

Select Provisions affecting Medicaid in the Senate, House, and Conference Committee Reconciliation Bills
(with five-year cost estimates)

	Senate	House	Conference Committee
Premiums and Cost-Sharing	<ul style="list-style-type: none"> No provisions to increase cost-sharing. 	<ul style="list-style-type: none"> Allows states, for the first time ever, to impose premiums on Medicaid beneficiaries with incomes above 100% of the federal poverty level. Allows states to impose copayments on any beneficiaries except mandatory children, foster children, certain institutionalized beneficiaries, and hospice patients. Preventive care for children, Secretary-defined “emergency services,” and family planning services are also exempt from cost-sharing. Sum of annual premiums and cost-sharing may total up to 5% of the beneficiary’s income. New premiums and cost-sharing save \$2.15 billion. States can charge higher copayments for “non-preferred” drugs. These copayments are tiered. All beneficiaries must pay something, and payments will increase with beneficiary income. Creates new copayments for the use of emergency rooms for “non-emergency care.” All beneficiaries would pay something, with no limits on the amount charged for those with incomes above 100% of poverty. New prescription drug and ER copayments save \$312 million. Retains the definition of “nominal” copay amount at \$3, but allows states to index future increases to medical inflation (twice the rate of general inflation, and thus, increases in workers’ wages). Changes in premiums and cost-sharing are enforceable; providers can deny services to those unable to afford copays, and premium payments later than 60 days can result in termination of eligibility. Allows states to establish non-emergency transportation programs. 	<ul style="list-style-type: none"> Allows states to impose cost sharing on families with incomes above 100 % of poverty. For those with incomes between 100 and 150 % of poverty, cost sharing for any individual service cannot exceed 10% of the total cost of the service, and total cost sharing for all beneficiaries in the family may not exceed 5% of family income. For those with incomes above 150% of poverty, cost sharing for any individual service cannot exceed 20% of the total cost of the service. Exempt from cost sharing: required services to mandatory children and foster children, preventive services provided to any children under age 18, pregnancy-related services, services to hospice patients, services to certain institutionalized populations, secretary-defined emergency services, family planning services, and women in breast or cervical cancer programs. Allows states to impose premiums on beneficiaries with family incomes above 150% of the federal poverty level. Exempt from premiums: mandatory children, foster kids, pregnant women, hospice patients, certain institutionalized populations, and women in breast or cervical cancer programs. For families with incomes above 150% of poverty, total cost sharing and premiums together for all members of the family may not exceed 5% of the family’s quarterly or monthly income (state chooses quarterly or monthly). Changes in premiums and cost-sharing are enforceable; providers can deny services to those unable to afford copays, and premium payments later than 60 days can result in termination of eligibility. ‘Nominal’ copay amounts remain at \$3,

			<p>but beginning in 2006, can be increased annually at the rate of increase of medical inflation.</p> <ul style="list-style-type: none"> ▪ Cost sharing and premium provisions save \$960 million. ▪ Beginning March 31, 2006, allows states to impose tiered copays on all beneficiaries for non-preferred drugs (limited to the nominal amount for those with incomes at or below 150 % of poverty and those exempt from other cost sharing, and limited to 20% of the cost of the drug for those with incomes above 150% of poverty). Waivers to this provision can be obtained if a physician determines that the preferred drug for a given condition would not be as effective as another non-preferred drug (saves \$960 million). ▪ Beginning January 2007, allows states to impose copays for non-emergency care obtained in the ER if the beneficiary has access to a non-emergency provider and if the hospital notifies the beneficiary and offers to refer the beneficiary to a non-emergency provider before dispensing service. ERs can refuse non-emergency care for failure to pay applicable copays. Cost sharing cannot exceed twice the nominal amount for beneficiaries with incomes at or below 100% of poverty. For beneficiaries otherwise exempt from cost sharing, copays cannot exceed the nominal amount (saves \$10 million). ▪ Establishes fund to pay states to establish non-emergency providers.
<p>Benefits</p>	<ul style="list-style-type: none"> ▪ No provisions to alter benefits packages. 	<ul style="list-style-type: none"> ▪ Allows changes to Medicaid benefits packages for all beneficiaries except mandatory children and pregnant women, dual eligibles, terminally ill hospice patients, some institutionalized populations, medically frail and special needs populations, and beneficiaries who qualify for long-term care. Packages can be modeled after the Federal 	<ul style="list-style-type: none"> ▪ Same as House provision, except: allows state to cut benefits for children. Eliminates requirement to provide EPSDT services to most children under age 19. ▪ Excludes additional groups from mandatory benefit cuts: blind and disabled individuals, children in foster care, mandatory parents, and certain women

		<p>Employees Health Benefits Plan or equivalent, the State Employees Health Benefits Plan or equivalent, the HMO in the state with the largest non-Medicaid enrollment, or the actuarial equivalent of any of these. (saves \$3.9 billion)</p>	<p>with breast or cervical cancer. <ul style="list-style-type: none"> ▪ Benefits changes save \$1.25 billion. </p>
<p>Health Savings Accounts</p>	<ul style="list-style-type: none"> ▪ No provisions to create health savings accounts. 	<ul style="list-style-type: none"> ▪ Up to 10 state demonstration programs would create "Health Opportunity Accounts." ▪ Beneficiaries who are over the age of 65, disabled, eligible for medical assistance because they are pregnant, or who have been eligible for medical assistance for 3 months or less are not eligible to participate in the demonstration. ▪ The initial amount in the account cannot exceed \$2,500 for adults and \$1,000 for children. This can be provided by the state and federal government using standard FMAP formulas. Beneficiaries may use this money for services deemed "medically necessary" and pay participating provider (Medicaid) rates. ▪ Once a beneficiary has spent the initial amount in his or her account, the beneficiary must pay any future medical expenses out of pocket, up to 110% of the original account balance (\$250 for adults, \$100 for children). ▪ After this deductible is met, future health services are paid by the state/federal government using the standard FMAP. ▪ If beneficiaries lose Medicaid eligibility, they can use 75% of their account balance toward other specified expenses. (spends \$60 million) 	<ul style="list-style-type: none"> ▪ Beginning January 2007, up to 10 state demonstrations would create "Health Opportunity Accounts" in select parts of the state. After first 5 years, if Secretary determines program has been 'successful', it may be extended to other parts of the states and to other states beyond the 10 initial participants. ▪ Authorizes \$550,000 for a GAO study of the demonstration, to be submitted to Congress no later than 3 months after the initial 5 year demonstration period. ▪ Beneficiaries who are over the age of 65, disabled, eligible for medical assistance because they are pregnant, or who have been eligible for medical assistance for 3 months or less are not eligible to participate in the demonstration. ▪ The initial amount in the account receiving federal match cannot exceed \$2,500 for adults and \$1,000 for children. This can be provided by the state and federal government using standard FMAP formulas. Beneficiaries may use this money for services deemed "medically necessary," and provided by a provider that has not been found involved in fraud or abuse. Beneficiaries pay participating provider (Medicaid) rates for these services. The account limit is indexed to medical inflation and will increase annually. ▪ Once a beneficiary has spent the initial amount in his or her account, the beneficiary must pay any future medical expenses out of pocket, up to 110% of the original account balance (\$250 for adults, \$100 for children).

			<ul style="list-style-type: none"> ▪ After this deductible is met, future health services are paid by the state/federal government using the standard FMAP. ▪ If beneficiaries lose Medicaid eligibility, they can use 75% of their account balance toward other specified expenses for up to 3 years after loss of eligibility. ▪ HOAs spend \$64 million.
<p>Prescription Drugs</p>	<ul style="list-style-type: none"> ▪ Revises provisions on how Medicaid pays for prescription drugs by redefining AMP and WAMP. (saves \$4.595 billion) ▪ Closes loopholes in authorized generic drugs. (saves \$180 million) ▪ Increases the rebate paid by drug manufacturers for covered outpatient drugs from 15.1% to 17%. (saves \$1.4 billion) ▪ Creates new rules for data collection on physician-administered drugs to ensure state gets proper rebates. (saves \$150 million) ▪ As proposed in amendment by Bingaman on 11/03/05, makes prescription drugs dispensed by Medicaid managed care plans subject to the federal prescription drug rebates. (no score available) 	<ul style="list-style-type: none"> ▪ Creates weak regulations on sale of generic and other drugs. ▪ Sets a Federal Upper Limit (FUL) for some drugs. ▪ Collects rebates and establishes new rules for data collection on physician-administered drugs. ▪ Calls for GAO study on new pharmacy reimbursement policy and allows delayed implementation if findings warrant. ▪ Makes children’s hospitals eligible for the 340B drug discount program. ▪ New prescription drug provisions save \$2.06 billion. 	<ul style="list-style-type: none"> ▪ Sets a Federal Upper Limit (FUL) for some drugs and redefines AMP. (saves \$3.585 billion) ▪ Closes loopholes in authorized generic drugs. (saves \$150 million) ▪ Collects rebates and establishes new rules for data collection on physician-administered drugs. (saves \$70 million) ▪ Makes children’s hospitals eligible for the 340B drug discount program. (saves \$50 million)
<p>Medicare</p>	<ul style="list-style-type: none"> ▪ Repeals funds to promote entry and retention of Medicare Advantage PPO programs since plans are experiencing fewer than anticipated challenges in entering regions and CMS has indicated that the program has “stabilized and flourished.” (saves \$5.44 billion) ▪ Eliminates budget-neutrality modification to risk adjusted payments to Medicare Advantage Plans. Payments to be based on a health-status risk adjusted system. (saves \$6.46 billion) ▪ Establishes a two-phased, pay-for-performance implementation for 	<ul style="list-style-type: none"> ▪ No provisions to improve Medicare spending. 	<ul style="list-style-type: none"> ▪ Does NOT repeal Medicare Advantage PPO “stabilization fund” designed to promote plans’ entry into new regions (even though plans are actually experiencing few challenges in entering regions) which could have saved \$5.44 billion. ▪ New provisions affecting hospitals as part of quality improvement program. (saves \$300 million) ▪ Eliminates budget-neutrality modification to risk adjusted payments to Medicare Advantage Plans for the next five years. Payments to be based on a health-status risk adjusted system. (saves \$6.5 billion over five years, but 10 year

	<p>acute care hospitals, physicians, MA Plans, ESRD providers, home health agencies with steps to incorporate SNFs. 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. (saves \$4.51 billion)</p> <ul style="list-style-type: none"> ▪ Reduces Medicare reimbursement of SNC bad debt from 100% to 70% of allowable costs. (saves \$250 million) ▪ Prohibits physician self-referrals to new physician-owned limited service hospitals. (saves \$22 million) ▪ Requires DME rentals be purchased after 13th, not 11th month, and eliminates maintenance payments, reducing Medicaid payment to DME suppliers from 170% to 105% (saves \$910 million) ▪ Gives a hospital more time to qualify for higher payment as an IRF by freezing the (“75% rule” at 50% for 2 years. (spends \$105 million) ▪ Extends Medicare Dependent Hospital program through 2011 and improves program payment rate. (spends \$14 million) ▪ Short term physician payment update (spends \$10.8 billion) ▪ Extends the moratorium on per-beneficiary caps on outpatient therapy services in Medicare Part B for 1 year, extends hold-harmless payments under the OPSS through 2006 for qualifying rural hospital outpatient departments, and increases the ESRD facilities’ composite rate update for 2006. (spends \$1.4 billion) 		<p>savings is only \$4.1 billion since payment formula is only changed through 2011; in 2012, it reverts to its current form.)</p> <ul style="list-style-type: none"> ▪ Reduces Medicare reimbursement of SNC bad debt. (saves \$100 million). ▪ Requires DME rentals be purchased after 13th, not 11th month, and makes other provisions relating to DME purchase and maintenance (saves \$2.9 billion) ▪ Payment for imaging services. (saves \$2.8 billion) ▪ Changes formula for calculating number of days per patient hospitals are eligible for Disproportionate Share Hospital (DSH) funding. (saves \$1.2 billion) ▪ Reduces Part B premium subsidy (in effect, raising Part B premiums). (saves \$1.6 billion) ▪ Reduces Home Health services payments. (saves \$2 billion) ▪ Provisions affecting payment for ambulatory surgical centers’ services. (saves \$300 million) ▪ Short term physician payment update. (spends \$7.3 billion) ▪ Gives a hospital more time to qualify for higher payment as an IRF by freezing the “75% rule” at 60% during 2006 and 65% during 2007. (spends \$100 million) ▪ Other provisions affecting payment for dialysis and therapy services. (spends \$1 billion) ▪ Other provisions affecting hospital paper claims (saves \$100 million), screening for abdominal aortic aneurysms (spends \$200 million), and creating a Medicare Integrity program (spends \$100 million).
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<p>Asset Transfers</p>	<ul style="list-style-type: none"> ▪ Requires states to enforce partial months of ineligibility, rather than rounding to whole months. ▪ Allows states to add together multiple asset transfers that happen in the look back period for purposes of calculating the penalty period. ▪ Includes life estate and annuity purchases during the look back period in asset transfer regulations (unless the state is named remainder beneficiary for annuities). ▪ Previous three bullets save \$335 million. 	<ul style="list-style-type: none"> ▪ Extends the look-back period of any asset transfers to 5 years. ▪ Changes the start of the penalty period from the date of asset transfer to the date of Medicaid eligibility. ▪ Look-back and penalty period changes save \$1.5 billion. ▪ Enhances third party recovery programs to reduce fraud, waste, and abuse. (saves \$480 million) ▪ Establishes new limits to long-term care eligibility for those with substantial home equity (home equity limit raised from \$500,000 to \$750,000 in final version of bill). (saves \$230 million) ▪ Makes new grant funding available for states working on quality improvement, fraud, and abuse reduction programs. ▪ Creates new provisions about disclosure and treatment of annuities. ▪ Establishes new rules about the application of spouse’s income to supplement a beneficiary’s medical expenses. ▪ Allows continuing care retirement and life care communities to enforce beneficiary spend down on certain declared assets before beneficiaries can apply for medical assistance. ▪ Last four bullets in this section save \$450 million. 	<ul style="list-style-type: none"> ▪ Extends the look-back period of any asset transfers to 5 years. ▪ Changes the start of the penalty period from the date of asset transfer to the date of Medicaid eligibility. ▪ Look-back and penalty period changes save \$1.475 billion. ▪ Establishes new limits to long-term care eligibility for those with substantial home equity (\$500,000 or above) (saves \$300 million). ▪ Creates new provisions about disclosure and treatment of annuities (saves \$278 million). ▪ Establishes new rules (the “income first” rule) about the application of spouse’s income to supplement a beneficiary’s medical expenses. (saves \$89 million) ▪ Allows continuing care retirement (CCRC) and life care communities to enforce beneficiary spend down on certain declared assets before beneficiaries can apply for medical assistance. ▪ Requires states to enforce partial months of ineligibility, rather than rounding to whole months. ▪ Allows states to add together multiple asset transfers that happen in the look back period for purposes of calculating the penalty period. ▪ Certain notes, loans, mortgages, and life estates can be considered assets, and if transferred, are subject to asset transfer provisions. ▪ Last 4 provisions save \$261 million.
<p>Transitional Medical Assistance (TMA) and Abstinence Education</p>	<ul style="list-style-type: none"> ▪ No provisions relating to TMA or abstinence education. 	<ul style="list-style-type: none"> ▪ No provisions relating to TMA or abstinence education. 	<ul style="list-style-type: none"> ▪ Reauthorizes TMA and Abstinence Education through December 2006 (spends \$761 million).
<p>SCHIP and the Family</p>	<ul style="list-style-type: none"> ▪ Redistributes states’ SCHIP surpluses to states with SCHIP 	<ul style="list-style-type: none"> ▪ No provisions to change SCHIP policies. ▪ No provisions to create Family Opportunity 	<ul style="list-style-type: none"> ▪ Appropriates \$283 million to states whose existing SCHIP allotment will fall

<p>Opportunity Act</p>	<p>shortfalls, allows states to use 10% of 2006 and 2007 SCHIP allotments on outreach, and prohibits new waivers for non-pregnant adults. (spends \$140 million)</p> <ul style="list-style-type: none"> ▪ Creates the Family Opportunity Act, which allows working parents of disabled children to retain coverage for their children if their income exceeds poverty-level wages. (spends \$720 million) 	<p>Act or similar program.</p>	<p>short of projected needs through September 30, 2006. Funds can be used for SCHIP expenditures during fiscal year 2006 (spends \$20 million).</p> <ul style="list-style-type: none"> ▪ Contains language prohibiting new programs covering childless adults with SCHIP funds. ▪ Creates the Family Opportunity Act, which allows working parents of disabled children to gain/retain coverage for their children if their income exceeds poverty-level wages by allowing them to purchase Medicaid coverage for their children on a sliding scale. (spends \$1.38 billion) ▪ Other provisions of the Family Opportunity Act: a demonstration for home and community based services for children in psychiatric RTFs (spends \$36 million), development of family to family health information centers for families of children with disabilities (spends \$11 million), and restoration of Medicaid for certain SSI beneficiaries (spends \$105 million).
<p>Hurricane Relief</p>	<ul style="list-style-type: none"> ▪ While falling far short of earlier relief proposals, provides 100 percent federal matching payments through May 15, 2006 for Medicaid and SCHIP services provided to individuals living in select parishes and counties in AL, MS, and LA prior to August 28, 2005. (spends \$1.8 billion) ▪ Also sets minimum FMAP for AK for FY 2006 and 2007 at FY 2005 level. (spends \$240 million) 	<ul style="list-style-type: none"> ▪ Provides 100 percent federal matching payments through May 15, 2006 for Medicaid and SCHIP services provided to individuals living in LA, MS, and parts of AL during the week prior to August 28, 2005. (spends \$2.5 billion) ▪ No changes to FMAP for AK. 	<ul style="list-style-type: none"> ▪ Allows federal match for state 1115 waiver programs to cover hurricane survivors. (spends \$2.14 billion) ▪ Also sets minimum FMAP for AK for FY 2006 and 2007 at FY 2005 level. (spends \$125 million)
<p>Other Changes</p>	<ul style="list-style-type: none"> ▪ Enhances third party recovery programs to reduce fraud, waste, and abuse. (saves \$512 million) ▪ Clarifies services included in Targeted Case Management. (saves \$760 million) ▪ Expands the long-term care partnership program. (spends \$10 million) 	<ul style="list-style-type: none"> ▪ New provider tax reform applicable to some managed care organizations. States with existing taxes on Medicaid managed care organizations are grandfathered in through FY '10, but are not permanently exempt. (saves \$615 million) ▪ Calls for stricter enforcement of beneficiaries' immigration documentation requirements 	<ul style="list-style-type: none"> ▪ New provider tax reform applicable to some managed care organizations. States with existing taxes on Medicaid managed care organizations are grandfathered in through FY '10, but are not permanently exempt. (saves \$435 million) ▪ Enhances third party recovery programs to reduce fraud, waste, and abuse. (saves \$100 million)

	<p>million)</p> <ul style="list-style-type: none"> ▪ Creates a money follows the person demonstration program to improve home and community based long-term care. (spends \$105 million) ▪ New provider tax reform applicable to some managed care organizations, with exemptions for states with existing taxes on Medicaid managed care organizations. (saves \$64 million) ▪ As proposed in amendment by Bingaman on 11/3/05, limits reduction of FMAP in thirty states to no greater than 0.5 percent during the fiscal year 2006. (no score available) ▪ Increases the Disproportionate Share Hospital (DSH) allotment for the District of Columbia. (spends \$100 million) ▪ No provisions relating to community and home based care, cash and counseling, increases in Medicaid payments, or changing documentation enforcement policies. 	<p>beginning July 1, 2006. Medicaid beneficiaries claiming to be US citizens must supply a passport or birth certificate during eligibility determination. (saves \$220 million)</p> <ul style="list-style-type: none"> ▪ Clarifies services included in Targeted Case Management. (saves \$760 million) ▪ Expands the long-term care partnership program. (spends \$10 million) ▪ Provides funding for some community and home based care for beneficiaries who are over 65 or disabled, to keep such beneficiaries out of hospitals or nursing homes. State can place limits on amount, duration, and scope of services covered. (spends \$815 million) ▪ Creates new, optional “self directed personal assistance services” (including cash and counseling programs). (spends \$130 million) ▪ New provisions regarding non-contract providers of emergency care to Medicaid managed care enrollees. (saves \$60 million) ▪ Increases Medicaid payments for select areas for FY 2006 and FY 2007.¹ (spends \$85 million) 	<p>\$570 million)</p> <ul style="list-style-type: none"> ▪ Encourages states to enact False Claims Acts and requires False Claims Act education programs. (saves \$32 million) ▪ Establishes a Medicaid Integrity program (spends \$529 million) ▪ Calls for stricter enforcement of beneficiaries’ immigration documentation requirements beginning July 1, 2006. Medicaid beneficiaries claiming to be US citizens must supply a passport or birth certificate during eligibility determination. (saves \$220 million) ▪ Clarifies services included in Targeted Case Management. (saves \$760 million) ▪ Expands the long-term care partnership program (spends \$30 million). ▪ Creates a money follows the person demonstration program to improve home and community based long-term care. (spends \$340 million) ▪ Allows states to establish non-emergency transportation programs. (saves \$55 million) ▪ Makes new grant funding available for states working on quality improvement, fraud, and abuse reduction programs (Medicaid Transformation Grants). (spends \$150 million) ▪ Provides funding for some community and home based care for beneficiaries who are over 65 or disabled, to keep such beneficiaries out of hospitals or nursing homes. State can place limits on amount, duration, and scope of services covered. Conference bill provides new language on needs-based eligibility criteria for institutionalization and far more detailed language on how home and community based care should be administered. (spends \$770) ▪ Creates new, optional “self directed personal assistance services” (including
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			<p>cash and counseling programs). Effective beginning January 1, 2007 (changed from January 1, 2006, as specified in House bill). (spends \$100 million)</p> <ul style="list-style-type: none">▪ New provisions regarding non-contract providers of emergency care to Medicaid managed care enrollees. (saves \$50 million)▪ Increases the Disproportionate Share Hospital (DSH) allotment for the District of Columbia. (spends \$125 million)▪ Increases Medicaid payments for select areas for FY 2006 and FY 2007.² (spends \$140 million)
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¹ Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

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