance Commissioner recommendations.
- Requires the Secretary, in consultation with stakeholders, to develop standards to permit reciprocity of policies across states.
- Establishes a national clearinghouse for information on long-term care insurance policies.

$10 million / 5 years

Other Provisions

- Targeted temporary relief to certain parishes in Louisiana, counties in Mississippi and Alabama, and the state of Alaska FMAP (Sec 6032). This section reimburses states at 100% FMAP for any claims paid on behalf of an individual living in a specific parish in Louisiana or county in Mississippi and Alabama the week of August 28, 2005. This increase is temporary, beginning on August 28, 2005 and ending on May 15, 2006. It also creates a statutory floor for the FMAP for the state of Alaska at the 2005 FMAP level for 2006 and 2007.

$1.940 billion / 5 years

- Provides an adjustment to the District of Columbia's DSH allotment reflective of actual audited base year costs that all other Medicaid programs now use in their computation.

$100 million / 5 years

- Provides for podiatrists to be treated as physicians, as is the case under Medicare. The provision expands the definition of "physician services" under Medicaid to include a doctor of podiatric medicine with respect to the functions such a person is legally authorized to perform by the state in which he/she practices. States would now be required to cover the medical services of podiatrists.

$55 million / 5 years

- Provides for a 10-state demonstration project under which institutions for mental diseases not publicly owned or operated, would be eligible to receive reimbursement for Medicaid eligible recipients between the ages of 21-64 for the sole purpose of stabilizing an emergency medical condition.

$30 million / 5 years

Subtotal Medicaid Spending: $3.722 billion / 5 years

MEDICARE

PART A

Rehabilitation 75% Rule

- Sets implementation of the "75% rule," which is a criteria used to determine whether a hospital or unit qualifies as an inpatient rehabilitation facility (IRF) and thus for higher Medicare payments, at the 50% level through June 30, 2007.
- Allows facilities more time to comply with the 50% threshold. Those IRFs that failed to meet the 50% compliance will be given an additional 6 months to meet this threshold. If after 6 months the facility remains noncompliant, the Secretary would revoke the facility's IRF status and collect any overpayments.
- Calls for a study to identify and review the types of patients, medical conditions and rehabilitation providers that are unable to meet CMS' qualifications. Establishes a rehabilitation advisory council to provide advice and recommendations on the coverage of rehabilitation service sunder Medicare.

$105 million / 5 years

Extend and Improve Medicare Dependant Hospital (MDH) Program

- Extends the Medicare Dependent Hospital (MDH) program, which was created to provide financial protections to certain rural hospitals with less than 100 beds that have a greater than 60 percent share of Medicare patients, through 2011.
- Allows hospitals the option to use 2002 base year costs, in addition to base year costs from 1982 or 1987.
- Improves the blended payment rate by raising it from 50 percent to 75 percent of the difference between prospective payment system (PPS) payments and cost-based payments.
- Removes the 12 percent disproportionate share hospital (DSH) payment cap for qualifying hospitals.

$14 million / 5 years

PART B

Short Term Physician Payment Update

- Physician payment updates are determined using the Sustainable Growth Rate (SGR) formula, which is based on four factors:
    - Medicare Economic Index (MEI)
    - Number of beneficiaries in Fee-For-Service Medicare
    - Expenditures due to changes in law or regulations
    - Growth in real GDP per capita.
- Actual spending has been higher than spending projected by the SGR formula, which will result in negative updates for the next six years.
- Eliminating the SGR formula and adjusting payments for inflation would cost $154.5 billion over 10 years.
- This provision would provide physicians with a positive 1.0% update in 2006.

$10.8 billion / 5 years

Therapy Cap Moratorium

- In 1997, the BBA created a financial cap on the amount of money Medicare could spend per beneficiary for outpatient therapy services.
- Two caps were set at $1,500 indexed to the Medicare Economic Index (MEI); one for physical therapy and speech language therapy, the other for occupational therapy.
- Since 1999, Congress has twice enacted a moratorium on implementation of the therapy caps. The moratorium is set to expire in 2006.
- This provision would extend the moratorium for one year.

$710 million / 5 years

Hold Harmless Payments for Rural Hospital Outpatient Departments

- MedPAC has stated that rural hospitals' financial performance under the outpatient prospective payment system (OPPS) is expected to decline by 2006.
- Hold harmless payments are targeted to rural sole community hospitals and other rural hospitals with 100 or fewer beds.
- The hold harmless policy should be extended because it targets the specific rural hospitals most affected.

- This provision would extend hold-harmless payments under the OPPS through calendar year 2006.
- This provision is consistent with a March 2005 MedPAC recommendation.

$170 million / 5 years

ESRD Composite Update

- MedPAC has found beneficiary access to care is good, provider capacity is increasing, quality is improving, and provider access to capital is good.
- This provision would provide a 1.6% increase in the composite rate update for 2006, consistent with the update provided in the MMA.
- ESRD facilities will be paid for quality and efficiency starting in 2007 under the Medicare Value-Based Purchasing Act.

$520 million / 5 years

Expand Availability of PACE in Rural Areas

- Establishes site development grants and a technical assistance program for up to 15 PACE sites in rural areas.
- Creates a fund to provide partial reimbursement for incurred expenditures above a certain level.

$37 million / 5 years

International Volunteers

- There are several older Americans that volunteer overseas for programs sponsored by 501(c)(3) organizations.
- During this time, volunteers are required to purchase insurance that provides international health benefits.
- Volunteers are also required to pay Medicare Part B premiums in order to avoid future penalties and delayed enrollment when they return to the United States.
- This provision would waive the Part B late enrollment penalty and would establish a special enrollment period for these individuals upon their return to the United States.

$20 million / 5 years

Medicare Payment Adjustment to Federal Qualified Health Centers

- Federal Qualified Health Centers (FQHCs) are located in areas where care is needed but scarce.
- This provision would allow FQHCs to provide diabetes outpatient self-management training services and medical nutrition therapy services.
- A health care professional (including registered dietician or nutrition professional) under contract with the center can now provide services in an FQHC.
- This provision would also allow FQHCs to be eligible for Health Care for the Homeless grants.

$40 million / 5 years

Subtotal Medicare Spending: $12.916 billion / 5 years

SUBTOTAL – GROSS SPENDING: $16.638 BILLION / 5 YEARS

PACKAGE TOTALS

Medicaid:	Savings: -$8.007 billion	**Medicare:**	Savings: -$18.637 billion
	Spending: $3.722 billion		Spending: $12.916 billion
	Net: -$4.285 billion		Net: -$5.721 billion
	(Figures are over five years.)		

Package Net Savings: - $10.006 billion over five years.