

DEFICIT REDUCTION ACT OF 2005

DECEMBER 19 (legislative day, DECEMBER 18), 2005.—Ordered to be printed

Mr. NUSSLE, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 1932]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 1932), to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95), having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Deficit Reduction Act of 2005”.

SEC. 2. TABLE OF TITLES.

The table of titles is as follows:

TITLE I—AGRICULTURE PROVISIONS

TITLE II—HOUSING AND DEPOSIT INSURANCE PROVISIONS

TITLE III—DIGITAL TELEVISION TRANSITION AND PUBLIC SAFETY

TITLE IV—TRANSPORTATION PROVISIONS

TITLE V—MEDICARE

TITLE VI—MEDICAID AND SCHIP

TITLE VII—HUMAN RESOURCES AND OTHER PROVISIONS

TITLE VIII—EDUCATION AND PENSION BENEFIT PROVISIONS

TITLE IX—LIHEAP PROVISIONS

TITLE X—JUDICIARY RELATED PROVISIONS

TITLE I—AGRICULTURE PROVISIONS**SECTION 1001. SHORT TITLE.**

This title may be cited as the “Agricultural Reconciliation Act of 2005”.

Subtitle A—Commodity Programs**SEC. 1101. NATIONAL DAIRY MARKET LOSS PAYMENTS.**

(a) AMOUNT.—Section 1502(c) of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 7982(c)) is amended by striking paragraph (3) and inserting the following new paragraph:

“(3)(A) during the period beginning on the first day of the month the producers on a dairy farm enter into a contract under this section and ending on September 30, 2005, 45 percent;

“(B) during the period beginning on October 1, 2005, and ending on August 31, 2007, 34 percent; and

“(C) during the period beginning on September 1, 2007, 0 percent.”.

(b) DURATION.—Section 1502 of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 7982) is amended by striking “2005” each place it appears in subsections (f) and (g)(1) and inserting “2007”.

(c) CONFORMING AMENDMENTS.—Section 1502 of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 7982) is amended—

(1) in subsection (g)(1), by striking “and subsection (h)”;
and

(2) by striking subsection (h).

SEC. 1102. ADVANCE DIRECT PAYMENTS.

(a) COVERED COMMODITIES.—Section 1103(d)(2) of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 7913(d)(2)) is amended in the first sentence by striking “2007 crop years” and inserting “2005 crop years, up to 40 percent of the direct payment for a covered commodity for the 2006 crop year, and up to 22 percent of the direct payment for a covered commodity for the 2007 crop year.”.

(b) *PEANUTS*.—Section 1303(e)(2) of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 7953(e)(2)) is amended in the first sentence by striking “2007 crop years” and inserting “2005 crop years, up to 40 percent of the direct payment for the 2006 crop year, and up to 22 percent of the direct payment for the 2007 crop year.”.

SEC. 1103. COTTON COMPETITIVENESS PROVISIONS.

(a) *REPEAL OF AUTHORITY TO ISSUE COTTON USER MARKETING CERTIFICATES*.—Section 1207 of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 7937) is amended—

(1) by striking subsection (a); and

(2) in subsection (b)(1)—

(A) in subparagraph (B), by striking “, adjusted for the value of any certificate issued under subsection (a),”; and

(B) in subparagraph (C), by striking “, for the value of any certificates issued under subsection (a)”.

(b) *EFFECTIVE DATE*.—The amendments made by this section take effect on August 1, 2006.

Subtitle B—Conservation

SEC. 1201. WATERSHED REHABILITATION PROGRAM.

The authority to obligate funds previously made available under section 14(h)(1) of the Watershed Protection and Flood Prevention Act (16 U.S.C. 1012(h)(1)) for a fiscal year and unobligated as of October 1, 2006, is hereby cancelled effective on that date.

SEC. 1202. CONSERVATION SECURITY PROGRAM.

(a) *EXTENSION*.—Section 1238A(a) of the Food Security Act of 1985 (16 U.S.C. 3838a(a)) is amended by striking “2007” and inserting “2011”.

(b) *FUNDING*.—Section 1241(a)(3) of the Food Security Act of 1985 (16 U.S.C. 3841(a)(3)) is amended by striking “not more than \$6,037,000,000” and all that follows through “2014.” and inserting the following: “not more than—

“(A) \$1,954,000,000 for the period of fiscal years 2006 through 2010; and

“(B) \$5,650,000,000 for the period of fiscal years 2006 through 2015.”.

SEC. 1203. ENVIRONMENTAL QUALITY INCENTIVES PROGRAM.

(a) *EXTENSION*.—Section 1240B(a)(1) of the Food Security Act of 1985 (16 U.S.C. 3839aa-2(a)(1)) is amended by striking “2007” and inserting “2010”.

(b) *LIMITATION ON PAYMENTS*.—Section 1240G of the Food Security Act of 1985 (16 U.S.C. 3839aa-7) is amended by striking “the period of fiscal years 2002 through 2007” and inserting “any six-year period”.

(c) *FUNDING*.—Section 1241(a)(6) of the Food Security Act of 1985 (16 U.S.C. 3841(a)(6)) is amended—

(1) by striking “and” at the end of subparagraph (D); and

(2) by striking subparagraph (E) and inserting the following new subparagraphs:

“(E) \$1,270,000,000 in each of fiscal years 2007 through 2009; and

“(F) \$1,300,000,000 in fiscal year 2010.”.

Subtitle C—Energy

SEC. 1301. RENEWABLE ENERGY SYSTEMS AND ENERGY EFFICIENCY IMPROVEMENTS PROGRAM.

Section 9006(f) of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 8106(f)) is amended by striking “2007” and inserting “2006 and \$3,000,000 for fiscal year 2007”.

Subtitle D—Rural Development

SEC. 1401. ENHANCED ACCESS TO BROADBAND TELECOMMUNICATIONS SERVICES IN RURAL AREAS.

The authority to obligate funds previously made available under section 601(j)(1) of the Rural Electrification Act of 1936 for a fiscal year and unobligated as of October 1, 2006, is hereby cancelled effective on that date.

SEC. 1402. VALUE-ADDED AGRICULTURAL PRODUCT MARKET DEVELOPMENT GRANTS.

The authority to obligate funds previously made available under section 231(b)(4) of the Agricultural Risk Protection Act of 2000 (Public Law 106–224; 7 U.S.C. 1621 note) for a fiscal year and unobligated as of October 1, 2006, is hereby cancelled effective on that date.

SEC. 1403. RURAL BUSINESS INVESTMENT PROGRAM.

(a) TERMINATION OF FISCAL YEAR 2007 AND SUBSEQUENT FUNDING.—Subsection (a)(1) of section 384S of the Consolidated Farm and Rural Development Act (7 U.S.C. 2009cc–18) is amended by inserting after “necessary” the following: “through fiscal year 2006”.

(b) CANCELLATION OF UNOBLIGATED PRIOR-YEAR FUNDS.—The authority to obligate funds previously made available under such section and unobligated as of October 1, 2006, is hereby cancelled effective on that date.

SEC. 1404. RURAL BUSINESS STRATEGIC INVESTMENT GRANTS.

The authority to obligate funds previously made available under section 385E of the Consolidated Farm and Rural Development Act and unobligated as of October 1, 2006, is hereby cancelled effective on that date.

SEC. 1405. RURAL FIREFIGHTERS AND EMERGENCY PERSONNEL GRANTS.

(a) TERMINATION OF FISCAL YEAR 2007 FUNDING.—Subsection (c) of section 6405 of the Farm Security and Rural Investment Act of 2002 (7 U.S.C. 2655) is amended by striking “2007” and inserting “2006”.

(b) CANCELLATION OF UNOBLIGATED PRIOR-YEAR FUNDS.—The authority to obligate funds previously made available under such section for a fiscal year and unobligated as of October 1, 2006, is hereby cancelled effective on that date.

Subtitle E—Research

SEC. 1501. INITIATIVE FOR FUTURE FOOD AND AGRICULTURE SYSTEMS.

(a) *TERMINATION OF FISCAL YEAR 2007, 2008, AND 2009 TRANSFERS.*—Subsection (b)(3)(D) of section 401 of the Agricultural Research, Extension, and Education Reform Act of 1998 (7 U.S.C. 7621) is amended by striking “2006” and inserting “2009”.

(b) *TERMINATION OF MULTI-YEAR AVAILABILITY OF FISCAL YEAR 2006 FUNDS.*—Paragraph (6) of subsection (f) of such section is amended to read as follows:

“(6) *AVAILABILITY OF FUNDS.*—

“(A) *TWO-YEAR AVAILABILITY.*—Except as provided in subparagraph (B), funds for grants under this section shall be available to the Secretary for obligation for a 2-year period beginning on the date of the transfer of the funds under subsection (b).

“(B) *EXCEPTION FOR FISCAL YEAR 2006 TRANSFER.*—In the case of the funds required to be transferred by subsection (b)(3)(C), the funds shall be available to the Secretary for obligation for the 1-year period beginning on October 1, 2005.”.

TITLE II—HOUSING AND DEPOSIT INSURANCE PROVISIONS

Subtitle A—FHA Asset Disposition

SEC. 2002. DEFINITIONS.

For purposes of this subtitle, the following definitions shall apply:

(1) The term “affordability requirements” means any requirements or restrictions imposed by the Secretary, at the time of sale, on a multifamily real property or a multifamily loan, such as use restrictions, rent restrictions, and rehabilitation requirements.

(2) The term “discount sale” means the sale of a multifamily real property in a transaction, such as a negotiated sale, in which the sale price is lower than the property market value and is set outside of a competitive bidding process that has no affordability requirements.

(3) The term “discount loan sale” means the sale of a multifamily loan in a transaction, such as a negotiated sale, in which the sale price is lower than the loan market value and is set outside of a competitive bidding process that has no affordability requirements.

(4) The term “loan market value” means the value of a multifamily loan, without taking into account any affordability requirements.

(5) The term “multifamily real property” means any rental or cooperative housing project of 5 or more units owned by the Secretary that prior to acquisition by the Secretary was security

for a loan or loans insured under title II of the National Housing Act.

(6) The term “multifamily loan” means a loan held by the Secretary and secured by a multifamily rental or cooperative housing project of 5 or more units that was formerly insured under title II of the National Housing Act.

(7) The term “property market value” means the value of a multifamily real property for its current use, without taking into account any affordability requirements.

(8) The term “Secretary” means the Secretary of Housing and Urban Development.

SEC. 2003. APPROPRIATED FUNDS REQUIREMENT FOR BELOW-MARKET SALES.

(a) **DISCOUNT SALES.**—Notwithstanding any other provision of law, except for affordability requirements for the elderly and disabled required by statute, disposition by the Secretary of a multifamily real property during fiscal years 2006 through 2010 through a discount sale under sections 207(l) or 246 of the National Housing Act (12 U.S.C. 1713(l), 1715z–11), section 203 of the Housing and Community Development Amendments of 1978 (12 U.S.C. 1701z–11), or section 204 of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997 (12 U.S.C. 1715z–11a), shall be subject to the availability of appropriations to the extent that the property market value exceeds the sale proceeds. If the multifamily real property is sold, during such fiscal years, for an amount equal to or greater than the property market value then the transaction is not subject to the availability of appropriations.

(b) **DISCOUNT LOAN SALES.**—Notwithstanding any other provision of law and in accordance with the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.), a discount loan sale during fiscal years 2006 through 2010 under section 207(k) of the National Housing Act (12 U.S.C. 1713(k)), section 203(k) of the Housing and Community Development Amendments of 1978 (12 U.S.C. 1701z–11(k)), or section 204(a) of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997 (12 U.S.C. 1715z–11a(a)), shall be subject to the availability of appropriations to the extent that the loan market value exceeds the sale proceeds. If the multifamily loan is sold, during such fiscal years, for an amount equal to or greater than the loan market value then the transaction is not subject to the availability of appropriations.

(c) **APPLICABILITY.**—This section shall not apply to any transaction that formally commences within one year prior to the enactment of this section.

SEC. 2004. UP-FRONT GRANTS.

(a) **1997 ACT.**—Section 204(a) of the Departments of Veterans Affairs and Housing And Urban Development, and Independent Agencies Appropriations Act, 1997 (12 U.S.C. 1715z–11a(a)) is amended by adding at the end the following new sentence: “A grant provided under this subsection during fiscal years 2006 through 2010 shall be available only to the extent that appropriations are made in advance for such purposes and shall not be derived from the General Insurance Fund.”.

(b) 1978 ACT.—Section 203(f)(4) of the *Housing and Community Development Amendments of 1978* (12 USC 1701z–11(f)(4)) is amended by adding at the end the following new sentence: “This paragraph shall be effective during fiscal years 2006 through 2010 only to the extent that such budget authority is made available for use under this paragraph in advance in appropriation Acts.”.

(c) APPLICABILITY.—The amendments made by this section shall not apply to any transaction that formally commences within one year prior to the enactment of this section.

Subtitle B—Deposit Insurance

SEC. 2101. SHORT TITLE.

This subtitle may be cited as the “Federal Deposit Insurance Reform Act of 2005”.

SEC. 2102. MERGING THE BIF AND SAIF.

(a) IN GENERAL.—

(1) MERGER.—The Bank Insurance Fund and the Savings Association Insurance Fund shall be merged into the Deposit Insurance Fund.

(2) DISPOSITION OF ASSETS AND LIABILITIES.—All assets and liabilities of the Bank Insurance Fund and the Savings Association Insurance Fund shall be transferred to the Deposit Insurance Fund.

(3) NO SEPARATE EXISTENCE.—The separate existence of the Bank Insurance Fund and the Savings Association Insurance Fund shall cease on the effective date of the merger thereof under this section.

(b) REPEAL OF OUTDATED MERGER PROVISION.—Section 2704 of the *Deposit Insurance Funds Act of 1996* (12 U.S.C. 1821 note) is repealed.

(c) EFFECTIVE DATE.—This section shall take effect no later than the first day of the first calendar quarter that begins after the end of the 90-day period beginning on the date of the enactment of this Act.

SEC. 2103. INCREASE IN DEPOSIT INSURANCE COVERAGE.

(a) IN GENERAL.—Section 11(a)(1) of the *Federal Deposit Insurance Act* (12 U.S.C. 1821(a)(1)) is amended—

(1) by striking subparagraph (B) and inserting the following new subparagraph:

“(B) NET AMOUNT OF INSURED DEPOSIT.—The net amount due to any depositor at an insured depository institution shall not exceed the standard maximum deposit insurance amount as determined in accordance with subparagraphs (C), (D), (E) and (F) and paragraph (3).”; and

(2) by adding at the end the following new subparagraphs:

“(E) STANDARD MAXIMUM DEPOSIT INSURANCE AMOUNT DEFINED.—For purposes of this Act, the term ‘standard maximum deposit insurance amount’ means \$100,000, adjusted as provided under subparagraph (F) after March 31, 2010.

“(F) INFLATION ADJUSTMENT.—

“(i) IN GENERAL.—By April 1 of 2010, and the 1st day of each subsequent 5-year period, the Board of Di-

rectors and the National Credit Union Administration Board shall jointly consider the factors set forth under clause (v), and, upon determining that an inflation adjustment is appropriate, shall jointly prescribe the amount by which the standard maximum deposit insurance amount and the standard maximum share insurance amount (as defined in section 207(k) of the Federal Credit Union Act) applicable to any depositor at an insured depository institution shall be increased by calculating the product of—

“(I) \$100,000; and

“(II) the ratio of the published annual value of the Personal Consumption Expenditures Chain-Type Price Index (or any successor index thereto), published by the Department of Commerce, for the calendar year preceding the year in which the adjustment is calculated under this clause, to the published annual value of such index for the calendar year preceding the date this subparagraph takes effect under the Federal Deposit Insurance Reform Act of 2005.

The values used in the calculation under subclause (II) shall be, as of the date of the calculation, the values most recently published by the Department of Commerce.

“(ii) ROUNDING.—If the amount determined under clause (i) for any period is not a multiple of \$10,000, the amount so determined shall be rounded down to the nearest \$10,000.

“(iii) PUBLICATION AND REPORT TO THE CONGRESS.—Not later than April 5 of any calendar year in which an adjustment is required to be calculated under clause (i) to the standard maximum deposit insurance amount and the standard maximum share insurance amount under such clause, the Board of Directors and the National Credit Union Administration Board shall—

“(I) publish in the Federal Register the standard maximum deposit insurance amount, the standard maximum share insurance amount, and the amount of coverage under paragraph (3)(A) and section 207(k)(3) of the Federal Credit Union Act, as so calculated; and

“(II) jointly submit a report to the Congress containing the amounts described in subclause (I).

“(iv) 6-MONTH IMPLEMENTATION PERIOD.—Unless an Act of Congress enacted before July 1 of the calendar year in which an adjustment is required to be calculated under clause (i) provides otherwise, the increase in the standard maximum deposit insurance amount and the standard maximum share insurance amount shall take effect on January 1 of the year immediately succeeding such calendar year.

“(v) INFLATION ADJUSTMENT CONSIDERATION.—In making any determination under clause (i) to increase

the standard maximum deposit insurance amount and the standard maximum share insurance amount, the Board of Directors and the National Credit Union Administration Board shall jointly consider—

“(I) the overall state of the Deposit Insurance Fund and the economic conditions affecting insured depository institutions;

“(II) potential problems affecting insured depository institutions; or

“(III) whether the increase will cause the reserve ratio of the fund to fall below 1.15 percent of estimated insured deposits.”

(b) COVERAGE FOR CERTAIN EMPLOYEE BENEFIT PLAN DEPOSITS.—Section 11(a)(1)(D) of the Federal Deposit Insurance Act (12 U.S.C. 1821(a)(1)(D)) is amended to read as follows:

“(D) COVERAGE FOR CERTAIN EMPLOYEE BENEFIT PLAN DEPOSITS.—

“(i) PASS-THROUGH INSURANCE.—The Corporation shall provide pass-through deposit insurance for the deposits of any employee benefit plan.

“(ii) PROHIBITION ON ACCEPTANCE OF BENEFIT PLAN DEPOSITS.—An insured depository institution that is not well capitalized or adequately capitalized may not accept employee benefit plan deposits.

“(iii) DEFINITIONS.—For purposes of this subparagraph, the following definitions shall apply:

“(I) CAPITAL STANDARDS.—The terms ‘well capitalized’ and ‘adequately capitalized’ have the same meanings as in section 38.

“(II) EMPLOYEE BENEFIT PLAN.—The term ‘employee benefit plan’ has the same meaning as in paragraph (5)(B)(ii), and includes any eligible deferred compensation plan described in section 457 of the Internal Revenue Code of 1986.

“(III) PASS-THROUGH DEPOSIT INSURANCE.—The term ‘pass-through deposit insurance’ means, with respect to an employee benefit plan, deposit insurance coverage based on the interest of each participant, in accordance with regulations issued by the Corporation.”

(c) INCREASED AMOUNT OF DEPOSIT INSURANCE FOR CERTAIN RETIREMENT ACCOUNTS.—Section 11(a)(3)(A) of the Federal Deposit Insurance Act (12 U.S.C. 1821(a)(3)(A)) is amended by striking “\$100,000” and inserting “\$250,000 (which amount shall be subject to inflation adjustments as provided in paragraph (1)(F), except that \$250,000 shall be substituted for \$100,000 wherever such term appears in such paragraph)”.

(h) EFFECTIVE DATE.—This section and the amendments made by this section shall take effect on the date the final regulations required under section 9(a)(2) take effect.

SEC. 2104. SETTING ASSESSMENTS AND REPEAL OF SPECIAL RULES RELATING TO MINIMUM ASSESSMENTS AND FREE DEPOSIT INSURANCE.

(a) SETTING ASSESSMENTS.—Section 7(b)(2) of the Federal Deposit Insurance Act (12 U.S.C. 1817(b)(2)) is amended—

(1) by striking subparagraphs (A) and (B) and inserting the following new subparagraphs:

“(A) *IN GENERAL.*—The Board of Directors shall set assessments for insured depository institutions in such amounts as the Board of Directors may determine to be necessary or appropriate, subject to subparagraph (D).

“(B) *FACTORS TO BE CONSIDERED.*—In setting assessments under subparagraph (A), the Board of Directors shall consider the following factors:

“(i) The estimated operating expenses of the Deposit Insurance Fund.

“(ii) The estimated case resolution expenses and income of the Deposit Insurance Fund.

“(iii) The projected effects of the payment of assessments on the capital and earnings of insured depository institutions.

“(iv) The risk factors and other factors taken into account pursuant to paragraph (1) under the risk-based assessment system, including the requirement under such paragraph to maintain a risk-based system.

“(v) Any other factors the Board of Directors may determine to be appropriate.”; and

(2) by inserting after subparagraph (C) the following new subparagraph:

“(D) *NO DISCRIMINATION BASED ON SIZE.*—No insured depository institution shall be barred from the lowest-risk category solely because of size.”.

(b) *ASSESSMENT RECORDKEEPING PERIOD SHORTENED.*—Paragraph (5) of section 7(b) of the Federal Deposit Insurance Act (12 U.S.C. 1817(b)) is amended to read as follows:

“(5) *DEPOSITORY INSTITUTION REQUIRED TO MAINTAIN ASSESSMENT-RELATED RECORDS.*—Each insured depository institution shall maintain all records that the Corporation may require for verifying the correctness of any assessment on the insured depository institution under this subsection until the later of—

“(A) the end of the 3-year period beginning on the due date of the assessment; or

“(B) in the case of a dispute between the insured depository institution and the Corporation with respect to such assessment, the date of a final determination of any such dispute.”.

(c) *INCREASE IN FEES FOR LATE ASSESSMENT PAYMENTS.*—Subsection (h) of section 18 of the Federal Deposit Insurance Act (12 U.S.C. 1828(h)) is amended to read as follows:

“(h) *PENALTY FOR FAILURE TO TIMELY PAY ASSESSMENTS.*—

“(1) *IN GENERAL.*—Subject to paragraph (3), any insured depository institution which fails or refuses to pay any assessment shall be subject to a penalty in an amount of not more than 1 percent of the amount of the assessment due for each day that such violation continues.

“(2) *EXCEPTION IN CASE OF DISPUTE.*—Paragraph (1) shall not apply if—

“(A) the failure to pay an assessment is due to a dispute between the insured depository institution and the Corporation over the amount of such assessment; and

“(B) the insured depository institution deposits security satisfactory to the Corporation for payment upon final determination of the issue.

“(3) SPECIAL RULE FOR SMALL ASSESSMENT AMOUNTS.—If the amount of the assessment which an insured depository institution fails or refuses to pay is less than \$10,000 at the time of such failure or refusal, the amount of any penalty to which such institution is subject under paragraph (1) shall not exceed \$100 for each day that such violation continues.

“(4) AUTHORITY TO MODIFY OR REMIT PENALTY.—The Corporation, in the sole discretion of the Corporation, may compromise, modify or remit any penalty which the Corporation may assess or has already assessed under paragraph (1) upon a finding that good cause prevented the timely payment of an assessment.”.

(e) STATUTE OF LIMITATIONS FOR ASSESSMENT ACTIONS.—Subsection (g) of section 7 of the Federal Deposit Insurance Act (12 U.S.C. 1817(g)) is amended to read as follows:

“(g) ASSESSMENT ACTIONS.—

“(1) IN GENERAL.—The Corporation, in any court of competent jurisdiction, shall be entitled to recover from any insured depository institution the amount of any unpaid assessment lawfully payable by such insured depository institution.

“(2) STATUTE OF LIMITATIONS.—The following provisions shall apply to actions relating to assessments, notwithstanding any other provision in Federal law, or the law of any State:

“(A) Any action by an insured depository institution to recover from the Corporation the overpaid amount of any assessment shall be brought within 3 years after the date the assessment payment was due, subject to the exception in subparagraph (E).

“(B) Any action by the Corporation to recover from an insured depository institution the underpaid amount of any assessment shall be brought within 3 years after the date the assessment payment was due, subject to the exceptions in subparagraphs (C) and (E).

“(C) If an insured depository institution has made a false or fraudulent statement with intent to evade any or all of its assessment, the Corporation shall have until 3 years after the date of discovery of the false or fraudulent statement in which to bring an action to recover the underpaid amount.

“(D) Except as provided in subparagraph (C), assessment deposit information contained in records no longer required to be maintained pursuant to subsection (b)(4) shall be considered conclusive and not subject to change.

“(E) Any action for the underpaid or overpaid amount of any assessment that became due before the amendment to this subsection under the Federal Deposit Insurance Reform Act of 2005 took effect shall be subject to the statute of limitations for assessments in effect at the time the assessment became due.”.

(f) *EFFECTIVE DATE.*—This section and the amendments made by this section shall take effect on the date that the final regulations required under section 9(a)(5) take effect.

SEC. 2105. REPLACEMENT OF FIXED DESIGNATED RESERVE RATIO WITH RESERVE RANGE.

(a) *IN GENERAL.*—Section 7(b)(3) of the Federal Deposit Insurance Act (12 U.S.C. 1817(b)(3)) is amended to read as follows:

“(3) *DESIGNATED RESERVE RATIO.*—

“(A) *ESTABLISHMENT.*—

“(i) *IN GENERAL.*—Before the beginning of each calendar year, the Board of Directors shall designate the reserve ratio applicable with respect to the Deposit Insurance Fund and publish the reserve ratio so designated.

“(ii) *RULEMAKING REQUIREMENT.*—Any change to the designated reserve ratio shall be made by the Board of Directors by regulation after notice and opportunity for comment.

“(B) *RANGE.*—The reserve ratio designated by the Board of Directors for any year—

“(i) may not exceed 1.5 percent of estimated insured deposits; and

“(ii) may not be less than 1.15 percent of estimated insured deposits.

“(C) *FACTORS.*—In designating a reserve ratio for any year, the Board of Directors shall—

“(i) take into account the risk of losses to the Deposit Insurance Fund in such year and future years, including historic experience and potential and estimated losses from insured depository institutions;

“(ii) take into account economic conditions generally affecting insured depository institutions so as to allow the designated reserve ratio to increase during more favorable economic conditions and to decrease during less favorable economic conditions, notwithstanding the increased risks of loss that may exist during such less favorable conditions, as determined to be appropriate by the Board of Directors;

“(iii) seek to prevent sharp swings in the assessment rates for insured depository institutions; and

“(iv) take into account such other factors as the Board of Directors may determine to be appropriate, consistent with the requirements of this subparagraph.

“(D) *PUBLICATION OF PROPOSED CHANGE IN RATIO.*—In soliciting comment on any proposed change in the designated reserve ratio in accordance with subparagraph (A), the Board of Directors shall include in the published proposal a thorough analysis of the data and projections on which the proposal is based.”.

(c) *EFFECTIVE DATE.*—This section and the amendments made by this section shall take effect on the date that the final regulations required under section 9(a)(1) take effect.

SEC. 2106. REQUIREMENTS APPLICABLE TO THE RISK-BASED ASSESSMENT SYSTEM.

Section 7(b)(1) of the Federal Deposit Insurance Act (12 U.S.C. 1817(b)(1)) is amended by adding at the end the following new subparagraphs:

“(E) INFORMATION CONCERNING RISK OF LOSS AND ECONOMIC CONDITIONS.—

“(i) SOURCES OF INFORMATION.—For purposes of determining risk of losses at insured depository institutions and economic conditions generally affecting depository institutions, the Corporation shall collect information, as appropriate, from all sources the Board of Directors considers appropriate, such as reports of condition, inspection reports, and other information from all Federal banking agencies, any information available from State bank supervisors, State insurance and securities regulators, the Securities and Exchange Commission (including information described in section 35), the Secretary of the Treasury, the Commodity Futures Trading Commission, the Farm Credit Administration, the Federal Trade Commission, any Federal reserve bank or Federal home loan bank, and other regulators of financial institutions, and any information available from credit rating entities, and other private economic or business analysts.

“(ii) CONSULTATION WITH FEDERAL BANKING AGENCIES.—

“(I) IN GENERAL.—Except as provided in subclause (II), in assessing the risk of loss to the Deposit Insurance Fund with respect to any insured depository institution, the Corporation shall consult with the appropriate Federal banking agency of such institution.

“(II) TREATMENT ON AGGREGATE BASIS.—In the case of insured depository institutions that are well capitalized (as defined in section 38) and, in the most recent examination, were found to be well managed, the consultation under subclause (I) concerning the assessment of the risk of loss posed by such institutions may be made on an aggregate basis.

“(iii) RULE OF CONSTRUCTION.—No provision of this paragraph shall be construed as providing any new authority for the Corporation to require submission of information by insured depository institutions to the Corporation.

“(F) MODIFICATIONS TO THE RISK-BASED ASSESSMENT SYSTEM ALLOWED ONLY AFTER NOTICE AND COMMENT.—In revising or modifying the risk-based assessment system at any time after the date of the enactment of the Federal Deposit Insurance Reform Act of 2005, the Board of Directors may implement such revisions or modification in final form only after notice and opportunity for comment.”.

SEC. 2107. REFUNDS, DIVIDENDS, AND CREDITS FROM DEPOSIT INSURANCE FUND.

(a) *IN GENERAL.*—Subsection (e) of section 7 of the Federal Deposit Insurance Act (12 U.S.C. 1817(e)) is amended to read as follows:

“(e) *REFUNDS, DIVIDENDS, AND CREDITS.*—

“(1) *REFUNDS OF OVERPAYMENTS.*—In the case of any payment of an assessment by an insured depository institution in excess of the amount due to the Corporation, the Corporation may—

“(A) refund the amount of the excess payment to the insured depository institution; or

“(B) credit such excess amount toward the payment of subsequent assessments until such credit is exhausted.

“(2) *DIVIDENDS FROM EXCESS AMOUNTS IN DEPOSIT INSURANCE FUND.*—

“(A) *RESERVE RATIO IN EXCESS OF 1.5 PERCENT OF ESTIMATED INSURED DEPOSITS.*—If, at the end of a calendar year, the reserve ratio of the Deposit Insurance Fund exceeds 1.5 percent of estimated insured deposits, the Corporation shall declare the amount in the Fund in excess of the amount required to maintain the reserve ratio at 1.5 percent of estimated insured deposits, as dividends to be paid to insured depository institutions.

“(B) *RESERVE RATIO EQUAL TO OR IN EXCESS OF 1.35 PERCENT OF ESTIMATED INSURED DEPOSITS AND NOT MORE THAN 1.5 PERCENT.*—If, at the end of a calendar year, the reserve ratio of the Deposit Insurance Fund equals or exceeds 1.35 percent of estimated insured deposits and is not more than 1.5 percent of such deposits, the Corporation shall declare the amount in the Fund that is equal to 50 percent of the amount in excess of the amount required to maintain the reserve ratio at 1.35 percent of the estimated insured deposits as dividends to be paid to insured depository institutions.

“(C) *BASIS FOR DISTRIBUTION OF DIVIDENDS.*—

“(i) *IN GENERAL.*—Solely for the purposes of dividend distribution under this paragraph, the Corporation shall determine each insured depository institution’s relative contribution to the Deposit Insurance Fund (or any predecessor deposit insurance fund) for calculating such institution’s share of any dividend declared under this paragraph, taking into account the factors described in clause (ii).

“(ii) *FACTORS FOR DISTRIBUTION.*—In implementing this paragraph in accordance with regulations, the Corporation shall take into account the following factors:

“(I) The ratio of the assessment base of an insured depository institution (including any predecessor) on December 31, 1996, to the assessment base of all eligible insured depository institutions on that date.

“(II) The total amount of assessments paid on or after January 1, 1997, by an insured depository

institution (including any predecessor) to the Deposit Insurance Fund (and any predecessor deposit insurance fund).

“(III) That portion of assessments paid by an insured depository institution (including any predecessor) that reflects higher levels of risk assumed by such institution.

“(IV) Such other factors as the Corporation may determine to be appropriate.

“(D) NOTICE AND OPPORTUNITY FOR COMMENT.—The Corporation shall prescribe by regulation, after notice and opportunity for comment, the method for the calculation, declaration, and payment of dividends under this paragraph.

“(E) LIMITATION.—The Board of Directors may suspend or limit dividends paid under subparagraph (B), if the Board determines in writing that—

“(i) a significant risk of losses to the Deposit Insurance Fund exists over the next 1-year period; and

“(ii) it is likely that such losses will be sufficiently high as to justify a finding by the Board that the reserve ratio should temporarily be allowed—

“(I) to grow without requiring dividends under subparagraph (B); or

“(II) to exceed the maximum amount established under subsection (b)(3)(B)(i).

“(F) CONSIDERATIONS.—In making a determination under subparagraph (E), the Board shall consider—

“(i) national and regional conditions and their impact on insured depository institutions;

“(ii) potential problems affecting insured depository institutions or a specific group or type of depository institution;

“(iii) the degree to which the contingent liability of the Corporation for anticipated failures of insured institutions adequately addresses concerns over funding levels in the Deposit Insurance Fund; and

“(iv) any other factors that the Board determines are appropriate.

“(H) REVIEW OF DETERMINATION.—

“(i) ANNUAL REVIEW.—A determination to suspend or limit dividends under subparagraph (E) shall be reviewed by the Board of Directors annually.

“(ii) ACTION BY BOARD.—Based on each annual review under clause (i), the Board of Directors shall either renew or remove a determination to suspend or limit dividends under subparagraph (E), or shall make a new determination in accordance with this paragraph. Unless justified under the terms of the renewal or new determination, the Corporation shall be required to provide cash dividends under subparagraph (A) or (B), as appropriate.

“(3) ONE-TIME CREDIT BASED ON TOTAL ASSESSMENT BASE AT YEAR-END 1996.—

“(A) *IN GENERAL.*—Before the end of the 270-day period beginning on the date of the enactment of the Federal Deposit Insurance Reform Act of 2005, the Board of Directors shall, by regulation after notice and opportunity for comment, provide for a credit to each eligible insured depository institution (or a successor insured depository institution), based on the assessment base of the institution on December 31, 1996, as compared to the combined aggregate assessment base of all eligible insured depository institutions, taking into account such factors as the Board of Directors may determine to be appropriate.

“(B) *CREDIT LIMIT.*—The aggregate amount of credits available under subparagraph (A) to all eligible insured depository institutions shall equal the amount that the Corporation could collect if the Corporation imposed an assessment of 10.5 basis points on the combined assessment base of the Bank Insurance Fund and the Savings Association Insurance Fund as of December 31, 2001.

“(C) *ELIGIBLE INSURED DEPOSITORY INSTITUTION DEFINED.*—For purposes of this paragraph, the term ‘eligible insured depository institution’ means any insured depository institution that—

“(i) was in existence on December 31, 1996, and paid a deposit insurance assessment prior to that date; or

“(ii) is a successor to any insured depository institution described in clause (i).

“(D) *APPLICATION OF CREDITS.*—

“(i) *IN GENERAL.*—Subject to clause (ii), the amount of a credit to any eligible insured depository institution under this paragraph shall be applied by the Corporation, subject to subsection (b)(3)(E), to the assessments imposed on such institution under subsection (b) that become due for assessment periods beginning after the effective date of regulations prescribed under subparagraph (A).

“(ii) *TEMPORARY RESTRICTION ON USE OF CREDITS.*—The amount of a credit to any eligible insured depository institution under this paragraph may not be applied to more than 90 percent of the assessments imposed on such institution under subsection (b) that become due for assessment periods beginning in fiscal years 2008, 2009, and 2010.

“(iii) *REGULATIONS.*—The regulations prescribed under subparagraph (A) shall establish the qualifications and procedures governing the application of assessment credits pursuant to clause (i).

“(E) *LIMITATION ON AMOUNT OF CREDIT FOR CERTAIN DEPOSITORY INSTITUTIONS.*—In the case of an insured depository institution that exhibits financial, operational, or compliance weaknesses ranging from moderately severe to unsatisfactory, or is not adequately capitalized (as defined in section 38) at the beginning of an assessment period, the amount of any credit allowed under this paragraph against the assessment on that depository institution for such pe-

riod may not exceed the amount calculated by applying to that depository institution the average assessment rate on all insured depository institutions for such assessment period.

“(F) SUCCESSOR DEFINED.—The Corporation shall define the term ‘successor’ for purposes of this paragraph, by regulation, and may consider any factors as the Board may deem appropriate.

“(4) ADMINISTRATIVE REVIEW.—

“(A) IN GENERAL.—The regulations prescribed under paragraphs (2)(D) and (3) shall include provisions allowing an insured depository institution a reasonable opportunity to challenge administratively the amount of the credit or dividend determined under paragraph (2) or (3) for such institution.

“(B) ADMINISTRATIVE REVIEW.—Any review under subparagraph (A) of any determination of the Corporation under paragraph (2) or (3) shall be final and not subject to judicial review.”

(b) DEFINITION OF RESERVE RATIO.—Section 3(y) of the Federal Deposit Insurance Act (12 U.S.C. 1813(y)) (as amended by section 2105(b) of this subtitle) is amended by adding at the end the following new paragraph:

“(3) RESERVE RATIO.—The term ‘reserve ratio’, when used with regard to the Deposit Insurance Fund other than in connection with a reference to the designated reserve ratio, means the ratio of the net worth of the Deposit Insurance Fund to the value of the aggregate estimated insured deposits.”

SEC. 2108. DEPOSIT INSURANCE FUND RESTORATION PLANS.

Section 7(b)(3) of the Federal Deposit Insurance Act (12 U.S.C. 1817(b)(3)) (as amended by section 2105(a) of this subtitle) is amended by adding at the end the following new subparagraph:

“(E) DIF RESTORATION PLANS.—

“(i) IN GENERAL.—Whenever—

“(I) the Corporation projects that the reserve ratio of the Deposit Insurance Fund will, within 6 months of such determination, fall below the minimum amount specified in subparagraph (B)(ii) for the designated reserve ratio; or

“(II) the reserve ratio of the Deposit Insurance Fund actually falls below the minimum amount specified in subparagraph (B)(ii) for the designated reserve ratio without any determination under subclause (I) having been made,

the Corporation shall establish and implement a Deposit Insurance Fund restoration plan within 90 days that meets the requirements of clause (ii) and such other conditions as the Corporation determines to be appropriate.

“(ii) REQUIREMENTS OF RESTORATION PLAN.—A Deposit Insurance Fund restoration plan meets the requirements of this clause if the plan provides that the reserve ratio of the Fund will meet or exceed the minimum amount specified in subparagraph (B)(ii) for the designated reserve ratio before the end of the 5-year pe-

riod beginning upon the implementation of the plan (or such longer period as the Corporation may determine to be necessary due to extraordinary circumstances).

“(iii) *RESTRICTION ON ASSESSMENT CREDITS.*—As part of any restoration plan under this subparagraph, the Corporation may elect to restrict the application of assessment credits provided under subsection (e)(3) for any period that the plan is in effect.

“(iv) *LIMITATION ON RESTRICTION.*—Notwithstanding clause (iii), while any restoration plan under this subparagraph is in effect, the Corporation shall apply credits provided to an insured depository institution under subsection (e)(3) against any assessment imposed on the institution for any assessment period in an amount equal to the lesser of—

“(I) the amount of the assessment; or

“(II) the amount equal to 3 basis points of the institution’s assessment base.

“(v) *TRANSPARENCY.*—Not more than 30 days after the Corporation establishes and implements a restoration plan under clause (i), the Corporation shall publish in the Federal Register a detailed analysis of the factors considered and the basis for the actions taken with regard to the plan.”.

SEC. 2109. REGULATIONS REQUIRED.

(a) *IN GENERAL.*—Not later than 270 days after the date of the enactment of this Act, the Board of Directors of the Federal Deposit Insurance Corporation shall prescribe final regulations, after notice and opportunity for comment—

(1) designating the reserve ratio for the Deposit Insurance Fund in accordance with section 7(b)(3) of the Federal Deposit Insurance Act (as amended by section 2105 of this subtitle);

(2) implementing increases in deposit insurance coverage in accordance with the amendments made by section 2103 of this subtitle;

(3) implementing the dividend requirement under section 7(e)(2) of the Federal Deposit Insurance Act (as amended by section 2107 of this subtitle);

(4) implementing the 1-time assessment credit to certain insured depository institutions in accordance with section 7(e)(3) of the Federal Deposit Insurance Act, as amended by section 2107 of this subtitle, including the qualifications and procedures under which the Corporation would apply assessment credits; and

(5) providing for assessments under section 7(b) of the Federal Deposit Insurance Act, as amended by this subtitle.

(b) *TRANSITION PROVISIONS.*—

(1) *CONTINUATION OF EXISTING ASSESSMENT REGULATIONS.*—No provision of this subtitle or any amendment made by this subtitle shall be construed as affecting the authority of the Corporation to set or collect deposit insurance assessments pursuant to any regulations in effect before the effective date of the final regulations prescribed under subsection (a).

(2) *TREATMENT OF DIF MEMBERS UNDER EXISTING REGULATIONS.*—As of the date of the merger of the Bank Insurance

Fund and the Savings Association Insurance Fund pursuant to section 2102, the assessment regulations in effect immediately before the date of the enactment of this Act shall continue to apply to all members of the Deposit Insurance Fund, until such regulations are modified by the Corporation, notwithstanding that such regulations may refer to “Bank Insurance Fund members” or “Savings Association Insurance Fund members”.

TITLE III—DIGITAL TELEVISION TRANSITION AND PUBLIC SAFETY

SEC. 3001. SHORT TITLE; DEFINITION.

(a) *SHORT TITLE.*—This title may be cited as the “Digital Television Transition and Public Safety Act of 2005”.

(b) *DEFINITION.*—As used in this Act, the term “Assistant Secretary” means the Assistant Secretary for Communications and Information of the Department of Commerce.

SEC. 3002. ANALOG SPECTRUM RECOVERY: FIRM DEADLINE.

(a) *AMENDMENTS.*—Section 309(j)(14) of the Communications Act of 1934 (47 U.S.C. 309(j)(14)) is amended—

(1) in subparagraph (A)—

(A) by inserting “full-power” before “television broadcast license”; and

(B) by striking “December 31, 2006” and inserting “February 17, 2009”;

(2) by striking subparagraph (B);

(3) in subparagraph (C)(i)(I), by striking “or (B)”;

(4) in subparagraph (D), by striking “subparagraph (C)(i)” and inserting “subparagraph (B)(i)”; and

(5) by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

(b) *TERMINATIONS OF ANALOG LICENSES AND BROADCASTING.*—The Federal Communications Commission shall take such actions as are necessary—

(1) to terminate all licenses for full-power television stations in the analog television service, and to require the cessation of broadcasting by full-power stations in the analog television service, by February 18, 2009; and

(2) to require by February 18, 2009, that all broadcasting by Class A stations, whether in the analog television service or digital television service, and all broadcasting by full-power stations in the digital television service, occur only on channels between channels 2 and 36, inclusive, or 38 and 51, inclusive (between frequencies 54 and 698 megahertz, inclusive).

(c) *CONFORMING AMENDMENTS.*—

(1) Section 337(e) of the Communications Act of 1934 (47 U.S.C. 337(e)) is amended—

(A) in paragraph (1)—

(i) by striking “CHANNELS 60 TO 69” and inserting “CHANNELS 52 TO 69”;

(ii) by striking “person who” and inserting “full-power television station licensee that”;

(iii) by striking “746 and 806 megahertz” and inserting “698 and 806 megahertz”; and

(iv) by striking “the date on which the digital television service transition period terminates, as determined by the Commission” and inserting “February 17, 2009”;

(B) in paragraph (2), by striking “746 megahertz” and inserting “698 megahertz”; and

SEC. 3003. AUCTION OF RECOVERED SPECTRUM.

(a) **DEADLINE FOR AUCTION.**—Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) is amended—

(1) by redesignating the second paragraph (15) of such section (as added by section 203(b) of the Commercial Spectrum Enhancement Act (P.L. 108–494; 118 Stat. 3993)), as paragraph (16) of such section; and

(2) in the first paragraph (15) of such section (as added by section 3(a) of the Auction Reform Act of 2002 (P.L. 107–195; 116 Stat. 716)), by adding at the end of subparagraph (C) the following new clauses:

“(v) **ADDITIONAL DEADLINES FOR RECOVERED ANALOG SPECTRUM.**—Notwithstanding subparagraph (B), the Commission shall conduct the auction of the licenses for recovered analog spectrum by commencing the bidding not later than January 28, 2008, and shall deposit the proceeds of such auction in accordance with paragraph (8)(E)(ii) not later than June 30, 2008.

“(vi) **RECOVERED ANALOG SPECTRUM.**—For purposes of clause (v), the term ‘recovered analog spectrum’ means the spectrum between channels 52 and 69, inclusive (between frequencies 698 and 806 megahertz, inclusive) reclaimed from analog television service broadcasting under paragraph (14), other than—

“(I) the spectrum required by section 337 to be made available for public safety services; and

“(II) the spectrum auctioned prior to the date of enactment of the Digital Television Transition and Public Safety Act of 2005.”.

(b) **EXTENSION OF AUCTION AUTHORITY.**—Section 309(j)(11) of such Act (47 U.S.C. 309(j)(11)) is amended by striking “2007” and inserting “2011”.

SEC. 3004. RESERVATION OF AUCTION PROCEEDS.

Section 309(j)(8) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B) or subparagraph (D)” and inserting “subparagraphs (B), (D), and (E)”;

(2) in subparagraph (C)(i), by inserting before the semicolon at the end the following: “, except as otherwise provided in subparagraph (E)(ii)”;

(3) by adding at the end the following new subparagraph:

“(E) **TRANSFER OF RECEIPTS.**—

“(i) **ESTABLISHMENT OF FUND.**—There is established in the Treasury of the United States a fund to be known as the Digital Television Transition and Public Safety Fund.

“(ii) *PROCEEDS FOR FUNDS.*—Notwithstanding subparagraph (A), the proceeds (including deposits and upfront payments from successful bidders) from the use of a competitive bidding system under this subsection with respect to recovered analog spectrum shall be deposited in the Digital Television Transition and Public Safety Fund.

“(iii) *TRANSFER OF AMOUNT TO TREASURY.*—On September 30, 2009, the Secretary shall transfer \$7,363,000,000 from the Digital Television Transition and Public Safety Fund to the general fund of the Treasury.

“(iv) *RECOVERED ANALOG SPECTRUM.*—For purposes of clause (i), the term ‘recovered analog spectrum’ has the meaning provided in paragraph (15)(C)(vi).”.

SEC. 3005. DIGITAL-TO-ANALOG CONVERTER BOX PROGRAM.

(a) *CREATION OF PROGRAM.*—The Assistant Secretary shall—

(1) implement and administer a program through which households in the United States may obtain coupons that can be applied toward the purchase of digital-to-analog converter boxes; and

(2) make payments of not to exceed \$990,000,000, in the aggregate, through fiscal year 2009 to carry out that program from the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)).

(b) *CREDIT.*—The Assistant Secretary may borrow from the Treasury beginning on October 1, 2006 such sums as may be necessary, but not to exceed \$1,500,000,000, to implement this section. The Assistant Secretary shall reimburse the Treasury, without interest, as funds are deposited into the Digital Television Transition and Public Safety Fund.

(c) *PROGRAM SPECIFICATIONS.*—

(1) *LIMITATIONS.*—

(A) *TWO-PER-HOUSEHOLD MAXIMUM.*—A household may obtain coupons by making a request as required by the regulations under this section between January 1, 2008, and March 31, 2009, inclusive. The Assistant Secretary shall ensure that each requesting household receives, via the United States Postal Service, no more than two coupons.

(B) *NO COMBINATIONS OF COUPONS.*—Two coupons may not be used in combination toward the purchase of a single digital-to-analog converter box.

(C) *DURATION.*—All coupons shall expire 3 months after issuance.

(2) *DISTRIBUTION OF COUPONS.*—The Assistant Secretary shall expend not more than \$100,000,000 on administrative expenses and shall ensure that the sum of—

(A) all administrative expenses for the program, including not more than \$5,000,000 for consumer education concerning the digital television transition and the availability of the digital-to-analog converter box program; and

(B) the total maximum value of all the coupons redeemed, and issued but not expired, does not exceed \$990,000,000.

(3) *USE OF ADDITIONAL AMOUNT.*—If the Assistant Secretary transmits to the Committee on Energy and Commerce of the House of Representatives and Committee on Commerce, Science, and Transportation of the Senate a statement certifying that the sum permitted to be expended under paragraph (2) will be insufficient to fulfill the requests for coupons from eligible households—

(A) paragraph (2) shall be applied—

(i) by substituting “\$160,000,000” for “\$100,000,000”; and

(ii) by substituting “\$1,500,000,000” for “\$990,000,000”;

(B) subsection (a)(2) shall be applied by substituting “\$1,500,000,000” for “\$990,000,000”; and

(C) the additional amount permitted to be expended shall be available 60 days after the Assistant Secretary sends such statement.

(4) *COUPON VALUE.*—The value of each coupon shall be \$40.

(e) *DEFINITION OF DIGITAL-TO-ANALOG CONVERTER BOX.*—For purposes of this section, the term “digital-to-analog converter box” means a stand-alone device that does not contain features or functions except those necessary to enable a consumer to convert any channel broadcast in the digital television service into a format that the consumer can display on television receivers designed to receive and display signals only in the analog television service, but may also include a remote control device.

SEC. 3006. PUBLIC SAFETY INTEROPERABLE COMMUNICATIONS.

(a) *CREATION OF PROGRAM.*—The Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security—

(1) may take such administrative action as is necessary to establish and implement a grant program to assist public safety agencies in the acquisition of, deployment of, or training for the use of interoperable communications systems that utilize, or enable interoperability with communications systems that can utilize, reallocated public safety spectrum for radio communication; and

(2) shall make payments of not to exceed \$1,000,000,000, in the aggregate, through fiscal year 2010 to carry out that program from the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)).

(b) *CREDIT.*—The Assistant Secretary may borrow from the Treasury beginning on October 1, 2006 such sums as may be necessary, but not to exceed \$1,000,000,000, to implement this section. The Assistant Secretary shall reimburse the Treasury, without interest, as funds are deposited into the Digital Television Transition and Public Safety Fund.

(c) *CONDITION OF GRANTS.*—In order to obtain a grant under the grant program, a public safety agency shall agree to provide, from non-Federal sources, not less than 20 percent of the costs of acquiring and deploying the interoperable communications systems funded under the grant program.

(d) *DEFINITIONS.*—For purposes of this section:

(1) *PUBLIC SAFETY AGENCY.*—The term “public safety agency” means any State, local, or tribal government entity, or non-governmental organization authorized by such entity, whose sole or principal purpose is to protect the safety of life, health, or property.

(2) *INTEROPERABLE COMMUNICATIONS SYSTEMS.*—The term “interoperable communications systems” means communications systems which enable public safety agencies to share information amongst local, State, Federal, and tribal public safety agencies in the same area via voice or data signals.

(3) *REALLOCATED PUBLIC SAFETY SPECTRUM.*—The term “re-allocated public safety spectrum” means the bands of spectrum located at 764–776 megahertz and 794–806 megahertz, inclusive.

SEC. 3007. NYC 9/11 DIGITAL TRANSITION.

(a) *FUNDS AVAILABLE.*—From the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)) the Assistant Secretary shall make payments of not to exceed \$30,000,000, in the aggregate, which shall be available to carry out this section for fiscal years 2007 through 2008. The Assistant Secretary may borrow from the Treasury beginning October 1, 2006 such sums as may be necessary not to exceed \$30,000,000 to implement and administer the program in accordance with this section. The Assistant Secretary shall reimburse the Treasury, without interest, as funds are deposited into the Digital Television Transition and Public Safety Fund.

(b) *USE OF FUNDS.*—The sums available under subsection (a) shall be made available by the Assistant Secretary by grant to be used to reimburse the Metropolitan Television Alliance for costs incurred in the design and deployment of a temporary digital television broadcast system to ensure that, until a permanent facility atop the Freedom Tower is constructed, the members of the Metropolitan Television Alliance can provide the New York City area with an adequate digital television signal as determined by the Federal Communications Commission.

(d) *DEFINITIONS.*—For purposes of this section:

(1) *METROPOLITAN TELEVISION ALLIANCE.*—The term “Metropolitan Television Alliance” means the organization formed by New York City television broadcast station licensees to locate new shared facilities as a result of the attacks on September 11, 2001 and the loss of use of shared facilities that housed broadcast equipment.

(2) *NEW YORK CITY AREA.*—The term “New York City area” means the five counties comprising New York City and counties of northern New Jersey in immediate proximity to New York City (Bergen, Essex, Union, and Hudson Counties).

SEC. 3008. LOW-POWER TELEVISION AND TRANSLATOR DIGITAL-TO-ANALOG CONVERSION.

(a) *CREATION OF PROGRAM.*—The Assistant Secretary shall make payments of not to exceed \$10,000,000, in the aggregate, during the fiscal year 2008 and 2009 period from the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C.

309(j)(8)(E)) to implement and administer a program through which each eligible low-power television station may receive compensation toward the cost of the purchase of a digital-to-analog conversion device that enables it to convert the incoming digital signal of its corresponding full-power television station to analog format for transmission on the low-power television station's analog channel. An eligible low-power television station may receive such compensation only if it submits a request for such compensation on or before February 17, 2009. Priority compensation shall be given to eligible low-power television stations in which the license is held by a non-profit corporation and eligible low-power television stations that serve rural areas of fewer than 10,000 viewers.

(b) *CREDIT*.—The Assistant Secretary may borrow from the Treasury beginning October 1, 2006 such sums as may be necessary, but not to exceed \$10,000,000, to implement this section. The Assistant Secretary shall reimburse the Treasury, without interest, as funds are deposited into the Digital Television Transition and Public Safety Fund.

(c) *ELIGIBLE STATIONS*.—For purposes of this section, the term “eligible low-power television station” means a low-power television broadcast station, Class A television station, television translator station, or television booster station—

(1) that is itself broadcasting exclusively in analog format; and

(2) that has not purchased a digital-to-analog conversion device prior to the date of enactment of the Digital Television Transition and Public Safety Act of 2005.

SEC. 3009. LOW-POWER TELEVISION AND TRANSLATOR UPGRADE PROGRAM.

(a) *ESTABLISHMENT*.—The Assistant Secretary shall make payments of not to exceed \$65,000,000, in the aggregate, during fiscal year 2009 from the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)) to implement and administer a program through which each licensee of an eligible low-power television station may receive reimbursement for equipment to upgrade low-power television stations from analog to digital in eligible rural communities, as that term is defined in section 610(b)(2) of the Rural Electrification Act of 1937 (7 U.S.C. 950bb(b)(2)). Such reimbursements shall be issued to eligible stations no earlier than October 1, 2010. Priority reimbursements shall be given to eligible low-power television stations in which the license is held by a non-profit corporation and eligible low-power television stations that serve rural areas of fewer than 10,000 viewers.

(b) *ELIGIBLE STATIONS*.—For purposes of this section, the term “eligible low-power television station” means a low-power television broadcast station, Class A television station, television translator station, or television booster station—

(1) that is itself broadcasting exclusively in analog format; and

(2) that has not converted from analog to digital operations prior to the date of enactment of the Digital Television Transition and Public Safety Act of 2005.

SEC. 3010. NATIONAL ALERT AND TSUNAMI WARNING PROGRAM.

The Assistant Secretary shall make payments of not to exceed \$156,000,000, in the aggregate, during the fiscal year 2007 through 2012 period from the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)) to implement a unified national alert system capable of alerting the public, on a national, regional, or local basis to emergency situations by using a variety of communications technologies. The Assistant Secretary shall use \$50,000,000 of such amounts to implement a tsunami warning and coastal vulnerability program.

SEC. 3011. ENHANCE 911.

The Assistant Secretary shall make payments of not to exceed \$43,500,000, in the aggregate, from the Digital Television Transition and Public Safety Fund established under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)) to implement the ENHANCE 911 Act of 2004.

SEC. 3012. ESSENTIAL AIR SERVICE PROGRAM.

(a) IN GENERAL.—If the amount appropriated to carry out the essential air service program under subchapter II of chapter 417 of title 49, United States Code, equals or exceeds \$110,000,000 for fiscal year 2007 or 2008, then the Secretary of Commerce shall make \$15,000,000 available, from the Digital Television Transition and Public Safety Fund established by section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)), to the Secretary of Transportation for use in carrying out the essential air service program for that fiscal year.

(b) APPLICATION WITH OTHER FUNDS.—Amounts made available under subsection (a) for any fiscal year shall be in addition to any amounts—

- (1) appropriated for that fiscal year; or*
- (2) derived from fees collected pursuant to section 45301(a)(1) of title 49, United States Code, that are made available for obligation and expenditure to carry out the essential air service program for that fiscal year.*

(c) ADVANCES.—The Secretary of Transportation may borrow from the Treasury such sums as may be necessary, but not to exceed \$30,000,000 on a temporary and reimbursable basis to implement subsection (a). The Secretary of Transportation shall reimburse the Treasury, without interest, as funds are deposited into the Digital Television Transition and Public Safety Fund under section 309(j)(8)(E) of the Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)) and made available to the Secretary under subsection (a).

SEC. 3014. SUPPLEMENTAL LICENSE FEES.

In addition to any fees assessed under the Communications Act of 1934 (47 U.S.C. 151 et seq.), the Federal Communications Commission shall assess extraordinary fees for licenses in the aggregate amount of \$10,000,000, which shall be deposited in the Treasury during fiscal year 2006 as offsetting receipts.

TITLE IV—TRANSPORTATION PROVISIONS

SEC. 4001. EXTENSION OF VESSEL TONNAGE DUTIES.

(a) *EXTENSION OF DUTIES.*—Section 36 of the Act entitled “An Act to provide revenue, equalize duties, and encourage the industries of the United States, and for other purposes”, approved August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121), is amended—

(1) by striking “9 cents per ton” and all that follows through “2002,” the first place it appears and inserting “4.5 cents per ton, not to exceed in the aggregate 22.5 cents per ton in any one year, for fiscal years 2006 through 2010,”; and

(2) by striking “27 cents per ton” and all that follows through “2002,” and inserting “13.5 cents per ton, not to exceed 67.5 cents per ton per annum, for fiscal years 2006 through 2010,”.

(b) *CONFORMING AMENDMENT.*—The Act entitled “An Act concerning tonnage duties on vessels entering otherwise than by sea”, approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132), is amended by striking “9 cents per ton” and all that follows through “and 2 cents” and inserting “4.5 cents per ton, not to exceed in the aggregate 22.5 cents per ton in any one year, for fiscal years 2006 through 2010, and 2 cents”.

TITLE V—MEDICARE

Subtitle A—Provisions Relating to Part A

SEC. 5001. HOSPITAL QUALITY IMPROVEMENT.

(a) *SUBMISSION OF HOSPITAL DATA.*—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (i)—

(A) in subclause (XIX), by striking “2007” and inserting “2006”; and

(B) in subclause (XX), by striking “for fiscal year 2008 and each subsequent fiscal year,” and inserting “for each subsequent fiscal year, subject to clause (viii),”;

(2) in clause (vii)—

(A) in subclause (I), by striking “for each of fiscal years 2005 through 2007” and inserting “for fiscal years 2005 and 2006”; and

(B) in subclause (II), by striking “Each” and inserting “For fiscal years 2005 and 2006, each”; and

(3) by adding at the end the following new clauses:

“(viii)(I) For purposes of clause (i) for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit, to the Secretary in accordance with this clause, data required to be submitted on measures selected under this clause with respect to such a fiscal year, the applicable percentage increase under clause (i) for such fiscal year shall be reduced by 2.0 percentage points. Such reduction shall apply only with respect to the fiscal year in-

involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year, and the Secretary and the Medicare Payment Advisory Commission shall carry out the requirements under section 5001(b) of the Deficit Reduction Act of 2005.

“(II) Each subsection (d) hospital shall submit data on measures selected under this clause to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

“(III) The Secretary shall expand, beyond the measures specified under clause (vii)(II) and consistent with the succeeding subclauses, the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings.

“(IV) Effective for payments beginning with fiscal year 2007, in expanding the number of measures under subclause (III), the Secretary shall begin to adopt the baseline set of performance measures as set forth in the November 2005 report by the Institute of Medicine of the National Academy of Sciences under section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

“(V) Effective for payments beginning with fiscal year 2008, the Secretary shall add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

“(VI) For purposes of this clause and clause (vii), the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

“(VII) The Secretary shall establish procedures for making data submitted under this clause available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients’ perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.”

(b) **PLAN FOR HOSPITAL VALUE BASED PURCHASING PROGRAM.—**

(1) **IN GENERAL.—**The Secretary of Health and Human Services shall develop a plan to implement a value based purchasing program for payments under the Medicare program for subsection (d) hospitals beginning with fiscal year 2009.

(2) **DETAILS.—**Such a plan shall include consideration of the following issues:

(A) *The on-going development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.*

(B) *The reporting, collection, and validation of quality data.*

(C) *The structure of value based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value based payments.*

(D) *The disclosure of information on hospital performance.*

In developing such a plan, the Secretary shall consult with relevant affected parties and shall consider experience with such demonstrations that are relevant to the value based purchasing program under this subsection.

(3) *CONGRESSIONAL REPORT.—By not later than August 1, 2007, the Secretary of Health and Human Services shall submit a report to Congress on the plan for the value based purchasing program developed under this subsection.*

(4) *MEDPAC REPORT ON HOSPITAL VALUE BASED PURCHASING PROGRAM.—*

(A) *IN GENERAL.—By not later than June 1, 2007, the Medicare Payment Advisory Commission shall submit to Congress a report that includes detailed recommendations on a structure of value based payment adjustments for hospital services under the Medicare program under title XVIII of the Social Security Act.*

(B) *CONTENTS.—Such report shall include the following:*

(i) *Determinations of the thresholds, the size of payments, the sources of funds, and the relationship of payments to improvement and attainment of quality.*

(ii) *An analysis of hospital efficiency measures such as costs per discharge, related services within an episode of care including payments for physicians' services associated with the discharge or episode of care.*

(iii) *An identification of other changes that are needed within the payment structure under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) to assure consistency between such structure and the value based payment program.*

(c) *QUALITY ADJUSTMENT IN DRG PAYMENTS FOR CERTAIN HOSPITAL ACQUIRED INFECTIONS.—*

(1) *IN GENERAL.—Section 1886(d)(4) of the Social Security Act (42 U.S.C. 1395ww(d)(4)) is amended by adding at the end the following new subparagraph:*

“(D)(i) For discharges occurring on or after October 1, 2008, the diagnosis-related group to be assigned under this paragraph for a discharge described in clause (ii) shall be a diagnosis-related group that does not result in higher payment based on the presence of a secondary diagnosis code described in clause (iv).

“(ii) A discharge described in this clause is a discharge which meets the following requirements:

“(I) The discharge includes a condition identified by a diagnosis code selected under clause (iv) as a secondary diagnosis.

“(II) But for clause (i), the discharge would have been classified to a diagnosis-related group that results in a higher payment based on the presence of a secondary diagnosis code selected under clause (iv).

“(III) At the time of admission, no code selected under clause (iv) was present.

“(iii) As part of the information required to be reported by a hospital with respect to a discharge of an individual in order for payment to be made under this subsection, for discharges occurring on or after October 1, 2007, the information shall include the secondary diagnosis of the individual at admission.

“(iv) By not later than October 1, 2007, the Secretary shall select diagnosis codes associated with at least two conditions, each of which codes meets all of the following requirements (as determined by the Secretary):

“(I) Cases described by such code have a high cost or high volume, or both, under this title.

“(II) The code results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis.

“(III) The code describes such conditions that could reasonably have been prevented through the application of evidence-based guidelines.

The Secretary may from time to time revise (through addition or deletion of codes) the diagnosis codes selected under this clause so long as there are diagnosis codes associated with at least two conditions selected for discharges occurring during any fiscal year.

“(v) In selecting and revising diagnosis codes under clause (iv), the Secretary shall consult with the Centers for Disease Control and Prevention and other appropriate entities.

“(vi) Any change resulting from the application of this subparagraph shall not be taken into account in adjusting the weighting factors under subparagraph (C)(i) or in applying budget neutrality under subparagraph (C)(iii).”.

(2) **NO JUDICIAL REVIEW.**—Section 1886(d)(7)(B) of such Act (42 U.S.C. 1395ww(d)(7)(B)) is amended by inserting before the period the following: “, including the selection and revision of codes under paragraph (4)(D)”.

SEC. 5002. CLARIFICATION OF DETERMINATION OF MEDICAID PATIENT DAYS FOR DSH COMPUTATION.

(a) **IN GENERAL.**—Section 1886(d)(5)(F)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) is amended by adding after and below subclause (II) the following:

“In determining under subclause (II) the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.”.

(b) **RATIFICATION AND PROSPECTIVE APPLICATION OF PREVIOUS REGULATIONS.**—

(1) **IN GENERAL.**—Subject to paragraph (2), regulations described in paragraph (3), insofar as such regulations provide for the treatment of individuals eligible for medical assistance under a demonstration project approved under title XI of the Social Security Act under section 1886(d)(5)(F)(vi) of such Act, are hereby ratified, effective as of the date of their respective promulgations.

(2) **NO APPLICATION TO CLOSED COST REPORTS.**—Paragraph (1) shall not be applied in a manner that requires the reopening of any cost reports which are closed as of the date of the enactment of this Act.

(3) **REGULATIONS DESCRIBED.**—For purposes of paragraph (1), the regulations described in this paragraph are as follows:

(A) **2000 REGULATION.**—Regulations promulgated on January 20, 2000, at 65 Federal Register 3136 et seq., including the policy in such regulations regarding discharges occurring prior to January 20, 2000.

(B) **2003 REGULATION.**—Regulations promulgated on August 1, 2003, at 68 Federal Register 45345 et seq.

SEC. 5003. IMPROVEMENTS TO THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) **5-YEAR EXTENSION.**—

(1) **EXTENSION OF PAYMENT METHODOLOGY.**—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking “October 1, 2006” and inserting “October 1, 2011”; and

(B) in clause (ii)(II)—

(i) by striking “October 1, 2006” and inserting “October 1, 2011”; and

(ii) by inserting “or for discharges in the fiscal year” after “for the cost reporting period”.

(2) **CONFORMING AMENDMENTS.**—

(A) **EXTENSION OF TARGET AMOUNT.**—Section 1886(b)(3)(D) of such Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(i) in the matter preceding clause (i)—

(I) by striking “beginning” and inserting “occurring”; and

(II) by striking “October 1, 2006” and inserting “October 1, 2011”; and

(ii) in clause (iv), by striking “through fiscal year 2005” and inserting “through fiscal year 2011”.

(B) **PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.**—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking “through fiscal year 2005” and inserting “through fiscal year 2011”.

(b) **OPTION TO USE 2002 AS BASE YEAR.**—Section 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (D), by inserting “subject to subparagraph (K),” after “(d)(5)(G),”; and

(2) by adding at the end the following new subparagraph:

“(K)(i) With respect to discharges occurring on or after October 1, 2006, in the case of a medicare-dependent, small rural hospital, for purposes of applying subparagraph (D)—

“(I) there shall be substituted for the base cost reporting period described in subparagraph (D)(i) the 12-month cost reporting period beginning during fiscal year 2002; and

“(II) any reference in such subparagraph to the ‘first cost reporting period’ described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2006.

“(ii) This subparagraph shall only apply to a hospital if the substitution described in clause (i)(I) results in an increase in the target amount under subparagraph (D) for the hospital.”.

(c) **ENHANCED PAYMENT FOR AMOUNT BY WHICH THE TARGET EXCEEDS THE PPS RATE.**—Section 1886(d)(5)(G)(ii)(II) of such Act (42 U.S.C. 1395ww(d)(5)(G)(iv)(II)) is amended by inserting “(or 75 percent in the case of discharges occurring on or after October 1, 2006)” after “50 percent”.

(d) **ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR MEDICARE DEPENDENT HOSPITALS.**—Section 1886(d)(5)(F)(xiv)(II) of such Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)(II)) is amended by inserting “or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv)” before the period at the end.

SEC. 5004. REDUCTION IN PAYMENTS TO SKILLED NURSING FACILITIES FOR BAD DEBT.

(a) **IN GENERAL.**—Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

“(V) In determining such reasonable costs for skilled nursing facilities with respect to cost reporting periods beginning on or after October 1, 2005, the amount of bad debts otherwise treated as allowed costs which are attributable to the coinsurance amounts under this title for individuals who are entitled to benefits under part A and—

“(i) are not described in section 1935(c)(6)(A)(ii) shall be reduced by 30 percent of such amount otherwise allowable; and

“(ii) are described in such section shall not be reduced.”.

(b) **TECHNICAL AMENDMENT.**—Section 1861(v)(1)(T) of such Act (42 U.S.C. 1395x(v)(1)(T)) is amended by striking “section 1833(t)(5)(B)” and inserting “section 1833(t)(8)(B)”.

SEC. 5005. EXTENDED PHASE-IN OF THE INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.

(a) **IN GENERAL.**—Notwithstanding section 412.23(b)(2) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall apply the applicable percent specified in subsection (b) in the classification criterion used under the IRF regulation (as defined in subsection (c)) to determine whether a hospital or unit of a hospital is an inpatient rehabilitation facility under the Medicare program under title XVIII of the Social Security Act.

(b) **APPLICABLE PERCENT.**—For purposes of subsection (a), the applicable percent specified in this subsection for cost reporting periods—

(1) beginning during the 12-month period beginning on July 1, 2006, is 60 percent;

(2) beginning during the 12-month period beginning on July 1, 2007, is 65 percent; and

(3) beginning on or after July 1, 2008, is 75 percent.

(c) *IRF REGULATION.*—For purposes of subsection (a), the term “IRF regulation” means the rule published in the Federal Register on May 7, 2004, entitled “Medicare Program; Final Rule; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility” (69 Fed. Reg. 25752).

SEC. 5006. DEVELOPMENT OF A STRATEGIC PLAN REGARDING PHYSICIAN INVESTMENT IN SPECIALTY HOSPITALS.

(a) *DEVELOPMENT.*—

(1) *IN GENERAL.*—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a strategic and implementing plan to address issues described in paragraph (2) regarding physician investment in specialty hospitals (as defined in section 1877(h)(7)(A) of the Social Security Act (42 U.S.C. 1395nn(h)(7)(A))).

(2) *ISSUES DESCRIBED.*—The issues described in this paragraph are the following:

(A) Proportionality of investment return.

(B) Bona fide investment.

(C) Annual disclosure of investment information.

(D) The provision by specialty hospitals of—

(i) care to patients who are eligible for medical assistance under a State plan approved under title XIX of the Social Security Act, including patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI of such Act; and

(ii) charity care.

(E) Appropriate enforcement.

(b) *REPORTS.*—

(1) *INTERIM REPORT.*—Not later than 3 months after the date of the enactment of this Act, the Secretary shall submit an interim report to the appropriate committees of jurisdiction of Congress on the status of the development of the plan under subsection (a).

(2) *FINAL REPORT.*—Not later than six months after the date of the enactment of this Act, the Secretary shall submit a final report to the appropriate committees of jurisdiction of Congress on the plan developed under subsection (a) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) *CONTINUATION OF SUSPENSION ON ENROLLMENT.*—

(1) *IN GENERAL.*—Subject to paragraph (2), the Secretary shall continue the suspension on enrollment of new specialty hospitals (as so defined) under title XVIII of the Social Security Act until the earlier of—

(A) the date that the Secretary submits the final report under subsection (b)(2); or

(B) the date that is six months after the date of the enactment of this Act.

(2) *EXTENSION OF SUSPENSION.*—If the Secretary fails to submit the final report described in subsection (b)(2) by the date required under such subsection, the Secretary shall—

(A) extend the suspension on enrollment under paragraph (1) for an additional two months; and

(B) provide a certification to the appropriate committees of jurisdiction of Congress of such failure.

(d) *WAIVER.*—In developing the plan and report required under this section, the Secretary may waive such requirements of section 553 of title 5, United States Code, as the Secretary determines necessary.

(e) *FUNDING.*—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2006, \$2,000,000 to carry out this section.

SEC. 5007. MEDICARE DEMONSTRATION PROJECTS TO PERMIT GAINSHARING ARRANGEMENTS.

(a) *ESTABLISHMENT.*—The Secretary shall establish under this section a qualified gainsharing demonstration program under which the Secretary shall approve demonstration projects by not later than November 1, 2006, to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with sharing of remuneration as specified in the project. Such projects shall be operational by not later than January 1, 2007.

(b) *REQUIREMENTS DESCRIBED.*—A demonstration project under this section shall meet the following requirements for purposes of maintaining or improving quality while achieving cost savings:

(1) *ARRANGEMENT FOR REMUNERATION AS SHARE OF SAVINGS.*—The demonstration project shall involve an arrangement between a hospital and a physician under which the hospital provides remuneration to the physician that represents solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician.

(2) *WRITTEN PLAN AGREEMENT.*—The demonstration project shall be conducted pursuant to a written agreement that—

(A) is submitted to the Secretary prior to implementation of the project; and

(B) includes a plan outlining how the project will achieve improvements in quality and efficiency.

(3) *PATIENT NOTIFICATION.*—The demonstration project shall include a notification process to inform patients who are treated in a hospital participating in the project of the participation of the hospital in such project.

(4) *MONITORING QUALITY AND EFFICIENCY OF CARE.*—The demonstration project shall provide measures to ensure that the quality and efficiency of care provided to patients who are treated in a hospital participating in the demonstration project is continuously monitored to ensure that such quality and efficiency is maintained or improved.

(5) *INDEPENDENT REVIEW.*—The demonstration project shall certify, prior to implementation, that the elements of the demonstration project are reviewed by an organization that is not

affiliated with the hospital or the physician participating in the project.

(6) *REFERRAL LIMITATIONS.—The demonstration project shall not be structured in such a manner as to reward any physician participating in the project on the basis of the volume or value of referrals to the hospital by the physician.*

(c) *WAIVER OF CERTAIN RESTRICTIONS.—*

(1) *IN GENERAL.—An incentive payment made by a hospital to a physician under and in accordance with a demonstration project shall not constitute—*

(A) *remuneration for purposes of section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);*

(B) *a payment intended to induce a physician to reduce or limit services to a patient entitled to benefits under Medicare or a State plan approved under title XIX of such Act in violation of section 1128A of such Act (42 U.S.C. 1320a–7a); or*

(C) *a financial relationship for purposes of section 1877 of such Act (42 U.S.C. 1395nn).*

(2) *PROTECTION FOR EXISTING ARRANGEMENTS.—In no case shall the failure to comply with the requirements described in paragraph (1) affect a finding made by the Inspector General of the Department of Health and Human Services prior to the date of the enactment of this Act that an arrangement between a hospital and a physician does not violate paragraph (1) or (2) of section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7(a)).*

(d) *PROGRAM ADMINISTRATION.—*

(1) *SOLICITATION OF APPLICATIONS.—By not later than 90 days after the date of the enactment of this Act, the Secretary shall solicit applications for approval of a demonstration project, in such form and manner, and at such time specified by the Secretary.*

(2) *NUMBER OF PROJECTS APPROVED.—The Secretary shall approve not more than 6 demonstration projects, at least 2 of which shall be located in a rural area.*

(3) *DURATION.—The qualified gainsharing demonstration program under this section shall be conducted for the period beginning on January 1, 2007, and ending on December 31, 2009.*

(e) *REPORTS.—*

(1) *INITIAL REPORT.—By not later than December 1, 2006, the Secretary shall submit to Congress a report on the number of demonstration projects that will be conducted under this section.*

(2) *PROJECT UPDATE.—By not later than December 1, 2007, the Secretary shall submit to Congress a report on the details of such projects (including the project improvements towards quality and efficiency described in subsection (b)(2)(B)).*

(3) *QUALITY IMPROVEMENT AND SAVINGS.—By not later than December 1, 2008, the Secretary shall submit to Congress a report on quality improvement and savings achieved as a result of the qualified gainsharing demonstration program established under subsection (a).*

(4) *FINAL REPORT.*—By not later than May 1, 2010, the Secretary shall submit to Congress a final report on the information described in paragraph (3).

(f) *FUNDING.*—

(1) *IN GENERAL.*—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2006 \$6,000,000, to carry out this section.

(2) *AVAILABILITY.*—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2010.

(g) *DEFINITIONS.*—For purposes of this section:

(1) *DEMONSTRATION PROJECT.*—The term “demonstration project” means a project implemented under the qualified gainsharing demonstration program established under subsection (a).

(2) *HOSPITAL.*—The term “hospital” means a hospital that receives payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), and does not include a critical access hospital (as defined in section 1861(mm) of such Act (42 U.S.C. 1395x(mm))).

(3) *MEDICARE.*—The term “Medicare” means the programs under title XVIII of the Social Security Act.

(4) *PHYSICIAN.*—The term “physician” means, with respect to a demonstration project, a physician described in paragraph (1) or (3) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) who is licensed as such a physician in the area in which the project is located and meets requirements to provide services for which benefits are provided under Medicare. Such term shall be deemed to include a practitioner described in section 1842(e)(18)(C) of such Act (42 U.S.C. 1395u(e)(18)(C)).

(5) *SECRETARY.*—The term “Secretary” means the Secretary of Health and Human Services.

SEC. 5008. POST-ACUTE CARE PAYMENT REFORM DEMONSTRATION PROGRAM.

(a) *ESTABLISHMENT.*—

(1) *IN GENERAL.*—By not later than January 1, 2008, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a demonstration program for purposes of understanding costs and outcomes across different post-acute care sites. Under such program, with respect to diagnoses specified by the Secretary, an individual who receives treatment from a provider for such a diagnosis shall receive a single comprehensive assessment on the date of discharge from a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) of the needs of the patient and the clinical characteristics of the diagnosis to determine the appropriate placement of such patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during the treatment and at discharge from each provider. Participants in the program shall provide information on the fixed and variable costs for each individual. An additional comprehensive assessment shall be provided at the end of the episode of care.

(2) *NUMBER OF SITES.*—The Secretary shall conduct the demonstration program under this section with sufficient numbers to determine statistically reliable results.

(3) *DURATION.*—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(b) *WAIVER AUTHORITY.*—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(c) *REPORT.*—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, that includes the results of the program and recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(d) *FUNDING.*—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i), \$6,000,000 for the costs of carrying out the demonstration program under this section.

Subtitle B—Provisions Relating to Part B

CHAPTER 1—PAYMENT PROVISIONS

SEC. 5101. BENEFICIARY OWNERSHIP OF CERTAIN DURABLE MEDICAL EQUIPMENT (DME).

(a) *DME.*—

(1) *IN GENERAL.*—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended to read as follows:

“(A) *PAYMENT.*—In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

“(i) *RENTAL.*—

“(I) *IN GENERAL.*—Except as provided in clause (iii), payment for the item shall be made on a monthly basis for the rental of the item during the period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

“(II) *PAYMENT AMOUNT.*—Subject to subparagraph (B), the amount recognized for the item, for each of the first 3 months of such period, is 10 percent of the purchase price recognized under paragraph (8) with respect to the item, and, for each of the remaining months of such period, is 7.5 percent of such purchase price.

“(ii) *OWNERSHIP AFTER RENTAL.*—On the first day that begins after the 13th continuous month during which payment is made for the rental of an item under clause (i), the supplier of the item shall transfer title to the item to the individual.

“(iii) **PURCHASE AGREEMENT OPTION FOR POWER-DRIVEN WHEELCHAIRS.**—In the case of a power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.

“(iv) **MAINTENANCE AND SERVICING.**—After the supplier transfers title to the item under clause (ii) or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii), maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier’s or manufacturer’s warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to items furnished for which the first rental month occurs on or after January 1, 2006.

(b) **OXYGEN EQUIPMENT.**—

(1) **IN GENERAL.**—Section 1834(a)(5) of such Act (42 U.S.C. 1395m(a)(5)) is amended—

(A) in subparagraph (A), by striking “and (E)” and inserting “(E), and (F)”; and

(B) by adding at the end the following new subparagraph:

“(F) **OWNERSHIP OF EQUIPMENT.**—

“(i) **IN GENERAL.**—Payment for oxygen equipment (including portable oxygen equipment) under this paragraph may not extend over a period of continuous use (as determined by the Secretary) of longer than 36 months.

“(ii) **OWNERSHIP.**—

“(I) **TRANSFER OF TITLE.**—On the first day that begins after the 36th continuous month during which payment is made for the equipment under this paragraph, the supplier of the equipment shall transfer title to the equipment to the individual.

“(II) **PAYMENTS FOR OXYGEN AND MAINTENANCE AND SERVICING.**—After the supplier transfers title to the equipment under subclause (I)—

“(aa) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

“(bb) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier’s or manufacturer’s warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in

an amount determined to be appropriate by the Secretary.”.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—*The amendments made by paragraph (1) shall take effect on January 1, 2006.*

(B) APPLICATION TO CERTAIN INDIVIDUALS.—*In the case of an individual receiving oxygen equipment on December 31, 2005, for which payment is made under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), the 36-month period described in paragraph (5)(F)(i) of such section, as added by paragraph (1), shall begin on January 1, 2006.*

SEC. 5102. ADJUSTMENTS IN PAYMENT FOR IMAGING SERVICES.

(a) MULTIPLE PROCEDURE PAYMENT REDUCTION FOR IMAGING EXEMPTED FROM BUDGET NEUTRALITY.—*Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(B)) is amended—*

(1) in clause (ii)(II), by striking “clause (iv)” and inserting “clauses (iv) and (v)”;

(2) in clause (iv) in the heading, by inserting “OF CERTAIN ADDITIONAL EXPENDITURES” after “EXEMPTION”; and

(3) by adding at the end the following new clause:

“(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

“(I) REDUCED PAYMENT FOR MULTIPLE IMAGING PROCEDURES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to the multiple procedure payment reduction for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) insofar as it relates to the physician fee schedules for 2006 and 2007.”.

(b) REDUCTION IN PHYSICIAN FEE SCHEDULE TO OPD PAYMENT AMOUNT FOR IMAGING SERVICES.—*Section 1848 of such Act (42 U.S.C. 1395w-4) is amended—*

(1) in subsection (b), by adding at the end the following new paragraph:

“(4) SPECIAL RULE FOR IMAGING SERVICES.—

“(A) IN GENERAL.—In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

“(i) the technical component (including the technical component portion of a global fee) of the service established for a year under the fee schedule described in paragraph (1) without application of the geographic adjustment factor described in paragraph (1)(C), exceeds

“(ii) the medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1833(t) for such service for such year,

determined without regard to geographic adjustment under paragraph (2)(D) of such section, the Secretary shall substitute the amount described in clause (ii), adjusted by the geographic adjustment factor described in paragraph (1)(C), for the fee schedule amount for such technical component for such year.

“(B) IMAGING SERVICES DESCRIBED.—For purposes of subparagraph (A), imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography.”; and

(2) in subsection (c)(2)(B)(v), as added by subsection (a)(3), by adding at the end the following new subclause:

“(II) OPD PAYMENT CAP FOR IMAGING SERVICES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).”.

SEC. 5103. LIMITATION ON PAYMENTS FOR PROCEDURES IN AMBULATORY SURGICAL CENTERS.

Section 1833(i)(2) of the Social Security Act (42 U.S.C. 1395l(i)(2)) is amended—

(1) in subparagraph (A), by inserting “subject to subparagraph (E),” after “subparagraph (D),”;

(2) in subparagraph (D)(ii), by inserting before the period at the end the following: “and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary”; and

(3) by adding at the end the following new subparagraph: “(E) With respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system under subparagraph (D), if—

“(i) the standard overhead amount under subparagraph (A) for a facility service for such procedure, without the application of any geographic adjustment, exceeds

“(ii) the medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under paragraph (3)(D) of section 1833(t) for such service for such year, determined without regard to geographic adjustment under paragraph (2)(D) of such section, the Secretary shall substitute under subparagraph (A) the amount described in clause (ii) for the standard overhead amount for such service referred to in clause (i).”.

SEC. 5104. UPDATE FOR PHYSICIANS’ SERVICES FOR 2006.

(a) UPDATE FOR 2006.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended—

(1) in paragraph (4)(B), in the matter preceding clause (i), by striking “paragraph (5)” and inserting “paragraphs (5) and (6)”; and

(2) by adding at the end the following new paragraph:

“(6) UPDATE FOR 2006.—The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be 0 percent.”.

(b) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by subsection (a) shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)).

(c) MEDPAC REPORT.—

(1) IN GENERAL.—By not later than March 1, 2007, the Medicare Payment Advisory Commission shall submit a report to Congress on mechanisms that could be used to replace the sustainable growth rate system under section 1848(f) of the Social Security Act (42 U.S.C. 1395w-4(f)).

(2) REQUIREMENTS.—The report required under paragraph (1) shall—

(A) identify and examine alternative methods for assessing volume growth;

(B) review options to control the volume of physicians’ services under the Medicare program while maintaining access to such services by Medicare beneficiaries;

(C) examine the application of volume controls under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4);

(D) identify levels of application of volume controls, such as group practice, hospital medical staff, type of service, geographic area, and outliers;

(E) examine the administrative feasibility of implementing the options reviewed under subparagraph (B), including the availability of data and time lags;

(F) examine the extent to which the alternative methods identified and examined under subparagraph (A) should be specified in such section 1848; and

(G) identify the appropriate level of discretion for the Secretary of Health and Human Services to change payment rates under the Medicare physician fee schedule or otherwise take steps that affect physician behavior.

Such report shall include such recommendations on alternative mechanisms to replace the sustainable growth rate system as the Medicare Payment Advisory Commission determines appropriate.

(3) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Medicare Payment Advisory Commission \$550,000, to carry out this subsection.

SEC. 5105. THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) by inserting “(I)” before “In the case”; and

(2) by adding at the end the following new subclause:

“(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is

not a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the previous sentence, with respect to covered OPD services furnished during 2006, 2007, or 2008, the applicable percentage shall be 95 percent, 90 percent, and 85 percent, respectively.”.

SEC. 5106. UPDATE TO THE COMPOSITE RATE COMPONENT OF THE BASIC CASE-MIX ADJUSTED PROSPECTIVE PAYMENT SYSTEM FOR DIALYSIS SERVICES.

Section 1881(b)(12) of the Social Security Act (42 U.S.C. 1395rr(b)(12)) is amended—

(1) in subparagraph (F), in the flush matter at the end, by striking “Nothing” and inserting “Except as provided in subparagraph (G), nothing”;

(2) by redesignating subparagraph (G) as subparagraph (H); and

(3) by inserting after subparagraph (F) the following new subparagraph:

“(G) The Secretary shall increase the amount of the composite rate component of the basic case-mix adjusted system under subparagraph (B) for dialysis services furnished on or after January 1, 2006, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005.”.

SEC. 5107. REVISIONS TO PAYMENTS FOR THERAPY SERVICES.

(a) EXCEPTION TO CAPS FOR 2006.—

(1) IN GENERAL.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(A) in each of paragraphs (1) and (3), by striking “paragraph (4)” and inserting “paragraphs (4) and (5)”;

and

(B) by adding at the end the following new paragraph:

“(5) With respect to expenses incurred during 2006 for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary’s receipt of the request, the Secretary shall be deemed to have found the services to be medically necessary.”.

(2) TIMELY IMPLEMENTATION.—The Secretary of Health and Human Services shall waive such provisions of law and regulation (including those described in section 110(c) of Public Law 108–173) as are necessary to implement the amendments made by paragraph (1) on a timely basis and, notwithstanding any other provision of law, may implement such amendments by program instruction or otherwise. There shall be no administrative or judicial review under section 1869 or section 1878 of the

Social Security Act (42 U.S.C. 1395ff and 1395oo), or otherwise of the process (including the establishment of the process) under section 1833(g)(5) of such Act, as added by paragraph (1).

(b) IMPLEMENTATION OF CLINICALLY APPROPRIATE CODE EDITS IN ORDER TO IDENTIFY AND ELIMINATE IMPROPER PAYMENTS FOR THERAPY SERVICES.—By not later than July 1, 2006, the Secretary of Health and Human Services shall implement clinically appropriate code edits with respect to payments under part B of title XVIII of the Social Security Act for physical therapy services, occupational therapy services, and speech-language pathology services in order to identify and eliminate improper payments for such services, including edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

CHAPTER 2—MISCELLANEOUS

SEC. 5111. ACCELERATED IMPLEMENTATION OF INCOME-RELATED REDUCTION IN PART B PREMIUM SUBSIDY.

Section 1839(i)(3)(B) of the Social Security Act (42 U.S.C. 1395r(i)(3)(B)) is amended—

(1) in the heading, by striking “5-YEAR” and inserting “3-YEAR”;

(2) in the matter preceding clause (i), by striking “2011” and inserting “2009”;

(3) in clause (i), by striking “20 percent” and inserting “33 percent”;

(4) in clause (ii), by striking “40 percent” and inserting “67 percent”; and

(5) by striking clauses (iii) and (iv).

SEC. 5112. MEDICARE COVERAGE OF ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSMS.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking “and” at the end of subparagraph (Y);

(B) by adding “and” at the end of subparagraph (Z) and moving such subparagraph 2 ems to the left; and

(C) by adding at the end the following new subparagraph:

“(AA) ultrasound screening for abdominal aortic aneurysm (as defined in subsection (bbb)) for an individual—

“(i) who receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (as defined in section 1861(w)(1));

“(ii) who has not been previously furnished such an ultrasound screening under this title; and

“(iii) who—

“(I) has a family history of abdominal aortic aneurysm; or

“(II) manifests risk factors included in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding abdominal aortic aneurysms;”; and

(2) by adding at the end the following new subsection:

“Ultrasound Screening for Abdominal Aortic Aneurysm

“(bbb) The term ‘ultrasound screening for abdominal aortic aneurysm’ means—

“(1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, that the Secretary may specify) provided for the early detection of abdominal aortic aneurysm; and

“(2) includes a physician’s interpretation of the results of the procedure.”.

(b) INCLUSION OF ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSM IN INITIAL PREVENTIVE PHYSICAL EXAMINATION.—Section 1861(w)(2) of such Act (42 U.S.C. 1395x(w)(2)) is amended by adding at the end the following new subparagraph:

“(L) Ultrasound screening for abdominal aortic aneurysm as defined in section 1861(bbb).”.

(c) PAYMENT FOR ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSM.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by inserting “(2)(AA),” after “(2)(W).”.

(d) FREQUENCY.—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking “and” at the end of subparagraph (L);

(2) by striking the semicolon at the end of subparagraph (M) and inserting “, and”; and

(3) by adding at the end the following new subparagraph:

“(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1861(s)(2)(AA).”.

(e) NON-APPLICATION OF PART B DEDUCTIBLE.—Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended in the first sentence—

(1) by striking “and” before “(6)”; and

(2) by inserting “, and (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1861(bbb))” before the period at the end.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2007.

SEC. 5113. IMPROVING PATIENT ACCESS TO, AND UTILIZATION OF, COLORECTAL CANCER SCREENING.

(a) NON-APPLICATION OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 5112(e), is amended in the first sentence—

(1) by striking “and” before “(7)”; and

(2) by inserting “, and (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))” before the period at the end.

(b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) of such Act (42 U.S.C. 1395m(d)) are each amended—

(1) by striking “DEDUCTIBLE AND” in the heading; and

(2) in subclause (I), by striking “deductible or” each place it appears.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2007.

SEC. 5114. DELIVERY OF SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) **COVERAGE.**—

(1) **IN GENERAL.**—Section 1861(aa)(3) of the Social Security Act (42 U.S.C. 1395x(aa)(3)) is amended—

(A) in subparagraph (A), by striking “, and” and inserting “and services described in subsections (qq) and (vv); and”;

(B) in subparagraph (B), by striking “sections 329, 330, and 340” and inserting “section 330”; and

(C) in the flush matter at the end, by inserting “by the center or by a health care professional under contract with the center” after “outpatient of a Federally qualified health center”.

(2) **CONSOLIDATED BILLING.**—The first sentence of section 1842(b)(6)(F) of such Act (42 U.S.C. 1395u(b)(6)(F)) is amended—

(A) by striking “and (G)” and inserting “(G)”; and

(B) by inserting before the period at the end the following: “, and (H) in the case of services described in section 1861(aa)(3) that are furnished by a health care professional under contract with a Federally qualified health center, payment shall be made to the center”.

(b) **TECHNICAL CORRECTIONS.**—Clauses (i) and (ii)(II) of section 1861(aa)(4)(A) of such Act (42 U.S.C. 1395x(aa)(4)(A)) are each amended by striking “(other than subsection (h))”.

(c) **EFFECTIVE DATES.**—The amendments made by this section shall apply to services furnished on or after January 1, 2006.

SEC. 5115. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN INTERNATIONAL VOLUNTEERS.

(a) **IN GENERAL.**—

(1) **WAIVER OF PENALTY.**—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended in the second sentence by inserting the following before the period at the end: “or months for which the individual can demonstrate that the individual was an individual described in section 1837(k)(3)”.

(2) **SPECIAL ENROLLMENT PERIOD.**—

(A) **IN GENERAL.**—Section 1837 of such Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

“(k)(1) In the case of an individual who—

“(A) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is described in paragraph (3), and has elected not to enroll (or to be deemed enrolled) under this section during the individual’s initial enrollment period; or

“(B) has terminated enrollment under this section during a month in which the individual is described in paragraph (3), there shall be a special enrollment period described in paragraph (2).

“(2) The special enrollment period described in this paragraph is the 6-month period beginning on the first day of the month which includes the date that the individual is no longer described in paragraph (3).

“(3) For purposes of paragraph (1), an individual described in this paragraph is an individual who—

“(A) is serving as a volunteer outside of the United States through a program—

“(i) that covers at least a 12-month period; and

“(ii) that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code; and

“(B) demonstrates health insurance coverage while serving in the program.”

(B) **COVERAGE PERIOD.**—Section 1838 of such Act (42 U.S.C. 1395q) is amended by adding at the end the following new subsection:

“(f) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(k), the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a)(1) shall apply to months beginning with January 2007 and the amendments made by subsection (a)(2) shall take effect on January 1, 2007.

Subtitle C—Provisions Relating to Parts A and B

SEC. 5201. HOME HEALTH PAYMENTS.

(a) **2006 UPDATE.**—Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (III), by striking “each of 2005 and 2006” and inserting “all of 2005”;

(2) by striking “or” at the end of subclause (III);

(3) in subclause (IV), by striking “2007 and” and by redesignating such subclause as subclause (V); and

(4) by inserting after subclause (III) the following new subclause:

“(IV) 2006, 0 percent; and”

(b) **APPLYING RURAL ADD-ON POLICY FOR 2006.**—Section 421(a) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283) is amended by inserting “and episodes and visits beginning on or after January 1, 2006, and before January 1, 2007,” after “April 1, 2005,”

(c) **HOME HEALTH CARE QUALITY IMPROVEMENT.**—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (ii)(V), as redesignated by subsection (a)(3), by inserting “subject to clause (v),” after “subsequent year,”; and

(2) by adding at the end the following new clause:

“(v) **ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.**—

“(I) **ADJUSTMENT.**—For purposes of clause (ii)(V), for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable

under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year, and the Medicare Payment Advisory Commission shall carry out the requirements under section 5201(d) of the Deficit Reduction Act of 2005.

“(II) SUBMISSION OF QUALITY DATA.—For 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

“(III) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subclause (II) available to the public. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public.”

(d) MEDPAC REPORT ON VALUE BASED PURCHASING.—

(1) IN GENERAL.—Not later than June 1, 2007, the Medicare Payment Advisory Commission shall submit to Congress a report that includes recommendations on a detailed structure of value based payment adjustments for home health services under the Medicare program under title XVIII of the Social Security Act. Such report shall include recommendations concerning the determination of thresholds, the size of such payments, sources of funds, and the relationship of payments for improvement and attainment of quality.

(2) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Medicare Payment Advisory Commission \$550,000, to carry out this subsection.

SEC. 5202. REVISION OF PERIOD FOR PROVIDING PAYMENT FOR CLAIMS THAT ARE NOT SUBMITTED ELECTRONICALLY.

(a) REVISION.—

(1) PART A.—Section 1816(c)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395h(c)(3)(B)(ii)) is amended by striking “26 days” and inserting “28 days”.

(2) PART B.—Section 1842(c)(3)(B)(ii) of such Act (42 U.S.C. 1395u(c)(3)(B)(ii)) is amended by striking “26 days” and inserting “28 days”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to claims submitted on or after January 1, 2006.

SEC. 5203. TIMEFRAME FOR PART A AND B PAYMENTS.

Notwithstanding sections 1816(c) and 1842(c)(2) of the Social Security Act or any other provision of law—

(1) any payment from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) for claims submitted under part A or B of title XVIII of such Act for items and services furnished under such part A or B, respectively, that would otherwise be payable during the period beginning on September 22, 2006, and ending on September 30, 2006, shall be paid on the first business day of October 2006; and

(2) no interest or late penalty shall be paid to an entity or individual for any delay in a payment by reason of the application of paragraph (1).

SEC. 5204. MEDICARE INTEGRITY PROGRAM FUNDING.

Section 1817(k)(4) of the Social Security Act (42 U.S.C. 1395i(k)(4)) is amended—

(1) in subparagraph (B), by striking “The amount” and inserting “Subject to subparagraph (C), the amount”; and

(2) by adding at the end the following new subparagraph:
“(C) ADJUSTMENTS.—The amount appropriated under subparagraph (A) for a fiscal year is increased as follows:
“(i) For fiscal year 2006, \$100,000,000.”

Subtitle D—Provisions Relating to Part C

SEC. 5301. PHASE-OUT OF RISK ADJUSTMENT BUDGET NEUTRALITY IN DETERMINING THE AMOUNT OF PAYMENTS TO MEDICARE ADVANTAGE ORGANIZATIONS.

(a) *IN GENERAL.*—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)—

(A) in subparagraph (A)—

(i) by inserting “(or, beginning with 2007, ¹/₁₂ of the applicable amount determined under subsection (k)(1))” after “1853(c)(1)”; and

(ii) by inserting “(for years before 2007)” after “adjusted as appropriate”;

(B) in subparagraph (B), by inserting “(for years before 2007)” after “adjusted as appropriate”; and

(2) by adding at the end the following new subsection:

“(k) DETERMINATION OF APPLICABLE AMOUNT FOR PURPOSES OF CALCULATING THE BENCHMARK AMOUNTS.—

“(1) APPLICABLE AMOUNT DEFINED.—For purposes of subsection (j), subject to paragraph (2), the term ‘applicable amount’ means for an area—

“(A) for 2007—

“(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

“(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity

and risk adjustment budget neutrality that were included in such factor); and

“(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

“(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

“(I) the amount determined under clause (i) for the area for the year; or

“(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

“(B) for a subsequent year—

“(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraph (2)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

“(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

“(I) the amount determined under clause (i) for the area for the year; or

“(II) the amount specified in subsection (c)(1)(D) for the area for the year.

“(2) PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—

“(A) IN GENERAL.—Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of—

“(i) the percent determined under subparagraph (B) for the year; and

“(ii) the applicable phase-out factor for the year under subparagraph (C).

“(B) PERCENT DETERMINED.—

“(i) IN GENERAL.—For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

“(ii) NUMERATOR BASED ON DIFFERENCE BETWEEN DEMOGRAPHIC RATE AND RISK RATE.—

“(I) IN GENERAL.—The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

“(II) DEMOGRAPHIC RATE.—The demographic rate described in this subclause is the Secretary’s estimate of the total payments that would have

been made under this part in the year if all the monthly payment amounts for all MA plans were equal to $\frac{1}{12}$ of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

“(III) RISK RATE.—The risk rate described in this subclause is the Secretary’s estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

“(iii) DENOMINATOR BASED ON RISK RATE.—The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

“(iv) REQUIREMENTS.—In estimating the amounts under the previous clauses, the Secretary shall—

“(I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

“(II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

“(III) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

“(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

“(V) as necessary, adjust the risk scores for lagged cohorts; and

“(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

“(v) AUTHORITY.—In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

“(C) APPLICABLE PHASE-OUT FACTOR.—For purposes of subparagraph (A)(ii), the term ‘applicable phase-out factor’ means—

“(i) for 2007, 0.55;

“(ii) for 2008, 0.40;

“(iii) for 2009, 0.25; and

“(iv) for 2010, 0.05.

“(D) TERMINATION OF APPLICATION.—Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater

than the amount estimated under subparagraph (B)(ii)(II) for the year.

“(3) NO REVISION IN PERCENT.—

“(A) IN GENERAL.—The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

“(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority of the Secretary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.”.

(b) REFINEMENTS TO HEALTH STATUS ADJUSTMENT.—Section 1853(a)(1)(C) of such Act (42 U.S.C. 1395w–23) is amended—

(1) by designating the matter after the heading as a clause (i) with the following heading: “IN GENERAL.—” and indenting appropriately; and

(2) by adding at the end the following:

“(ii) APPLICATION DURING PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—For 2006 through 2010:

“(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.

“(II) In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated into the risk scores only for 2008, 2009, and 2010. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available.”.

SEC. 5302. RURAL PACE PROVIDER GRANT PROGRAM.

(a) DEFINITIONS.—In this section:

(1) CMS.—The term “CMS” means the Centers for Medicare & Medicaid Services.

(2) PACE PROGRAM.—The term “PACE program” has the meaning given that term in sections 1894(a)(2) and 1934(a)(2) of the Social Security Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).

(3) PACE PROVIDER.—The term “PACE provider” has the meaning given that term in section 1894(a)(3) or 1934(a)(3) of the Social Security Act (42 U.S.C. 1395eee(a)(3); 1396u–4(a)(3)).

(4) RURAL AREA.—The term “rural area” has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) RURAL PACE PILOT SITE.—The term “rural PACE pilot site” means a PACE provider that has been approved to provide services in a geographic service area that is, in whole or in part,

a rural area, and that has received a site development grant under this section.

(6) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(b) SITE DEVELOPMENT GRANTS AND TECHNICAL ASSISTANCE PROGRAM.—

(1) SITE DEVELOPMENT GRANTS.—

(A) IN GENERAL.—The Secretary shall establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area.

(B) AMOUNT PER AWARD.—A site development grant awarded under subparagraph (A) to any individual rural PACE pilot site shall not exceed \$750,000.

(C) NUMBER OF AWARDS.—Not more than 15 rural PACE pilot sites shall be awarded a site development grant under subparagraph (A).

(D) USE OF FUNDS.—Funds made available under a site development grant awarded under subparagraph (A) may be used for the following expenses only to the extent such expenses are incurred in relation to establishing or delivering PACE program services in a rural area:

(i) Feasibility analysis and planning.

(ii) Interdisciplinary team development.

(iii) Development of a provider network, including contract development.

(iv) Development or adaptation of claims processing systems.

(v) Preparation of special education and outreach efforts required for the PACE program.

(vi) Development of expense reporting required for calculation of outlier payments or reconciliation processes.

(vii) Development of any special quality of care or patient satisfaction data collection efforts.

(viii) Establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size.

(ix) Startup and development costs incurred prior to the approval of the rural PACE pilot site’s PACE provider application by CMS.

(x) Any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

(E) APPROPRIATION.—

(i) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for fiscal year 2006, \$7,500,000.

(ii) AVAILABILITY.—Funds appropriated under clause (i) shall remain available for expenditure through fiscal year 2008.

(2) TECHNICAL ASSISTANCE PROGRAM.—The Secretary shall establish a technical assistance program to provide—

(A) outreach and education to State agencies and provider organizations interested in establishing PACE programs in rural areas; and

(B) technical assistance necessary to support rural PACE pilot sites.

(c) **COST OUTLIER PROTECTION FOR RURAL PACE PILOT SITES.**—

(1) **ESTABLISHMENT OF FUND FOR REIMBURSEMENT OF OUTLIER COSTS.**—Notwithstanding any other provision of law, the Secretary shall establish an outlier fund to reimburse rural PACE pilot sites for recognized outlier costs (as defined in paragraph (3)) incurred for eligible outlier participants (as defined in paragraph (2)) in an amount, subject to paragraph (4), equal to 80 percent of the amount by which the recognized outlier costs exceeds \$50,000.

(2) **ELIGIBLE OUTLIER PARTICIPANT.**—For purposes of this subsection, the term “eligible outlier participant” means a PACE program eligible individual (as defined in sections 1894(a)(5) and 1934(a)(5) of the Social Security Act (42 U.S.C. 1395eee(a)(5); 1396u–4(a)(5)) who resides in a rural area and with respect to whom the rural PACE pilot site incurs more than \$50,000 in recognized costs in a 12-month period.

(3) **RECOGNIZED OUTLIER COSTS DEFINED.**—

(A) **IN GENERAL.**—For purposes of this subsection, the term “recognized outlier costs” means, with respect to services furnished to an eligible outlier participant by a rural PACE pilot site, the least of the following (as documented by the site to the satisfaction of the Secretary) for the provision of inpatient and related physician and ancillary services for the eligible outlier participant in a given 12-month period:

(i) If the services are provided under a contract between the pilot site and the provider, the payment rate specified under the contract.

(ii) The payment rate established under the original medicare fee-for-service program for such service.

(iii) The amount actually paid for the services by the pilot site.

(B) **INCLUSION IN ONLY ONE PERIOD.**—Recognized outlier costs may not be included in more than one 12-month period.

(3) **OUTLIER EXPENSE PAYMENT.**—

(A) **PAYMENT FOR OUTLIER COSTS.**—Subject to subparagraph (B), in the case of a rural PACE pilot site that has incurred outlier costs for an eligible outlier participant, the rural PACE pilot site shall receive an outlier expense payment equal to 80 percent of such costs that exceed \$50,000.

(4) **LIMITATIONS.**—

(A) **COSTS INCURRED PER ELIGIBLE OUTLIER PARTICIPANT.**—The total amount of outlier expense payments made under this subsection to a rural PACE pilot site with respect to an eligible outlier participant for any 12-month period shall not exceed \$100,000 for the 12-month period used to calculate the payment.

(B) *COSTS INCURRED PER PROVIDER.*—No rural PACE pilot site may receive more than \$500,000 in total outlier expense payments in a 12-month period.

(C) *LIMITATION OF OUTLIER COST REIMBURSEMENT PERIOD.*—A rural PACE pilot site shall only receive outlier expense payments under this subsection with respect to costs incurred during the first 3 years of the site's operation.

(5) *REQUIREMENT TO ACCESS RISK RESERVES PRIOR TO PAYMENT.*—A rural PACE pilot site shall access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves maintained to satisfy the requirements of section 460.80(c) of title 42, Code of Federal Regulations) and any working capital established through a site development grant awarded under subsection (b)(1), prior to receiving any payment from the outlier fund.

(6) *APPLICATION.*—In order to receive an outlier expense payment under this subsection with respect to an eligible outlier participant, a rural PACE pilot site shall submit an application containing—

(A) documentation of the costs incurred with respect to the participant;

(B) a certification that the site has complied with the requirements under paragraph (4); and

(C) such additional information as the Secretary may require.

(7) *APPROPRIATION.*—

(A) *IN GENERAL.*—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for fiscal year 2006, \$10,000,000.

(B) *AVAILABILITY.*—Funds appropriated under subparagraph (A) shall remain available for expenditure through fiscal year 2010.

(d) *EVALUATION OF PACE PROVIDERS SERVING RURAL SERVICE AREAS.*—Not later than 60 months after the date of enactment of this Act, the Secretary shall submit a report to Congress containing an evaluation of the experience of rural PACE pilot sites.

(e) *AMOUNTS IN ADDITION TO PAYMENTS UNDER SOCIAL SECURITY ACT.*—Any amounts paid under the authority of this section to a PACE provider shall be in addition to payments made to the provider under section 1894 or 1934 of the Social Security Act (42 U.S.C. 1395eee; 1396u-4).

TITLE VI—MEDICAID AND SCHIP

Subtitle A—Medicaid

CHAPTER 1—PAYMENT FOR PRESCRIPTION DRUGS

SEC. 6001. FEDERAL UPPER PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS AND OTHER DRUG PAYMENT PROVISIONS.

(a) *MODIFICATION OF FEDERAL UPPER PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS; DEFINITION OF MULTIPLE SOURCE DRUGS.*—Section 1927 of the Social Security Act (42 U.S.C. 1396r-8) is amended—

- (1) in subsection (e)(4)—
- (A) by striking “The Secretary” and inserting “Subject to paragraph (5), the Secretary”; and
- (B) by inserting “(or, effective January 1, 2007, two or more)” after “three or more”;
- (2) by adding at the end of subsection (e) the following new paragraph:
- “(5) *USE OF AMP IN UPPER PAYMENT LIMITS.*—Effective January 1, 2007, in applying the Federal upper reimbursement limit under paragraph (4) and section 447.332(b) of title 42 of the Code of Federal Regulations, the Secretary shall substitute 250 percent of the average manufacturer price (as computed without regard to customary prompt pay discounts extended to wholesalers) for 150 percent of the published price.”;
- (3) in subsection (k)(7)(A)(i), in the matter preceding subclause (I), by striking “are 2 or more drug products” and inserting “at least 1 other drug product”; and
- (4) in subclauses (I), (II), and (III) of subsection (k)(7)(A)(i), by striking “are” and inserting “is” each place it appears.
- (b) *DISCLOSURE OF PRICE INFORMATION TO STATES AND THE PUBLIC.*—Subsection (b)(3) of such section is amended—
- (1) in subparagraph (A)—
- (A) in clause (i), by inserting “month of a” after “last day of each”; and
- (B) by adding at the end the following: “Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v).”; and
- (2) in subparagraph (D)—
- (A) by striking “and” at the end of clause (ii);
- (B) by striking the period at the end of clause (iii) and inserting a comma; and
- (C) by inserting after clause (iii) the following new clauses:
- “(iv) to States to carry out this title, and
- “(v) to the Secretary to disclose (through a website accessible to the public) average manufacturer prices.”.
- (c) *DEFINITION OF AVERAGE MANUFACTURER PRICE.*—
- (1) *EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS.*—Subsection (k)(1) of such section is amended—
- (A) by striking “The term” and inserting the following: “(A) *IN GENERAL.*—Subject to subparagraph (B), the term”;
- (B) by striking “, after deducting customary prompt pay discounts”; and
- (C) by adding at the end the following:
- “(B) *EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS.*—The average manufacturer price for a covered outpatient drug shall be determined without regard to customary prompt pay discounts extended to wholesalers.”.

(2) *MANUFACTURER REPORTING OF PROMPT PAY DISCOUNTS.*—Subsection (b)(3)(A)(i) of such section is amended by inserting “, customary prompt pay discounts extended to wholesalers,” after “(k)(1)”.

(3) *REQUIREMENT TO PROMULGATE REGULATION.*—

(A) *INSPECTOR GENERAL RECOMMENDATIONS.*—Not later than June 1, 2006, the Inspector General of the Department of Health and Human Services shall—

(i) review the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, as amended by this section; and

(ii) shall submit to the Secretary of Health and Human Services and Congress such recommendations for changes in such requirements or manner as the Inspector General determines to be appropriate.

(B) *DEADLINE FOR PROMULGATION.*—Not later than July 1, 2007, the Secretary of Health and Human Services shall promulgate a regulation that clarifies the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, taking into consideration the recommendations submitted to the Secretary in accordance with subparagraph (A)(ii).

(d) *EXCLUSION OF SALES AT A NOMINAL PRICE FROM DETERMINATION OF BEST PRICE.*—

(1) *MANUFACTURER REPORTING OF SALES.*—Subsection (b)(3)(A)(iii) of such section is amended by inserting before the period at the end the following: “, and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs”.

(2) *LIMITATION ON SALES AT A NOMINAL PRICE.*—Subsection (c)(1) of such section is amended by adding at the end the following new subparagraph:

“(D) *LIMITATION ON SALES AT A NOMINAL PRICE.*—

“(i) *IN GENERAL.*—For purposes of subparagraph (C)(ii)(III) and subsection (b)(3)(A)(iii)(III), only sales by a manufacturer of covered outpatient drugs at nominal prices to the following shall be considered to be sales at a nominal price or merely nominal in amount:

“(I) A covered entity described in section 340B(a)(4) of the Public Health Service Act.

“(II) An intermediate care facility for the mentally retarded.

“(III) A State-owned or operated nursing facility.

“(IV) Any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at a nominal price would be appropriate based on the factors described in clause (ii).

“(ii) *FACTORS.*—The factors described in this clause with respect to a facility or entity are the following:

“(I) The type of facility or entity.

“(II) The services provided by the facility or entity.

“(III) The patient population served by the facility or entity.

“(IV) The number of other facilities or entities eligible to purchase at nominal prices in the same service area.

“(iii) NONAPPLICATION.—Clause (i) shall not apply with respect to sales by a manufacturer at a nominal price of covered outpatient drugs pursuant to a master agreement under section 8126 of title 38, United States Code.”.

(e) RETAIL SURVEY PRICES; STATE PAYMENT AND UTILIZATION RATES; AND PERFORMANCE RANKINGS.—Such section is further amended by inserting after subsection (e) the following new subsection:

“(f) SURVEY OF RETAIL PRICES; STATE PAYMENT AND UTILIZATION RATES; AND PERFORMANCE RANKINGS.—

“(1) SURVEY OF RETAIL PRICES.—

“(A) USE OF VENDOR.—The Secretary may contract services for—

“(i) the determination on a monthly basis of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available); and

“(ii) the notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available.

“(B) SECRETARY RESPONSE TO NOTIFICATION OF AVAILABILITY OF MULTIPLE SOURCE PRODUCTS.—If contractor notifies the Secretary under subparagraph (A)(ii) that a drug product described in such subparagraph has become generally available, the Secretary shall make a determination, within 7 days after receiving such notification, as to whether the product is now described in subsection (e)(4).

“(C) USE OF COMPETITIVE BIDDING.—In contracting for such services, the Secretary shall competitively bid for an outside vendor that has a demonstrated history in—

“(i) surveying and determining, on a representative nationwide basis, retail prices for ingredient costs of prescription drugs;

“(ii) working with retail pharmacies, commercial payers, and States in obtaining and disseminating such price information; and

“(iii) collecting and reporting such price information on at least a monthly basis.

In contracting for such services, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this subsection, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

“(D) ADDITIONAL PROVISIONS.—A contract with a vendor under this paragraph shall include such terms and conditions as the Secretary shall specify, including the following:

“(i) The vendor must monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug generally available.

“(ii) The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs.

“(iii) The contract shall be effective for a term of 2 years.

“(E) AVAILABILITY OF INFORMATION TO STATES.—Information on retail survey prices obtained under this paragraph, including applicable information on single source drugs, shall be provided to States on at least a monthly basis. The Secretary shall devise and implement a means for providing access to each State agency designated under section 1902(a)(5) with responsibility for the administration or supervision of the administration of the State plan under this title of the retail survey price determined under this paragraph.

“(2) ANNUAL STATE REPORT.—Each State shall annually report to the Secretary information on—

“(A) the payment rates under the State plan under this title for covered outpatient drugs;

“(B) the dispensing fees paid under such plan for such drugs; and

“(C) utilization rates for noninnovator multiple source drugs under such plan.

“(3) ANNUAL STATE PERFORMANCE RANKINGS.—

“(A) COMPARATIVE ANALYSIS.—The Secretary annually shall compare, for the 50 most widely prescribed drugs identified by the Secretary, the national retail sales price data (collected under paragraph (1)) for such drugs with data on prices under this title for each such drug for each State.

“(B) AVAILABILITY OF INFORMATION.—The Secretary shall submit to Congress and the States full information regarding the annual rankings made under subparagraph (A).

“(4) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services \$5,000,000 for each of fiscal years 2006 through 2010 to carry out this subsection.”.

(f) MISCELLANEOUS AMENDMENTS.—

(1) IN GENERAL.—Sections 1927(g)(1)(B)(i)(II) and 1861(t)(2)(B)(ii)(I) of such Act are each amended by inserting “(or its successor publications)” after “United States Pharmacopoeia-Drug Information”.

(2) PAPERWORK REDUCTION.—The last sentence of section 1927(g)(2)(A)(ii) of such Act (42 U.S.C. 1396r-8(g)(2)(A)(ii)) is amended by inserting before the period at the end the following: “, or to require verification of the offer to provide consultation or a refusal of such offer”.

(3) *EFFECTIVE DATE.*—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(g) *EFFECTIVE DATE.*—Except as otherwise provided, the amendments made by this section shall take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 6002. COLLECTION AND SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.

(a) *IN GENERAL.*—Section 1927(a) of the Social Security Act (42 U.S.C. 1396r–8(a)) is amended by adding at the end the following new paragraph:

“(7) *REQUIREMENT FOR SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.*—

“(A) *SINGLE SOURCE DRUGS.*—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a single source drug that is physician administered under this title (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the collection and submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section for drugs administered for which payment is made under this title.

“(B) *MULTIPLE SOURCE DRUGS.*—

“(i) *IDENTIFICATION OF MOST FREQUENTLY PHYSICIAN ADMINISTERED MULTIPLE SOURCE DRUGS.*—Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of physician administered drugs dispensed under this title. The Secretary may modify such list from year to year to reflect changes in such volume.

“(ii) *REQUIREMENT.*—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (i), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section.

“(C) *USE OF NDC CODES.*—Not later than January 1, 2007, the information shall be submitted under subparagraphs (A) and (B)(ii) using National Drug Code codes unless the Secretary specifies that an alternative coding system should be used.

“(D) *HARDSHIP WAIVER.*—The Secretary may delay the application of subparagraph (A) or (B)(ii), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.”

(b) *LIMITATION ON PAYMENT.*—Section 1903(i)(10) of such Act (42 U.S.C. 1396b(i)(10)), is amended—

- (1) by striking “and” at the end of subparagraph (A);
- (2) by striking “or” at the end of subparagraph (B) and inserting “and”; and
- (3) by adding at the end the following new subparagraph:
“(C) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section; or”.

SEC. 6003. IMPROVED REGULATION OF DRUGS SOLD UNDER A NEW DRUG APPLICATION APPROVED UNDER SECTION 505(c) OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) *INCLUSION WITH OTHER REPORTED AVERAGE MANUFACTURER AND BEST PRICES.*—Section 1927(b)(3)(A) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—

- (1) by striking clause (i) and inserting the following:
“(i) not later than 30 days after the last day of each rebate period under the agreement—
“(I) on the average manufacturer price (as defined in subsection (k)(1)) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act); and
“(II) for single source drugs and innovator multiple source drugs (including all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), on the manufacturer’s best price (as defined in subsection (c)(1)(C)) for such drugs for the rebate period under the agreement;” and
- (2) in clause (ii), by inserting “(including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)” after “drugs”.

(b) *CONFORMING AMENDMENTS.*—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—

- (1) in subsection (c)(1)(C)—
 - (A) in clause (i), in the matter preceding subclause (I), by inserting after “or innovator multiple source drug of a manufacturer” the following: “(including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)”; and
 - (B) in clause (ii)—
 - (i) in subclause (II), by striking “and” at the end;
 - (ii) in subclause (III), by striking the period at the end and inserting “; and”; and
 - (iii) by adding at the end the following:

“(IV) in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, non-profit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i).”; and

(2) in subsection (k), as amended by section 6001(c)(1), by adding at the end the following:

“(C) INCLUSION OF SECTION 505(c) DRUGS.—In the case of a manufacturer that approves, allows, or otherwise permits any drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, such term shall be inclusive of the average price paid for such drug by wholesalers for drugs distributed to the retail pharmacy class of trade.”.

(c) *EFFECTIVE DATE.*—The amendments made by this section take effect on January 1, 2007.

SEC. 6004. CHILDREN’S HOSPITAL PARTICIPATION IN SECTION 340B DRUG DISCOUNT PROGRAM.

(a) *IN GENERAL.*—Section 1927(a)(5)(B) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)(B)) is amended by inserting before the period at the end the following: “and a children’s hospital described in section 1886(d)(1)(B)(iii) which meets the requirements of clauses (i) and (ii) of section 340B(b)(4)(L) of the Public Health Service Act and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care provided by the hospital to patients eligible for medical assistance under a State plan under this title”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall apply to drugs purchased on or after the date of the enactment of this Act.

CHAPTER 2—LONG-TERM CARE UNDER MEDICAID

Subchapter A—Reform of Asset Transfer Rules

SEC. 6011. LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.

(a) *LENGTHENING LOOK-BACK PERIOD FOR ALL DISPOSALS TO 5 YEARS.*—Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is amended by inserting “or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005” before “, 60 months”.

(b) *CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.*—Section 1917(c)(1)(D) of such Act (42 U.S.C. 1396p(c)(1)(D)) is amended—

(1) by striking “(D) The date” and inserting “(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date”; and

(2) by adding at the end the following new clause:
 “(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to transfers made on or after the date of the enactment of this Act.

(d) **AVAILABILITY OF HARDSHIP WAIVERS.**—Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))—

(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

(A) of medical care such that the individual’s health or life would be endangered; or

(B) of food, clothing, shelter, or other necessities of life;

and

(2) which provides for—

(A) notice to recipients that an undue hardship exception exists;

(B) a timely process for determining whether an undue hardship waiver will be granted; and

(C) a process under which an adverse determination can be appealed.

(e) **ADDITIONAL PROVISIONS ON HARDSHIP WAIVERS.**—

(1) **APPLICATION BY FACILITY.**—Section 1917(c)(2) of the Social Security Act (42 U.S.C. 1396p(c)(2)) is amended—

(A) by striking the semicolon at the end of subparagraph (D) and inserting a period; and

(B) by adding after and below such subparagraph the following:

“The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual.”.

(2) **AUTHORITY TO MAKE BED HOLD PAYMENTS FOR HARDSHIP APPLICANTS.**—Such section is further amended by adding at the end the following: “While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.”.

SEC. 6012. DISCLOSURE AND TREATMENT OF ANNUITIES.

(a) **IN GENERAL.**—Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended by redesignating subsection (e) as sub-

section (f) and by inserting after subsection (d) the following new subsection:

“(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

“(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State’s remainder interest under such subsection.

“(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State’s obligations for medical assistance or in the individual’s eligibility for such assistance.

“(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

“(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).”

(b) REQUIREMENT FOR STATE TO BE NAMED AS A REMAINDER BENEFICIARY.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), is amended by adding at the end the following:

“(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

“(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

“(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.”

(c) INCLUSION OF TRANSFERS TO PURCHASE BALLOON ANNUITIES.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as

amended by subsection (b), is amended by adding at the end the following:

“(G) For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—

“(i) the annuity is—

“(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

“(II) purchased with proceeds from—

“(aa) an account or trust described in subsection (a), (c), (p) of section 408 of such Code;

“(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

“(cc) a Roth IRA described in section 408A of such Code; or

“(ii) the annuity—

“(I) is irrevocable and nonassignable;

“(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

“(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.”

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act.

SEC. 6013. APPLICATION OF “INCOME-FIRST” RULE IN APPLYING COMMUNITY SPOUSE’S INCOME BEFORE ASSETS IN PROVIDING SUPPORT OF COMMUNITY SPOUSE.

(a) **IN GENERAL.**—Section 1924(d) of the Social Security Act (42 U.S.C. 1396r-5(d)) is amended by adding at the end the following new subparagraph:

“(6) **APPLICATION OF ‘INCOME FIRST’ RULE TO REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.**—For purposes of this subsection and subsections (c) and (e), a State must consider that all income of the institutionalized spouse that could be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

SEC. 6014. DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY.

(a) **IN GENERAL.**—Section 1917 of the Social Security Act, as amended by section 6012(a), is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

“(f)(1)(A) Notwithstanding any other provision of this title, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual’s equity interest in the individual’s home exceeds \$500,000.

“(B) A State may elect, without regard to the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), to apply subparagraph (A) by substituting for ‘\$500,000’, an amount that exceeds such amount, but does not exceed \$750,000.

“(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

“(2) Paragraph (1) shall not apply with respect to an individual if—

“(A) the spouse of such individual, or

“(B) such individual’s child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual’s home.

“(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual’s total equity interest in the home.

“(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

SEC. 6015. ENFORCEABILITY OF CONTINUING CARE RETIREMENT COMMUNITIES (CCRC) AND LIFE CARE COMMUNITY ADMISSION CONTRACTS.

(a) **ADMISSION POLICIES OF NURSING FACILITIES.**—Section 1919(c)(5) of the Social Security Act (42 U.S.C. 1396r(c)(5)) is amended—

(1) in subparagraph (A)(i)(II), by inserting “subject to clause (v),” after “(II)”; and

(2) by adding at the end of subparagraph (B) the following new clause:

“(v) **TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITIES ADMISSION CONTRACTS.**—Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1924, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require resi-

dents to spend on their care resources declared for the purposes of admission before applying for medical assistance.”.

(b) *TREATMENT OF ENTRANCE FEES.*—Section 1917 of such Act (42 U.S.C. 1396p), as amended by sections 6012(a) and 6014(a), is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

“(g) *TREATMENT OF ENTRANCE FEES OF INDIVIDUALS RESIDING IN CONTINUING CARE RETIREMENT COMMUNITIES.*—

“(1) *IN GENERAL.*—For purposes of determining an individual’s eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

“(2) *TREATMENT OF ENTRANCE FEE.*—For purposes of this subsection, an individual’s entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

“(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

“(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

“(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.”.

SEC. 6016. ADDITIONAL REFORMS OF MEDICAID ASSET TRANSFER RULES.

(a) *REQUIREMENT TO IMPOSE PARTIAL MONTHS OF INELIGIBILITY.*—Section 1917(c)(1)(E) of the Social Security Act (42 U.S.C. 1396p(c)(1)(E)) is amended by adding at the end the following:

“(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.”.

(b) *AUTHORITY FOR STATES TO ACCUMULATE MULTIPLE TRANSFERS INTO ONE PENALTY PERIOD.*—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsections (b) and (c) of section 6012, is amended by adding at the end the following:

“(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual’s spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

“(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual’s spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

“(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.”.

(c) INCLUSION OF TRANSFER OF CERTAIN NOTES AND LOANS ASSETS.—Section 1917(c)(1) of such Act (42 U.S.C. 1396 p(c)(1)), as amended by subsection (b), is amended by adding at the end the following:

“(I) For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

“(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

“(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

“(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual’s application for medical assistance for services described in subparagraph (C).”.

(d) INCLUSION OF TRANSFERS TO PURCHASE LIFE ESTATES.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (c), is amended by adding at the end the following:

“(J) For purposes of this paragraph with respect to a transfer of assets, the term ‘assets’ includes the purchase of a life estate interest in another individual’s home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.”.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) EXCEPTIONS.—The amendments made by this section shall not apply—

(A) to medical assistance provided for services furnished before the date of enactment;

(B) with respect to assets disposed of on or before the date of enactment of this Act; or

(C) with respect to trusts established on or before the date of enactment of this Act.

(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first

regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

Subchapter B—Expanded Access to Certain Benefits

SEC. 6021. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) **EXPANSION AUTHORITY.**—

(1) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(A) in paragraph (1)(C)—

(i) in clause (ii), by inserting “and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))” after “1993,”; and

(ii) by adding at the end the following new clauses:

“(iii) For purposes of this paragraph, the term ‘qualified State long-term care insurance partnership’ means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

“(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

“(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

“(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

“(IV) If the policy is sold to an individual who—

“(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

“(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

“(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

“(V) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department’s role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

“(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Sec-

retary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

“(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term ‘long-term care insurance policy’ includes a certificate issued under a group insurance contract

“(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

“(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

“(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.”; and

(B) by adding at the end the following:

“(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

“(i) In the case of the model regulation, the following requirements:

- “(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.
- “(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.
- “(III) Section 6C (relating to extension of benefits).
- “(IV) Section 6D (relating to continuation or conversion of coverage).
- “(V) Section 6E (relating to discontinuance and replacement of policies).
- “(VI) Section 7 (relating to unintentional lapse).
- “(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.
- “(VIII) Section 9 (relating to required disclosure of rating practices to consumer).
- “(IX) Section 11 (relating to prohibitions against post-claims underwriting).
- “(X) Section 12 (relating to minimum standards).
- “(XI) Section 14 (relating to application forms and replacement coverage).
- “(XII) Section 15 (relating to reporting requirements).
- “(XIII) Section 22 (relating to filing requirements for marketing).
- “(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.
- “(XV) Section 24 (relating to suitability).
- “(XVI) Section 25 (relating to prohibition against pre-existing conditions and probationary periods in replacement policies or certificates).
- “(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).
- “(XVIII) Section 29 (relating to standard format outline of coverage).
- “(XIX) Section 30 (relating to requirement to deliver shopper’s guide).
- “(ii) In the case of the model Act, the following:
- “(I) Section 6C (relating to preexisting conditions).
- “(II) Section 6D (relating to prior hospitalization).
- “(III) The provisions of section 8 relating to contingent nonforfeiture benefits.
- “(IV) Section 6F (relating to right to return).
- “(V) Section 6G (relating to outline of coverage).
- “(VI) Section 6H (relating to requirements for certificates under group plans).
- “(VII) Section 6J (relating to policy summary).
- “(VIII) Section 6K (relating to monthly reports on accelerated death benefits).
- “(IX) Section 7 (relating to incontestability period).
- “(B) For purposes of this paragraph and paragraph (1)(C)—
- “(i) the terms ‘model regulation’ and ‘model Act’ mean the long-term care insurance model regulation, and the long-term

care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

“(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

“(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

“(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.”

(2) STATE REPORTING REQUIREMENTS.—Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

(3) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary of Health and Human Services.

(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

(1) *benefits paid under such policies will be treated the same by all such States; and*

(2) *States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.*

(c) *ANNUAL REPORTS TO CONGRESS.—*

(1) *IN GENERAL.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.*

(2) *APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, \$1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).*

(d) *NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—*

(1) *ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The Clearinghouse may be established through a contract or interagency agreement.*

(2) *DUTIES.—*

(A) *IN GENERAL.—The National Clearinghouse for Long-Term Care Information shall—*

(i) *educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;*

(ii) *provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and*

(iii) *maintain a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.*

(B) *REQUIREMENT.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.*

(3) *APPROPRIATION.*—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, \$3,000,000 for each of fiscal years 2006 through 2010.

CHAPTER 3—ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID

SEC. 6032. ENCOURAGING THE ENACTMENT OF STATE FALSE CLAIMS ACTS.

(a) *IN GENERAL.*—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908A the following:

“STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE SHARE OF RECOVERIES

“*SEC. 1909. (a) IN GENERAL.*—Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

“(b) *REQUIREMENTS.*—For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

“(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a).

“(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code.

“(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

“(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code.

“(c) *DEEMED COMPLIANCE.*—A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

“(d) *NO PRECLUSION OF BROADER LAWS.*—Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.”.

(b) *EFFECTIVE DATE.*—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2007.

SEC. 6033. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.

(a) *IN GENERAL.*—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (66), by striking “and” at the end;
 (2) in paragraph (67) by striking the period at the end and inserting “; and”; and

(3) by inserting after paragraph (67) the following:
 “(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

“(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

“(B) include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse; and

“(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.”.

(b) *EFFECTIVE DATE.*—Except as provided in section 6035(e), the amendments made by subsection (a) take effect on January 1, 2007.

SEC. 6034. PROHIBITION ON RESTOCKING AND DOUBLE BILLING OF PRESCRIPTION DRUGS.

(a) *IN GENERAL.*—Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 6002(b), is amended—

(1) in subparagraph (B), by striking “and” at the end;
 (2) in subparagraph (C), by striking “; or” at the end and inserting “; and”; and

(3) by adding at the end the following:
 “(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or”.

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 6035. MEDICAID INTEGRITY PROGRAM.

(a) *ESTABLISHMENT OF MEDICAID INTEGRITY PROGRAM.*—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1936 as section 1937; and
 (2) by inserting after section 1935 the following:

“MEDICAID INTEGRITY PROGRAM

“SEC. 1936. (a) *IN GENERAL.*—There is hereby established the Medicaid Integrity Program (in this section referred to as the ‘Program’) under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

“(b) *ACTIVITIES DESCRIBED.*—Activities described in this subsection are as follows:

“(1) *Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.*

“(2) *Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including—*

“(A) *cost reports;*

“(B) *consulting contracts; and*

“(C) *risk contracts under section 1903(m).*

“(3) *Identification of overpayments to individuals or entities receiving Federal funds under this title.*

“(4) *Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.*

“(c) *ELIGIBLE ENTITY AND CONTRACTING REQUIREMENTS.*—

“(1) *IN GENERAL.*—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

“(2) *ELIGIBILITY REQUIREMENTS.*—The requirements of this paragraph are the following:

“(A) *The entity has demonstrated capability to carry out the activities described in subsection (b).*

“(B) *In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities.*

“(C) *The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.*

“(D) *The entity meets such other requirements as the Secretary may impose.*

“(3) *CONTRACTING REQUIREMENTS.*—The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

“(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

“(B) Competitive procedures to be used—

“(i) when entering into new contracts under this section;

“(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

“(iii) at any other time considered appropriate by the Secretary.

“(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

“(4) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor’s liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

“(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY.—

“(1) 5-YEAR PLAN.—With respect to the 5 fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse.

“(2) CONSULTATION.—Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title.

“(e) APPROPRIATION.—

“(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation—

“(A) for fiscal year 2006, \$5,000,000;

“(B) for each of fiscal years 2007 and 2008, \$50,000,000; and

“(C) for each fiscal year thereafter, \$75,000,000.

“(2) AVAILABILITY.—Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

“(3) INCREASE IN CMS STAFFING DEVOTED TO PROTECTING MEDICAID PROGRAM INTEGRITY.—From the amounts appropriated under paragraph (1), the Secretary shall increase by 100 the number of full-time equivalent employees whose duties

consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

“(4) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

“(A) the use of funds appropriated pursuant to paragraph (1); and

“(B) the effectiveness of the use of such funds.”.

(b) STATE REQUIREMENT TO COOPERATE WITH INTEGRITY PROGRAM EFFORTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 6033(a), is amended—

(1) in paragraph (67), by striking “and” at the end;

(2) in paragraph (68), by striking the period at the end and inserting “; and”; and

(3) by inserting after paragraph (68), the following:

“(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936.”.

(c) INCREASED FUNDING FOR MEDICAID FRAUD AND ABUSE CONTROL ACTIVITIES.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of Health and Human Services, without further appropriation, \$25,000,000 for each of fiscal years 2006 through 2010, for activities of such Office with respect to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Office of the Inspector General of the Department of Health and Human Services for activities of such Office with respect to the Medicaid program.

(3) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Inspector General of the Department of Health and Human Services shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(d) NATIONAL EXPANSION OF THE MEDICARE-MEDICAID (MEDI-MEDI) DATA MATCH PILOT PROGRAM.—

(1) REQUIREMENT OF THE MEDICARE INTEGRITY PROGRAM.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(A) in subsection (b), by adding at the end the following:

“(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).”; and

(B) by adding at the end the following:

“(g) **MEDICARE-MEDICAID DATA MATCH PROGRAM.**—

“(1) **EXPANSION OF PROGRAM.**—

“(A) **IN GENERAL.**—The Secretary shall enter into contracts with eligible entities for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the ‘Medi-Medi Program’) is conducted with respect to the program established under this title and State Medicaid programs under title XIX for the purpose of—

“(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to look for payment anomalies (including billing or billing patterns identified with respect to service, time, or patient that appear to be suspect or otherwise implausible);

“(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title; and

“(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures.

“(B) **REPORTING REQUIREMENTS.**—The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a medicaid fraud and abuse control unit described in section 1903(q)). Such information shall be disseminated no less frequently than quarterly.

“(2) **LIMITED WAIVER AUTHORITY.**—The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).”.

(2) **FUNDING.**—Section 1817(k)(4) of such Act (42 U.S.C. 1395i(k)(4)), as amended by section 5204 of this Act, is amended—

(A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B), (C), and (D)”; and (B) by adding at the end the following:

“(D) **EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PROGRAM.**—The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1893(b)(6) for the respective fiscal year:

“(i) \$12,000,000 for fiscal year 2006.

“(ii) \$24,000,000 for fiscal year 2007.

“(iii) \$36,000,000 for fiscal year 2008.

“(iv) \$48,000,000 for fiscal year 2009.

“(v) \$60,000,000 for fiscal year 2010 and each fiscal year thereafter.”.

(e) **DELAYED EFFECTIVE DATE FOR CHAPTER.**—Except as otherwise provided in this chapter, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 6036. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.

(a) **CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE.**—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting “, self-insured plans” after “health insurers”; and

(B) by striking “and health maintenance organizations” and inserting “managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service”; and

(2) in subparagraph (G)—

(A) by inserting “a self-insured plan,” after “1974,”; and

(B) by striking “and a health maintenance organization” and inserting “a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service”.

(b) **REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA.**—Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (G), by striking “and” at the end;

(2) in subparagraph (H), by adding “and” after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

“(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

“(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

“(ii) accept the State’s right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

“(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

“(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

“(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

“(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State’s submission of such claim;”.

(c) **EFFECTIVE DATE.**—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

SEC. 6037. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) **IN GENERAL.**—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (i), as amended by section 104 of Public Law 109-91—

(A) by striking “or” at the end of paragraph (20);

(B) by striking the period at the end of paragraph (21) and inserting “; or”; and

(C) by inserting after paragraph (21) the following new paragraph:

“(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.”; and

(2) by adding at the end the following new subsection:

“(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

“(2) *The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title—*

“(A) *and is entitled to or enrolled for benefits under any part of title XVIII;*

“(B) *on the basis of receiving supplemental security income benefits under title XVI; or*

“(C) *on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.*

“(3)(A) *For purposes of this subsection, the term ‘satisfactory documentary evidence of citizenship or nationality’ means—*

“(i) *any document described in subparagraph (B); or*

“(ii) *a document described in subparagraph (C) and a document described in subparagraph (D).*

“(B) *The following are documents described in this subparagraph:*

“(i) *A United States passport.*

“(ii) *Form N-550 or N-570 (Certificate of Naturalization).*

“(iii) *Form N-560 or N-561 (Certificate of United States Citizenship).*

“(iv) *A valid State-issued driver’s license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.*

“(v) *Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.*

“(C) *The following are documents described in this subparagraph:*

“(i) *A certificate of birth in the United States.*

“(ii) *Form FS-545 or Form DS-1350 (Certification of Birth Abroad).*

“(iii) *Form I-97 (United States Citizen Identification Card).*

“(iv) *Form FS-240 (Report of Birth Abroad of a Citizen of the United States).*

“(v) *Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.*

“(D) *The following are documents described in this subparagraph:*

“(i) *Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.*

“(ii) *Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.*

“(E) *A reference in this paragraph to a form includes a reference to any successor form.”*

(b) *EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligi-*

bility made on or after such date in the case of individuals for whom the requirement of section 1903(z) of the Social Security Act, as added by such amendments, was not previously met.

(c) **IMPLEMENTATION REQUIREMENT.**—As soon as practicable after the date of enactment of this Act, the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(23) and (x) of section 1903 of the Social Security Act (as added by subsection (a)) about such requirements and how they may be satisfied.

CHAPTER 4—FLEXIBILITY IN COST SHARING AND BENEFITS

SEC. 6041. STATE OPTION FOR ALTERNATIVE MEDICAID PREMIUMS AND COST SHARING.

(a) **IN GENERAL.**—Title XIX of the Social Security Act is amended by inserting after section 1916 the following new section:

“STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING

“SEC. 1916A. (a) STATE FLEXIBILITY.—

“(1) IN GENERAL.—Notwithstanding sections 1916 and 1902(a)(10)(B), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) section 1916(g).

“(2) DEFINITIONS.—In this section:

“(A) PREMIUM.—The term ‘premium’ includes any enrollment fee or similar charge.

“(B) COST SHARING.—The term ‘cost sharing’ includes any deduction, copayment, or similar charge.

“(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—

“(1) INDIVIDUALS WITH FAMILY INCOME BETWEEN 100 AND 150 PERCENT OF THE POVERTY LINE.—In the case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved, subject to subsections (c)(2) and (e)(2)(A)—

“(A) no premium may be imposed under the plan; and

“(B) with respect to cost sharing—

“(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

“(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

“(2) INDIVIDUALS WITH FAMILY INCOME ABOVE 150 PERCENT OF THE POVERTY LINE.—In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to

a family of the size involved, subject to subsections (c)(2) and (e)(2)(A)—

“(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

“(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

“(3) ADDITIONAL LIMITATIONS.—

“(A) PREMIUMS.—No premiums shall be imposed under this section with respect to the following:

“(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

“(ii) Pregnant women.

“(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

“(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual’s income required for personal needs.

“(v) Women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

“(B) COST SHARING.—Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

“(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

“(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

“(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

“(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

“(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual’s income required for personal needs.

“(vi) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

“(vii) Family planning services and supplies described in section 1905(a)(4)(C).

“(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

“(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

“(4) DETERMINATIONS OF FAMILY INCOME.—In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this title.

“(5) POVERTY LINE DEFINED.—For purposes of this section, the term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(6) CONSTRUCTION.—Nothing in this section shall be construed—

“(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

“(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

“(C) as affecting any such waiver of requirements in effect under this title before the date of the enactment of this section with regard to the imposition of premiums and cost sharing.

“(d) ENFORCEABILITY OF PREMIUMS AND OTHER COST SHARING.—

“(1) PREMIUMS.—Notwithstanding section 1916(c)(3) and section 1902(a)(10)(B), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this

title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

“(2) COST SHARING.—Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this title for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.”.

(b) INDEXING NOMINAL COST SHARING AND CONFORMING AMENDMENT.—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(1) in subsection (f), by inserting “and section 1916A” after “(b)(3)”; and

(2) by adding at the end the following new subsection:

“(h) In applying this section and subsections (c) and (e) of section 1916A, with respect to cost sharing that is ‘nominal’ in amount, the Secretary shall increase such ‘nominal’ amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.

SEC. 6042. SPECIAL RULES FOR COST SHARING FOR PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 6041(a), is amended by inserting after subsection (b) the following new subsection:

“(c) SPECIAL RULES FOR COST SHARING FOR PRESCRIPTION DRUGS.—

“(1) IN GENERAL.—In order to encourage beneficiaries to use drugs (in this subsection referred to as ‘preferred drugs’) identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may—

“(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under section 1916, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

“(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not otherwise be imposed under subsection (b)(3)(B).

“(2) LIMITATIONS.—

“(A) BY INCOME GROUP.—In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed—

“(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1916); or

“(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

“(B) LIMITATION TO NOMINAL FOR EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost sharing due to the application of subsection (b)(3)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1916).

“(C) CONTINUED APPLICATION OF AGGREGATE CAP.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be.

“(3) WAIVER.—In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

“(4) EXCLUSION AUTHORITY.—Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.

SEC. 6043. EMERGENCY ROOM COPAYMENTS FOR NON-EMERGENCY CARE.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 6041 and as amended by section 6042, is further amended by adding at the end the following new subsection:

“(e) STATE OPTION FOR PERMITTING HOSPITALS TO IMPOSE COST SHARING FOR NON-EMERGENCY CARE FURNISHED IN AN EMERGENCY DEPARTMENT.—

“(1) IN GENERAL.—Notwithstanding section 1916 and section 1902(a)(1) or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this title, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

“(A) ACCESS TO NON-EMERGENCY ROOM PROVIDER.—The individual has actually available and accessible (as such terms are applied by the Secretary under section 1916(b)(3)) an alternate non-emergency services provider with respect to such services.

“(B) NOTICE.—The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1867 and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

“(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

“(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

“(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

“(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

“(2) LIMITATIONS.—

“(A) FOR POOREST BENEFICIARIES.—In the case of an individual described in subsection (b)(1), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under section 1916, subject to the percent of income limitation otherwise applicable under subsection (b)(1).

“(B) APPLICATION TO EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost sharing under subsection (b)(3), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1916) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

“(C) CONTINUED APPLICATION OF AGGREGATE CAP; RELATION TO OTHER COST SHARING.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a).

“(3) CONSTRUCTION.—Nothing in this section shall be construed—

“(A) to limit a hospital’s obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867; or

“(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

“(4) STANDARD REGARDING IMPOSITION OF COST SHARING.—No hospital or physician shall be liable in any civil action or proceeding for the imposition of cost-sharing under this section, absent a finding by clear and convincing evidence of gross negligence by the hospital or physician. The previous sentence shall not affect any liability under section 1867 or otherwise applicable under State law based upon the provision of (or failure to provide) care.

“(5) DEFINITIONS.—For purposes of this subsection:

“(A) 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 section 1867.

“(B) ALTERNATE NON-EMERGENCY SERVICES PROVIDER.—The term ‘alternative non-emergency services provider’ means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician’s office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this title.”.

(b) GRANT FUNDS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 6037(a)(2), is amended by adding at the end the following new subsection:

“(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

“(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

“(2) LIMITATION.—The total amount of payments under this subsection shall not exceed \$50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

“(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to

States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

“(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

“(B) are in partnership with local community hospitals.

“(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to non-emergency services furnished on or after January 1, 2007.

SEC. 6044. USE OF BENCHMARK BENEFIT PACKAGES.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by section 6035, is amended by redesignating section 1937 as section 1938 and by inserting after section 1936 the following new section:

“STATE FLEXIBILITY IN BENEFIT PACKAGES

“SEC. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

“(1) AUTHORITY.—

“(A) IN GENERAL.—Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in coverage that provides—

“(i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

“(ii) for any child under 19 years of age who is covered under the State plan under section 1902(a)(10)(A), wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).

“(B) LIMITATION.—The State may only exercise the option under subparagraph (A) for an individual eligible under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.

“(C) OPTION OF WRAP-AROUND BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.

“(D) TREATMENT AS MEDICAL ASSISTANCE.—Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

“(2) APPLICATION.—

“(A) *IN GENERAL.*—Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

“(B) *LIMITATION ON APPLICATION.*—A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

“(i) *MANDATORY PREGNANT WOMEN.*—The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

“(ii) *BLIND OR DISABLED INDIVIDUALS.*—The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

“(iii) *DUAL ELIGIBLES.*—The individual is entitled to benefits under any part of title XVIII.

“(iv) *TERMINALLY ILL HOSPICE PATIENTS.*—The individual is terminally ill and is receiving benefits for hospice care under this title.

“(v) *ELIGIBLE ON BASIS OF INSTITUTIONALIZATION.*—The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual’s income required for personal needs.

“(vi) *MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS.*—The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

“(vii) *BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES.*—The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).

“(viii) *CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.*—The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

“(ix) *TANF AND SECTION 1931 PARENTS.*—The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after the welfare reform effective date defined in section 1931(i)).

“(x) *WOMEN IN THE BREAST OR CERVICAL CANCER PROGRAM.*—The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

“(xii) *LIMITED SERVICES BENEFICIARIES.*—The individual—

“(I) qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII); or

“(II) is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

“(C) *FULL-BENEFIT ELIGIBLE INDIVIDUALS.*—

“(i) *IN GENERAL.*—For purposes of this paragraph, subject to clause (ii), the term ‘full-benefit eligible individual’ means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1905(a) which are covered under the State plan under this title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for all such services under this title, as determined by the Secretary.

“(ii) *EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS.*—Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

“(b) *BENCHMARK BENEFIT PACKAGES.*—

“(1) *IN GENERAL.*—For purposes of subsection (a)(1), each of the following coverage shall be considered to be benchmark coverage:

“(A) *FEHBP-EQUIVALENT HEALTH INSURANCE COVERAGE.*—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

“(B) *STATE EMPLOYEE COVERAGE.*—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

“(C) *COVERAGE OFFERED THROUGH HMO.*—The health insurance coverage plan that—

“(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

“(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

“(D) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

“(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

“(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the following categories of basic services:

“(i) Inpatient and outpatient hospital services.

“(ii) Physicians’ surgical and medical services.

“(iii) Laboratory and x-ray services.

“(iv) Well-baby and well-child care, including age-appropriate immunizations.

“(v) Other appropriate preventive services, as designated by the Secretary.

“(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

“(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

“(i) Coverage of prescription drugs.

“(ii) Mental health services.

“(iii) Vision services.

“(iv) Hearing services.

“(3) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

“(A) by an individual who is a member of the American Academy of Actuaries;

“(B) using generally accepted actuarial principles and methodologies;

“(C) using a standardized set of utilization and price factors;

“(D) using a standardized population that is representative of the population involved;

“(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

“(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

“(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

“(4) COVERAGE OF RURAL HEALTH CLINIC AND FQHC SERVICES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless—

“(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2); and

“(B) payment for such services is made in accordance with the requirements of section 1902(bb).”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on March 31, 2006.

CHAPTER 5—STATE FINANCING UNDER MEDICAID

SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

“(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).”.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) DELAY IN EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

(B) SPECIFIED STATES.—For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a medicaid managed care organization with a contract under section 1903(m) of the Social Security Act as of December 8, 2005.

(c) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS.—

(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State’s use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or

certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(2) **CENTER DESCRIBED.**—A center described in this paragraph is a publicly-owned regional medical center that—

(A) provides level 1 trauma and burn care services;

(B) provides level 3 neonatal care services;

(C) is obligated to serve all patients, regardless of State of origin;

(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act in at least one State other than the one in which the center is located.

(3) **EFFECTIVE PERIOD.**—This subsection shall apply through December 31, 2006.

SEC. 6052. REFORMS OF CASE MANAGEMENT AND TARGETED CASE MANAGEMENT.

(a) **IN GENERAL.**—Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) is amended by striking paragraph (2) and inserting the following:

“(2) For purposes of this subsection:

“(A)(i) The term ‘case management services’ means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

“(ii) Such term includes the following:

“(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, social, educational, social, or other services. Such assessment activities include the following:

“(aa) Taking client history.

“(bb) Identifying the needs of the individual, and completing related documentation.

“(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

“(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

“(III) Referral and related activities to help an individual obtain needed services, including activities that help

link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

“(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

“(aa) whether services are being furnished in accordance with an individual’s care plan;

“(bb) whether the services in the care plan are adequate; and

“(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

“(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

“(I) Research gathering and completion of documentation required by the foster care program.

“(II) Assessing adoption placements.

“(III) Recruiting or interviewing potential foster care parents.

“(IV) Serving legal papers.

“(V) Home investigations.

“(VI) Providing transportation.

“(VII) Administering foster care subsidies.

“(VIII) Making placement arrangements.

“(B) The term ‘targeted case management services’ are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas.

“(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

“(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual’s care; and

“(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual’s needs and care.

“(4)(A) In accordance with section 1902(a)(25), Federal financial participation only is available under this title for case management services or targeted case management services if there are no

other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

“(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

“(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act or by the Indian Health Service.”

(b) **REGULATIONS.**—The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on January 1, 2006.

SEC. 6053. ADDITIONAL FMAP ADJUSTMENTS.

(a) **HOLD HARMLESS FOR CERTAIN DECREASE.**—Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), if, for purposes of titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.), the Federal medical assistance percentage determined for the State specified in section 4725(a) of Public Law 105-33 for fiscal year 2006 or fiscal year 2007 is less than the Federal medical assistance percentage determined for such State for fiscal year 2005, the Federal medical assistance percentage determined for such State for fiscal year 2005 shall be substituted for the Federal medical assistance percentage otherwise determined for such State for fiscal year 2006 or fiscal year 2007, as the case may be.

(b) **HOLD HARMLESS FOR KATRINA IMPACT.**—Notwithstanding any other provision of law, for purposes of titles XIX and XXI of the Social Security Act, the Secretary of Health and Human Services, in computing the Federal medical assistance percentage under section 1905(b) of such Act (42 U.S.C. 1396d(b)) for any year after 2006 for a State that the Secretary determines has a significant number of evacuees who were evacuated to, and live in, the State as a result of Hurricane Katrina as of October 1, 2005, shall disregard such evacuees (and income attributable to such evacuees) from such computation.

SEC. 6054. DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.

(a) **IN GENERAL.**—For purposes of determining the DSH allotment for the District of Columbia under section 1923 of the Social Security Act (42 U.S.C. 1396r-4) for fiscal year 2006 and each subsequent fiscal year, the table in subsection (f)(2) of such section is amended under each of the columns for FY 00, FY 01, and FY 02, in the entry for the District of Columbia by striking “32” and inserting “49”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect as if enacted on October 1, 2005, and shall only

apply to disproportionate share hospital adjustment expenditures applicable to fiscal year 2006 and subsequent fiscal years made on or after that date.

SEC. 6055. INCREASE IN MEDICAID PAYMENTS TO INSULAR AREAS.

Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by inserting “and subject to paragraph (3)” after “subsection (f)”; and

(2) by adding at the end the following new paragraph:

“(3) *FISCAL YEARS 2006 AND 2007 FOR CERTAIN INSULAR AREAS.*—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2006 and fiscal year 2007 shall be increased by the following amounts:

“(A) For Puerto Rico, \$12,000,000 for fiscal year 2006 and \$12,000,000 for fiscal year 2007.

“(B) For the Virgin Islands, \$2,500,000 for fiscal year 2006 and \$5,000,000 for fiscal year 2007.

“(C) For Guam, \$2,500,000 for fiscal year 2006 and \$5,000,000 for fiscal year 2007.

“(D) For the Northern Mariana Islands, \$1,000,000 for fiscal year 2006 and \$2,000,000 for fiscal year 2007.

“(E) For American Samoa, \$2,000,000 for fiscal year 2006 and \$4,000,000 for fiscal year 2007.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal year 2007 but shall be taken into account in applying such paragraph for fiscal year 2008 and subsequent fiscal years.”.

CHAPTER 6—OTHER PROVISIONS

Subchapter A—Family Opportunity Act

SEC. 6061. SHORT TITLE OF SUBCHAPTER.

This subchapter may be cited as the “Family Opportunity Act of 2005” or the “Dylan Lee James Act”.

SEC. 6062. OPPORTUNITY FOR FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.

(a) *STATE OPTION TO ALLOW FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.*—

(1) *IN GENERAL.*—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) by striking “or” at the end of subclause (XVII);

(ii) by adding “or” at the end of subclause (XVIII);

and

(iii) by adding at the end the following new subclause:

“(XIX) who are disabled children described in subsection (cc)(1);”;

(B) by adding at the end the following new subsection:

“(cc)(1) Individuals described in this paragraph are individuals—

“(A) who are children who have not attained 19 years of age and are born—

“(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

“(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

“(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

“(B) who would be considered disabled under section 1614(a)(3)(C) (as determined under title XVI for children but without regard to any income or asset eligibility requirements that apply under such title with respect to children); and

“(C) whose family income does not exceed such income level as the State establishes and does not exceed—

“(i) 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; or

“(ii) such higher percent of such poverty line as a State may establish, except that—

“(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

“(II) no Federal financial participation shall be provided under section 1903(a) for any medical assistance provided to such an individual.”

(2) INTERACTION WITH EMPLOYER-SPONSORED FAMILY COVERAGE.—Section 1902(cc) of such Act (42 U.S.C. 1396a(cc)), as added by paragraph (1)(B), is amended by adding at the end the following new paragraph:

“(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act), the State shall—

“(i) notwithstanding section 1906, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent’s child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

“(ii) if such coverage is obtained—

“(I) subject to paragraph (2) of section 1916(h), reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

“(II) treat such coverage as a third party liability under subsection (a)(25).

“(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding section 1906 but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay.

Any payments made by the State under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.”

(b) *STATE OPTION TO IMPOSE INCOME-RELATED PREMIUMS.*—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(1) in subsection (a), by striking “subsection (g)” and inserting “subsections (g) and (i)”;

(2) by adding at the end, as amended by section 6041(b)(2), the following new subsection:

“(i)(1) With respect to disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX), subject to paragraph (2), a State may (in a uniform manner for such children) require the families of such children to pay monthly premiums set on a sliding scale based on family income.

“(2) A premium requirement imposed under paragraph (1) may only apply to the extent that—

“(A) in the case of a disabled child described in that paragraph whose family income—

“(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) and other cost-sharing charges do not exceed 5 percent of the family’s income; and

“(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) and other cost-sharing charges do not exceed 7.5 percent of the family’s income; and

“(B) the requirement is imposed consistent with section 1902(cc)(2)(A)(ii)(I).

“(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under section 1902(a)(10)(A)(ii)(XIX) for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.”

(c) *CONFORMING AMENDMENTS.*—(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A), by inserting “1902(a)(10)(A)(ii)(XIX),” after “1902(a)(10)(A)(ii)(XVIII),”.

(2) Section 1905(u)(2)(B) of such Act (42 U.S.C. 1396d(u)(2)(B)) is amended by adding at the end the following sentence: “Such term excludes any child eligible for medical assistance only by reason of section 1902(a)(10)(A)(ii)(XIX).”

(d) *EFFECTIVE DATE.*—The amendments made by this section shall apply to medical assistance for items and services furnished on or after January 1, 2007.

SEC. 6063. DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN.

(a) *IN GENERAL.*—The Secretary is authorized to conduct, during each of fiscal years 2007 through 2011, demonstration projects (each in the section referred to as a “demonstration project”) in accordance with this section under which up to 10 States (as defined for purposes of title XIX of the Social Security Act) are awarded grants, on a competitive basis, to test the effectiveness in improving or maintaining a child’s functional level and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment for children enrolled in the Medicaid program under title XIX of such Act.

(b) *APPLICATION OF TERMS AND CONDITIONS.*—

(1) *IN GENERAL.*—Subject to the provisions of this section, for the purposes of the demonstration projects, and only with respect to children enrolled under such demonstration projects, a psychiatric residential treatment facility (as defined in section 483.352 of title 42 of the Code of Federal Regulations) shall be deemed to be a facility specified in section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), and to be included in each reference in such section 1915(c) to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

(2) *STATE OPTION TO ASSURE CONTINUITY OF MEDICAID COVERAGE.*—Upon the termination of a demonstration project under this section, the State that conducted the project may elect, only with respect to a child who is enrolled in such project on the termination date, to continue to provide medical assistance for coverage of home and community-based alternatives to psychiatric residential treatment for the child in accordance with section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as modified through the application of paragraph (1). Expenditures incurred for providing such medical assistance shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

(c) *TERMS OF DEMONSTRATION PROJECTS.*—

(1) *IN GENERAL.*—Except as otherwise provided in this section, a demonstration project shall be subject to the same terms and conditions as apply to a waiver under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), including the waiver of certain requirements under the first sentence of paragraph (3) of such section but not applying the second sentence of such paragraph.

(2) *BUDGET NEUTRALITY.*—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under that title if the demonstration projects under this section had not been implemented.

(3) *EVALUATION.*—The application for a demonstration project shall include an assurance to provide for such interim and final evaluations of the demonstration project by inde-

pendent third parties, and for such interim and final reports to the Secretary, as the Secretary may require.

(d) **PAYMENTS TO STATES; LIMITATIONS TO SCOPE AND FUNDING.**—

(1) **IN GENERAL.**—Subject to paragraph (2), a demonstration project approved by the Secretary under this section shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

(2) **LIMITATION.**—In no case may the amount of payments made by the Secretary under this section for State demonstration projects for a fiscal year exceed the amount available under subsection (f)(2)(A) for such fiscal year.

(e) **SECRETARY'S EVALUATION AND REPORT.**—The Secretary shall conduct an interim and final evaluation of State demonstration projects under this section and shall report to the President and Congress the conclusions of such evaluations within 12 months of completing such evaluations.

(f) **FUNDING.**—

(1) **IN GENERAL.**—For the purpose of carrying out this section, there are appropriated, from amounts in the Treasury not otherwise appropriated, for fiscal years 2007 through 2011, a total of \$218,000,000, of which—

(A) the amount specified in paragraph (2) shall be available for each of fiscal years 2007 through 2011; and

(B) a total of \$1,000,000 shall be available to the Secretary for the evaluations and report under subsection (e).

(2) **FISCAL YEAR LIMIT.**—

(A) **IN GENERAL.**—For purposes of paragraph (1), the amount specified in this paragraph for a fiscal year is the amount specified in subparagraph (B) for the fiscal year plus the difference, if any, between the total amount available under this paragraph for prior fiscal years and the total amount previously expended under paragraph (1)(A) for such prior fiscal years.

(B) **FISCAL YEAR AMOUNTS.**—The amount specified in this subparagraph for—

(i) fiscal year 2007 is \$21,000,000;

(ii) fiscal year 2008 is \$37,000,000;

(iii) fiscal year 2009 is \$49,000,000;

(iv) fiscal year 2010 is \$53,000,000; and

(v) fiscal year 2011 is \$57,000,000.

SEC. 6064. DEVELOPMENT AND SUPPORT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501 of the Social Security Act (42 U.S.C. 701) is amended by adding at the end the following new subsection:

“(c)(1)(A) For the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance for the development and support of family-to-family health information centers described in paragraph (2), there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated—

“(i) \$3,000,000 for fiscal year 2007;

“(ii) \$4,000,000 for fiscal year 2008; and

“(iii) \$5,000,000 for fiscal year 2009.

“(B) Funds appropriated or authorized to be appropriated under subparagraph (A) shall—

“(i) be in addition to amounts appropriated under subsection (a) and retained under section 502(a)(1) for the purpose of carrying out activities described in subsection (a)(2); and

“(ii) remain available until expended.

“(2) The family-to-family health information centers described in this paragraph are centers that—

“(A) assist families of children with disabilities or special health care needs to make informed choices about health care in order to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children;

“(B) provide information regarding the health care needs of, and resources available for, such children;

“(C) identify successful health delivery models for such children;

“(D) develop with representatives of health care providers, managed care organizations, health care purchasers, and appropriate State agencies, a model for collaboration between families of such children and health professionals;

“(E) provide training and guidance regarding caring for such children;

“(F) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals; and

“(G) are staffed—

“(i) by such families who have expertise in Federal and State public and private health care systems; and

“(ii) by health professionals.

“(3) The Secretary shall develop family-to-family health information centers described in paragraph (2) in accordance with the following:

“(A) With respect to fiscal year 2007, such centers shall be developed in not less than 25 States.

“(B) With respect to fiscal year 2008, such centers shall be developed in not less than 40 States.

“(C) With respect to fiscal year 2009 and each fiscal year thereafter, such centers shall be developed in all States.

“(4) The provisions of this title that are applicable to the funds made available to the Secretary under section 502(a)(1) apply in the same manner to funds made available to the Secretary under paragraph (1)(A).

“(5) For purposes of this subsection, the term ‘State’ means each of the 50 States and the District of Columbia.”

SEC. 6065. RESTORATION OF MEDICAID ELIGIBILITY FOR CERTAIN SSI BENEFICIARIES.

(a) *IN GENERAL.*—Section 1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended—

(1) by inserting “(aa)” after “(II)”;

(2) by striking “) and” and inserting “and”;

(3) by striking “section or who are” and inserting “section), (bb) who are”; and

(4) by inserting before the comma at the end the following: “, or (cc) who are under 21 years of age and with respect to

whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(c)(7) were applied without regard to the phrase ‘the first day of the month following’”.

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) shall apply to medical assistance for items and services furnished on or after the date that is 1 year after the date of enactment of this Act.

Subchapter B—Money Follows the Person Rebalancing Demonstration

SEC. 6071. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) *PROGRAM PURPOSE AND AUTHORITY.*—The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an “MFP demonstration project”) designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

(1) *REBALANCING.*—Increase the use of home and community-based, rather than institutional, long-term care services.

(2) *MONEY FOLLOWS THE PERSON.*—Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

(3) *CONTINUITY OF SERVICE.*—Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

(4) *QUALITY ASSURANCE AND QUALITY IMPROVEMENT.*—Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) 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.

(b) *DEFINITIONS.*—For purposes of this section:

(1) *HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.*—The term “home and community-based long-term care services” means, with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State’s qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program.

(2) *ELIGIBLE INDIVIDUAL.*—The term “eligible individual” means, with respect to an MFP demonstration project of a State, an individual in the State—

(A) who, immediately before beginning participation in the MFP demonstration project—

(i) resides (and has resided, for a period of not less than 6 months or for such longer minimum period, not

to exceed 2 years, as may be specified by the State) in an inpatient facility;

(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, the individual must continue to require at least the level of care which had resulted in admission to the institution; and

(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

(3) **INPATIENT FACILITY.**—The term “inpatient facility” means a hospital, nursing facility, or intermediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

(4) **MEDICAID.**—The term “Medicaid” means, with respect to a State, the State program under title XIX of the Social Security Act (including any waiver or demonstration under such title or under section 1115 of such Act relating to such title).

(5) **QUALIFIED HCB PROGRAM.**—The term “qualified HCB program” means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

(6) **QUALIFIED RESIDENCE.**—The term “qualified residence” means, with respect to an eligible individual—

(A) a home owned or leased by the individual or the individual’s family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual’s family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

(7) **QUALIFIED EXPENDITURES.**—The term “qualified expenditures” means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

(8) **SELF-DIRECTED SERVICES.**—The term “self-directed” means, with respect to home and community-based long-term care services for an eligible individual, such services for the individual which are planned and purchased under the direction and control of such individual or the individual’s authorized

representative (as defined by the Secretary), including the amount, duration, scope, provider, and location of such services, under the State Medicaid program consistent with the following requirements:

(A) *ASSESSMENT.*—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(B) *SERVICE PLAN.*—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that—

(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(iv) is developed through a person-centered process that—

(I) is directed by the individual or the individual's authorized representative;

(II) builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities; and

(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(C) *BUDGET PROCESS.*—With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)—

(i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(iii) provides a procedure to evaluate expenditures under such budgets.

(9) *STATE*.—The term “State” has the meaning given such term for purposes of title XIX of the Social Security Act.

(c) *STATE APPLICATION*.—A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

(1) *ASSURANCE OF A PUBLIC DEVELOPMENT PROCESS*.—The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

(2) *OPERATION IN CONNECTION WITH QUALIFIED HCB PROGRAM TO ASSURE CONTINUITY OF SERVICES*.—The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

(3) *DEMONSTRATION PROJECT PERIOD*.—The application shall specify the period of the MFP demonstration project, which shall include at least 2 consecutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2007.

(4) *SERVICE AREA*.—The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or 1 or more geographic areas of the State.

(5) *TARGETED GROUPS AND NUMBERS OF INDIVIDUALS SERVED*.—The application shall specify—

(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

(6) *INDIVIDUAL CHOICE, CONTINUITY OF CARE*.—The application shall contain assurances that—

(A) each eligible individual or the individual’s authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project;

(B) each eligible individual or the individual’s authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services;

(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based long-term care services to each individual who completes

participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to requiring a level of care provided in an inpatient facility and continuing to require such services, and, if the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, meeting the requirement for at least the level of care which had resulted in the individual's admission to the institution).

(7) *REBALANCING.—The application shall—*

(A) *provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services;*

(B)(i) *specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services; and*

(ii) *describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a).*

(8) *MONEY FOLLOWS THE PERSON.—The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other barriers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.*

(9) *MAINTENANCE OF EFFORT AND COST-EFFECTIVENESS.—The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that—*

(A) *total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for—*

(i) *fiscal year 2005; or*

(ii) *any succeeding fiscal year before the first year of the MFP demonstration project; and*

(B) *in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or com-*

parable requirements under subsection (d)(5) of such section, respectively.

(10) **WAIVER REQUESTS.**—*The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.*

(11) **QUALITY ASSURANCE AND QUALITY IMPROVEMENT.**—*The application shall include—*

(A) *a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and*

(B) *an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement systems for home and community-based long-term care services.*

(12) **OPTIONAL PROGRAM FOR SELF-DIRECTED SERVICES.**—*If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:*

(A) **MEETING REQUIREMENTS.**—*A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.*

(B) **VOLUNTARY ELECTION.**—*A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.*

(C) **STATE SUPPORT IN SERVICE PLAN DEVELOPMENT.**—*Satisfactory assurances that the State will provide support to eligible individuals who self-direct in developing and implementing their service plans.*

(D) **OVERSIGHT OF RECEIPT OF SERVICES.**—*Satisfactory assurances that the State will provide oversight of eligible individual's receipt of such self-directed services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.*

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

(13) **REPORTS AND EVALUATION.**—*The application shall provide that—*

(A) *the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reli-*

able comparisons of MFP demonstration projects across States; and

(B) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

(d) SECRETARY'S AWARD OF COMPETITIVE GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

(2) SELECTION AND MODIFICATION OF STATE APPLICATIONS.—In selecting State applications for the awarding of such a grant, the Secretary—

(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

(C) shall give preference to State applications proposing—

(i) to provide transition assistance to eligible individuals within multiple target groups; and

(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services, as defined in subsection (b)(8); and

(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

(3) WAIVER AUTHORITY.—The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

(A) STATEWIDENESS.—Section 1902(a)(1), in order to permit implementation of a State initiative in a selected area or areas of the State.

(B) COMPARABILITY.—Section 1902(a)(10)(B), in order to permit a State initiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

(C) INCOME AND RESOURCES ELIGIBILITY.—Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

(D) PROVIDER AGREEMENTS.—Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

(4) CONDITIONAL APPROVAL OF OUTYEAR GRANT.—In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

(A) NUMERICAL BENCHMARKS.—The State must demonstrate to the satisfaction of the Secretary that it is meet-

ing numerical benchmarks specified in the grant agreement for—

(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

(ii) numbers of eligible individuals assisted to transition to qualified residences.

(B) *QUALITY OF CARE.*—The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under subsection (c)(11) to assure the health and welfare of MFP demonstration project participants.

(e) *PAYMENTS TO STATES; CARRYOVER OF UNUSED GRANT AMOUNTS.*—

(1) *PAYMENTS.*—For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of—

(A) the MFP-enhanced FMAP (as defined in paragraph (5)) of the amount of qualified expenditures made during such quarter; or

(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

(2) *CARRYOVER OF UNUSED AMOUNTS.*—Any portion of a State grant award for a fiscal year under this section remaining at the end of such fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3).

(3) *REAWARDING OF CERTAIN UNUSED AMOUNTS.*—In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

(4) *PREVENTING DUPLICATION OF PAYMENT.*—The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

(5) *MFP-ENHANCED FMAP.*—For purposes of paragraph (1)(A), the “MFP-enhanced FMAP”, for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 50 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent; but in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

(f) *QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT.*—

(1) *IN GENERAL.*—*The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including—*

(A) *dissemination of information on promising practices;*

(B) *guidance on system design elements addressing the unique needs of participating beneficiaries;*

(C) *ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and*

(D) *guidance on remedying programmatic and systemic problems.*

(2) *FUNDING.*—*From the amounts appropriated under subsection (h)(1) for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, not more than \$2,400,000 shall be available to the Secretary to carry out this subsection during the period that begins on January 1, 2007, and ends on September 30, 2011.*

(g) *RESEARCH AND EVALUATION.*—

(1) *IN GENERAL.*—*The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of projected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.*

(2) *FINAL REPORT.*—*The Secretary shall make a final report to the President and Congress, not later than September 30, 2011, reflecting the evaluation described in paragraph (1) and providing findings and conclusions on the conduct and effectiveness of MFP demonstration projects.*

(3) *FUNDING.*—*From the amounts appropriated under subsection (h)(1) for each of fiscal years 2008 through 2011, not more than \$1,100,000 per year shall be available to the Secretary to carry out this subsection.*

(h) *APPROPRIATIONS.*—

(1) *IN GENERAL.*—*There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section—*

(A) *\$250,000,000 for the portion of fiscal year 2007 beginning on January 1, 2007, and ending on September 30, 2007;*

(B) *\$300,000,000 for fiscal year 2008;*

(C) *\$350,000,000 for fiscal year 2009;*

(D) *\$400,000,000 for fiscal year 2010; and*

(E) *\$450,000,000 for fiscal year 2011.*

(2) *AVAILABILITY.*—*Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30, 2011.*

Subchapter C—Miscellaneous**SEC. 6081. MEDICAID TRANSFORMATION GRANTS.**

(a) *IN GENERAL.*—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by sections 6037(a)(2) and 6043(b), is amended by adding at the end the following new subsection:

“(z) *MEDICAID TRANSFORMATION PAYMENTS.*—

“(1) *IN GENERAL.*—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

“(2) *PERMISSIBLE USES OF FUNDS.*—The following are examples of innovative methods for which funds provided under this subsection may be used:

“(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

“(B) Methods for improving rates of collection from estates of amounts owed under this title.

“(C) Methods for reducing waste, fraud, and abuse under the program under this title, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

“(D) Implementation of a medication risk management program as part of a drug use review program under section 1927(g).

“(E) Methods in reducing, in clinically appropriate ways, expenditures under this title for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

“(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

“(3) *APPLICATION; TERMS AND CONDITIONS.*—

“(A) *IN GENERAL.*—No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

“(B) *TERMS AND CONDITIONS.*—Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

“(C) *ANNUAL REPORT.*—Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

“(i) the specific uses of such payment;

“(ii) an assessment of quality improvements and clinical outcomes under such programs; and

“(iii) estimates of cost savings resulting from such programs.

“(4) *FUNDING.*—

“(A) *LIMITATION ON FUNDS.*—The total amount of payments under this subsection shall be equal to, and shall not exceed—

“(i) \$75,000,000 for fiscal year 2007; and

“(ii) \$75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

“(B) *ALLOCATION OF FUNDS.*—The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

“(C) *FORM AND MANNER OF PAYMENT.*—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

“(5) *MEDICATION RISK MANAGEMENT PROGRAM.*—

“(A) *IN GENERAL.*—For purposes of this subsection, the term ‘medication risk management program’ means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

“(B) *ELEMENTS.*—Such program may include the following elements:

“(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

“(ii) On an ongoing basis provide outlier physicians—

“(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

“(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician’s care; and

“(III) applicable best practice guidelines and empirical references.

“(iii) Monitor outlier physician’s prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

“(C) *TARGETED BENEFICIARIES.*—For purposes of this paragraph, the term ‘targeted beneficiaries’ means Medicaid eligible beneficiaries who are identified as having

high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.”.

SEC. 6082. HEALTH OPPORTUNITY ACCOUNTS.

Title XIX of the Social Security Act, as amended by sections 6035 and 6044, is amended—

- (1) by redesignating section 1938 as section 1939; and*
- (2) by inserting after section 1937 the following new section:*

“HEALTH OPPORTUNITY ACCOUNTS

“SEC. 1938. (a) AUTHORITY.—

“(1) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish a demonstration program under which States may provide under their State plans under this title (including such a plan operating under a statewide waiver under section 1115) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a ‘State demonstration program’.

“(2) INITIAL DEMONSTRATION.—

“(A) IN GENERAL.—The demonstration program under this section shall begin on January 1, 2007. During the first 5 years of such program, the Secretary shall not approve more than 10 States to conduct demonstration programs under this section, with each State demonstration program covering 1 or more geographic areas specified by the State. After such 5-year period—

“(i) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

“(ii) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

“(B) GAO REPORT.—

“(i) IN GENERAL.—Not later than 3 months after the end of the 5-year period described in subparagraph (A), the Comptroller General of the United States shall submit a report to Congress evaluating the demonstration programs conducted under this section during such period.

“(ii) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Comptroller General of the United States, \$550,000 for the period of fiscal years 2007 through 2010 to carry out clause (i).

“(3) APPROVAL.—The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

“(A) Creating patient awareness of the high cost of medical care.

“(B) Providing incentives to patients to seek preventive care services.

“(C) Reducing inappropriate use of health care services.

“(D) Enabling patients to take responsibility for health outcomes.

“(E) Providing enrollment counselors and ongoing education activities.

“(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

“(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

“(4) NO REQUIREMENT FOR STATEWIDENESS.—Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide basis.

“(b) ELIGIBLE POPULATION GROUPS.—

“(1) IN GENERAL.—A State demonstration program under this section shall specify the eligible population groups consistent with paragraphs (2) and (3).

“(2) ELIGIBILITY LIMITATIONS DURING INITIAL DEMONSTRATION PERIOD.—During the initial 5 years of the demonstration program under this section, a State demonstration program shall not apply to any of the following individuals:

“(A) Individuals who are 65 years of age or older.

“(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this title is based on such disability.

“(C) Individuals who are eligible for medical assistance under this title only because they are (or were within the previous 60 days) pregnant.

“(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

“(3) ADDITIONAL LIMITATIONS.—A State demonstration program shall not apply to any individual within a category of individuals described in section 1937(a)(2)(B).

“(4) LIMITATIONS.—

“(A) STATE OPTION.—This subsection shall not be construed as preventing a State from further limiting eligibility.

“(B) ON ENROLLEES IN MEDICAID MANAGED CARE ORGANIZATIONS.—Insofar as the State provides for eligibility of individuals who are enrolled in medicaid managed care organizations, such individuals may participate in the State

demonstration program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

“(i) In no case may the number of such individuals enrolled in the organization who participate in the program exceed 5 percent of the total number of individuals enrolled in such organization.

“(ii) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

“(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

“(5) VOLUNTARY PARTICIPATION.—An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

“(6) 1-YEAR MORATORIUM FOR REENROLLMENT.—An eligible individual who, for any reason, is disenrolled from a State demonstration program conducted under this section shall not be permitted to reenroll in such program before the end of the 1-year period that begins on the effective date of such disenrollment.

“(c) ALTERNATIVE BENEFITS.—

“(1) IN GENERAL.—The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

“(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this title after an annual deductible described in paragraph (2) has been met; and

“(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

“(2) ANNUAL DEDUCTIBLE.—The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(i)(II).

“(3) ACCESS TO NEGOTIATED PROVIDER PAYMENT RATES.—

“(A) FEE-FOR-SERVICE ENROLLEES.—In the case of an individual who is participating in a State demonstration program and who is not enrolled with a medicaid managed care organization, the State shall provide that the individual may obtain demonstration program medicaid services from—

“(i) any participating provider under this title at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

“(ii) any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this title if the deductible described in paragraph (1)(A) was not applicable.

“(B) TREATMENT UNDER MEDICAID MANAGED CARE PLANS.—In the case of an individual who is participating in a State demonstration program and is enrolled with a medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration program medicaid services from any provider described in clause (ii) of subparagraph (A) at payment rates that do not exceed the payment rates that may be imposed under that clause.

“(C) COMPUTATION.—The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost sharing that would be otherwise applicable under sections 1916 and 1916A.

“(D) DEFINITIONS.—For purposes of this paragraph:

“(i) The term ‘demonstration program medicaid services’ means, with respect to an individual participating in a State demonstration program, services for which the individual would be provided medical assistance under this title but for the application of the deductible described in paragraph (1)(A).

“(ii) The term ‘participating provider’ means—

“(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

“(II) with respect to an individual described in subparagraph (B) who is enrolled in a medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this title.

“(4) NO EFFECT ON SUBSEQUENT BENEFITS.—Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost sharing relating to such benefits.

“(5) OVERRIDING COST SHARING AND COMPARABILITY REQUIREMENTS FOR ALTERNATIVE BENEFITS.—The provisions of this title relating to cost sharing for benefits (including sections 1916 and 1916A) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1902(a)(10)(B) (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

“(6) *TREATMENT AS MEDICAL ASSISTANCE.*—Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1903(a).

“(7) *USE OF TIERED DEDUCTIBLE AND COST SHARING.*—

“(A) *IN GENERAL.*—A State—

“(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

“(ii) may vary the amount of the maximum out-of-pocket cost sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

“(B) *MAXIMUM OUT-OF-POCKET COST SHARING.*—For purposes of subparagraph (A)(ii), the term ‘maximum out-of-pocket cost sharing’ means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

“(8) *CONTRIBUTIONS BY EMPLOYERS.*—Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

“(d) *HEALTH OPPORTUNITY ACCOUNT.*—

“(1) *IN GENERAL.*—For purposes of this section, the term ‘health opportunity account’ means an account that meets the requirements of this subsection.

“(2) *CONTRIBUTIONS.*—

“(A) *IN GENERAL.*—No contribution may be made into a health opportunity account except—

“(i) contributions by the State under this title; and

“(ii) contributions by other persons and entities, such as charitable organizations, as permitted under section 1903(w).

“(B) *STATE CONTRIBUTION.*—A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

“(C) *LIMITATION ON ANNUAL STATE CONTRIBUTION PROVIDED AND PERMITTING IMPOSITION OF MAXIMUM ACCOUNT BALANCE.*—

“(i) *IN GENERAL.*—A State—

“(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

“(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

“(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions

described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, \$2,500 for each individual (or family member) who is an adult and \$1,000 for each individual (or family member) who is a child.

“(ii) INDEXING OF DOLLAR LIMITATIONS.—For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

“(iii) BUDGET NEUTRAL ADJUSTMENT.—A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

“(D) LIMITATIONS ON FEDERAL MATCHING.—

“(i) STATE CONTRIBUTION.—A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under section 1903(a) with respect to contributions in excess of such limitations.

“(ii) NO FFP FOR PRIVATE CONTRIBUTIONS.—No Federal financial participation shall be provided under section 1903(a) with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

“(E) APPLICATION OF DIFFERENT MATCHING RATES.—

The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1903(a) exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

“(3) USE.—

“(A) GENERAL USES.—

“(i) IN GENERAL.—Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

“(ii) GENERAL LIMITATION.—Subject to subparagraph (B)(ii), in no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

“(iii) *STATE RESTRICTIONS.*—In applying clause (i), a State may restrict payment for—

“(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this title or any other health benefit program, to have failed to meet quality standards or to have committed 1 or more acts of fraud or abuse; and

“(II) items and services insofar as the State finds they are not medically appropriate or necessary.

“(iv) *ELECTRONIC WITHDRAWALS.*—The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

“(B) *MAINTENANCE OF HEALTH OPPORTUNITY ACCOUNT AFTER BECOMING INELIGIBLE FOR PUBLIC BENEFIT.*—

“(i) *IN GENERAL.*—Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this title because of an increase in income or assets—

“(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

“(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

“(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits, and such withdrawals shall be treated as medical assistance in accordance with subsection (c)(6).

“(ii) *SPECIAL RULES.*—Withdrawals under this subparagraph from an account—

“(I) shall be available for the purchase of health insurance coverage; and

“(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

“(iii) *EXCEPTION FROM 25 PERCENT SAVINGS TO GOVERNMENT FOR PRIVATE CONTRIBUTIONS.*—Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

“(iv) *CONDITION FOR NON-HEALTH WITHDRAWALS.*—No withdrawal may be made from an account under clause (ii)(II) unless the account holder has participated in the program under this section for at least 1 year.

“(v) *NO REQUIREMENT FOR CONTINUATION OF COVERAGE.*—An account holder of a health opportunity account, after becoming ineligible for medical assistance under this title, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

“(4) *ADMINISTRATION.*—A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1903(a)(7).

“(5) *TREATMENT.*—Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this title.

“(6) *UNAUTHORIZED WITHDRAWALS.*—A State may establish procedures—

“(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

“(B) to recoup costs that derive from such nonqualified withdrawals.”

SEC. 6083. STATE OPTION TO ESTABLISH NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM.

(a) *IN GENERAL.*—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 6033(a) and 6035(b), is amended—

(1) in paragraph (68), by striking “and” at the end;

(2) in paragraph (69) by striking the period at the end and inserting “; and”; and

(3) by inserting after paragraph (69) the following:

“(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

“(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

“(B) may be conducted under contract with a broker who—

“(i) is selected through a competitive bidding process based on the State’s evaluation of the broker’s experience, performance, references, resources, qualifications, and costs;

“(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that trans-

port personnel are licensed, qualified, competent, and courteous;

“(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

“(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).”.

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

SEC. 6084. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM.

Effective as if enacted on December 31, 2005, activities authorized by sections 510 and 1925 of the Social Security Act shall continue through December 31, 2006, in the manner authorized for fiscal year 2005, notwithstanding section 1902(e)(1)(A) of such Act, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the first quarter of fiscal year 2007 at the level provided for such activities through the first quarter of fiscal year 2006.

SEC. 6085. EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS FOR MEDICAID MANAGED CARE ENROLLEES.

(a) *IN GENERAL.*—Section 1932(b)(2) of the Social Security Act (42 U.S.C. 1396u–2(b)(2)) is amended by adding at the end the following new subparagraph:

“(D) *EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.*—Any provider of emergency services that does not have in effect a contract with a medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity’s Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall take effect on January 1, 2007.

SEC. 6086. EXPANDED ACCESS TO HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY AND DISABLED.

(a) *HOME AND COMMUNITY-BASED SERVICES AS AN OPTIONAL BENEFIT FOR ELDERLY AND DISABLED INDIVIDUALS.*—Section 1915

of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

“(i) STATE PLAN AMENDMENT OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND DISABLED INDIVIDUALS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board or such other services requested by the State as the Secretary may approve) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

“(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, HOME AND COMMUNITY-BASED SERVICES.—The State establishes needs-based criteria for determining an individual’s eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

“(B) ESTABLISHMENT OF MORE STRINGENT NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITUTIONALIZED CARE.—The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

“(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—

“(i) IN GENERAL.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

“(ii) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services.

“(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

“(i) IN GENERAL.—The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual’s support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of

daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

“(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

“(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

“(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services; and

“(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

“(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

“(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

“(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

“(I) determine a necessary level of services and supports to be provided, consistent with an individual’s physical and mental capacity;

“(II) prevent the provision of unnecessary or inappropriate care; and

“(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

“(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

“(i) An objective evaluation of an individual’s inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal

Revenue Code of 1986) or the need for significant assistance to perform such activities.

“(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

“(iii) Where appropriate, consultation with the individual’s family, spouse, guardian, or other responsible individual.

“(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

“(v) An examination of the individual’s relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

“(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual’s representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

“(G) INDIVIDUALIZED CARE PLAN.—

“(i) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

“(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

“(I) is developed—

“(aa) in consultation with the individual, the individual’s treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual’s family, caregiver, or representative; and

“(bb) taking into account the extent of, and need for, any family or other supports for the individual;

“(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

“(III) is reviewed at least annually and as needed when there is a significant change in the individual’s circumstances.

“(iii) STATE OPTION TO OFFER ELECTION FOR SELF-DIRECTED SERVICES.—

“(I) INDIVIDUAL CHOICE.—At the option of the State, the State may allow an individual or the individual’s representative to elect to receive self-di-

rected home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

“(II) *SELF-DIRECTED SERVICES*.—The term ‘self-directed’ means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

“(aa) *ASSESSMENT*.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

“(bb) *SERVICE PLAN*.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

“(III) *PLAN REQUIREMENTS*.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

“(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

“(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

“(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

“(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

“(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the

resources and capabilities of the individual or the individual's authorized representative; and
 "(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

"(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

"(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

"(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

"(cc) provides a procedure to evaluate expenditures under such budgets.

"(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

"(i) QUALITY ASSURANCE.—The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

"(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

"(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

"(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

"(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term 'individual's representative' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

"(3) NONAPPLICATION.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes

of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

“(4) **NO EFFECT ON OTHER WAIVER AUTHORITY.**—Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1115.

“(5) **CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION FOR MEDICAL ASSISTANCE PROVIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF STATE PLAN AMENDMENT.**—Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1115 that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.”

(b) **QUALITY OF CARE MEASURES.**—

(1) **IN GENERAL.**—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

(2) **BEST PRACTICES.**—The Secretary shall—

(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act; and

(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

(3) **APPROPRIATION.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, \$1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) take effect on January 1, 2007, and apply to expenditures

for medical assistance for home and community-based services provided in accordance with section 1915(i) of the Social Security Act (as added by subsections (a) and (b)) on or after that date.

SEC. 6087. OPTIONAL CHOICE OF SELF-DIRECTED PERSONAL ASSISTANCE SERVICES (CASH AND COUNSELING).

(a) *EXEMPTION FROM CERTAIN REQUIREMENTS.*—Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 6086(a), is amended by adding at the end the following new subsection:

“(j)(1) A State may provide, as ‘medical assistance’, payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

“(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

“(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

“(B) The State will provide, with respect to individuals who—

“(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

“(ii) may require self-directed personal assistance services; and

“(iii) may be eligible for self-directed personal assistance services, an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

“(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State’s self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

“(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

“(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

“(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1902(a)(1) and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1902(a)(10)(B).

“(4)(A) For purposes of this subsection, the term ‘self-directed personal assistance services’ means personal care and related services, or home and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

“(B) At the election of the State—

“(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

“(ii) the individual may use the individual’s budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

“(5) For purpose of this section, the term ‘approved self-directed services plan and budget’ means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

“(A) SELF-DIRECTION.—The participant (or in the case of a participant who is a minor child, the participant’s parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

“(B) ASSESSMENT OF NEEDS.—There is an assessment of the needs, strengths, and preferences of the participants for such services.

“(C) SERVICE PLAN.—A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

“(i) builds upon the participant’s capacity to engage in activities that promote community life and that respects the participant’s preferences, choices, and abilities; and

“(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

“(D) SERVICE BUDGET.—A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

“(E) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT.—There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant’s resources and capabilities.

“(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1903(a).”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2007.

Subtitle B—SCHIP

SEC. 6101. ADDITIONAL ALLOTMENTS TO ELIMINATE FISCAL YEAR 2006 FUNDING SHORTFALLS.

(a) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by inserting after subsection (c) the following:

“(d) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS.—

“(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments to shortfall States described in paragraph (2), there is appropriated, out of any money in the Treasury not otherwise appropriated, \$283,000,000 for fiscal year 2006.

“(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (1), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of December 16, 2005, that the projected expenditures under such plan for such State for fiscal year 2006 will exceed the sum of—

“(A) the amount of the State’s allotments for each of fiscal years 2004 and 2005 that will not be expended by the end of fiscal year 2005;

“(B) the amount, if any, that is to be redistributed to the State during fiscal year 2006 in accordance with subsection (f); and

“(C) the amount of the State’s allotment for fiscal year 2006.

“(3) **ALLOTMENTS.**—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2006, the Secretary shall allot—

“(A) to each shortfall State described in paragraph (2) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

“(B) to each commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth’s or territory’s allotment under subsection (c) (determined without regard to subsection (f)) to 1.05 percent of the amount appropriated under paragraph (1).

“(4) **USE OF ADDITIONAL ALLOTMENT.**—Additional allotments provided under this subsection are only available for amounts expended under a State plan approved under this title for child health assistance for targeted low-income children.

“(5) **1-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.**—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2006 shall only remain available for expenditure by the State through September 30, 2006. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f) and shall revert to the Treasury on October 1, 2006.”

(b) **CONFORMING AMENDMENTS.**—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(1) in subsection (a), by inserting “subject to subsection (d),” after “under this section,”;

(2) in subsection (b)(1), by inserting “and subsection (d)” after “Subject to paragraph (4)”;

(3) in subsection (c)(1), by inserting “subject to subsection (d),” after “for a fiscal year,”.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to items and services furnished on or after October 1, 2005, without regard to whether or not regulations implementing such amendments have been issued.

SEC. 6102. PROHIBITION AGAINST COVERING NONPREGNANT CHILDLESS ADULTS WITH SCHIP FUNDS.

(a) **PROHIBITION ON USE OF SCHIP FUNDS.**—Section 2107 of the Social Security Act (42 U.S.C. 1397gg) is amended by adding at the end the following:

“(f) **LIMITATION OF WAIVER AUTHORITY.**—Notwithstanding subsection (e)(2)(A) and section 1115(a), the Secretary may not approve a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.”

(b) **CONFORMING AMENDMENTS.**—Section 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is amended—

(1) by inserting “and may not include coverage of a nonpregnant childless adult” after “section 2101”;

(2) by adding at the end the following: “For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.”

(c) **RULE OF CONSTRUCTION.**—Nothing in this section or the amendments made by this section shall be construed to—

(1) authorize the waiver of any provision of title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) that is not otherwise authorized to be waived under such titles or under title XI of such Act (42 U.S.C. 1301 et seq.) as of the date of enactment of this Act;

(2) imply congressional approval of any waiver, experimental, pilot, or demonstration project affecting funds made available under the State children’s health insurance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) or any amendment to such a waiver or project that has been approved as of such date of enactment; or

(3) apply to any waiver, experimental, pilot, or demonstration project that would allow funds made available under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult that is approved before the date of enactment of this Act or to any extension, renewal, or amendment of such a waiver or project that is approved on or after such date of enactment.

(d) **EFFECTIVE DATE.**—This section and the amendments made by this section shall take effect as if enacted on October 1, 2005, and shall apply to any waiver, experimental, pilot, or demonstration project that is approved on or after that date.

SEC. 6103. CONTINUED AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.

(a) **IN GENERAL.**—Section 2105(g)(1)(A) of the Social Security Act (42 U.S.C. 1397ee(g)(1)(A)) is amended by striking “or 2001” and inserting “2001, 2004, or 2005”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to expenditures made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after October 1, 2005.

Subtitle C—Katrina Relief

SEC. 6201. ADDITIONAL FEDERAL PAYMENTS UNDER HURRICANE-RELATED MULTI-STATE SECTION 1115 DEMONSTRATIONS.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall pay to each eligible State, from amounts appropriated pursuant to subsection (e), amounts for the following purposes:

(1) Under the authority of an approved Multi-State Section 1115 Demonstration Project (in this section referred to as an “section 1115 project”)—

(A) with respect to evacuees receiving health care under such project, for the non-Federal share of expenditures:

(i) for medical assistance furnished under title XIX of the Social Security Act, and

(ii) for child health assistance furnished under title XXI of such Act; and

(B) with respect to evacuees who do not have other coverage for such assistance through insurance, including (but not limited to) private insurance, under title XIX or title XXI of the Social Security Act, or under State-funded health insurance programs, for the total uncompensated care costs incurred for medically necessary services and supplies or premium assistance for such persons, and for those evacuees receiving medical assistance under the project for the total uncompensated care costs incurred for medically necessary services and supplies beyond those included as medical assistance or child health assistance under the State's approved plan under title XIX or title XXI of the Social Security Act;

(C) with respect to affected individuals receiving health care under such project for the non-Federal share of the following expenditures:

(i) for medical assistance furnished under title XIX of the Social Security Act, and

(ii) for child health assistance furnished under title XXI of such Act; and

(D) with respect to affected individuals who do not have other coverage for such assistance through insurance, including (but not limited to) private insurance, under title XIX or title XXI of the Social Security Act, or under State-funded health insurance programs, for the total uncompensated care costs incurred for medically necessary services and supplies or premium assistance for such persons, and for those affected individuals receiving medical assistance under the project for the total uncompensated care costs incurred for medically necessary services and supplies beyond those included as medical assistance or child health assistance under the State's approved plan under title XIX or title XXI of the Social Security Act.

(2) For reimbursement of the reasonable administrative costs related to subparagraphs (A) through (D) of paragraph (1) as determined by the Secretary.

(3) Only with respect to affected counties or parishes, for reimbursement with respect to individuals receiving medical assistance under existing State plans approved by the Secretary of Health and Human Services for the following non-Federal share of expenditures:

(A) For medical assistance furnished under title XIX of the Social Security Act.

(B) For child health assistance furnished under title XXI of such Act.

(4) For other purposes, if approved by the Secretary under the Secretary's authority, to restore access to health care in impacted communities.

(b) DEFINITIONS.—For purposes of this section:

(1) The term "affected individual" means an individual who resided in an individual assistance designation county or parish pursuant to section 408 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as declared by the President as a result of Hurricane Katrina and continues to reside in the same State that such county or parish is located in.

(2) The term “affected counties or parishes” means a county or parish described in paragraph (1).

(3) The term “evacuee” means an affected individual who has been displaced to another State.

(4) The term “eligible State” means a State that has provided care to affected individuals or evacuees under a section 1115 project.

(c) **APPLICATION TO MATCHING REQUIREMENTS.**—The non-Federal share paid under this section shall not be regarded as Federal funds for purposes of Medicaid matching requirements, the effect of which is to provide fiscal relief to the State in which the Medicaid eligible individual originally resided.

(d) **TIME LIMITS ON PAYMENTS.**—

(1) No payments shall be made by the Secretary under subsection (a)(1)(A) or (a)(1)(C), for costs of health care provided to an eligible evacuee or affected individual for services for such individual incurred after June 30, 2006.

(2) No payments shall be made by the Secretary under subsection (a)(1)(B) or (a)(1)(D) for costs of health care incurred after January 31, 2006.

(3) No payments may be made under subsection (a)(1)(B) or (a)(1)(D) for an item or service that an evacuee or an affected individual has received from an individual or organization as part of a public or private hurricane relief effort.

(e) **APPROPRIATIONS.**—For the purpose of providing funds for payments under this section, in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina, including under a section 1115 project, there is appropriated out of any money in the Treasury not otherwise appropriated, \$2,000,000,000, to remain available to the Secretary until expended. The total amount of payments made under subsection (a) may not exceed the total amount appropriated under this subsection.

SEC. 6202. STATE HIGH RISK HEALTH INSURANCE POOL FUNDING.

(a) **IN GENERAL.**—There are hereby authorized and appropriated for fiscal year 2006—

(1) \$75,000,000 for grants under subsection (b)(1) of section 2745 of the Public Health Service Act (42 U.S.C. 300gg-45); and

(2) \$15,000,000 for grants under subsection (a) of such section.

(b) **TREATMENT.**—The amount appropriated under—

(1) paragraph (1) shall be treated as if it had been appropriated under subsection (c)(2) of such section; and

(2) paragraph (2) shall be treated as if it had been appropriated under subsection (c)(1) of such section.

(c) **REFERENCES.**—Effective upon the enactment of the State High Risk Pool Funding Extension Act of 2005—

(1) subsection (a)(1) shall be applied by substituting “subsections (b)(2) and (c)(3)” for “subsection (b)(1)”; and

(2) subsection (b)(1) shall be applied by substituting “(d)(1)(B)” for “(c)(2)”; and

(3) subsection (b)(2) shall be applied by substituting “(d)(1)(A)” for “(c)(1)”.

SEC. 6203. IMPLEMENTATION FUNDING.

For purposes of implementing the provisions of, and amendments made by, title V of this Act and this title—

(1) the Secretary of Health and Human Services shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of \$30,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2006; and

(2) out of any funds in the Treasury not otherwise appropriated, there are appropriated to such Secretary for the Centers for Medicare & Medicaid Services Program Management Account, \$30,000,000 for fiscal year 2006.

TITLE VII—HUMAN RESOURCES AND OTHER PROVISIONS

SEC. 7002. REFERENCES.

Except as otherwise expressly provided, wherever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the amendment or repeal shall be considered to be made to a section or other provision of the Social Security Act.

Subtitle A—TANF

SEC. 7101. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES AND RELATED PROGRAMS FUNDING THROUGH SEPTEMBER 30, 2010.

(a) IN GENERAL.—Activities authorized by part A of title IV and section 1108(b) of the Social Security Act (adjusted, as applicable, by or under this subtitle, the amendments made by this subtitle, and the TANF Emergency Response and Recovery Act of 2005) shall continue through September 30, 2010, in the manner authorized for fiscal year 2004, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority on a quarterly basis through fiscal year 2010 at the level provided for such activities for the corresponding quarter of fiscal year 2004 (or, as applicable, at such greater level as may result from the application of this subtitle, the amendments made by this subtitle, and the TANF Emergency Response and Recovery Act of 2005), except that in the case of section 403(a)(3) of the Social Security Act, grants and payments may be made pursuant to this authority only through fiscal year 2008 and in the case of section 403(a)(4) of the Social Security Act, no grants shall be made for any fiscal year occurring after fiscal year 2005.

(b) CONFORMING AMENDMENTS.—Part A of title IV (42 U.S.C. 601 et seq.) is amended—

(1) in section 403(a)(3)(H)(ii), by striking “December, 31, 2005” and inserting “fiscal year 2008”;

(2) in section 403(b)(3)(C)(ii), by striking “2006” and inserting “2010”; and

(3) in section 409(a)(7)—

(A) in subparagraph (A), by striking “or 2007” and inserting “2007, 2008, 2009, 2010, or 2011”; and

(B) in subparagraph (B)(ii), by striking “2006” and inserting “2010”.

(c) **EXTENSION OF THE NATIONAL RANDOM SAMPLE STUDY OF CHILD WELFARE THROUGH SEPTEMBER 30, 2010.**—Activities authorized by section 429A of the Social Security Act shall continue through September 30, 2010, in the manner authorized for fiscal year 2004, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority on a quarterly basis through fiscal year 2010 at the level provided for such activities for the corresponding quarter of fiscal year 2004.

SEC. 7102. IMPROVED CALCULATION OF WORK PARTICIPATION RATES AND PROGRAM INTEGRITY.

(a) **RECALIBRATION OF CASELOAD REDUCTION CREDIT.**—

(1) **IN GENERAL.**—Section 407(b)(3)(A) (42 U.S.C. 607(b)(3)(A)) is amended—

(A) in clause (i), by inserting “or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i))” after “this part”; and

(B) by striking clause (ii) and inserting the following:
“(ii) the average monthly number of families that received assistance under any State program referred to in clause (i) during fiscal year 2005.”.

(2) **CONFORMING AMENDMENT.**—Section 407(b)(3)(B) (42 U.S.C. 607(b)(3)(B)) is amended by striking “and eligibility criteria” and all that follows through the close parenthesis and inserting “and the eligibility criteria in effect during fiscal year 2005”.

(b) **INCLUSION OF FAMILIES RECEIVING ASSISTANCE UNDER SEPARATE STATE PROGRAMS IN CALCULATION OF PARTICIPATION RATES.**—

(1) Section 407 (42 U.S.C. 607) is amended in each of subsections (a)(1), (a)(2), (b)(1)(B)(i), (c)(2)(A)(i), (e)(1), and (e)(2), by inserting “or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i))” after “this part”.

(2) Section 411(a)(1) (42 U.S.C. 611(a)(1)) is amended—

(A) in subparagraph (A), by inserting “or any other State program funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i))” before the colon; and

(B) in subparagraph (B)(ii), by inserting “and any other State programs funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i))” after “this part”.

(c) **IMPROVED VERIFICATION AND OVERSIGHT OF WORK PARTICIPATION.**—

(1) **IN GENERAL.**—Section 407(i) (42 U.S.C. 607(i)) is amended to read as follows:

“(i) VERIFICATION OF WORK AND WORK-ELIGIBLE INDIVIDUALS IN ORDER TO IMPLEMENT REFORMS.—

“(1) SECRETARIAL DIRECTION AND OVERSIGHT.—

“(A) REGULATIONS FOR DETERMINING WHETHER ACTIVITIES MAY BE COUNTED AS ‘WORK ACTIVITIES’, HOW TO COUNT AND VERIFY REPORTED HOURS OF WORK, AND DETERMINING WHO IS A WORK-ELIGIBLE INDIVIDUAL.—

“(i) IN GENERAL.—Not later than June 30, 2006, the Secretary shall promulgate regulations to ensure consistent measurement of work participation rates under State programs funded under this part and State programs funded with qualified State expenditures (as defined in section 409(a)(7)(B)(i)), which shall include information with respect to—

“(I) determining whether an activity of a recipient of assistance may be treated as a work activity under subsection (d);

“(II) uniform methods for reporting hours of work by a recipient of assistance;

“(III) the type of documentation needed to verify reported hours of work by a recipient of assistance; and

“(IV) the circumstances under which a parent who resides with a child who is a recipient of assistance should be included in the work participation rates.

“(ii) ISSUANCE OF REGULATIONS ON AN INTERIM FINAL BASIS.—The regulations referred to in clause (i) may be effective and final immediately on an interim basis as of the date of publication of the regulations. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comment on the regulation after the date of publication. The Secretary may change or revise the regulation after the public comment period.

“(B) OVERSIGHT OF STATE PROCEDURES.—The Secretary shall review the State procedures established in accordance with paragraph (2) to ensure that such procedures are consistent with the regulations promulgated under subparagraph (A) and are adequate to ensure an accurate measurement of work participation under the State programs funded under this part and any other State programs funded with qualified State expenditures (as so defined).

“(2) REQUIREMENT FOR STATES TO ESTABLISH AND MAINTAIN WORK PARTICIPATION VERIFICATION PROCEDURES.—Not later than September 30, 2006, a State to which a grant is made under section 403 shall establish procedures for determining, with respect to recipients of assistance under the State program funded under this part or under any State programs funded with qualified State expenditures (as so defined), whether activities may be counted as work activities, how to count and verify reported hours of work, and who is a work-eligible individual, in accordance with the regulations promulgated pursuant to paragraph (1)(A)(i) and shall establish internal controls to ensure compliance with the procedures.”

(2) *STATE PENALTY FOR FAILURE TO ESTABLISH OR COMPLY WITH WORK PARTICIPATION VERIFICATION PROCEDURES.*—Section 409(a) (42 U.S.C. 609(a)) is amended by adding at the end the following:

“(15) *PENALTY FOR FAILURE TO ESTABLISH OR COMPLY WITH WORK PARTICIPATION VERIFICATION PROCEDURES.*—

“(A) *IN GENERAL.*—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(i)(2) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

“(B) *PENALTY BASED ON SEVERITY OF FAILURE.*—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of non-compliance.”

(d) *EFFECTIVE DATE.*—The amendments made by subsections (a) and (b) shall take effect on October 1, 2006.

SEC. 7103. GRANTS FOR HEALTHY MARRIAGE PROMOTION AND RESPONSIBLE FATHERHOOD.

(a) *HEALTHY MARRIAGE AND FAMILY FUNDS.*—Section 403(a)(2) (42 U.S.C. 603(a)(2)) is amended to read as follows:

“(2) *HEALTHY MARRIAGE PROMOTION AND RESPONSIBLE FATHERHOOD GRANTS.*—

“(A) *IN GENERAL.*—

“(i) *USE OF FUNDS.*—Subject to subparagraphs (B) and (C), the Secretary may use the funds made available under subparagraph (D) for the purpose of conducting and supporting research and demonstration projects by public or private entities, and providing technical assistance to States, Indian tribes and tribal organizations, and such other entities as the Secretary may specify that are receiving a grant under another provision of this part.

“(ii) *LIMITATIONS.*—The Secretary may not award funds made available under this paragraph on a non-competitive basis, and may not provide any such funds to an entity for the purpose of carrying out healthy marriage promotion activities or for the purpose of carrying out activities promoting responsible fatherhood unless the entity has submitted to the Secretary an application which—

“(I) describes—

“(aa) how the programs or activities proposed in the application will address, as appropriate, issues of domestic violence; and

“(bb) what the applicant will do, to the extent relevant, to ensure that participation in the programs or activities is voluntary, and to inform potential participants that their participation is voluntary; and

“(II) contains a commitment by the entity—

“(aa) to not use the funds for any other purpose; and

“(bb) to consult with experts in domestic violence or relevant community domestic violence coalitions in developing the programs and activities.

“(iii) *HEALTHY MARRIAGE PROMOTION ACTIVITIES.*—*In clause (ii), the term ‘healthy marriage promotion activities’ means the following:*

“(I) *Public advertising campaigns on the value of marriage and the skills needed to increase marital stability and health.*

“(II) *Education in high schools on the value of marriage, relationship skills, and budgeting.*

“(III) *Marriage education, marriage skills, and relationship skills programs, that may include parenting skills, financial management, conflict resolution, and job and career advancement, for non-married pregnant women and non-married expectant fathers.*

“(IV) *Pre-marital education and marriage skills training for engaged couples and for couples or individuals interested in marriage.*

“(V) *Marriage enhancement and marriage skills training programs for married couples.*

“(VI) *Divorce reduction programs that teach relationship skills.*

“(VII) *Marriage mentoring programs which use married couples as role models and mentors in at-risk communities.*

“(VIII) *Programs to reduce the disincentives to marriage in means-tested aid programs, if offered in conjunction with any activity described in this subparagraph.*

“(B) *LIMITATION ON USE OF FUNDS FOR DEMONSTRATION PROJECTS FOR COORDINATION OF PROVISION OF CHILD WELFARE AND TANF SERVICES TO TRIBAL FAMILIES AT RISK OF CHILD ABUSE OR NEGLECT.*—

“(i) *IN GENERAL.*—*Of the amounts made available under subparagraph (D) for a fiscal year, the Secretary may not award more than \$2,000,000 on a competitive basis to fund demonstration projects designed to test the effectiveness of tribal governments or tribal consortia in coordinating the provision to tribal families at risk of child abuse or neglect of child welfare services and services under tribal programs funded under this part.*

“(ii) *LIMITATION ON USE OF FUNDS.*—*A grant made pursuant to clause (i) to such a project shall not be used for any purpose other than—*

“(I) *to improve case management for families eligible for assistance from such a tribal program;*

“(II) *for supportive services and assistance to tribal children in out-of-home placements and the*

tribal families caring for such children, including families who adopt such children; and

“(III) for prevention services and assistance to tribal families at risk of child abuse and neglect.

“(iii) REPORTS.—The Secretary may require a recipient of funds awarded under this subparagraph to provide the Secretary with such information as the Secretary deems relevant to enable the Secretary to facilitate and oversee the administration of any project for which funds are provided under this subparagraph.

“(C) LIMITATION ON USE OF FUNDS FOR ACTIVITIES PROMOTING RESPONSIBLE FATHERHOOD.—

“(i) IN GENERAL.—Of the amounts made available under subparagraph (D) for a fiscal year, the Secretary may not award more than \$50,000,000 on a competitive basis to States, territories, Indian tribes and tribal organizations, and public and nonprofit community entities, including religious organizations, for activities promoting responsible fatherhood.

“(ii) ACTIVITIES PROMOTING RESPONSIBLE FATHERHOOD.—In this paragraph, the term ‘activities promoting responsible fatherhood’ means the following:

“(I) Activities to promote marriage or sustain marriage through activities such as counseling, mentoring, disseminating information about the benefits of marriage and 2-parent involvement for children, enhancing relationship skills, education regarding how to control aggressive behavior, disseminating information on the causes of domestic violence and child abuse, marriage preparation programs, premarital counseling, marital inventories, skills-based marriage education, financial planning seminars, including improving a family’s ability to effectively manage family business affairs by means such as education, counseling, or mentoring on matters related to family finances, including household management, budgeting, banking, and handling of financial transactions and home maintenance, and divorce education and reduction programs, including mediation and counseling.

“(II) Activities to promote responsible parenting through activities such as counseling, mentoring, and mediation, disseminating information about good parenting practices, skills-based parenting education, encouraging child support payments, and other methods.

“(III) Activities to foster economic stability by helping fathers improve their economic status by providing activities such as work first services, job search, job training, subsidized employment, job retention, job enhancement, and encouraging education, including career-advancing education, dissemination of employment materials, coordination with existing employment services such as welfare-

to-work programs, referrals to local employment training initiatives, and other methods.

“(IV) Activities to promote responsible fatherhood that are conducted through a contract with a nationally recognized, nonprofit fatherhood promotion organization, such as the development, promotion, and distribution of a media campaign to encourage the appropriate involvement of parents in the life of any child and specifically the issue of responsible fatherhood, and the development of a national clearinghouse to assist States and communities in efforts to promote and support marriage and responsible fatherhood.

“(D) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated \$150,000,000 for each of fiscal years 2006 through 2010, for expenditure in accordance with this paragraph.”

(b) COUNTING OF SPENDING ON CERTAIN PRO-FAMILY ACTIVITIES.—Section 409(a)(7)(B)(i) (42 U.S.C. 609(a)(7)(B)(i)) is amended by adding at the end the following:

“(V) COUNTING OF SPENDING ON CERTAIN PRO-FAMILY ACTIVITIES.—The term ‘qualified State expenditures’ includes the total expenditures by the State during the fiscal year under all State programs for a purpose described in paragraph (3) or (4) of section 401(a).”

Subtitle B—Child Care

SEC. 7201. ENTITLEMENT FUNDING.

Section 418(a)(3) (42 U.S.C. 618(a)(3)) is amended—

- (1) by striking “and” at the end of subparagraph (E);
- (2) by striking the period at the end of subparagraph (F) and inserting a semicolon; and
- (3) by adding at the end the following:

“(G) \$2,917,000,000 for each of fiscal years 2006 through 2010.”

Subtitle C—Child Support

SEC. 7301. ASSIGNMENT AND DISTRIBUTION OF CHILD SUPPORT.

(a) MODIFICATION OF RULE REQUIRING ASSIGNMENT OF SUPPORT RIGHTS AS A CONDITION OF RECEIVING TANF.—Section 408(a)(3) (42 U.S.C. 608(a)(3)) is amended to read as follows:

“(3) NO ASSISTANCE FOR FAMILIES NOT ASSIGNING CERTAIN SUPPORT RIGHTS TO THE STATE.—A State to which a grant is made under section 403 shall require, as a condition of paying assistance to a family under the State program funded under this part, that a member of the family assign to the State any right the family member may have (on behalf of the family member or of any other person for whom the family member has applied for or is receiving such assistance) to support from any other person, not exceeding the total amount of assistance

so paid to the family, which accrues during the period that the family receives assistance under the program.”.

(b) INCREASING CHILD SUPPORT PAYMENTS TO FAMILIES AND SIMPLIFYING CHILD SUPPORT DISTRIBUTION RULES.—

(1) DISTRIBUTION RULES.—

(A) IN GENERAL.—Section 457(a) (42 U.S.C. 657(a)) is amended to read as follows:

“(a) IN GENERAL.—Subject to subsections (d) and (e), the amounts collected on behalf of a family as support by a State pursuant to a plan approved under this part shall be distributed as follows:

“(1) FAMILIES RECEIVING ASSISTANCE.—In the case of a family receiving assistance from the State, the State shall—

“(A) pay to the Federal Government the Federal share of the amount collected, subject to paragraph (3)(A);

“(B) retain, or pay to the family, the State share of the amount collected, subject to paragraph (3)(B); and

“(C) pay to the family any remaining amount.

“(2) FAMILIES THAT FORMERLY RECEIVED ASSISTANCE.—In the case of a family that formerly received assistance from the State:

“(A) CURRENT SUPPORT.—To the extent that the amount collected does not exceed the current support amount, the State shall pay the amount to the family.

“(B) ARREARAGES.—Except as otherwise provided in an election made under section 454(34), to the extent that the amount collected exceeds the current support amount, the State—

“(i) shall first pay to the family the excess amount, to the extent necessary to satisfy support arrearages not assigned pursuant to section 408(a)(3);

“(ii) if the amount collected exceeds the amount required to be paid to the family under clause (i), shall—

“(I) pay to the Federal Government the Federal share of the excess amount described in this clause, subject to paragraph (3)(A); and

“(II) retain, or pay to the family, the State share of the excess amount described in this clause, subject to paragraph (3)(B); and

“(iii) shall pay to the family any remaining amount.

“(3) LIMITATIONS.—

“(A) FEDERAL REIMBURSEMENTS.—The total of the amounts paid by the State to the Federal Government under paragraphs (1) and (2) of this subsection with respect to a family shall not exceed the Federal share of the amount assigned with respect to the family pursuant to section 408(a)(3).

“(B) STATE REIMBURSEMENTS.—The total of the amounts retained by the State under paragraphs (1) and (2) of this subsection with respect to a family shall not exceed the State share of the amount assigned with respect to the family pursuant to section 408(a)(3).

“(4) FAMILIES THAT NEVER RECEIVED ASSISTANCE.—In the case of any other family, the State shall distribute to the family

the portion of the amount so collected that remains after withholding any fee pursuant to section 454(6)(B)(ii).

“(5) FAMILIES UNDER CERTAIN AGREEMENTS.—Notwithstanding paragraphs (1) through (3), in the case of an amount collected for a family in accordance with a cooperative agreement under section 454(33), the State shall distribute the amount collected pursuant to the terms of the agreement.”.

(B) STATE OPTION TO PASS THROUGH ADDITIONAL SUPPORT WITH FEDERAL FINANCIAL PARTICIPATION BEGINNING WITH FISCAL YEAR 2009.—

(i) IN GENERAL.—Section 457(a) (42 U.S.C. 657(a)) is amended by adding at the end the following:

“(7) STATE OPTION TO PASS THROUGH ADDITIONAL SUPPORT WITH FEDERAL FINANCIAL PARTICIPATION.—

“(A) FAMILIES THAT FORMERLY RECEIVED ASSISTANCE.—Notwithstanding paragraph (2), a State shall not be required to pay to the Federal Government the Federal share of an amount collected on behalf of a family that formerly received assistance from the State to the extent that the State pays the amount to the family.

“(B) FAMILIES THAT CURRENTLY RECEIVE ASSISTANCE.—

“(i) IN GENERAL.—Notwithstanding paragraph (1), in the case of a family that receives assistance from the State, a State shall not be required to pay to the Federal Government the Federal share of the excepted portion (as defined in clause (ii)) of any amount collected on behalf of such family during a month to the extent that—

“(I) the State pays the excepted portion to the family; and

“(II) the excepted portion is disregarded in determining the amount and type of assistance provided to the family under such program.

“(ii) EXCEPTED PORTION DEFINED.—For purposes of this subparagraph, the term “excepted portion” means that portion of the amount collected on behalf of a family during a month that does not exceed \$100 per month, or in the case of a family that includes 2 or more children, that does not exceed an amount established by the State that is not more than \$200 per month.”.

(ii) EFFECTIVE DATE.—The amendment made by clause (i) shall take effect on October 1, 2008.

(iii) REDESIGNATION.—Effective October 1, 2009, paragraph (7) of section 457(a) of the Social Security Act (as added by clause (i)) is redesignated as paragraph (6).

(C) STATE PLAN TO INCLUDE ELECTION AS TO WHICH RULES TO APPLY IN DISTRIBUTING CHILD SUPPORT ARREARAGES COLLECTED ON BEHALF OF FAMILIES FORMERLY RECEIVING ASSISTANCE.—Section 454 (42 U.S.C. 654) is amended—

(i) by striking “and” at the end of paragraph (32);

(ii) by striking the period at the end of paragraph (33) and inserting “; and”; and

(iii) by inserting after paragraph (33) the following:

“(34) include an election by the State to apply section 457(a)(2)(B) of this Act or former section 457(a)(2)(B) of this Act (as in effect for the State immediately before the date this paragraph first applies to the State) to the distribution of the amounts which are the subject of such sections and, for so long as the State elects to so apply such former section, the amendments made by subsection (b)(1) of section 7301 of the Deficit Reduction Act of 2005 shall not apply with respect to the State, notwithstanding subsection (e) of such section 7301.”

(2) CURRENT SUPPORT AMOUNT DEFINED.—Section 457(c) (42 U.S.C. 657(c)) is amended by adding at the end the following:

“(5) CURRENT SUPPORT AMOUNT.—The term ‘current support amount’ means, with respect to amounts collected as support on behalf of a family, the amount designated as the monthly support obligation of the noncustodial parent in the order requiring the support or calculated by the State based on the order.”

(c) STATE OPTION TO DISCONTINUE OLDER SUPPORT ASSIGNMENTS.—Section 457(b) (42 U.S.C. 657(b)) is amended to read as follows:

“(b) CONTINUATION OF ASSIGNMENTS.—

“(1) STATE OPTION TO DISCONTINUE PRE-1997 SUPPORT ASSIGNMENTS.—

“(A) IN GENERAL.—Any rights to support obligations assigned to a State as a condition of receiving assistance from the State under part A and in effect on September 30, 1997 (or such earlier date on or after August 22, 1996, as the State may choose), may remain assigned after such date.

“(B) DISTRIBUTION OF AMOUNTS AFTER ASSIGNMENT DISCONTINUATION.—If a State chooses to discontinue the assignment of a support obligation described in subparagraph (A), the State may treat amounts collected pursuant to the assignment as if the amounts had never been assigned and may distribute the amounts to the family in accordance with subsection (a)(4).

“(2) STATE OPTION TO DISCONTINUE POST-1997 ASSIGNMENTS.—

“(A) IN GENERAL.—Any rights to support obligations accruing before the date on which a family first receives assistance under part A that are assigned to a State under that part and in effect before the implementation date of this section may remain assigned after such date.

“(B) DISTRIBUTION OF AMOUNTS AFTER ASSIGNMENT DISCONTINUATION.—If a State chooses to discontinue the assignment of a support obligation described in subparagraph (A), the State may treat amounts collected pursuant to the assignment as if the amounts had never been assigned and may distribute the amounts to the family in accordance with subsection (a)(4).”

(d) **CONFORMING AMENDMENTS.**—Section 6402(c) of the Internal Revenue Code of 1986 (relating to offset of past-due support against overpayments) is amended—

(1) in the first sentence, by striking “the Social Security Act.” and inserting “of such Act.”; and

(2) by striking the third sentence and inserting the following: “The Secretary shall apply a reduction under this subsection first to an amount certified by the State as past due support under section 464 of the Social Security Act before any other reductions allowed by law.”.

(e) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—Except as otherwise provided in this section, the amendments made by the preceding provisions of this section shall take effect on October 1, 2009, and shall apply to payments under parts A and D of title IV of the Social Security Act for calendar quarters beginning on or after such date, and without regard to whether regulations to implement the amendments (in the case of State programs operated under such part D) are promulgated by such date.

(2) **STATE OPTION TO ACCELERATE EFFECTIVE DATE.**—Notwithstanding paragraph (1), a State may elect to have the amendments made by the preceding provisions of this section apply to the State and to amounts collected by the State (and the payments under parts A and D), on and after such date as the State may select that is not earlier than October 1, 2008, and not later than September 30, 2009.

(f) **USE OF TAX REFUND INTERCEPT PROGRAM TO COLLECT PAST-DUE CHILD SUPPORT ON BEHALF OF CHILDREN WHO ARE NOT MINORS.**—

(1) **IN GENERAL.**—Section 464 (42 U.S.C. 664) is amended—

(A) in subsection (a)(2)(A), by striking “(as that term is defined for purposes of this paragraph under subsection (c))”; and

(B) in subsection (c)—

(i) in paragraph (1)—

(I) by striking “(1) Except as provided in paragraph (2), as used in” and inserting “In”; and

(II) by inserting “(whether or not a minor)” after “a child” each place it appears; and

(ii) by striking paragraphs (2) and (3).

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall take effect on October 1, 2007.

(g) **STATE OPTION TO USE STATEWIDE AUTOMATED DATA PROCESSING AND INFORMATION RETRIEVAL SYSTEM FOR INTERSTATE CASES.**—Section 466(a)(14)(A)(iii) (42 U.S.C. 666(a)(14)(A)(iii)) is amended by inserting before the semicolon the following: “(but the assisting State may establish a corresponding case based on such other State’s request for assistance)”.

SEC. 7302. MANDATORY REVIEW AND ADJUSTMENT OF CHILD SUPPORT ORDERS FOR FAMILIES RECEIVING TANF.

(a) **IN GENERAL.**—Section 466(a)(10)(A)(i) (42 U.S.C. 666(a)(10)(A)(i)) is amended—

(1) by striking “parent, or,” and inserting “parent or”; and

(2) by striking “upon the request of the State agency under the State plan or of either parent,”.

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) shall take effect on October 1, 2007.

SEC. 7303. DECREASE IN AMOUNT OF CHILD SUPPORT ARREARAGE TRIGGERING PASSPORT DENIAL.

(a) *IN GENERAL.*—Section 452(k)(1) (42 U.S.C. 652(k)(1)) is amended by striking “\$5,000” and inserting “\$2,500”.

(b) *CONFORMING AMENDMENT.*—Section 454(31) (42 U.S.C. 654(31)) is amended by striking “\$5,000” and inserting “\$2,500”.

(c) *EFFECTIVE DATE.*—The amendments made by this section shall take effect on October 1, 2006.

SEC. 7304. MAINTENANCE OF TECHNICAL ASSISTANCE FUNDING.

Section 452(j) (42 U.S.C. 652(j)) is amended by inserting “or the amount appropriated under this paragraph for fiscal year 2002, whichever is greater” before “, which shall be available”.

SEC. 7305. MAINTENANCE OF FEDERAL PARENT LOCATOR SERVICE FUNDING.

Section 453(o) (42 U.S.C. 653(o)) is amended—

(1) in the first sentence, by inserting “or the amount appropriated under this paragraph for fiscal year 2002, whichever is greater” before “, which shall be available”; and

(2) in the second sentence, by striking “for each of fiscal years 1997 through 2001”.

SEC. 7306. INFORMATION COMPARISONS WITH INSURANCE DATA.

(a) *DUTIES OF THE SECRETARY.*—Section 452 (42 U.S.C. 652) is amended by adding at the end the following:

“(l) *COMPARISONS WITH INSURANCE INFORMATION.*—

“(1) *IN GENERAL.*—The Secretary, through the Federal Parent Locator Service, may—

“(A) compare information concerning individuals owing past-due support with information maintained by insurers (or their agents) concerning insurance claims, settlements, awards, and payments; and

“(B) furnish information resulting from the data matches to the State agencies responsible for collecting child support from the individuals.

“(2) *LIABILITY.*—An insurer (including any agent of an insurer) shall not be liable under any Federal or State law to any person for any disclosure provided for under this subsection, or for any other action taken in good faith in accordance with this subsection.”.

(b) *STATE REIMBURSEMENT OF FEDERAL COSTS.*—Section 453(k)(3) (42 U.S.C. 653(k)(3)) is amended by inserting “or section 452(l)” after “pursuant to this section”.

SEC. 7307. REQUIREMENT THAT STATE CHILD SUPPORT ENFORCEMENT AGENCIES SEEK MEDICAL SUPPORT FOR CHILDREN FROM EITHER PARENT.

(a) *STATE AGENCIES REQUIRED TO SEEK MEDICAL SUPPORT FROM EITHER PARENT.*—

(1) *IN GENERAL.*—Section 466(a)(19)(A) (42 U.S.C. 666(a)(19)(A)) is amended by striking “which include a provision for the health care coverage of the child are enforced” and inserting “shall include a provision for medical support for the child to be provided by either or both parents, and shall be enforced”.

(2) CONFORMING AMENDMENTS.—

(A) TITLE IV—D.—

(i) Section 452(f) (42 U.S.C. 652(f)) is amended by striking “include medical support as part of any child support order and enforce medical support” and inserting “enforce medical support included as part of a child support order”.

(ii) Section 466(a)(19) (42 U.S.C. 666(a)(19)), as amended by paragraph (1) of this subsection, is amended—

(I) in subparagraph (A)—

(aa) by striking “section 401(e)(3)(C)” and inserting “section 401(e)”; and

(bb) by striking “section 401(f)(5)(C)” and inserting “section 401(f)”; and

(II) in subparagraph (B)—

(aa) by striking “noncustodial” each place it appears; and

(bb) in clause (iii), by striking “section 466(b)” and inserting “subsection (b)”; and

(III) in subparagraph (C), by striking “noncustodial” each place it appears and inserting “obligated”.

(B) STATE OR LOCAL GOVERNMENTAL GROUP HEALTH PLANS.—Section 401(e)(2) of the Child Support Performance and Incentive Act of 1998 (29 U.S.C. 1169 note) is amended, in the matter preceding subparagraph (A), by striking “who is a noncustodial parent of the child”.

(C) CHURCH PLANS.—Section 401(f)(5)(C) of the Child Support Performance and Incentive Act of 1998 (29 U.S.C. 1169 note) is amended by striking “noncustodial” each place it appears.

(b) ENFORCEMENT OF MEDICAL SUPPORT REQUIREMENTS.—Section 452(f) (42 U.S.C. 652(f)), as amended by subsection (a)(2)(A)(i), is amended by inserting after the first sentence the following: “A State agency administering the program under this part may enforce medical support against a custodial parent if health care coverage is available to the custodial parent at a reasonable cost, notwithstanding any other provision of this part.”

(c) DEFINITION OF MEDICAL SUPPORT.—Section 452(f) (42 U.S.C. 652(f)), as amended by subsections (a)(2)(A)(i) and (b) of this section, is amended by adding at the end the following: “For purposes of this part, the term ‘medical support’ may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, co-payments, and deductibles) and payment for medical expenses incurred on behalf of a child.”

SEC. 7308. REDUCTION OF FEDERAL MATCHING RATE FOR LABORATORY COSTS INCURRED IN DETERMINING PATERNITY.

(a) IN GENERAL.—Section 455(a)(1)(C) (42 U.S.C. 655(a)(1)(C)) is amended by striking “90 percent (rather than the percentage specified in subparagraph (A))” and inserting “66 percent”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 2006, and shall apply to costs incurred on or after that date.

SEC. 7309. ENDING FEDERAL MATCHING OF STATE SPENDING OF FEDERAL INCENTIVE PAYMENTS.

(a) *IN GENERAL.*—Section 455(a)(1) (42 U.S.C. 655(a)(1)) is amended by inserting “from amounts paid to the State under section 458 or” before “to carry out an agreement”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall take effect on October 1, 2007.

SEC. 7310. MANDATORY FEE FOR SUCCESSFUL CHILD SUPPORT COLLECTION FOR FAMILY THAT HAS NEVER RECEIVED TANF.

(a) *IN GENERAL.*—Section 454(6)(B) (42 U.S.C. 654(6)(B)) is amended—

- (1) by inserting “(i)” after “(B)”;
- (2) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;
- (3) by adding “and” after the semicolon; and
- (4) by adding after and below the end the following new clause:

“(ii) in the case of an individual who has never received assistance under a State program funded under part A and for whom the State has collected at least \$500 of support, the State shall impose an annual fee of \$25 for each case in which services are furnished, which shall be retained by the State from support collected on behalf of the individual (but not from the 1st \$500 so collected), paid by the individual applying for the services, recovered from the absent parent, or paid by the State out of its own funds (the payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and the fees shall be considered income to the program).”

(b) *CONFORMING AMENDMENTS.*—Section 457(a)(3) (42 U.S.C. 657(a)(3)) is amended to read as follows:

“(3) *FAMILIES THAT NEVER RECEIVED ASSISTANCE.*—In the case of any other family, the State shall distribute to the family the portion of the amount so collected that remains after withholding any fee pursuant to section 454(6)(B)(ii).”

(c) *EFFECTIVE DATE.*—The amendments made by this section shall take effect on October 1, 2006.

SEC. 7311. EXCEPTION TO GENERAL EFFECTIVE DATE FOR STATE PLANS REQUIRING STATE LAW AMENDMENTS.

In the case of a State plan under part D of title IV of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this subtitle, the effective date of the amendments imposing the additional requirements shall be 3 months after the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

Subtitle D—Child Welfare

SEC. 7401. STRENGTHENING COURTS.

(a) COURT IMPROVEMENT GRANTS.—

(1) IN GENERAL.—Section 438(a) (42 U.S.C. 629h(a)) is amended—

(A) by striking “and” at the end of paragraph (1);

(B) by striking the period at the end of paragraph (2) and inserting a semicolon; and

(C) by adding at the end the following:

“(3) to ensure that the safety, permanence, and well-being needs of children are met in a timely and complete manner; and

“(4) to provide for the training of judges, attorneys and other legal personnel in child welfare cases.”.

(2) APPLICATIONS.—Section 438(b) (42 U.S.C. 629h(b)) is amended to read as follows:

“(b) APPLICATIONS.—

“(1) IN GENERAL.—In order to be eligible to receive a grant under this section, a highest State court shall submit to the Secretary an application at such time, in such form, and including such information and assurances as the Secretary may require, including—

“(A) in the case of a grant for the purpose described in subsection (a)(3), a description of how courts and child welfare agencies on the local and State levels will collaborate and jointly plan for the collection and sharing of all relevant data and information to demonstrate how improved case tracking and analysis of child abuse and neglect cases will produce safe and timely permanency decisions;

“(B) in the case of a grant for the purpose described in subsection (a)(4), a demonstration that a portion of the grant will be used for cross-training initiatives that are jointly planned and executed with the State agency or any other agency under contract with the State to administer the State program under the State plan under subpart 1, the State plan approved under section 434, or the State plan approved under part E; and

“(C) in the case of a grant for any purpose described in subsection (a), a demonstration of meaningful and ongoing collaboration among the courts in the State, the State agency or any other agency under contract with the State who is responsible for administering the State program under part B or E, and, where applicable, Indian tribes..

“(2) SEPARATE APPLICATIONS.— A highest State court desiring grants under this section for 2 or more purposes shall submit separate applications for the following grants:

“(A) A grant for the purposes described in paragraphs (1) and (2) of subsection (a).

“(B) A grant for the purpose described in subsection (a)(3).

“(C) A grant for the purpose described in subsection (a)(4).”.

(3) ALLOTMENTS.—Section 438(c) (42 U.S.C. 429h(c)) is amended—

(A) in paragraph (1)—

(i) by inserting “of this section for a grant described in subsection (b)(2)(A) of this section” after “subsection (b)”; and

(ii) by striking “paragraph (2) of this subsection” and inserting “subparagraph (B) of this paragraph”;

(B) in paragraph (2)—

(i) by striking “this paragraph” and inserting “this subparagraph”;

(ii) by striking “paragraph (1) of this subsection” and inserting “subparagraph (A) of this paragraph”; and

(iii) by inserting “for such a grant” after “subsection (b)”;

(C) by redesignating and indenting paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(D) by inserting before and above such subparagraph (A) the following:

“(1) GRANTS TO ASSESS AND IMPROVE HANDLING OF COURT PROCEEDINGS RELATING TO FOSTER CARE AND ADOPTION.—”; and

(E) by adding at the end the following:

“(2) GRANTS FOR IMPROVED DATA COLLECTION AND TRAINING.—

“(A) IN GENERAL.—Each highest State court which has an application approved under subsection (b) of this section for a grant referred to in subparagraph (B) or (C) of subsection (b)(2) shall be entitled to payment, for each of fiscal years 2006 through 2010, from the amount made available under whichever of paragraph (1) or (2) of subsection (e) applies with respect to the grant, of an amount equal to the sum of \$85,000 plus the amount described in subparagraph (B) of this paragraph for the fiscal year with respect to the grant.

“(B) FORMULA.—The amount described in this subparagraph for any fiscal year with respect to a grant referred to in subparagraph (B) or (C) of subsection (b)(2) is the amount that bears the same ratio to the amount made available under subsection (e) for such a grant (reduced by the dollar amount specified in subparagraph (A) of this paragraph) as the number of individuals in the State who have not attained 21 years of age bears to the total number of such individuals in all States the highest State courts of which have approved applications under subsection (b) for such a grant.”.

(4) FUNDING.—Section 438 (42 U.S.C. 629h) is amended by adding at the end the following:

“(e) FUNDING FOR GRANTS FOR IMPROVED DATA COLLECTION AND TRAINING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary, for each of fiscal years 2006 through 2010—

“(1) \$10,000,000 for grants referred to in subsection (b)(2)(B); and

“(2) \$10,000,000 for grants referred to in subsection (b)(2)(C).”.

(b) **REQUIREMENT TO DEMONSTRATE MEANINGFUL COLLABORATION BETWEEN COURTS AND AGENCIES IN CHILD WELFARE SERVICES PROGRAMS.**—Section 422(b) (42 U.S.C. 622(b)) is amended—

(1) by striking “and” at the end of paragraph (13);
 (2) by striking the period at the end of paragraph (14) and inserting “; and”; and

(3) by adding at the end the following:
 “(15) demonstrate substantial, ongoing, and meaningful collaboration with State courts in the development and implementation of the State plan under subpart 1, the State plan approved under subpart 2, and the State plan approved under part E, and in the development and implementation of any program improvement plan required under section 1123A.”.

(c) **USE OF CHILD WELFARE RECORDS IN STATE COURT PROCEEDINGS.**—Section 471 (42 U.S.C. 671) is amended—

(1) in subsection (a)(8), by inserting “subject to subsection (c),” after “(8)”; and

(2) by adding at the end the following:

“(c) **USE OF CHILD WELFARE RECORDS IN STATE COURT PROCEEDINGS.**—Subsection (a)(8) shall not be construed to limit the flexibility of a State in determining State policies relating to public access to court proceedings to determine child abuse and neglect or other court hearings held pursuant to part B or this part, except that such policies shall, at a minimum, ensure the safety and well-being of the child, parents, and family.”.

SEC. 7402. FUNDING OF SAFE AND STABLE FAMILIES PROGRAMS.

Section 436(a) (42 U.S.C. 629f(a)) is amended to read as follows:

“(a) **AUTHORIZATION.**—In addition to any amount otherwise made available to carry out this subpart, there are authorized to be appropriated to carry out this subpart \$345,000,000 for fiscal year 2006. Notwithstanding the preceding sentence, the total amount authorized to be so appropriated for fiscal year 2006 under this subsection and under this subsection (as in effect before the date of the enactment of the Deficit Reduction Act of 2005) is \$345,000,000.”.

SEC. 7403. CLARIFICATION REGARDING FEDERAL MATCHING OF CERTAIN ADMINISTRATIVE COSTS UNDER THE FOSTER CARE MAINTENANCE PAYMENTS PROGRAM.

(a) **ADMINISTRATIVE COSTS RELATING TO UNLICENSED CARE.**—Section 472 (42 U.S.C. 672) is amended by inserting after subsection (h) the following:

“(i) **ADMINISTRATIVE COSTS ASSOCIATED WITH OTHERWISE ELIGIBLE CHILDREN NOT IN LICENSED FOSTER CARE SETTINGS.**—Expenditures by a State that would be considered administrative expenditures for purposes of section 474(a)(3) if made with respect to a child who was residing in a foster family home or child-care institution shall be so considered with respect to a child not residing in such a home or institution—

“(1) in the case of a child who has been removed in accordance with subsection (a) of this section from the home of a relative specified in section 406(a) (as in effect on July 16, 1996), only for expenditures—

“(A) with respect to a period of not more than the lesser of 12 months or the average length of time it takes for the State to license or approve a home as a foster home, in

which the child is in the home of a relative and an application is pending for licensing or approval of the home as a foster family home; or

“(B) with respect to a period of not more than 1 calendar month when a child moves from a facility not eligible for payments under this part into a foster family home or child care institution licensed or approved by the State; and

“(2) in the case of any other child who is potentially eligible for benefits under a State plan approved under this part and at imminent risk of removal from the home, only if—

“(A) reasonable efforts are being made in accordance with section 471(a)(15) to prevent the need for, or if necessary to pursue, removal of the child from the home; and

“(B) the State agency has made, not less often than every 6 months, a determination (or redetermination) as to whether the child remains at imminent risk of removal from the home.”

(b) CONFORMING AMENDMENT.—Section 474(a)(3) (42 U.S.C. 674(a)(3)) is amended by inserting “subject to section 472(i)” before “an amount equal to”.

SEC. 7404. CLARIFICATION OF ELIGIBILITY FOR FOSTER CARE MAINTENANCE PAYMENTS AND ADOPTION ASSISTANCE.

(a) FOSTER CARE MAINTENANCE PAYMENTS.—Section 472(a) (42 U.S.C. 672(a)) is amended to read as follows:

“(a) IN GENERAL.—

“(1) ELIGIBILITY.—Each State with a plan approved under this part shall make foster care maintenance payments on behalf of each child who has been removed from the home of a relative specified in section 406(a) (as in effect on July 16, 1996) into foster care if—

“(A) the removal and foster care placement met, and the placement continues to meet, the requirements of paragraph (2); and

“(B) the child, while in the home, would have met the AFDC eligibility requirement of paragraph (3).

“(2) REMOVAL AND FOSTER CARE PLACEMENT REQUIREMENTS.—The removal and foster care placement of a child meet the requirements of this paragraph if—

“(A) the removal and foster care placement are in accordance with—

“(i) a voluntary placement agreement entered into by a parent or legal guardian of the child who is the relative referred to in paragraph (1); or

“(ii) a judicial determination to the effect that continuation in the home from which removed would be contrary to the welfare of the child and that reasonable efforts of the type described in section 471(a)(15) for a child have been made;

“(B) the child’s placement and care are the responsibility of—

“(i) the State agency administering the State plan approved under section 471; or

“(ii) any other public agency with which the State agency administering or supervising the administra-

tion of the State plan has made an agreement which is in effect; and

“(C) the child has been placed in a foster family home or child-care institution.

“(3) AFDC ELIGIBILITY REQUIREMENT.—

“(A) IN GENERAL.—A child in the home referred to in paragraph (1) would have met the AFDC eligibility requirement of this paragraph if the child—

“(i) would have received aid under the State plan approved under section 402 (as in effect on July 16, 1996) in the home, in or for the month in which the agreement was entered into or court proceedings leading to the determination referred to in paragraph (2)(A)(ii) of this subsection were initiated; or

“(ii)(I) would have received the aid in the home, in or for the month referred to in clause (i), if application had been made therefor; or

“(II) had been living in the home within 6 months before the month in which the agreement was entered into or the proceedings were initiated, and would have received the aid in or for such month, if, in such month, the child had been living in the home with the relative referred to in paragraph (1) and application for the aid had been made.

“(B) RESOURCES DETERMINATION.—For purposes of subparagraph (A), in determining whether a child would have received aid under a State plan approved under section 402 (as in effect on July 16, 1996), a child whose resources (determined pursuant to section 402(a)(7)(B), as so in effect) have a combined value of not more than \$10,000 shall be considered a child whose resources have a combined value of not more than \$1,000 (or such lower amount as the State may determine for purposes of section 402(a)(7)(B)).

“(4) ELIGIBILITY OF CERTAIN ALIEN CHILDREN.—Subject to title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, if the child is an alien disqualified under section 245A(h) or 210(f) of the Immigration and Nationality Act from receiving aid under the State plan approved under section 402 in or for the month in which the agreement described in paragraph (2)(A)(i) was entered into or court proceedings leading to the determination described in paragraph (2)(A)(ii) were initiated, the child shall be considered to satisfy the requirements of paragraph (3), with respect to the month, if the child would have satisfied the requirements but for the disqualification.”.

(b) ADOPTION ASSISTANCE.—Section 473(a)(2) (42 U.S.C. 673(a)(2)) is amended to read as follows:

“(2)(A) For purposes of paragraph (1)(B)(ii), a child meets the requirements of this paragraph if the child—

“(i)(I)(aa) was removed from the home of a relative specified in section 406(a) (as in effect on July 16, 1996) and placed in foster care in accordance with a voluntary placement agreement with respect to which Federal payments are provided under section 474 (or section 403, as such section was in effect on July

16, 1996), or in accordance with a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child; and

“(bb) met the requirements of section 472(a)(3) with respect to the home referred to in item (aa) of this subclause;

“(II) meets all of the requirements of title XVI with respect to eligibility for supplemental security income benefits; or

“(III) is a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to the minor parent of the child as provided in section 475(4)(B); and

“(ii) has been determined by the State, pursuant to subsection (c) of this section, to be a child with special needs.

“(B) Section 472(a)(4) shall apply for purposes of subparagraph (A) of this paragraph, in any case in which the child is an alien described in such section.

“(C) A child shall be treated as meeting the requirements of this paragraph for the purpose of paragraph (1)(B)(ii) if the child—

“(i) meets the requirements of subparagraph (A)(ii);

“(ii) was determined eligible for adoption assistance payments under this part with respect to a prior adoption;

“(iii) is available for adoption because—

“(I) the prior adoption has been dissolved, and the parental rights of the adoptive parents have been terminated;

or

“(II) the child’s adoptive parents have died; and

“(iv) fails to meet the requirements of subparagraph (A) but would meet such requirements if—

“(I) the child were treated as if the child were in the same financial and other circumstances the child was in the last time the child was determined eligible for adoption assistance payments under this part; and

“(II) the prior adoption were treated as never having occurred.”.

Subtitle E—Supplemental Security Income

SEC. 7501. REVIEW OF STATE AGENCY BLINDNESS AND DISABILITY DETERMINATIONS.

Section 1633 (42 U.S.C. 1383b) is amended by adding at the end the following:

“(e)(1) The Commissioner of Social Security shall review determinations, made by State agencies pursuant to subsection (a) in connection with applications for benefits under this title on the basis of blindness or disability, that individuals who have attained 18 years of age are blind or disabled as of a specified onset date. The Commissioner of Social Security shall review such a determination before any action is taken to implement the determination.

“(2)(A) In carrying out paragraph (1), the Commissioner of Social Security shall review—

“(i) at least 20 percent of all determinations referred to in paragraph (1) that are made in fiscal year 2006;

“(ii) at least 40 percent of all such determinations that are made in fiscal year 2007; and

“(iii) at least 50 percent of all such determinations that are made in fiscal year 2008 or thereafter.

“(B) In carrying out subparagraph (A), the Commissioner of Social Security shall, to the extent feasible, select for review the determinations which the Commissioner of Social Security identifies as being the most likely to be incorrect.”

SEC. 7502. PAYMENT OF CERTAIN LUMP SUM BENEFITS IN INSTALLMENTS UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM.

(a) *IN GENERAL.*—Section 1631(a)(10)(A)(i) (42 U.S.C. 1383(a)(10)(A)(i)) is amended by striking “12” and inserting “3”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall take effect 3 months after the date of the enactment of this Act.

Subtitle F—Repeal of Continued Dumping and Subsidy Offset

SEC. 7601. REPEAL OF CONTINUED DUMPING AND SUBSIDY OFFSET.

(a) *REPEAL.*—Effective upon the date of enactment of this Act, section 754 of the Tariff Act of 1930 (19 U.S.C. 1675c), and the item relating to section 754 in the table of contents for title VII of that Act, are repealed.

(b) *DISTRIBUTIONS ON CERTAIN ENTRIES.*—All duties on entries of goods made and filed before October 1, 2007, that would, but for subsection (a) of this section, be distributed under section 754 of the Tariff Act of 1930, shall be distributed as if section 754 of the Tariff Act of 1930 had not been repealed by subsection (a).

Subtitle G—Effective Date

SEC. 7701. EFFECTIVE DATE.

Except as otherwise provided in this title, this title and the amendments made by this title shall take effect as if enacted on October 1, 2005.

TITLE VIII—EDUCATION AND PENSION BENEFIT PROVISIONS

Subtitle A—Higher Education Provisions

SEC. 8001. SHORT TITLE; REFERENCE; EFFECTIVE DATE.

(a) *SHORT TITLE.*—This subtitle may be cited as the “Higher Education Reconciliation Act of 2005”.

(b) *REFERENCES.*—Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.).

(c) *EFFECTIVE DATE.*—Except as otherwise provided in this subtitle or the amendments made by this subtitle, the amendments made by this subtitle shall be effective July 1, 2006.

SEC. 8002. MODIFICATION OF 50/50 RULE.

Section 102(a)(3) (20 U.S.C. 1002(a)(3)) is amended—

(1) in subparagraph (A), by inserting “(excluding courses offered by telecommunications as defined in section 484(l)(4))” after “courses by correspondence”; and

(2) in subparagraph (B), by inserting “(excluding courses offered by telecommunications as defined in section 484(l)(4))” after “correspondence courses”.

SEC. 8003. ACADEMIC COMPETITIVENESS GRANTS.

Subpart 1 of part A of title IV (20 U.S.C. 1070a) is amended by adding after section 401 the following new section:

“SEC. 401A. ACADEMIC COMPETITIVENESS GRANTS.

“(a) ACADEMIC COMPETITIVENESS GRANT PROGRAM.—

“(1) ACADEMIC COMPETITIVENESS GRANTS AUTHORIZED.—The Secretary shall award grants, in the amounts specified in subsection (d)(1), to eligible students to assist the eligible students in paying their college education expenses.

“(2) ACADEMIC COMPETITIVENESS COUNCIL.—

“(A) ESTABLISHMENT.—There is established an Academic Competitiveness Council (referred to in this paragraph as the ‘Council’). From the funds made available under subsection (e) for fiscal year 2006, \$50,000 shall be available to the Council to carry out the duties described in subparagraph (B). The Council shall be chaired by the Secretary of Education, and the membership of the Council shall consist of officials from Federal agencies with responsibilities for managing existing Federal programs that promote mathematics and science (or designees of such officials with significant decision-making authority).

“(B) DUTIES.—The Council shall—

“(i) identify all Federal programs with a mathematics or science focus;

“(ii) identify the target populations being served by such programs;

“(iii) determine the effectiveness of such programs;

“(iv) identify areas of overlap or duplication in such programs; and

“(v) recommend ways to efficiently integrate and coordinate such programs.

“(C) REPORT.—Not later than one year after the date of enactment of the Higher Education Reconciliation Act of 2005, the Council shall transmit a report to each committee of Congress with jurisdiction over a Federal program identified under subparagraph (B)(i), detailing the findings and recommendations under subparagraph (B), including recommendations for legislative or administrative action.

“(b) DESIGNATION.—A grant under this section—

“(1) for the first or second academic year of a program of undergraduate education shall be known as an ‘Academic Competitiveness Grant’; and

“(2) for the third or fourth academic year of a program of undergraduate education shall be known as a ‘National Science and Mathematics Access to Retain Talent Grant’ or a ‘National SMART Grant’.

“(c) *DEFINITION OF ELIGIBLE STUDENT.*—*In this section the term ‘eligible student’ means a full-time student who, for the academic year for which the determination of eligibility is made—*

“(1) *is a citizen of the United States;*

“(2) *is eligible for a Federal Pell Grant; and*

“(3) *in the case of a student enrolled or accepted for enrollment in—*

“(A) *the first academic year of a program of undergraduate education at a two- or four-year degree-granting institution of higher education—*

“(i) *has successfully completed, after January 1, 2006, a rigorous secondary school program of study established by a State or local educational agency and recognized as such by the Secretary; and*

“(ii) *has not been previously enrolled in a program of undergraduate education;*

“(B) *the second academic year of a program of undergraduate education at a two- or four-year degree-granting institution of higher education—*

“(i) *has successfully completed, after January 1, 2005, a rigorous secondary school program of study established by a State or local educational agency and recognized as such by the Secretary; and*

“(ii) *has obtained a cumulative grade point average of at least 3.0 (or the equivalent as determined under regulations prescribed by the Secretary) at the end of the first academic year of such program of undergraduate education; or*

“(C) *the third or fourth academic year of a program of undergraduate education at a four-year degree-granting institution of higher education—*

“(i) *is pursuing a major in—*

“(I) *the physical, life, or computer sciences, mathematics, technology, or engineering (as determined by the Secretary pursuant to regulations); or*

“(II) *a foreign language that the Secretary, in consultation with the Director of National Intelligence, determines is critical to the national security of the United States; and*

“(ii) *has obtained a cumulative grade point average of at least 3.0 (or the equivalent as determined under regulations prescribed by the Secretary) in the coursework required for the major described in clause (i).*

“(d) *GRANT AWARD.*—

“(1) *AMOUNTS.*—

“(A) *The Secretary shall award a grant under this section in the amount of—*

“(i) *\$750 for an eligible student under subsection (d)(3)(A);*

“(ii) *\$1,300 for an eligible student under subsection (d)(3)(B); or*

“(iii) *\$4,000 for an eligible student under subsection (d)(3)(C).*

“(B) *Notwithstanding subparagraph (A)—*

“(i) the amount of such grant, in combination with the Federal Pell Grant assistance and other student financial assistance available to such student, shall not exceed the student’s cost of attendance;

“(ii) if the amount made available under subsection (f) for any fiscal year is less than the amount required to provide grants to all eligible students in the amounts determined under subparagraph (A) and clause (i) of this subparagraph, then the amount of the grant to each eligible student shall be ratably reduced; and

“(iii) if additional amounts are appropriated for any such fiscal year, such reduced amounts shall be increased on the same basis as they were reduced.

“(2) LIMITATIONS.—The Secretary shall not award a grant under this section—

“(A) to any student for an academic year of a program of undergraduate education described in subparagraph (A), (B), or (C) of subsection (d)(3) for which the student received credit before the date of enactment of the Higher Education Reconciliation Act of 2005; or

“(B) to any student for more than—

“(i) one academic year under subsection (d)(3)(A);

“(ii) one academic year under subsection (d)(3)(B);

or

“(iii) two academic years under subsection (d)(3)(C).

“(e) FUNDING.—

“(1) AUTHORIZATION AND APPROPRIATION OF FUNDS.—There are authorized to be appropriated, and there are appropriated, out of any money in the Treasury not otherwise appropriated, for the Department of Education to carry out this section—

“(A) \$790,000,000 for fiscal year 2006;

“(B) \$850,000,000 for fiscal year 2007;

“(C) \$920,000,000 for fiscal year 2008;

“(D) \$960,000,000 for fiscal year 2009; and

“(E) \$1,010,000,000 for fiscal year 2010.

“(2) USE OF EXCESS FUNDS.—If, at the end of a fiscal year, the funds available for awarding grants under this section exceed the amount necessary to make such grants in the amounts authorized by subsection (d), then all of the excess funds shall remain available for awarding grants under this section during the subsequent fiscal year.

“(f) RECOGNITION OF PROGRAMS OF STUDY.—The Secretary shall recognize at least one rigorous secondary school program of study in each State under subsection (c)(3)(A) and (B) for the purpose of determining student eligibility under such subsection.

“(g) SUNSET PROVISION.—The authority to make grants under this section shall expire at the end of academic year 2010–2011.”.

SEC. 8004. REAUTHORIZATION OF FEDERAL FAMILY EDUCATION LOAN PROGRAM.

(a) AUTHORIZATION OF APPROPRIATIONS.—Section 421(b)(5) (20 U.S.C. 1071(b)(5)) is amended by striking “an administrative cost allowance” and inserting “a loan processing and issuance fee”.

(b) EXTENSION OF AUTHORITY.—

(1) *FEDERAL INSURANCE LIMITATIONS*.—Section 424(a) (20 U.S.C. 1074(a)) is amended—

- (A) by striking “2004” and inserting “2012”; and
- (B) by striking “2008” and inserting “2016”.

(2) *GUARANTEED LOANS*.—Section 428(a)(5) (20 U.S.C. 1078(a)(5)) is amended—

- (A) by striking “2004” and inserting “2012”; and
- (B) by striking “2008” and inserting “2016”.

(3) *CONSOLIDATION LOANS*.—Section 428C(e) (20 U.S.C. 1078–3(e)) is amended by striking “2004” and inserting “2012”.

SEC. 8005. LOAN LIMITS.

(a) *FEDERAL INSURANCE LIMITS*.—Section 425(a)(1)(A) (20 U.S.C. 1075(a)(1)(A)) is amended—

(1) in clause (i)(I), by striking “\$2,625” and inserting “\$3,500”; and

(2) in clause (ii)(I), by striking “\$3,500” and inserting “\$4,500”.

(b) *GUARANTEE LIMITS*.—Section 428(b)(1)(A) (20 U.S.C. 1078(b)(1)(A)) is amended—

(1) in clause (i)(I), by striking “\$2,625” and inserting “\$3,500”; and

(2) in clause (ii)(I), by striking “\$3,500” and inserting “\$4,500”.

(c) *FEDERAL PLUS LOANS*.—Section 428B (20 U.S.C. 1078–2) is amended—

(1) in subsection (a)(1)—

(A) in the matter preceding subparagraph (A), by striking “Parents” and inserting “A graduate or professional student or the parents”;

(B) in subparagraph (A), by striking “the parents” and inserting “the graduate or professional student or the parents”; and

(C) in subparagraph (B), by striking “the parents” and inserting “the graduate or professional student or the parents”;

(2) in subsection (b), by striking “any parent” and inserting “any graduate or professional student or any parent”;

(3) in subsection (c)(2), by striking “parent” and inserting “graduate or professional student or parent”; and

(4) in subsection (d)(1), by striking “the parent” and inserting “the graduate or professional student or the parent”.

(d) *UNSUBSIDIZED STAFFORD LOANS FOR GRADUATE OR PROFESSIONAL STUDENTS*.—Section 428H(d)(2) (20 U.S.C. 1078–8(d)(2)) is amended—

(1) in subparagraph (C), by striking “\$10,000” and inserting “\$12,000”; and

(2) in subparagraph (D)—

(A) in clause (i), by striking “\$5,000” and inserting “\$7,000”; and

(B) in clause (ii), by striking “\$5,000” and inserting “\$7,000”.

(e) *EFFECTIVE DATE OF INCREASES*.—The amendments made by subsections (a), (b), and (d) shall be effective July 1, 2007.

SEC. 8006. PLUS LOAN INTEREST RATES AND ZERO SPECIAL ALLOWANCE PAYMENT.

(a) **PLUS LOANS.**—Section 427A(l)(2) (20 U.S.C. 1077a(l)(2)) is amended by striking “7.9 percent” and inserting “8.5 percent”.

(b) **CONFORMING AMENDMENTS FOR SPECIAL ALLOWANCES.**—

(1) **AMENDMENTS.**—Subparagraph (I) of section 438(b)(2) (20 U.S.C. 1087–1(b)(2)) is amended—

(A) in clause (iii), by striking “, subject to clause (v) of this subparagraph”;

(B) in clause (iv), by striking “, subject to clause (vi) of this subparagraph”; and

(C) by striking clauses (v), (vi), and (vii) and inserting the following:

“(v) **RECAPTURE OF EXCESS INTEREST.**—

“(I) **EXCESS CREDITED.**—With respect to a loan on which the applicable interest rate is determined under subsection (k) or (l) of section 427A and for which the first disbursement of principal is made on or after April 1, 2006, if the applicable interest rate for any 3-month period exceeds the special allowance support level applicable to such loan under this subparagraph for such period, then an adjustment shall be made by calculating the excess interest in the amount computed under subclause (II) of this clause, and by crediting the excess interest to the Government not less often than annually.

“(II) **CALCULATION OF EXCESS.**—The amount of any adjustment of interest on a loan to be made under this subsection for any quarter shall be equal to—

“(aa) the applicable interest rate minus the special allowance support level determined under this subparagraph; multiplied by

“(bb) the average daily principal balance of the loan (not including unearned interest added to principal) during such calendar quarter; divided by

“(cc) four.

“(III) **SPECIAL ALLOWANCE SUPPORT LEVEL.**—For purposes of this clause, the term ‘special allowance support level’ means, for any loan, a number expressed as a percentage equal to the sum of the rates determined under subclauses (I) and (III) of clause (i), and applying any substitution rules applicable to such loan under clauses (ii), (iii), and (iv) in determining such sum.”.

(2) **EFFECTIVE DATE.**—The amendments made by this subsection shall not apply with respect to any special allowance payment made under section 438 of the Higher Education Act of 1965 (20 U.S.C 1087–1) before April 1, 2006.

SEC. 8007. DEFERMENT OF STUDENT LOANS FOR MILITARY SERVICE.

(a) **FEDERAL FAMILY EDUCATION LOANS.**—Section 428(b)(1)(M) (20 U.S.C. 1078(b)(1)(M)) is amended—

(1) by striking “or” at the end of clause (ii);

(2) by redesignating clause (iii) as clause (iv); and

(3) by inserting after clause (ii) the following new clause:

“(iii) not in excess of 3 years during which the borrower—

“(I) is serving on active duty during a war or other military operation or national emergency; or

“(II) is performing qualifying National Guard duty during a war or other military operation or national emergency; or”.

(b) *DIRECT LOANS*.—Section 455(f)(2) (20 U.S.C. 1087e(f)(2)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D); and

(2) by inserting after subparagraph (B) the following new subparagraph:

“(C) not in excess of 3 years during which the borrower—

“(i) is serving on active duty during a war or other military operation or national emergency; or

“(ii) is performing qualifying National Guard duty during a war or other military operation or national emergency; or”.

(c) *PERKINS LOANS*.—Section 464(c)(2)(A) (20 U.S.C. 1087dd(c)(2)(A)) is amended—

(1) by redesignating clauses (iii) and (iv) as clauses (iv) and (v), respectively; and

(2) by inserting after clause (ii) the following new clause:

“(iii) not in excess of 3 years during which the borrower—

“(I) is serving on active duty during a war or other military operation or national emergency; or

“(II) is performing qualifying National Guard duty during a war or other military operation or national emergency;”.

(d) *DEFINITIONS*.—Section 481 (20 U.S.C. 1088) is amended by adding at the end the following new subsection:

“(d) *DEFINITIONS FOR MILITARY DEFERMENTS*.—For purposes of parts B, D, and E of this title:

“(1) *ACTIVE DUTY*.—The term ‘active duty’ has the meaning given such term in section 101(d)(1) of title 10, United States Code, except that such term does not include active duty for training or attendance at a service school.

“(2) *MILITARY OPERATION*.—The term ‘military operation’ means a contingency operation as such term is defined in section 101(a)(13) of title 10, United States Code.

“(3) *NATIONAL EMERGENCY*.—The term ‘national emergency’ means the national emergency by reason of certain terrorist attacks declared by the President on September 14, 2001, or subsequent national emergencies declared by the President by reason of terrorist attacks.

“(4) *SERVING ON ACTIVE DUTY*.—The term ‘serving on active duty during a war or other military operation or national emergency’ means service by an individual who is—

“(A) a Reserve of an Armed Force ordered to active duty under section 12301(a), 12301(g), 12302, 12304, or 12306 of title 10, United States Code, or any retired mem-

ber of an Armed Force ordered to active duty under section 688 of such title, for service in connection with a war or other military operation or national emergency, regardless of the location at which such active duty service is performed; and

“(B) any other member of an Armed Force on active duty in connection with such emergency or subsequent actions or conditions who has been assigned to a duty station at a location other than the location at which such member is normally assigned.

“(5) QUALIFYING NATIONAL GUARD DUTY.—The term ‘qualifying National Guard duty during a war or other military operation or national emergency’ means service as a member of the National Guard on full-time National Guard duty (as defined in section 101(d)(5) of title 10, United States Code) under a call to active service authorized by the President or the Secretary of Defense for a period of more than 30 consecutive days under section 502(f) of title 32, United States Code, in connection with a war, other military operation, or a national emergency declared by the President and supported by Federal funds.”

(e) *RULE OF CONSTRUCTION.*—Nothing in the amendments made by this section shall be construed to authorize any refunding of any repayment of a loan.

(f) *EFFECTIVE DATE.*—The amendments made by this section shall apply with respect to loans for which the first disbursement is made on or after July 1, 2001.

SEC. 8008. ADDITIONAL LOAN TERMS AND CONDITIONS.

(a) *DISBURSEMENT.*—Section 428(b)(1)(N) (20 U.S.C. 1078(b)(1)(N)) is amended—

(1) by striking “or” at the end of clause (i); and

(2) by striking clause (ii) and inserting the following:

“(ii) in the case of a student who is studying outside the United States in a program of study abroad that is approved for credit by the home institution at which such student is enrolled, and only after verification of the student’s enrollment by the lender or guaranty agency, are, at the request of the student, disbursed directly to the student by the means described in clause (i), unless such student requests that the check be endorsed, or the funds transfer be authorized, pursuant to an authorized power-of-attorney; or

“(iii) in the case of a student who is studying outside the United States in a program of study at an eligible foreign institution, are, at the request of the foreign institution, disbursed directly to the student, only after verification of the student’s enrollment by the lender or guaranty agency by the means described in clause (i).”

(b) *REPAYMENT PLANS: DIRECT LOANS.*—Section 455(d)(1) (20 U.S.C. 1087e(d)(1)) is amended by striking subparagraphs (A), (B), and (C) and inserting the following:

“(A) a standard repayment plan, consistent with subsection (a)(1) of this section and with section 428(b)(9)(A)(i);

“(B) a graduated repayment plan, consistent with section 428(b)(9)(A)(ii);

“(C) an extended repayment plan, consistent with section 428(b)(9)(A)(v), except that the borrower shall annually repay a minimum amount determined by the Secretary in accordance with section 428(b)(1)(L); and”.

(c) ORIGINATION FEES.—

(1) FFEL PROGRAM.—Paragraph (2) of section 438(c) (20 U.S.C. 1087–1(c)) is amended—

(A) by striking the designation and heading of such paragraph and inserting the following:

“(2) AMOUNT OF ORIGINATION FEES.—

“(A) IN GENERAL.—”; and

(B) by adding at the end the following new subparagraph:

“(B) SUBSEQUENT REDUCTIONS.—Subparagraph (A) shall be applied to loans made under this part (other than loans made under sections 428C and 439(o))—

“(i) by substituting ‘2.0 percent’ for ‘3.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2006, and before July 1, 2007;

“(ii) by substituting ‘1.5 percent’ for ‘3.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2007, and before July 1, 2008;

“(iii) by substituting ‘1.0 percent’ for ‘3.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2008, and before July 1, 2009;

“(iv) by substituting ‘0.5 percent’ for ‘3.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2009, and before July 1, 2010; and

“(v) by substituting ‘0.0 percent’ for ‘3.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2010.”.

(2) DIRECT LOAN PROGRAM.—Subsection (c) of section 455 (20 U.S.C. 1087e(c)) is amended—

(A) by striking “(c) LOAN FEE.—” and inserting the following:

“(c) LOAN FEE.—

“(1) IN GENERAL.—”; and

(B) by adding at the end the following:

“(2) SUBSEQUENT REDUCTION.—Paragraph (1) shall be applied to loans made under this part, other than Federal Direct Consolidation loans and Federal Direct PLUS loans—

“(A) by substituting ‘3.0 percent’ for ‘4.0 percent’ with respect to loans for which the first disbursement of principal is made on or after the date of enactment of the Higher Education Reconciliation Act of 2005, and before July 1, 2007;

“(B) by substituting ‘2.5 percent’ for ‘4.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2007, and before July 1, 2008;

“(C) by substituting ‘2.0 percent’ for ‘4.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2008, and before July 1, 2009;

“(D) by substituting ‘1.5 percent’ for ‘4.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2009, and before July 1, 2010; and

“(E) by substituting ‘1.0 percent’ for ‘4.0 percent’ with respect to loans for which the first disbursement of principal is made on or after July 1, 2010.”.

(3) **CONFORMING AMENDMENT.**—Section 455(b)(8)(A) (20 U.S.C. 1087e(b)(8)(A)) is amended by inserting “or origination fee” after “reductions in the interest rate”.

SEC. 8009. CONSOLIDATION LOAN CHANGES.

(a) **CONSOLIDATION BETWEEN PROGRAMS.**—Section 428C (20 U.S.C. 1078–3) is amended—

(1) in subsection (a)(3)(B)(i)—

(A) by inserting “or under section 455(g)” after “under this section” both places it appears;

(B) by inserting “under both sections” after “terminates”;

(C) by striking “and” at the end of subclause (III);

(D) by striking the period at the end of subclause (IV) and inserting “; and”; and

(E) by adding at the end the following new subclause:

“(V) an individual may obtain a subsequent consolidation loan under section 455(g) only for the purposes of obtaining an income contingent repayment plan, and only if the loan has been submitted to the guaranty agency for default aversion.”; and

(2) in subsection (b)(5), by striking the first sentence and inserting the following: “In the event that a lender with an agreement under subsection (a)(1) of this section denies a consolidation loan application submitted to the lender by an eligible borrower under this section, or denies an application submitted to the lender by such a borrower for a consolidation loan with income-sensitive repayment terms, the Secretary shall offer any such borrower who applies for it, a Federal Direct Consolidation loan. The Secretary shall offer such a loan to a borrower who has defaulted, for the purpose of resolving the default.”.

(b) **REPEAL OF IN-SCHOOL CONSOLIDATION.**—

(1) **DEFINITION OF REPAYMENT PERIOD.**—Section 428(b)(7)(A) (20 U.S.C. 1078(b)(7)(A)) is amended by striking “shall begin—” and all that follows through “earlier date.” and inserting the following: “shall begin the day after 6 months after the date the student ceases to carry at least one-half the normal full-time academic workload (as determined by the institution).”.

(2) **CONFORMING CHANGE TO ELIGIBLE BORROWER DEFINITION.**—Section 428C(a)(3)(A)(ii)(I) (20 U.S.C. 1078–3(a)(3)(A)(ii)(I)) is amended by inserting “as determined under section 428(b)(7)(A)” after “repayment status”.

(c) **ADDITIONAL AMENDMENTS.**—Section 428C (20 U.S.C. 1078–3) is amended in subsection (a)(3), by striking subparagraph (C).

(d) *CONFORMING AMENDMENTS TO DIRECT LOAN PROGRAM.*—
Section 455 (20 U.S.C. 1087e) is amended—

(1) in subsection (a)(1) by inserting “428C,” after “428B,”;

(2) in subsection (a)(2)—

(A) by striking “and” at the end of subparagraph (B);

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following:

“(C) section 428C shall be known as ‘Federal Direct Consolidation Loans’; and”;

(3) in subsection (g)—

(A) by striking the second sentence; and

(B) by adding at the end the following new sentences:

“To be eligible for a consolidation loan under this part, a borrower shall meet the eligibility criteria set forth in section 428C(a)(3). The Secretary, upon application for such a loan, shall comply with the requirements applicable to a lender under section 428C(b)(1)(F).”.

SEC. 8010. REQUIREMENTS FOR DISBURSEMENTS OF STUDENT LOANS.

Section 428G (20 U.S.C. 1078–7) is amended—

(1) in subsection (a)(3), by adding at the end the following: “Notwithstanding section 422(d) of the Higher Education Amendments of 1998, this paragraph shall be effective beginning on the date of enactment of the Higher Education Reconciliation Act of 2005.”;

(2) in subsection (b)(1), by adding at the end the following: “Notwithstanding section 422(d) of the Higher Education Amendments of 1998, the second sentence of this paragraph shall be effective beginning on the date of enactment of the Higher Education Reconciliation Act of 2005.”; and

(3) in subsection (e), by striking “; made to a student to cover the cost of attendance at an eligible institution outside the United States”.

SEC. 8011. SCHOOL AS LENDER.

Paragraph (2) of section 435(d) (20 U.S.C. 1085(d)(2)) is amended to read as follows:

“(2) **REQUIREMENTS FOR ELIGIBLE INSTITUTIONS.**—

“(A) **IN GENERAL.**—To be an eligible lender under this part, an eligible institution—

“(i) shall employ at least one person whose full-time responsibilities are limited to the administration of programs of financial aid for students attending such institution;

“(ii) shall not be a home study school;

“(iii) shall not—

“(I) make a loan to any undergraduate student;

“(II) make a loan other than a loan under section 428 or 428H to a graduate or professional student; or

“(III) make a loan to a borrower who is not enrolled at that institution;

“(iv) shall award any contract for financing, servicing, or administration of loans under this title on a competitive basis;

“(v) shall offer loans that carry an origination fee or an interest rate, or both, that are less than such fee or rate authorized under the provisions of this title;

“(vi) shall not have a cohort default rate (as defined in section 435(m)) greater than 10 percent;

“(vii) shall, for any year for which the institution engages in activities as an eligible lender, provide for a compliance audit conducted in accordance with section 428(b)(1)(U)(iii)(I), and the regulations thereunder, and submit the results of such audit to the Secretary;

“(viii) shall use any proceeds from special allowance payments and interest payments from borrowers, interest subsidies received from the Department of Education, and any proceeds from the sale or other disposition of loans, for need-based grant programs; and

“(ix) shall have met the requirements of subparagraphs (A) through (F) of this paragraph as in effect on the day before the date of enactment of the Higher Education Reconciliation Act of 2005, and made loans under this part, on or before April 1, 2006.

“(B) ADMINISTRATIVE EXPENSES.—An eligible lender under subparagraph (A) shall be permitted to use a portion of the proceeds described in subparagraph (A)(viii) for reasonable and direct administrative expenses.

“(C) SUPPLEMENT, NOT SUPPLANT.—An eligible lender under subparagraph (A) shall ensure that the proceeds described in subparagraph (A)(viii) are used to supplement, and not to supplant, non-Federal funds that would otherwise be used for need-based grant programs.”.

SEC. 8012. REPAYMENT BY THE SECRETARY OF LOANS OF BANKRUPT, DECEASED, OR DISABLED BORROWERS; TREATMENT OF BORROWERS ATTENDING SCHOOLS THAT FAIL TO PROVIDE A REFUND, ATTENDING CLOSED SCHOOLS, OR FALSELY CERTIFIED AS ELIGIBLE TO BORROW.

Section 437 (20 U.S.C. 1087) is amended—

(1) in the section heading, by striking “**CLOSED SCHOOLS OR FALSELY CERTIFIED AS ELIGIBLE TO BORROW**” and inserting “**SCHOOLS THAT FAIL TO PROVIDE A REFUND, ATTENDING CLOSED SCHOOLS, OR FALSELY CERTIFIED AS ELIGIBLE TO BORROW**”; and

(2) in the first sentence of subsection (c)(1), by inserting “or was falsely certified as a result of a crime of identity theft” after “falsely certified by the eligible institution”.

SEC. 8013. ELIMINATION OF TERMINATION DATES FROM TAXPAYER-TEACHER PROTECTION ACT OF 2004.

(a) EXTENSION OF LIMITATIONS ON SPECIAL ALLOWANCE FOR LOANS FROM THE PROCEEDS OF TAX EXEMPT ISSUES.—Section 438(b)(2)(B) (20 U.S.C. 1087–1(b)(2)(B)) is amended—

(1) in clause (iv), by striking “and before January 1, 2006,”; and

(2) in clause (v)(II)—

(A) by striking “and before January 1, 2006,” each place it appears in divisions (aa) and (bb); and

(B) by striking “, and before January 1, 2006” in division (cc).

(b) **ADDITIONAL LIMITATION ON SPECIAL ALLOWANCE FOR LOANS FROM THE PROCEEDS OF TAX EXEMPT ISSUES.**—Section 438(b)(2)(B) (20 U.S.C. 1087–1(b)(2)(B)) is further amended by adding at the end thereof the following new clauses:

“(vi) Notwithstanding clauses (i), (ii), and (v), but subject to clause (vii), the quarterly rate of the special allowance shall be the rate determined under subparagraph (A), (E), (F), (G), (H), or (I) of this paragraph, as the case may be, for a holder of loans—

“(I) that were made or purchased on or after the date of enactment of the Higher Education Reconciliation Act of 2005; or

“(II) that were not earning a quarterly rate of special allowance determined under clauses (i) or (ii) of subparagraph (B) of this paragraph (20 U.S.C. 1087–1(b)(2)(b)) as of the date of enactment of the Higher Education Reconciliation Act of 2005.

“(vii) Clause (vi) shall be applied by substituting ‘December 31, 2010’ for ‘the date of enactment of the Higher Education Reconciliation Act of 2005’ in the case of a holder of loans that—

“(I) was, as of the date of enactment of the Higher Education Reconciliation Act of 2005, and during the quarter for which the special allowance is paid, a unit of State or local government or a nonprofit private entity;

“(II) was, as of such date of enactment, and during such quarter, not owned or controlled by, or under common ownership or control with, a for-profit entity; and

“(III) held, directly or through any subsidiary, affiliate, or trustee, a total unpaid balance of principal equal to or less than \$100,000,000 on loans for which special allowances were paid under this subparagraph in the most recent quarterly payment prior to September 30, 2005.”.

(c) **ELIMINATION OF EFFECTIVE DATE LIMITATION ON HIGHER TEACHER LOAN FORGIVENESS BENEFITS.**—

(1) **TECHNICAL CLARIFICATION.**—The matter preceding paragraph (1) of section 2 of the Taxpayer-Teacher Protection Act of 2004 (Public Law 108–409; 118 Stat. 2299) is amended by inserting “of the Higher Education Act of 1965” after “Section 438(b)(2)(B)”.

(2) **AMENDMENT.**—Paragraph (3) of section 3(b) of the Taxpayer-Teacher Protection Act of 2004 (20 U.S.C. 1078–10 note) is amended by striking “, and before October 1, 2005”.

(3) **EFFECTIVE DATES.**—The amendment made by paragraph (1) shall be effective as if enacted on October 30, 2004, and the amendment made by paragraph (2) shall be effective as if enacted on October 1, 2005.

(d) **COORDINATION WITH SECOND HIGHER EDUCATION EXTENSION ACT OF 2005.**—

(1) *REPEAL.*—Section 2 of the Second Higher Education Extension Act of 2005 is amended by striking subsections (b) and (c).

(2) *EFFECT ON AMENDMENTS.*—The amendments made by subsections (a) and (c) of this section shall be effective as if the amendments made subsections (b) and (c) of section 2 of the Second Higher Education Extension Act of 2005 had not been enacted.

(e) *ADDITIONAL CHANGES TO TEACHER LOAN FORGIVENESS PROVISIONS.*—

(1) *FFEL PROVISIONS.*—Section 428J (20 U.S.C. 1078–10) is amended—

(A) in subsection (b)(1)(B), by inserting after “1965” the following: “, or meets the requirements of subsection (g)(3)”; and

(B) in subsection (g), by adding at the end the following new paragraph:

“(3) *PRIVATE SCHOOL TEACHERS.*—An individual who is employed as a teacher in a private school and is exempt from State certification requirements (unless otherwise applicable under State law), may, in lieu of the requirement of subsection (b)(1)(B), have such employment treated as qualifying employment under this section if such individual is permitted to and does satisfy rigorous subject knowledge and skills tests by taking competency tests in the applicable grade levels and subject areas. For such purposes, the competency tests taken by such a private school teacher shall be recognized by 5 or more States for the purpose of fulfilling the highly qualified teacher requirements under section 9101 of the Elementary and Secondary Education Act of 1965, and the score achieved by such teacher on each test shall equal or exceed the average passing score of those 5 States.”.

(2) *DIRECT LOAN PROVISIONS.*—Section 460 (20 U.S.C. 1087j) is amended—

(A) in subsection (b)(1)(A)(ii), by inserting after “1965” the following: “, or meets the requirements of subsection (g)(3)”; and

(B) in subsection (g), by adding at the end the following new paragraph:

“(3) *PRIVATE SCHOOL TEACHERS.*—An individual who is employed as a teacher in a private school and is exempt from State certification requirements (unless otherwise applicable under State law), may, in lieu of the requirement of subsection (b)(1)(A)(ii), have such employment treated as qualifying employment under this section if such individual is permitted to and does satisfy rigorous subject knowledge and skills tests by taking competency tests in the applicable grade levels and subject areas. For such purposes, the competency tests taken by such a private school teacher shall be recognized by 5 or more States for the purpose of fulfilling the highly qualified teacher requirements under section 9101 of the Elementary and Secondary Education Act of 1965, and the score achieved by such teacher on each test shall equal or exceed the average passing score of those 5 States.”.

SEC. 8014. ADDITIONAL ADMINISTRATIVE PROVISIONS.**(a) INSURANCE PERCENTAGE.—**

(1) AMENDMENT.—Subparagraph (G) of section 428(b)(1) (20 U.S.C. 1078(b)(1)(G)) is amended to read as follows:

“(G) insures 98 percent of the unpaid principal of loans insured under the program, except that—

“(i) such program shall insure 100 percent of the unpaid principal of loans made with funds advanced pursuant to section 428(j) or 439(q);

“(ii) for any loan for which the first disbursement of principal is made on or after July 1, 2006, the preceding provisions of this subparagraph shall be applied by substituting ‘97 percent’ for ‘98 percent’; and

“(iii) notwithstanding the preceding provisions of this subparagraph, such program shall insure 100 percent of the unpaid principal amount of exempt claims as defined in subsection (c)(1)(G);”.

(2) EFFECTIVE DATE OF AMENDMENT.—The amendment made by this subsection shall apply with respect to loans for which the first disbursement of principal is made on or after July 1, 2006.

(b) FEDERAL DEFAULT FEES.—

(1) IN GENERAL.—Subparagraph (H) of section 428(b)(1) (20 U.S.C. 1078(b)(1)(H)) is amended to read as follows:

“(H) provides—

“(i) for loans for which the date of guarantee of principal is before July 1, 2006, for the collection of a single insurance premium equal to not more than 1.0 percent of the principal amount of the loan, by deduction proportionately from each installment payment of the proceeds of the loan to the borrower, and ensures that the proceeds of the premium will not be used for incentive payments to lenders; or

“(ii) for loans for which the date of guarantee of principal is on or after July 1, 2006, for the collection, and the deposit into the Federal Student Loan Reserve Fund under section 422A of a Federal default fee of an amount equal to 1.0 percent of the principal amount of the loan, which fee shall be collected either by deduction from the proceeds of the loan or by payment from other non-Federal sources, and ensures that the proceeds of the Federal default fee will not be used for incentive payments to lenders;”.

(2) UNSUBSIDIZED LOANS.—Section 428H(h) (20 U.S.C. 1078–8(h)) is amended by adding at the end the following new sentences: “Effective for loans for which the date of guarantee of principal is on or after July 1, 2006, in lieu of the insurance premium authorized under the preceding sentence, each State or nonprofit private institution or organization having an agreement with the Secretary under section 428(b)(1) shall collect and deposit into the Federal Student Loan Reserve Fund under section 422A, a Federal default fee of an amount equal to 1.0 percent of the principal amount of the loan, which fee shall be collected either by deduction from the proceeds of the loan or by payment from other non-Federal sources. The Fed-

eral default fee shall not be used for incentive payments to lenders.”.

(3) *VOLUNTARY FLEXIBLE AGREEMENTS.*—Section 428A(a)(1) (20 U.S.C. 1078–1(a)(1)) is amended—

(A) by striking “or” at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting “; or”; and

(C) by adding at the end the following new subparagraph:

“(C) the Federal default fee required by section 428(b)(1)(H) and the second sentence of section 428H(h).”.

(c) *TREATMENT OF EXEMPT CLAIMS.*—

(1) *AMENDMENT.*—Section 428(c)(1) (20 U.S.C. 1078(c)(1)) is amended—

(A) by redesignating subparagraph (G) as subparagraph (H), and moving such subparagraph 2 em spaces to the left; and

(B) by inserting after subparagraph (F) the following new subparagraph:

“(G)(i) Notwithstanding any other provisions of this section, in the case of exempt claims, the Secretary shall apply the provisions of—

“(I) the fourth sentence of subparagraph (A) by substituting ‘100 percent’ for ‘95 percent’;

“(II) subparagraph (B)(i) by substituting ‘100 percent’ for ‘85 percent’; and

“(III) subparagraph (B)(ii) by substituting ‘100 percent’ for ‘75 percent’.

“(ii) For purposes of clause (i) of this subparagraph, the term ‘exempt claims’ means claims with respect to loans for which it is determined that the borrower (or the student on whose behalf a parent has borrowed), without the lender’s or the institution’s knowledge at the time the loan was made, provided false or erroneous information or took actions that caused the borrower or the student to be ineligible for all or a portion of the loan or for interest benefits thereon.”.

(2) *EFFECTIVE DATE OF AMENDMENTS.*—The amendments made by this subsection shall apply with respect to loans for which the first disbursement of principal is made on or after July 1, 2006.

(d) *CONSOLIDATION OF DEFAULTED LOANS.*—Section 428(c) (20 U.S.C. 1078(c)) is further amended—

(1) in paragraph (2)(A)—

(A) by inserting “(i)” after “including”; and

(B) by inserting before the semicolon at the end the following: “and (ii) requirements establishing procedures to preclude consolidation lending from being an excessive proportion of guaranty agency recoveries on defaulted loans under this part”;

(2) in paragraph (2)(D), by striking “paragraph (6)” and inserting “paragraph (6)(A)”; and

(3) in paragraph (6)—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(B) by inserting “(A)” before “For the purpose of paragraph (2)(D),”; and

(C) by adding at the end the following new subparagraphs:

“(B) A guaranty agency shall—

“(i) on or after October 1, 2006—

“(I) not charge the borrower collection costs in an amount in excess of 18.5 percent of the outstanding principal and interest of a defaulted loan that is paid off through consolidation by the borrower under this title; and

“(II) remit to the Secretary a portion of the collection charge under subclause (I) equal to 8.5 percent of the outstanding principal and interest of such defaulted loan; and

“(ii) on and after October 1, 2009, remit to the Secretary the entire amount charged under clause (i)(I) with respect to each defaulted loan that is paid off with excess consolidation proceeds.

“(C) For purposes of subparagraph (B), the term ‘excess consolidation proceeds’ means, with respect to any guaranty agency for any Federal fiscal year beginning on or after October 1, 2009, the proceeds of consolidation of defaulted loans under this title that exceed 45 percent of the agency’s total collections on defaulted loans in such Federal fiscal year.”.

(e) DOCUMENTATION OF FORBEARANCE AGREEMENTS.—Section 428(c) (20 U.S.C. 1078(c)) is further amended—

(1) in paragraph (3)(A)(i)—

(A) by striking “in writing”; and

(B) by inserting “and documented in accordance with paragraph (10)” after “approval of the insurer”; and

(2) by adding at the end the following new paragraph:

“(10) DOCUMENTATION OF FORBEARANCE AGREEMENTS.—For the purposes of paragraph (3), the terms of forbearance agreed to by the parties shall be documented by confirming the agreement of the borrower by notice to the borrower from the lender, and by recording the terms in the borrower’s file.”.

(f) VOLUNTARY FLEXIBLE AGREEMENTS.—Section 428A(a) (20 U.S.C. 1078–1(a)) is further amended—

(1) in paragraph (1)(B), by striking “unless the Secretary” and all that follows through “designated guarantor”;

(2) by striking paragraph (2);

(3) by redesignating paragraph (3) as paragraph (2); and

(4) by striking paragraph (4).

(g) FRAUD: REPAYMENT REQUIRED.—Section 428B(a)(1) (20 U.S.C. 1078–2(a)(1)) is further amended—

(1) by striking “and” at the end of subparagraph (A);

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following new subparagraph:

“(B) in the case of a graduate or professional student or parent who has been convicted of, or has pled *nolo contendere* or guilty to, a crime involving fraud in obtaining funds under this title, such graduate or professional

student or parent has completed the repayment of such funds to the Secretary, or to the holder in the case of a loan under this title obtained by fraud; and”.

(h) DEFAULT REDUCTION PROGRAM.—Section 428F(a)(1) (20 U.S.C. 1078–6(a)(1)) is amended—

(1) in subparagraph (A), by striking “consecutive payments for 12 months” and inserting “9 payments made within 20 days of the due date during 10 consecutive months”;

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

“(C) A guaranty agency may charge the borrower and retain collection costs in an amount not to exceed 18.5 percent of the outstanding principal and interest at the time of sale of a loan rehabilitated under subparagraph (A).”.

(j) EXCEPTIONAL PERFORMANCE INSURANCE RATE.—Section 428I(b)(1) (20 U.S.C. 1078–9(b)(1)) is amended—

(1) in the heading, by striking “100 PERCENT” and inserting “99 PERCENT”; and

(2) by striking “100 percent of the unpaid” and inserting “99 percent of the unpaid”.

(k) UNIFORM ADMINISTRATIVE AND CLAIMS PROCEDURE.—Section 432(l)(1)(H) (20 U.S.C. 1082(l)(1)(H)) is amended by inserting “and anticipated graduation date” after “status change”.

(2) Section 428(a)(3)(A)(v) (20 U.S.C. 1078(a)(3)(A)(v)) is amended—

(A) by striking “or” at the end of subclause (I);

(B) by striking the period at the end of subclause (II) and inserting “; or”; and

(C) by adding after subclause (II) the following new subclause:

“(III) in the case of a loan disbursed through an escrow agent, 3 days before the first disbursement of the loan.”.

(3) Section 428(c)(1)(A) (20 U.S.C. 1078(c)(1)(A)) is amended by striking “45 days” in the last sentence and inserting “30 days”.

(4) Section 428(i)(1) (20 U.S.C. 1078(i)(1)) is amended by striking “21 days” in the third sentence and inserting “10 days”.

SEC. 8015. FUNDS FOR ADMINISTRATIVE EXPENSES.

Section 458 is amended to read as follows:

“SEC. 458. FUNDS FOR ADMINISTRATIVE EXPENSES.

“(a) ADMINISTRATIVE EXPENSES.—

“(1) MANDATORY FUNDS FOR FISCAL YEAR 2006.—For fiscal year 2006, there shall be available to the Secretary, from funds not otherwise appropriated, funds to be obligated for—

“(A) administrative costs under this part and part B, including the costs of the direct student loan programs under this part; and

“(B) account maintenance fees payable to guaranty agencies under part B and calculated in accordance with subsections (b) and (c), not to exceed (from such funds not otherwise appropriated) \$820,000,000 in fiscal year 2006.

“(2) *AUTHORIZATION FOR ADMINISTRATIVE COSTS BEGINNING IN FISCAL YEARS 2007 THROUGH 2011.*—For each of the fiscal years 2007 through 2011, there are authorized to be appropriated such sums as may be necessary for administrative costs under this part and part B, including the costs of the direct student loan programs under this part.

“(3) *CONTINUING MANDATORY FUNDS FOR ACCOUNT MAINTENANCE FEES.*—For each of the fiscal years 2007 through 2011, there shall be available to the Secretary, from funds not otherwise appropriated, funds to be obligated for account maintenance fees payable to guaranty agencies under part B and calculated in accordance with subsection (b).

“(4) *ACCOUNT MAINTENANCE FEES.*—Account maintenance fees under paragraph (3) shall be paid quarterly and deposited in the Agency Operating Fund established under section 422B.

“(5) *CARRYOVER.*—The Secretary may carry over funds made available under this section to a subsequent fiscal year.

“(b) *CALCULATION BASIS.*—Account maintenance fees payable to guaranty agencies under subsection (a)(3) shall not exceed the basis of 0.10 percent of the original principal amount of outstanding loans on which insurance was issued under part B.

“(c) *BUDGET JUSTIFICATION.*—No funds may be expended under this section unless the Secretary includes in the Department of Education’s annual budget justification to Congress a detailed description of the specific activities for which the funds made available by this section have been used in the prior and current years (if applicable), the activities and costs planned for the budget year, and the projection of activities and costs for each remaining year for which administrative expenses under this section are made available.”.

SEC. 8016. COST OF ATTENDANCE.

Section 472 (20 U.S.C. 1087ll) is amended—

(1) by striking paragraph (4) and inserting the following:

“(4) for less than half-time students (as determined by the institution), tuition and fees and an allowance for only—

“(A) books, supplies, and transportation (as determined by the institution);

“(B) dependent care expenses (determined in accordance with paragraph (8)); and

“(C) room and board costs (determined in accordance with paragraph (3)), except that a student may receive an allowance for such costs under this subparagraph for not more than 3 semesters or the equivalent, of which not more than 2 semesters or the equivalent may be consecutive;”;

(2) in paragraph (11), by striking “and” after the semicolon;

(3) in paragraph (12), by striking the period and inserting “; and”; and

(4) by adding at the end the following:

“(13) at the option of the institution, for a student in a program requiring professional licensure or certification, the one time cost of obtaining the first professional credentials (as determined by the institution).”.

SEC. 8017. FAMILY CONTRIBUTION.

(a) *FAMILY CONTRIBUTION FOR DEPENDENT STUDENTS.*—

(1) *AMENDMENTS.*—Section 475 (20 U.S.C. 1087oo) is amended—

(A) in subsection (g)(2)(D), by striking “\$2,200” and inserting “\$3,000”; and

(B) in subsection (h), by striking “35” and inserting “20”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply with respect to determinations of need for periods of enrollment beginning on or after July 1, 2007.

(b) *FAMILY CONTRIBUTION FOR INDEPENDENT STUDENTS WITHOUT DEPENDENTS OTHER THAN A SPOUSE.*—

(1) *AMENDMENTS.*—Section 476 (20 U.S.C. 1087pp) is amended—

(A) in subsection (b)(1)(A)(iv)—

(i) in subclause (I), by striking “\$5,000” and inserting “\$6,050”; and

(ii) in subclause (II), by striking “\$5,000” and inserting “\$6,050”; and

(iii) in subclause (III), by striking “\$8,000” and inserting “\$9,700”; and

(B) in subsection (c)(4), by striking “35” and inserting “20”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply with respect to determinations of need for periods of enrollment beginning on or after July 1, 2007.

(c) *FAMILY CONTRIBUTION FOR INDEPENDENT STUDENTS WITH DEPENDENTS OTHER THAN A SPOUSE.*—

(1) *AMENDMENT.*—Section 477(c)(4) (20 U.S.C. 1087qq(c)(4)) is amended by striking “12” and inserting “7”.

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall apply with respect to determinations of need for periods of enrollment beginning on or after July 1, 2007.

(d) *REGULATIONS; UPDATED TABLES.*—Section 478(b) (20 U.S.C. 1087rr(b)) is amended—

(1) in paragraph (1), by adding at the end the following: “For the 2007–2008 academic year, the Secretary shall revise the tables in accordance with this paragraph, except that the Secretary shall increase the amounts contained in the table in section 477(b)(4) by a percentage equal to the greater of the estimated percentage increase in the Consumer Price Index (as determined under the preceding sentence) or 5 percent.”; and

(2) in paragraph (2)—

(A) by striking “2000–2001” and inserting “2007–2008”; and

(B) by striking “1999” and inserting “2006”.

(e) *EMPLOYMENT EXPENSE ALLOWANCE.*—Section 478(h) (20 U.S.C. 1087rr(h)) is amended—

(1) by striking “476(b)(4)(B),”; and

(2) by striking “meals away from home, apparel and upkeep, transportation, and housekeeping services” and inserting “food away from home, apparel, transportation, and household furnishings and operations”.

SEC. 8018. SIMPLIFIED NEED TEST AND AUTOMATIC ZERO IMPROVEMENTS.

(a) **AMENDMENTS.**—Section 479 (20 U.S.C. 1087ss) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking clause (i) and inserting the following:

“(i) the student’s parents—

“(I) file, or are eligible to file, a form described in paragraph (3);

“(II) certify that the parents are not required to file a Federal income tax return; or

“(III) received, or the student received, benefits at some time during the previous 12-month period under a means-tested Federal benefit program as defined under subsection (d); and”; and

(ii) in subparagraph (B), by striking clause (i) and inserting the following:

“(i) the student (and the student’s spouse, if any)—

“(I) files, or is eligible to file, a form described in paragraph (3);

“(II) certifies that the student (and the student’s spouse, if any) is not required to file a Federal income tax return; or

“(III) received benefits at some time during the previous 12-month period under a means-tested Federal benefit program as defined under subsection (d); and”; and

(B) in the matter preceding subparagraph (A) of paragraph (3), by striking “A student or family files a form described in this subsection, or subsection (c), as the case may be, if the student or family, respectively, files” and inserting “In the case of an independent student, the student, or in the case of a dependent student, the family, files a form described in this subsection, or subsection (c), as the case may be, if the student or family, as appropriate, files”;

(2) in subsection (c)—

(A) in paragraph (1)—

(i) by striking subparagraph (A) and inserting the following:

“(A) the student’s parents—

“(i) file, or are eligible to file, a form described in subsection (b)(3);

“(ii) certify that the parents are not required to file a Federal income tax return; or

“(iii) received, or the student received, benefits at some time during the previous 12-month period under a means-tested Federal benefit program as defined under subsection (d); and”; and

(ii) by striking subparagraph (B) and inserting the following:

“(B) the sum of the adjusted gross income of the parents is less than or equal to \$20,000; or”; and

(B) in paragraph (2)—

(i) by striking subparagraph (A) and inserting the following:

“(A) the student (and the student’s spouse, if any)—

“(i) files, or is eligible to file, a form described in subsection (b)(3);

“(ii) certifies that the student (and the student’s spouse, if any) is not required to file a Federal income tax return; or

“(iii) received benefits at some time during the previous 12-month period under a means-tested Federal benefit program as defined under subsection (d); and”;

and

(ii) by striking subparagraph (B) and inserting the following:

“(B) the sum of the adjusted gross income of the student and spouse (if appropriate) is less than or equal to \$20,000.”; and

(3) by adding at the end the following:

“(d) DEFINITION OF MEANS-TESTED FEDERAL BENEFIT PROGRAM.—In this section, the term ‘means-tested Federal benefit program’ means a mandatory spending program of the Federal Government, other than a program under this title, in which eligibility for the program’s benefits, or the amount of such benefits, are determined on the basis of income or resources of the individual or family seeking the benefit, and may include such programs as—

“(1) the supplemental security income program under title XVI of the Social Security Act (42 U.S.C. 1381 et seq.);

“(2) the food stamp program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.);

“(3) the free and reduced price school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.);

“(4) the program of block grants for States for temporary assistance for needy families established under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.);

“(5) the special supplemental nutrition program for women, infants, and children established by section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

“(6) other programs identified by the Secretary.”.

(b) EVALUATION OF SIMPLIFIED NEEDS TEST.—

(1) ELIGIBILITY GUIDELINES.—The Secretary of Education shall regularly evaluate the impact of the eligibility guidelines in subsections (b)(1)(A)(i), (b)(1)(B)(i), (c)(1)(A), and (c)(2)(A) of section 479 of the Higher Education Act of 1965 (20 U.S.C. 1087ss(b)(1)(A)(i), (b)(1)(B)(i), (c)(1)(A), and (c)(2)(A)).

(2) MEANS-TESTED FEDERAL BENEFIT PROGRAM.—For each 3-year period, the Secretary of Education shall evaluate the impact of including the receipt of benefits by a student or parent under a means-tested Federal benefit program (as defined in section 479(d) of the Higher Education Act of 1965 (20 U.S.C. 1087ss(d)) as a factor in determining eligibility under subsections (b) and (c) of section 479 of the Higher Education Act of 1965 (20 U.S.C. 1087ss(b) and (c)).

SEC. 8019. ADDITIONAL NEED ANALYSIS AMENDMENTS.

(a) **TREATING ACTIVE DUTY MEMBERS OF THE ARMED FORCES AS INDEPENDENT STUDENTS.**—Section 480(d)(3) (20 U.S.C. 1087vv(d)(3)) is amended by inserting before the semicolon at the end the following: “or is currently serving on active duty in the Armed Forces for other than training purposes”.

(b) **DEFINITION OF ASSETS.**—Section 480(f)(1) (20 U.S.C. 1087vv(f)(1)) is amended by inserting “qualified education benefits (except as provided in paragraph (3)),” after “tax shelters,”.

(d) **TREATMENT OF FAMILY OWNERSHIP OF SMALL BUSINESSES.**—Section 480(f)(2) (20 U.S.C. 1087vv(f)(2)) is amended—

(1) in subparagraph (A), by striking “or”;

(2) in subparagraph (B), by striking the period at the end and inserting “; or”; and

(3) by adding at the end the following new subparagraph:
“(C) a small business with not more than 100 full-time or full-time equivalent employees (or any part of such a small business) that is owned and controlled by the family.”.

(d) **ADDITIONAL DEFINITIONS.**—Section 480(f) is further amended by adding at the end the following new paragraphs:

“(3) A qualified education benefit shall not be considered an asset of a student for purposes of section 475.

“(4) In determining the value of assets in a determination of need under this title (other than for subpart 4 of part A), the value of a qualified education benefit shall be—

“(A) the refund value of any tuition credits or certificates purchased under a qualified education benefit; and

“(B) in the case of a program in which contributions are made to an account that is established for the purpose of meeting the qualified higher education expenses of the designated beneficiary of the account, the current balance of such account.

“(5) In this subsection:

“(A) The term ‘qualified education benefit’ means—

“(i) a qualified tuition program (as defined in section 529(b)(1)(A) of the Internal Revenue Code of 1986) or other prepaid tuition plan offered by a State; and

“(ii) a Coverdell education savings account (as defined in section 530(b)(1) of the Internal Revenue Code of 1986).

“(B) The term ‘qualified higher education expenses’ has the meaning given the term in section 529(e) of the Internal Revenue Code of 1986.”.

(f) **DESIGNATED ASSISTANCE.**—Section 480(j) (20 U.S.C. 1087vv(j)) is amended—

(1) in the subsection heading, by striking “; TUITION PREPAYMENT PLANS”;

(2) by striking paragraph (2);

(3) by redesignating paragraph (3) as paragraph (2); and

(4) by adding at the end the following new paragraph:

“(3) Notwithstanding paragraph (1) and section 472, assistance not received under this title may be excluded from both estimated financial assistance and cost of attendance, if that assistance is provided by a State and is designated by such State to offset a specific component of the cost of attendance. If that assistance is excluded from either estimated financial assistance or cost of attendance, it shall be excluded from both.”.

SEC. 8020. GENERAL PROVISIONS.

(a) **ACADEMIC YEAR.**—Paragraph (2) of section 481(a) (20 U.S.C. 1088(a)) is amended to read as follows:

“(2)(A) For the purpose of any program under this title, the term ‘academic year’ shall—

“(i) require a minimum of 30 weeks of instructional time for a course of study that measures its program length in credit hours; or

“(ii) require a minimum of 26 weeks of instructional time for a course of study that measures its program length in clock hours; and

“(iii) require an undergraduate course of study to contain an amount of instructional time whereby a full-time student is expected to complete at least—

“(I) 24 semester or trimester hours or 36 quarter credit hours in a course of study that measures its program length in credit hours; or

“(II) 900 clock hours in a course of study that measures its program length in clock hours.

“(B) The Secretary may reduce such minimum of 30 weeks to not less than 26 weeks for good cause, as determined by the Secretary on a case-by-case basis, in the case of an institution of higher education that provides a 2-year or 4-year program of instruction for which the institution awards an associate or baccalaureate degree.”

(b) **DISTANCE EDUCATION: ELIGIBLE PROGRAM.**—Section 481(b) (20 U.S.C. 1088(b)) is amended by adding at the end the following new paragraphs:

“(3) An otherwise eligible program that is offered in whole or in part through telecommunications is eligible for the purposes of this title if the program is offered by an institution, other than a foreign institution, that has been evaluated and determined (before or after the date of enactment of the Higher Education Reconciliation Act of 2005) to have the capability to effectively deliver distance education programs by an accrediting agency or association that—

“(A) is recognized by the Secretary under subpart 2 of part H; and

“(B) has evaluation of distance education programs within the scope of its recognition, as described in section 496(n)(3).

“(4) For purposes of this title, the term ‘eligible program’ includes an instructional program that, in lieu of credit hours or clock hours as the measure of student learning, utilizes direct assessment of student learning, or recognizes the direct assessment of student learning by others, if such assessment is consistent with the accreditation of the institution or program utilizing the results of the assessment. In the case of a program being determined eligible for the first time under this paragraph, such determination shall be made by the Secretary before such program is considered to be an eligible program.”

(c) **CORRESPONDENCE COURSES.**—Section 484(l)(1) (20 U.S.C. 1091(l)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking “for a program of study of 1 year or longer”; and

(B) by striking “unless the total” and all that follows through “courses at the institution”; and

(2) by amending subparagraph (B) to read as follows:

“(B) EXCEPTION.—Subparagraph (A) shall not apply to an institution or school described in section 3(3)(C) of the Carl D. Perkins Vocational and Technical Education Act of 1998.”.

SEC. 8021. STUDENT ELIGIBILITY.

(a) FRAUD: REPAYMENT REQUIRED.—Section 484(a) (20 U.S.C. 1091(a)) is amended—

(1) by striking the period at the end of paragraph (5) and inserting “; and”; and

(2) by adding at the end the following new paragraph:

“(6) if the student has been convicted of, or has pled *nolo contendere* or guilty to, a crime involving fraud in obtaining funds under this title, have completed the repayment of such funds to the Secretary, or to the holder in the case of a loan under this title obtained by fraud.”.

(b) VERIFICATION OF INCOME DATE.—Paragraph (1) of section 484(q) (20 U.S.C. 1091(q)) is amended to read as follows:

“(1) CONFIRMATION WITH IRS.—The Secretary of Education, in cooperation with the Secretary of the Treasury, is authorized to confirm with the Internal Revenue Service the information specified in section 6103(l)(13) of the Internal Revenue Code of 1986 reported by applicants (including parents) under this title on their Federal income tax returns for the purpose of verifying the information reported by applicants on student financial aid applications.”.

(c) SUSPENSION OF ELIGIBILITY FOR DRUG OFFENSES.—Section 484(r)(1) (20 U.S.C. 1091(r)(1)) is amended by striking everything preceding the table and inserting the following:

“(1) IN GENERAL.—A student who is convicted of any offense under any Federal or State law involving the possession or sale of a controlled substance for conduct that occurred during a period of enrollment for which the student was receiving any grant, loan, or work assistance under this title shall not be eligible to receive any grant, loan, or work assistance under this title from the date of that conviction for the period of time specified in the following table.”.

SEC. 8022. INSTITUTIONAL REFUNDS.

Section 484B (20 U.S.C. 1091b) is amended—

(1) in the matter preceding clause (i) of subsection (a)(2)(A), by striking “a leave of” and inserting “1 or more leaves of”;

(2) in subsection (a)(3)(B)(ii), by inserting “(as determined in accordance with subsection (d))” after “student has completed”;

(3) in subsection (a)(3)(C)(i), by striking “grant or loan assistance under this title” and inserting “grant assistance under subparts 1 and 3 of part A, or loan assistance under parts B, D, and E,”;

(4) in subsection (a)(4), by amending subparagraph (A) to read as follows:

“(A) IN GENERAL.—After determining the eligibility of the student for a late disbursement or post-withdrawal dis-

bursement (as required in regulations prescribed by the Secretary), the institution of higher education shall contact the borrower and obtain confirmation that the loan funds are still required by the borrower. In making such contact, the institution shall explain to the borrower the borrower's obligation to repay the funds following any such disbursement. The institution shall document in the borrower's file the result of such contact and the final determination made concerning such disbursement.”;

(5) in subsection (b)(1), by inserting “not later than 45 days from the determination of withdrawal” after “return”;

(6) in subsection (b)(2), by amending subparagraph (C) to read as follows:

“(C) GRANT OVERPAYMENT REQUIREMENTS.—

“(i) IN GENERAL.—Notwithstanding subparagraphs (A) and (B), a student shall only be required to return grant assistance in the amount (if any) by which—

“(I) the amount to be returned by the student (as determined under subparagraphs (A) and (B)), exceeds

“(II) 50 percent of the total grant assistance received by the student under this title for the payment period or period of enrollment.

“(ii) MINIMUM.—A student shall not be required to return amounts of \$50 or less.”;

(7) in subsection (d), by striking “(a)(3)(B)(i)” and inserting “(a)(3)(B)”;

(8) in subsection (d)(2), by striking “clock hours—” and all that follows through the period and inserting “clock hours scheduled to be completed by the student in that period as of the day the student withdrew.”.

SEC. 8023. COLLEGE ACCESS INITIATIVE.

Part G is further amended by inserting after section 485C (20 U.S.C. 1092c) the following new section:

“SEC. 485D. COLLEGE ACCESS INITIATIVE.

“(a) STATE-BY-STATE INFORMATION.—The Secretary shall direct each guaranty agency with which the Secretary has an agreement under section 428(c) to provide to the Secretary the information necessary for the development of Internet web links and access for students and families to a comprehensive listing of the postsecondary education opportunities, programs, publications, Internet web sites, and other services available in the States for which such agency serves as the designated guarantor.

“(b) GUARANTY AGENCY ACTIVITIES.—

“(1) PLAN AND ACTIVITY REQUIRED.—Each guaranty agency with which the Secretary has an agreement under section 428(c) shall develop a plan, and undertake the activity necessary, to gather the information required under subsection (a) and to make such information available to the public and to the Secretary in a form and manner as prescribed by the Secretary.

“(2) ACTIVITIES.—Each guaranty agency shall undertake such activities as are necessary to promote access to postsecondary education for students through providing information on college planning, career preparation, and paying for college.

The guaranty agency shall publicize such information and coordinate such activities with other entities that either provide or distribute such information in the States for which such guaranty agency serves as the designated guarantor.

“(3) FUNDING.—The activities required by this section may be funded from the guaranty agency’s Operating Fund established pursuant to section 422B and, to the extent funds remain, from earnings on the restricted account established pursuant to section 422(h)(4).

“(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a guaranty agency to duplicate any efforts under way on the date of enactment of the Higher Education Reconciliation Act of 2005 that meet the requirements of this section.

“(c) ACCESS TO INFORMATION.—

“(1) SECRETARY’S RESPONSIBILITY.—The Secretary shall ensure the availability of the information provided, by the guaranty agencies in accordance with this section, to students, parents, and other interested individuals, through Internet web links or other methods prescribed by the Secretary.

“(2) GUARANTY AGENCY RESPONSIBILITY.—The guaranty agencies shall ensure that the information required by this section is available without charge in printed format for students and parents requesting such information.

“(3) PUBLICITY.—Not later than 270 days after the date of enactment of the Higher Education Reconciliation Act of 2005, the Secretary and guaranty agencies shall publicize the availability of the information required by this section, with special emphasis on ensuring that populations that are traditionally underrepresented in postsecondary education are made aware of the availability of such information.”.

SEC. 8024. WAGE GARNISHMENT REQUIREMENT.

Section 488A(a)(1) (20 U.S.C. 1095a(a)(1)) is amended by striking “10 percent” and inserting “15 percent”.

Subtitle B—Pensions

SEC. 8201. INCREASES IN PBGC PREMIUMS.

(a) FLAT-RATE PREMIUMS.—

(1) SINGLE-EMPLOYER PLANS.—

(A) IN GENERAL.—Clause (i) of section 4006(a)(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1306(a)(3)(A)) is amended by striking “\$19” and inserting “\$30”.

(B) ADJUSTMENT FOR INFLATION.—Section 4006(a)(3) of such Act (29 U.S.C. 1306(a)(3)) is amended by adding at the end the following new subparagraph:

“(F) For each plan year beginning in a calendar year after 2006, there shall be substituted for the premium rate specified in clause (i) of subparagraph (A) an amount equal to the greater of—

“(i) the product derived by multiplying the premium rate specified in clause (i) of subparagraph (A) by the ratio of—

“(I) the national average wage index (as defined in section 209(k)(1) of the Social Security Act) for the first of the

2 calendar years preceding the calendar year in which such plan year begins, to

“(II) the national average wage index (as so defined) for 2004; and

“(ii) the premium rate in effect under clause (i) of subparagraph (A) for plan years beginning in the preceding calendar year.

If the amount determined under this subparagraph is not a multiple of \$1, such product shall be rounded to the nearest multiple of \$1.”.

(2) **MULTIEMPLOYER PLANS.**—

(A) **IN GENERAL.**—Section 4006(a)(3)(A) of such Act (29 U.S.C. 1306(a)(3)(A)) is amended—

(i) in clause (iii)—

(I) by inserting “and before January 1, 2006,” after “Act of 1980,”; and

(II) by striking the period at the end and inserting “, or”; and

(ii) by adding at the end the following:

“(iv) in the case of a multiemployer plan, for plan years beginning after December 31, 2005, \$8.00 for each individual who is a participant in such plan during the applicable plan year.”.

(B) **ADJUSTMENT FOR INFLATION.**—Section 4006(a)(3) of such Act (29 U.S.C. 1306(a)(3)), as amended by this subsection, is amended by adding at the end the following new subparagraph:

“(G) For each plan year beginning in a calendar year after 2006, there shall be substituted for the premium rate specified in clause (iv) of subparagraph (A) an amount equal to the greater of—

“(i) the product derived by multiplying the premium rate specified in clause (iv) of subparagraph (A) by the ratio of—

“(I) the national average wage index (as defined in section 209(k)(1) of the Social Security Act) for the first of the 2 calendar years preceding the calendar year in which such plan year begins, to

“(II) the national average wage index (as so defined) for 2004; and

“(ii) the premium rate in effect under clause (iv) of subparagraph (A) for plan years beginning in the preceding calendar year.

If the amount determined under this subparagraph is not a multiple of \$1, such product shall be rounded to the nearest multiple of \$1.”.

(b) **PREMIUM RATE FOR CERTAIN TERMINATED SINGLE-EMPLOYER PLANS.**—Subsection (a) of section 4006 of such Act (29 U.S.C. 1306) is amended by adding at the end the following:

“(7) **PREMIUM RATE FOR CERTAIN TERMINATED SINGLE-EMPLOYER PLANS.**—

“(A) **IN GENERAL.**—If there is a termination of a single-employer plan under clause (ii) or (iii) of section 4041(c)(2)(B) or section 4042, there shall be payable to the corporation, with respect to each applicable 12-month period, a premium at a rate equal to \$1,250 multiplied by the number of individuals who were participants in the plan immediately before the termi-

nation date. Such premium shall be in addition to any other premium under this section.

“(B) SPECIAL RULE FOR PLANS TERMINATED IN BANKRUPTCY REORGANIZATION.—In the case of a single-employer plan terminated under section 4041(c)(2)(B)(ii) or under section 4042 during pendency of any bankruptcy reorganization proceeding under chapter 11 of title 11, United States Code, or under any similar law of a State or a political subdivision of a State (or a case described in section 4041(c)(2)(B)(i) filed by or against such person has been converted, as of such date, to such a case in which reorganization is sought), subparagraph (A) shall not apply to such plan until the date of the discharge or dismissal of such person in such case.

“(C) APPLICABLE 12-MONTH PERIOD.—For purposes of subparagraph (A)—

“(i) IN GENERAL.—The term ‘applicable 12-month period’ means—

“(I) the 12-month period beginning with the first month following the month in which the termination date occurs, and

“(II) each of the first two 12-month periods immediately following the period described in subclause (I).

“(ii) PLANS TERMINATED IN BANKRUPTCY REORGANIZATION.—In any case in which the requirements of subparagraph (B)(i)(I) are met in connection with the termination of the plan with respect to 1 or more persons described in such subparagraph, the 12-month period described in clause (i)(I) shall be the 12-month period beginning with the first month following the month which includes the earliest date as of which each such person is discharged or dismissed in the case described in such clause in connection with such person.

“(D) COORDINATION WITH SECTION 4007.—

“(i) Notwithstanding section 4007—

“(I) premiums under this paragraph shall be due within 30 days after the beginning of any applicable 12-month period, and

“(II) the designated payor shall be the person who is the contributing sponsor as of immediately before the termination date.

“(ii) The fifth sentence of section 4007(a) shall not apply in connection with premiums determined under this paragraph.

“(E) TERMINATION.—Subparagraph (A) shall not apply with respect to any plan terminated after December 31, 2010.”.

(c) CONFORMING AMENDMENT.—Section 4006(a)(3)(B) of such Act (29 U.S.C. 1306(a)(3)(B)) is amended by striking “subparagraph (A)(iii)” and inserting “clause (iii) or (iv) of subparagraph (A)”.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to plan years beginning after December 31, 2005.

(2) PREMIUM RATE FOR CERTAIN TERMINATED SINGLE-EMPLOYER PLANS.—

(A) *IN GENERAL.*—Except as provided in subparagraph (B), the amendment made by subsection (b) shall apply to plans terminated after December 31, 2005.

(B) *SPECIAL RULE FOR PLANS TERMINATED IN BANKRUPTCY.*—The amendment made by subsection (b) shall not apply to a termination of a single-employer plan that is terminated during the pendency of any bankruptcy reorganization proceeding under chapter 11 of title 11, United States Code (or under any similar law of a State or political subdivision of a State), if the proceeding is pursuant to a bankruptcy filing occurring before October 18, 2005.

TITLE IX—LIHEAP PROVISIONS

SEC. 9001. FUNDING AVAILABILITY.

(a) *IN GENERAL.*—In addition to amounts otherwise made available, there are appropriated, out of any money in the Treasury not otherwise appropriated, to the Secretary of Health and Human Services for a 1-time only obligation and expenditure—

(1) \$250,000,000 for fiscal year 2007 for allocation under section 2604(a) through (d) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623(a) through (d)); and

(2) \$750,000,000 for fiscal year 2007 for allocation under section 2604(e) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623(e)).

(b) *SUNSET.*—The provisions of this section shall terminate, be null and void, and have no force and effect whatsoever after September 30, 2007. No monies provided for under this section shall be available after such date.

TITLE X—JUDICIARY RELATED PROVISIONS

Subtitle A—Civil Filing Adjustments

SEC. 10001. CIVIL CASE FILING FEE INCREASES.

(a) *CIVIL ACTIONS FILED IN DISTRICT COURTS.*—Section 1914(a) of title 28, United States Code, is amended by striking “\$250” and inserting “\$350”.

(b) *APPEALS FILED IN COURTS OF APPEALS.*—The \$250 fee for docketing a case on appeal or review, or docketing any other proceeding, in a court of appeals, as prescribed by the Judicial Conference, effective as of January 1, 2005, under section 1913 of title 28, United States Code, shall be increased to \$450.

(c) *EXPENDITURE LIMITATION.*—Incremental amounts collected by reason of the enactment of this section shall be deposited in a special fund in the Treasury to be established after the enactment of this Act. Such amounts shall be available for the purposes specified in section 1931(a) of title 28, United States Code, but only to the extent specifically appropriated by an Act of Congress enacted after the enactment of this Act.

(d) *EFFECTIVE DATE.*—This section and the amendment made by this section shall take effect 60 days after the date of the enactment of this Act.

Subtitle B—Bankruptcy Fees

SEC. 10002. BANKRUPTCY FEES.

(a) *BANKRUPTCY FILING FEES.*—Section 1930(a) of title 28, United States Code, is amended—

(1) in paragraph (1)—

(A) in subparagraph (A) by striking “\$220” and inserting “\$245”; and

(B) in subparagraph (B) by striking “\$150” and inserting “\$235”; and

(2) in paragraph (2) by striking “\$1,000” and inserting “\$2,750”.

(b) *EXPENDITURE LIMITATION.*—Incremental amounts collected by reason of the amendments made by subsection (a) shall be deposited in a special fund in the Treasury to be established after the enactment of this Act. Such amounts shall be available for the purposes specified in section 1931(a) of title 28, United States Code, but only to the extent specifically appropriated by an Act of Congress enacted after the enactment of this Act.

(c) *EFFECTIVE DATE.*—This section and the amendments made by this section shall take effect 60 days after the date of the enactment of this Act.

And the House agree to the same.

For consideration of the Senate bill, and the House amendment thereto, and modifications committed to conference:

JIM NUSSLE,
JIM RYUN,
ANDER CRENSHAW,
ADAM PUTNAM,
ROGER F. WICKER,
KENNY C. HULSHOF,
PAUL D. RYAN,
ROY BLUNT,
TOM DELAY,

From the Committee on Agriculture, for consideration of title I of the Senate bill and title I of the House amendment, and modifications committed to conference:

BOB GOODLATTE,
FRANK D. LUCAS,

From the Committee on Education and the Workforce, for consideration of title VII of the Senate bill and title II and subtitle C of title III of the House amendment, and modifications committed to conference:

JOHN BOEHNER,
HOWARD P. MCKEON,

From the Committee on Energy and Commerce, for consideration of title III and title VI of the Senate bill and title III of the House amendment, and modifications committed to conference:

JOE BARTON,
NATHAN DEAL,

From the Committee on Financial Services, for consideration of title II of the Senate bill and title IV of the House amendment, and modifications committed to conference:

MICHAEL G. OXLEY,
SPENCER BAUCUS,

(Provided that Mr. Ney is appointed in lieu of Mr. Bachus for consideration of subtitles C and D of title II of the Senate bill and subtitle B of title IV of the House amendment:)

From the Committee on the Judiciary, for consideration of title VIII of the Senate bill and title V of the House amendment, and modifications committed to conference:

F. JAMES SENSENBRENNER, Jr.,
LAMAR SMITH,

From the Committee on Resources, for consideration of title IV of the Senate bill and title VI of the House amendment, and modifications committed to conference:

RICHARD POMBO,
JIM GIBBONS,

From the Committee on Transportation and Infrastructure, for consideration of title V and division A of the Senate bill and title VII of the House amendment, and modifications committed to conference:

DON YOUNG,
FRANK LOBIONDO,

From the Committee on Ways and Means, for consideration of sections 6039, 6071, and subtitle B of title VI of the Senate bill and title VIII of the House amendment, and modifications committed to conference:

WILLIAM THOMAS,
WALLY HERGER,

Managers on the Part of the House.

JUDD GREGG,
PETE DOMENICI,
CHUCK GRASSLEY,
MICHAEL B. ENZI,
WAYNE ALLARD,
JEFF SESSIONS,
TED STEVENS,
RICHARD SHELBY,
ARLEN SPECTER,
SAXBY CHAMBLISS,
MITCH MCCONNELL,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 1932), to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95), submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment struck all of the Senate bill after the enacting clause and inserted a substitute text:

The Senate recedes from its disagreement to the amendment of the House with an amendment that is a substitute for the Senate bill and the House amendment. The differences between the Senate bill, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

The managers representing authorizing committees submitted separate joint statements explaining the provisions within their respective jurisdictions: Committee on Agriculture, Committee on Education and the Workforce, Committee on Energy and Commerce, Committee on Financial Services, Committee on Transportation and Infrastructure, Committee on Ways and Means.

TITLE I—COMMITTEE ON AGRICULTURE

(1) Short Title

The Senate bill cites this Title as the “Agricultural Reconciliation Act of 2005.” (Section 1001)

The House amendment cites this Title as the “Agricultural Reconciliation Act of 2005” and contains a table of contents. (Section 1001)

The Conference substitute adopts the Senate provision.

Subtitle A—Commodity Programs

(2) Reduction of Commodity Program Payments

The Senate bill adds a new section to Title I of the Farm Security and Rural Investment Act to reauthorize direct payments, counter-cyclical payments and marketing assistance loans through 2011 and reduce these program payments 2.5 percent for crop years 2006 through 2010. It also reduces by 2.5 percent payments to dairy producers pursuant to section 1502 of the Farm Security and Rural Investment Act (known as “MILC”) during the period of October 1, 2005, through September 30, 2007. The reauthorization

does not include 1104(f) and 1304(g) which specify the times at which the Secretary is required to make partial counter-cyclical payments. It also does not include section 1307(a)(6) which requires the Secretary to pay storage, handling, and other costs for peanut crops. Further, the Senate bill extends the period during which the prevailing world market price for upland cotton must be further adjusted to July 31, 2012, and extends the extra long staple competitiveness program through July 31, 2012. (Section 1101)

The House amendment amends section 1103 of the Farm Security and Rural Investment Act to reduce the total amount of direct payments to be paid to producers of covered commodities by 1 percent for crop years 2006 and 2007, and for crop years 2008 and 2009 if direct payments are made in these years. The House amendment also amends section 1303 of the Farm Security and Rural Investment Act to reduce the total amount of the direct payments to be paid to producers of peanuts by 1 percent for crop years 2006 and 2007, and for crop years 2008 and 2009 if direct payments are made in these years. (Section 1101)

The Conference substitute adopts neither provision.

(3) Forfeiture Penalty for Nonrecourse Sugar Loans

The Senate bill amends the Federal Agriculture Improvement and Reform (FAIR) Act of 1996 to require that a penalty be assessed on the forfeiture of any sugar from the 2006 through 2010 crops of sugar beets and sugarcane pledged as collateral for a non-recourse loan. It provides that the penalty is 1.2 percent of the loan rate established under section 156 of the FAIR Act. Further, it reduces payments owed to a producer by a processor that forfeits sugar pledged as collateral in proportion to the penalty incurred by the processor. (Section 1102)

The House amendment has no comparable provision.

The Conference substitute deletes the Senate provision.

(4) Cotton Competitiveness Provisions

The Senate bill amends the Farm Security and Rural Investment Act to eliminate authority for the establishment of the upland cotton user marketing certificate program known as "Step 2." It also repeals section 136 of the Federal Agriculture Improvement and Reform Act of 1996 which has duplicate language for the establishment of Step 2. Further, it provides that the above amendments take effect on August 1, 2006. (Section 1103)

The House amendment has identical language. (Section 1103)

The Conference substitute adopts the Senate provision with an amendment that eliminates the language repealing section 136 of the Federal Agriculture Improvement and Reform Act of 1996.

(5) National dairy market loss payments

The Senate bill amends the MILC Program (section 1502 of the Farm Security and Rural Investment Act) by extending until September 30, 2007, the period during which the Secretary must offer to enter into contracts with producers. It also includes a new provision that decreases the multiplier used to calculate payments from 45 percent to 34 percent during the period of October 1, 2005, through September 30, 2007. In addition it extends until Sep-

tember 30, 2007, the period during which eligible production must be covered in any contract entered into by a producer. It also strikes section 1502(h) of the Farm Security and Rural Investment Act and strikes an obsolete reference to section 1502. (Section 1104)

The House amendment has no comparable provision.

The Conference substitute adopts the Senate provision with an amendment that will decrease the multiplier used to calculate payments from 45 percent to 34 percent during the period from October 1, 2005, through August 31, 2007, and from 34 percent to 0 percent after September 1, 2007.

(6) Advance direct payments

The Senate bill reduces the direct payment amounts that producers are eligible to receive in advance for the 2006 through 2011 crop years. It gives producers the option of receiving up to 40 percent of their direct payments in advance for the 2006 crop year and up to 29 percent of their direct payments in advance for any of the 2007 through 2011 crop years.

The Senate bill provides for a corresponding reduction in the direct payment amount that peanut producers may receive in advance for any of the 2006 through 2011 crop years. It gives peanut producers the option of receiving up to 40 percent of their direct payments in advance for the 2006 crop year and up to 29 percent of their direct payments in advance for any of the 2007 through 2011 crop years. (Section 1105)

The House amendment reduces the direct payment amounts that producers are eligible to receive in advance for the 2006 and 2007 crop years. It gives producers the option of receiving up to 40 percent of their direct payments in advance for the 2006 and 2007 crop years.

The House amendment provides for a corresponding reduction in the direct payment amounts that producers of peanuts are eligible to receive in advance for the 2006 and 2007 crop years. It gives peanut producers the option of receiving up to 40 percent of their direct payments in advance for the 2006 and 2007 crop years. (Section 1102)

The Conference substitute adopts the House provision with an amendment that reduces the direct payment amounts that producers are eligible to receive in advance from 50 percent to 40 percent for the 2006 crop year and to 22 percent for the 2007 crop year. Advance direct payments to peanut producers are reduced in an identical fashion.

Subtitle B—Conservation

(7) Conservation Reserve Program

The Senate bill extends the Conservation Reserve Program (CRP) through 2011. It decreases the amount of acres that the Secretary is authorized to maintain in the conservation reserve program to 36.4 million acres through calendar year 2010, and 38.3 million acres in 2011. It extends the period during which the Secretary may enroll acres, and it extends the requirement to enroll wetland and buffer acreage in reserve through 2011.

It also requires the Secretary, in implementing the amendments made by this section, to achieve the new maximum acreage enrollment limit not later than 2 years after the date of enactment of the bill without affecting conservation reserve existing contracts. (Section 1201)

The House amendment has no comparable provision.

The Conference substitute deletes the Senate provision.

(8) Conservation Security Program

The Senate bill extends the authorization for the Conservation Security Program (CSP) through 2011. It strikes the current limitation on funding and inserts a new limitation with two restraints. The new limits are \$1,954,000,000 for fiscal years 2006 through 2010 and \$5,200,000,000 for fiscal years 2006 through 2015. (Section 1202)

The House amendment extends the authorization for the Conservation Security Program through 2011, strikes the current limitation on funding and inserts a new limitation with two restraints. The new limits are \$2,213,000,000 for fiscal years 2006 through 2010 and \$5,729,000,000 for fiscal years 2006 through 2015. (Section 1202)

The Conference substitute adopts the Senate provision with an amendment that provides for a limit of \$5,650,000,000 for fiscal years 2006 through 2015.

(9) Environmental Quality Incentives Program

The Senate bill extends the authorization for the Environmental Quality Incentives Program (EQIP) through 2011, and extends the aggregate payment limit for all EQIP payments through 2011. It also amends the funding provisions to provide: \$1,017,000,000 for fiscal year 2005; \$1,185,000,000 for fiscal year 2006; \$1,270,000,000 for fiscal year 2007 through 2010; and \$1,300,000,000 for fiscal year 2011. (Section 1203)

The House amendment has no comparable provision.

The Conference substitute adopts the Senate provision with an amendment that provides for \$1,270,000,000 in each of fiscal years 2007 and 2009 and \$1,300,000,000 in fiscal year 2010, limits payments under this program to \$450,000 during any six-year period, and extends the authorization for EQIP through fiscal year 2010.

(10) Limitation on use of Commodity Credit Corporation funds to carry out watershed rehabilitation program

The Senate bill has no comparable provision.

The House amendment removes the requirement that funds for the watershed rehabilitation program remain available to the Secretary until expended. It reduces funding for the watershed rehabilitation program by \$15 million in fiscal year 2007, and it rescinds funds that are previously made available and are unobligated as of September 30, 2006. (Section 1201)

The Conference substitute adopts the House provision with an amendment that cancels the authority to obligate funds previously made available for a fiscal year and unobligated as of October 1, 2006, but permits funding to remain available until expended and maintains funding at \$65,000,000 for fiscal year 2007.

(11) *Limitation on use of Commodity Credit Corporation funds to carry out the agricultural management assistance program*

The Senate bill has no comparable provision.

The House amendment eliminates funding for the agricultural management assistance program in 2007. (Section 1203)

The Conference substitute deletes the House provision.

Subtitle C—Miscellaneous (Senate Bill)

Subtitle E—Research (House Amendment)

(12) *Initiative for Future Agriculture and Food Systems*

The Senate bill reduces the amount of funds the Secretary is required to transfer on October 1, 2005, to \$104 million and on October 1, 2006 through 2009 to \$130 million. It provides \$200,000,000 of funding in 2010 and in subsequent fiscal years, and provides that the amendments take effect on October 1, 2005. (Section 1301)

The House amendment eliminates funding for the Initiative for Future Agriculture and Food Systems in fiscal years 2007, 2008, and 2009. It provides \$200,000,000 of funding in 2010 and in subsequent fiscal years, and limits availability of fiscal year 2006 funds to the one year period beginning on October 1, 2005, while maintaining the two-year period of availability for funds made available in other fiscal years. (Section 1501)

The Conference substitute adopts the House provision.

Subtitle C—Energy

(13) *Termination of use of commodity credit funds to carry out renewable energy systems and energy efficiency improvement program*

The Senate bill has no comparable provision.

The House amendment eliminates the requirement that the Secretary make funding available for loans and grants under the renewable energy systems and energy efficiency improvements program. (Section 1301)

The Conference substitute adopts the House provision with an amendment that maintains \$3,000,000 of funding for this program in fiscal year 2007.

Subtitle D—Rural Development

(14) *Enhanced access to broadband telecommunication services in rural areas*

The Senate bill has no comparable provision.

The House amendment eliminates the requirement that the Secretary provide loans for enhanced broadband access in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1401)

The Conference substitute adopts the House provision with an amendment that cancels funding previously made available for a fiscal year and unobligated as of October 1, 2006, but permits fund-

ing to remain available until expended and maintains the funding for fiscal year 2007.

(15) Value-added agricultural product market development grants

The Senate bill has no comparable provision.

The House amendment eliminates funding for value-added agricultural product grants in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1402)

The Conference substitute adopts the House provision with an amendment that cancels funding previously made available for a fiscal year and unobligated as of October 1, 2006, but permits funding to remain available until expended and maintains the funding for fiscal year 2007.

(16) Rural business investment program

The Senate bill has no comparable provision.

The House amendment eliminates funding for the rural business investment program in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1403).

The Conference substitute adopts the House provision with an amendment that eliminates funding in fiscal year 2007 and rescinds all funding that is available and unobligated as of October 1, 2006, but permits funding to remain available until expended.

(17) Rural business strategic investment grants

Senate bill has no comparable provision.

The House amendment eliminates funding for rural business strategic investment grants in fiscal year 2007 and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1404)

The Conference substitute adopts the House provision with an amendment that cancels funding previously made for a fiscal year and unobligated as of October 1, 2006, but maintains the funding for fiscal year 2007.

(18) Rural firefighters and emergency personnel grants

The Senate bill has no comparable provision.

The House amendment eliminates funding for rural firefighter and emergency personnel grants in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1405).

The Conference substitute adopts the House provision with an amendment that permits funding to remain available until expended, but eliminates funding in fiscal year 2007, and rescinds all funding that is available and unobligated as of October 1, 2006.

Subtitle F—Nutrition

(19) Eligible households

The Senate bill has no comparable provision.

The House amendment amends the Food Stamp Act to restrict categorical eligibility status, during fiscal years 2006 through 2010, to only those households in which each member receives cash benefits under the Temporary Assistance for Needy Families program (TANF). It provides an exception to the “cash benefits” rule for households in which each member receives substantial and ongoing non-cash benefits under TANF. It further provides that such non-cash benefits must be provided for purposes of shelter, utilities, child care, health care, transportation, or job training, and it requires that such households must have a monthly income that does not exceed 150 percent of the poverty line.

The House amendment reauthorizes provisions in the Food Stamp Act through 2011 (except assistance for community food projects (section 25(b)) and innovative programs for addressing common community problems (section 25(h)). It also amends the eligibility categories for free school lunch and breakfast to provide a new eligibility category that will include a child who is a member of a household: (1) in which each member receives or is eligible to receive non-cash or in-kind benefits under TANF; and (2) that has a gross monthly income at or below 200 percent of the Federal poverty level. (Section 1601)

The Conference substitute deletes the House provision.

(20) Availability of commodities for the Emergency Food Assistance Program

The Senate bill has no comparable provision.

The House amendment reauthorizes the purchase of \$140,000,000 worth of commodities per year for the Emergency Food Assistance Program through 2011, and it authorizes the purchase of an additional \$12,000,000 worth of commodities in 2006 to be distributed to States affected by Hurricanes Katrina and Rita. (Section 1602)

The Conference substitute deletes the House provision.

(21) Residency requirement

The Senate bill has no comparable provision.

The House amendment amends the Personal Responsibility and Work Opportunity Reconciliation Act to require that, until fiscal year 2010, non-citizens must reside in the U.S. for 7 years or more before becoming eligible for food stamp benefits. It provides an exemption, however, for aliens who currently receive food stamp benefits and who are 60 years of age or older or have petitioned for naturalization as a U.S. citizen. It also provides that on October 1, 2010, these provisions will expire. (Section 1603)

The Conference substitute deletes the House provision.

(22) Disaster Food Stamp Program

The Senate bill has no comparable provision.

The House amendment authorizes the Secretary of Agriculture to pay to state agencies 100 percent of the administrative costs in-

curred in the delivery of food stamp benefits under the disaster food stamp program initiated in response to Hurricanes Katrina and Rita (Section 1604)

The Conference substitute deletes the House provision.

TITLE II—SENATE COMMITTEE ON BANKING AND HOUSE COMMITTEE
ON FINANCIAL SERVICES

Subtitle A—FHA Asset Disposition

SUMMARY OF FHA RECONCILIATION LANGUAGE (DECEMBER 15, 2005)

The House Financial Services and Senate Banking Committees approved reconciliation language that will make several FHA multifamily authorities subject to appropriations. This move to discretionary spending will enable the Administration and Congress to set the level of activity for these FHA authorities and better control their use. This legislation authorizes \$100 million to be appropriated for fiscal year 2006 to make these reforms.

Bill summary

Originally proposed in the President's budget, the FHA Asset Disposition Act of 2005 will make several FHA multifamily authorities subject to appropriations, including (1) discount property sales; (2) discount loan sales; and (3) up-front grant assistance.

The Congressional Budget Office estimate of total savings in outlays are as follows (in millions):

FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	Total
\$30	\$60	\$60	\$60	\$60	\$270

The savings from this proposal, taken together with Deposit Insurance Reform, constitute the reconciliation recommendations of the House Financial Services and Senate Banking Committees. Together the proposals will save an estimated \$520 million over fiscal years 2006–10, with \$30 million in fiscal 2006. This amount is the savings target for these committees contemplated in the budget resolution.

Background

Since 1934, FHA and HUD have insured almost 33 million home mortgages and multifamily project mortgages. Within HUD, FHA provides mortgage insurance to lenders to protect against losses as a result of borrower default. Currently, FHA has the authority to sell, at below-market rates, properties taken over by the agency because of mortgage defaults. FHA also has the authority to sell discount loans. This legislation will make these mandatory authorities discretionary and subject to appropriations. Additionally, FHA can provide up-front grants to rehabilitate dilapidated multifamily properties. Funding for the grants currently comes from the General Insurance Fund, which collects money from premiums and servicing of insured mortgages. The amount spent on the grants is left to the discretion of FHA. Under this legislation, funding for these grants will no longer be drawn from the General

Insurance Fund and would be subject to appropriations. Finally, this proposal is effective during fiscal years 2006 through 2010.

Subtitle B—Deposit Insurance

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 2101. Short title; table of contents

This section establishes the short title of the subtitle, the ‘Federal Deposit Insurance Reform Act of 2005,’ and provides a table of contents.

Section 2102. Merging the BIF and SAIF

This section amends provisions of the Federal Deposit Insurance Act to merge the Bank Insurance Fund and the Savings Association Insurance Fund no later than the first day of the first calendar quarter that begins after the end of the 90-day period beginning on the date of the enactment of this Act.

Section 2103. Increase in deposit insurance coverage

This section provides for an inflation index for general depositors and a higher level of deposit insurance coverage for certain individual retirement accounts. Credit unions are provided with complete parity in coverage with other insured depository institutions.

The section also retains the \$100,000 deposit insurance limit on accounts at insured depository institutions, to be known as the “standard maximum deposit insurance amount,” subject to future cost of living adjustments.

Beginning April 1, 2010, and every succeeding five years, the Board of Directors of the FDIC and the National Credit Union Administration Board shall jointly determine whether an increase in the standard maximum deposit insurance is appropriate after considering certain factors. If appropriate, the new standard maximum deposit insurance limit would be increased by a cost of living adjustment. This adjustment would be calculated according to the Personal Consumption Expenditures Chain-Type Index (PCE) published by the Department of Commerce and rounded down to the nearest \$10,000. The FDIC and National Credit Union Administration (NCUA) Boards of Directors are required to publish the new standard maximum deposit insurance amount in the Federal Register and provide a corresponding report to Congress by April 5, 2010, and April 5 of every succeeding fifth year. The approved adjustment in the standard maximum deposit insurance amount would automatically occur unless a Congressional act provides otherwise and would take effect on January 1 of the year immediately succeeding the calendar year in which the new amount is calculated.

The section also provides pass-through coverage to certain employee benefit plans, even if the institution is not authorized to accept employee benefit plan deposits because it is not well-capitalized or adequately capitalized.

The section also increases the deposit insurance limit for certain retirement accounts to \$250,000, also subject to future cost-of-living adjustments.

Section 2104. Setting assessments and repeal of special rules relating to minimum assessments and free deposit insurance

This section allows the FDIC Board to set assessments in such amounts as it may determine to be necessary or appropriate. This provision also eliminates the existing restrictions on the FDIC's authority to levy assessments on any institution above amounts needed to achieve and maintain the existing DRR of 1.25 percent. The minimum statutory rate (23 basis point cliff rate) applicable in certain circumstances is eliminated.

This section also provides that under the FDIC's risk-based assessment system, no depository institution shall be barred from the lowest-risk category solely because of size.

The section also requires insured depository institutions to maintain all records that the FDIC may require for verifying the accuracy of any assessment for 3 years or, in the case of disputed assessments, until the dispute has been resolved, and increases the fees that the FDIC can impose for late payments of premium assessments from \$100 to 1 percent of assessments per day, for institutions with assessments greater than \$10,000. Institutions with assessments lower than \$10,000 would face a maximum penalty of \$100 for each day they were delinquent in paying their premium assessments.

The bill repeals a number of provisions requiring the FDIC to set premiums on a semiannual basis, replacing them with a provision granting the FDIC greater flexibility in the timing of those evaluations.

Section 2105. Replacement of fixed designated reserve ratio with reserve range

This section eliminates the current 1.25 percent 'hard target' DRR and provides the FDIC Board with the discretion to set the DRR within a range of 1.15 to 1.50 percent for any given year, using the following criteria as a basis for making these determinations: (1) present and future risk of losses to the deposit insurance fund; (2) economic conditions; and (3) any other factors the Board may determine to be appropriate.

In designating the reserve ratio, the FDIC must follow notice-and-comment rulemaking procedures, and is required to publish a thorough analysis of the data and projections if it proposes to change the DRR.

Section 2106. Requirements applicable to the risk-based assessment system

This section directs the FDIC to collect information from all appropriate sources in determining risk of losses to the DIF. This provision does not authorize the FDIC to impose additional record-keeping requirements on insured depository institutions.

The FDIC is required to consult with the appropriate Federal banking agency in assessing the risk of loss to the DIF with respect to any insured depository institution. This risk of loss evaluation may be done on an aggregate basis for institutions that are determined to be well-capitalized and well-managed.

The FDIC is also required to provide notice and opportunity for comment prior to revising or modifying the risk-based assessment system.

Section 2107. Refunds, dividends, and credits from Deposit Insurance Fund

This section provides for refunds or credits of any assessment payment that was made by an insured depository institution in excess of the amount due the FDIC.

The section specifies two circumstances under which the FDIC is required to pay dividends to insured depository institutions: (1) whenever the reserve ratio of the DIF equals or exceeds 1.35 percent of estimated insured deposits and is less than or equal to 1.5 percent of such deposits, the FDIC is required to pay dividends equal to 50 percent of the amount in excess of what is required to maintain the reserve ratio at 1.35 percent unless the FDIC determines that a significant risk of losses to the DIF exists and such losses justify the growth of the reserve ratio; and (2) whenever the reserve ratio of the DIF exceeds 1.5 percent of estimated insured deposits, the FDIC is required to pay dividends in the amount of the excess of what is necessary to maintain the ratio at 1.5 percent.

The section also provides for a transitional credit of 10.5 basis points of the total assessment base as of December 31, 2001 (or about \$4.7 billion) to eligible insured depository institutions based on their respective percentage of total industry assessable deposits held as of December 31, 1996. Eligible insured depository institutions had to be in existence at December 31, 1996, or be a successor to such an institution, and to have paid a deposit insurance assessment prior to that date.

For purposes of allocating dividends, the FDIC is required to determine each insured depository institution's relative contribution to the DIF (or any predecessor deposit insurance fund), taking into account the institution's share of the assessment base as of December 31, 1996; the total amount of deposit insurance assessments paid by the institution after December 31, 1996; that portion of assessments paid by an institution that reflects higher levels of risk assumed by the institution; and such other factors as the FDIC deems appropriate. The FDIC's calculation, declaration and payment of dividends are made subject to notice-and-comment rulemaking.

For any insured depository institution that exhibits financial, operational or compliance weaknesses ranging from moderately severe to unsatisfactory at the beginning of the assessment period, credits may not exceed the amount calculated by applying to that institution the average assessment rate on all insured depository institutions for that assessment period.

In promulgating regulations establishing a system for dividends and credits, the FDIC is required to include provisions allowing insured depository institutions a reasonable opportunity to challenge administratively the amount of their dividends or credits.

In determining the appropriate distribution of dividends, the FDIC must weigh a number of factors in its rulemaking process. The calculation should recognize past contributions to the deposit insurance funds by incorporating the ratio determined for an insti-

tution in the calculation of the institution's one-time credit based on total assessment base at year-end 1996, as well as the actual assessments paid since that time. In establishing the dividend system, the FDIC should also take into account and make adjustments that reflect the higher risk profiles of some institutions so that they are not rewarded for riskier behavior. The FDIC is given the discretion to incorporate additional factors, through the rulemaking process, as it deems appropriate.

Section 2108. Deposit Insurance Fund restoration plans

Whenever the reserve ratio falls or is projected to fall below the low end of the range within which the FDIC is authorized to set the DRR, the FDIC is required, within 90 days, to establish and implement a plan for restoring the DIF to that level within five years or a longer period in extraordinary circumstances. While such a restoration plan is in effect, the FDIC has the authority to restrict the use of assessment credits by insured depository institutions, but is required to apply to an institution's assessment an amount that is the lesser of the institution's assessment or 3 basis points of an institution's assessment base. The FDIC must publish the details of its restoration plan in the Federal Register within 30 days of its implementation.

Section 2109. Regulations required

This section provides that the FDIC has 270 days after the date of enactment to prescribe final regulations, after notice and opportunity for public comment, establishing the DRR, implementing increases in deposit insurance coverage, implementing the dividend requirement and the one-time assessment credit, and providing for premium assessments under the amended Act.

Section 2010. Studies of FDIC structure and expenses and certain activities and further possible changes to deposit insurance system

This section provides that within one year of enactment, reports must be submitted to Congress on the following issues:

(1) The efficiency and effectiveness of the administration of the prompt corrective action (PCA) program, including the degree of effectiveness of the Federal banking agencies in identifying troubled depository institutions and the degree of accuracy of the risk assessments made by the FDIC;

(2) The appropriateness of the FDIC's organizational structure for the mission of the FDIC, to take into account the current size and complexity of the business of insured depository institutions; the extent to which the organizational structure contributes to or reduces operational inefficiencies that increase operational costs; and the effectiveness of internal controls;

(3) The feasibility of establishing a voluntary deposit insurance system for deposits in excess of the maximum amount of deposit insurance for any depositor;

(4) The feasibility of increasing the limit on deposit insurance for deposits of municipalities and other units of general local government;

(5) The feasibility of privatizing all deposit insurance at insured depository institutions and insured credit unions; and,

(6) The feasibility of using an alternative to estimated insured deposits in calculating the DIF's reserve ratio and the DRR.

(7) The section directs the FDIC to conduct a study of the reserve methodology and loss accounting for insured depository institutions in a troubled condition over the period January 1, 1992 through December 31, 2004, and report its findings and conclusions to Congress within one year of the date of enactment. The FDIC is required to obtain comments on the design of this study from the Government Accountability Office (GAO), and to provide a draft of the final report to GAO prior to its submission to Congress.

(8) The section directs the Comptroller General to report to the Committee on Financial Services of the House and the Committee on Banking, Housing, and Urban Affairs in the Senate, the potential impact on the United States financial system, the implementation of the new Basel Capital Accord and the proposed revisions to current reserve requirement regulations for non-Basel II banks.

Section 2111. Bi-annual FDIC survey and report on increasing the deposit base by encouraging use of depository institutions by the unbanked

This section requires the FDIC to conduct a bi-annual survey on efforts by insured depository institutions to bring the 'unbanked' into the conventional finance system, and report its findings and conclusions to the House Committee on Financial Services and the Senate Committee on Banking, Housing and Urban Affairs, together with any recommendations for legislative or administrative action.

Section 2112. Technical and conforming amendments to the Federal Deposit Insurance Act relating to the merger of the BIF and SAIF

This section makes numerous amendments to ensure the technical conformity of the Federal Deposit Insurance Reform Act to various provisions in the Federal Deposit Insurance Act and other banking laws, to include the authority of the DIF to borrow from insured depository institutions and the Federal Home Loan Banks.

In particular, this section repeals section 5(d)(2) of the Federal Deposit Insurance Act, dealing with exit fees collected from institutions leaving the Savings Association Insurance Fund (SAIF). These funds will be returned to the DIF upon the repeal of this provision.

Section 2113. Other Technical and conforming amendments relating to the merger of the BIF and SAIF

This section ensures the technical conformity of the Federal Deposit Insurance Reform Act to various provisions in the Federal Deposit Insurance Act and other banking laws.

The managers on the part of the House and Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to bill (S. 1932), to expedite the digital television (DTV) transition while helping consumers to continue to use their analog televisions, to free spectrum for public safety and com-

mercial use, to improve emergency communications, to provide resources for the design and deployment of a temporary digital television broadcast system for New York City in response to the destruction of the World Trade Center during the terrorist attacks of September 11, 2001, and to ensure continued air service to rural communities through the Essential Air Service program and for other purposes, submit the following joint statement to the House and Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

CONGRESSIONAL DIRECTIVES

The statement of the managers remains silent on provisions that were in both the House and Senate bills that remain unchanged by this conference agreement, except as noted in this statement of the managers.

The conferees agree that executive branch wishes cannot substitute for Congress' own statements as to the best evidence of congressional intentions—that is, the official reports of the Congress.

TITLE III—DIGITAL TELEVISION TRANSITION

Section 3001. Short title

Section 3001 would provide that this Title may be cited as the “Digital Television Transition and Public Safety Act of 2005.”

Sec. 3002. Analog spectrum recovery; firm deadline

Section 3002 directs the Federal Communication Commission (FCC) to take all steps necessary to require, by February 18, 2009, that full-power television stations stop analog broadcasting, and that Class A stations, whether broadcasting in analog or digital format, and full-power television stations broadcasting in digital format, conduct such broadcasting on channels 2 to 36 and 38 to 51. This enables channels 52 to 62 and 65 to 67 to be auctioned, and channels 63, 64, 68, and 69 to be used for public-safety purposes. Among the necessary steps the FCC will need to take are to issue a report and order on the digital television table of channel allotments, and to coordinate those allotments with Canada and Mexico to resolve any international interference issues.

Section 3002 also clarifies that only full-power stations, not low-power stations, must cease analog broadcasting by February 18, 2009. Low-power stations, including Class A stations, may continue broadcasting in analog format after February 18, 2009, subject to future decisions by the FCC on how to complete the digital television transition for such stations. Low-power stations other than Class A stations may also continue such analog broadcasting above channel 51, subject to future FCC decisions, so long as those stations' use of those channels is secondary to the use of those channels by the auction winners and public safety officials.

Section 3003. Auction of recovered spectrum

Section 3003 would amend the Communications Act of 1934 to require the FCC to conduct an auction of the recovered spectrum

commencing by January 28, 2008. The FCC's auction authority would be extended through September 30, 2011.

Sec. 3004. Reservation of auction proceeds

This provision requires that the proceeds from the auction of analog spectrum be deposited in a single separate fund in the Treasury, to be called the "Digital Television Transition and Public Safety Fund," in order to fund several programs. On September 30, 2009, \$7,363,000,000 shall be transferred from the Digital Television Transition and Public Safety Fund to the general fund of the Treasury.

Section 3005. Digital transition and public safety fund

To help consumers who wish to continue receiving broadcast programming over the air using analog-only televisions not connected to cable or satellite service, the bill authorizes the National Telecommunications and Information Administration (NTIA) to create a digital-to-analog converter box assistance program. Under the program, the NTIA is initially allocated up to \$990 million of the spectrum auction revenues to send by U.S. mail up to two \$40 coupons to each U.S. household that requests to participate in the program. Consumers may use the coupons toward the purchase of eligible digital-to-analog converter-boxes. Such boxes, and over-the-air digital televisions in general, can work with the antennas consumers already use in their homes for analog over-the-air broadcasts. The NTIA may use up to \$100 million of the \$990 million for administrative costs. Up to \$5,000,000 of the administrative funds may be used to educate consumers about the digital television transition and the digital-to-analog converter-box program. If, as the program progresses, it appears the NTIA will need additional funds, the NTIA may certify to Congress that it cannot operate the program without more money, at which point the funds available for the program shall increase to \$1.5 billion and the cap on administrative expenses shall increase to \$160 million. The NTIA would be allowed access to the additional funds 60 days after the certification.

Even if NTIA spends \$100 million on administrative costs, the remaining \$890 million in converter-box program proceeds would fund 22,250,000 coupons. And each additional \$40 the NTIA does not spend on administration is another coupon it can make available to consumers. Thus, the Managers expect in any NTIA certification to raise the caps that the NTIA explain in detail why access to additional funds is necessary, whether those funds are to be used for administrative costs or for the coupons themselves, and why the NTIA was unable to operate the program within the \$990 million overall cap and \$100 million administrative cap.

The Managers note that the February 17, 2009, firm deadline will have little impact on most television households. Only consumers relying on over-the-air broadcasts should need to participate in the converter-box program. Only 14.86 percent of U.S. television households relied exclusively on over-the-air transmission as of June 2004, according to the FCC. By contrast, the FCC reports that 92.3 million households, representing 85.14 percent, sub-

scribed to a multichannel video programming distribution (MVPD) service, such as those offered by a cable or satellite operator.

The coupon structure of the program and requiring consumers to make affirmative requests for coupons takes into account that many consumers will neither need nor want a subsidized converter box. By contrast, if converter-boxes were made directly available at subsidized rates at stores, or coupons were automatically sent to every U.S. household, impulse participation by consumers who do not really need either a converter-box or a subsidy would cause the program to run out of funds before consumers who really do need a subsidized box avail themselves of the program.

The Managers expect NTIA to promulgate regulations within nine months of enactment governing: (1) the content and distribution of coupon request forms and coupons; (2) consumer redemption of, and retailer reimbursement for, the coupons; (3) the types of converter boxes that shall be eligible for purchase with a coupon; (4) certification, education, and auditing of retailers involved in the program; and (5) consumer and retailer appeals. The requirement to send the coupons through the U.S. mail is designed to help NTIA administer the two-coupon per household limit. That limit would be much more difficult to implement if the coupons themselves were distributed electronically or simply made available at government buildings such as post offices. The U.S. mail requirement is also intended to reduce fraud that might occur with electronically distributed coupons. The Managers expect NTIA to take additional measures to reduce fraud and abuse, such as including anti-counterfeit measures and perhaps unique serial numbers on the coupons. The Managers do expect NTIA to use the efficiencies of electronic media and networks, however, to make other aspects of the program more efficient, such as outreach efforts, the distribution of coupon request forms, and the reimbursement of retailers for coupons that consumers redeem. NTIA should also take measures to protect consumer privacy in the use of information provided in conjunction with participation in the program.

Sec. 3006. Public safety interoperable communications

Section 3006 provides funding in the amount of \$1,000,000,000 to help ensure interoperability for our nation's first responders. In order to obtain a grant under this section, a public safety agency shall—(1) submit an application to the Assistant Secretary at such time, in such form, and containing or accompanied by such information and assurances as the Assistant Secretary shall require; (2) agree that, if awarded a grant, the public safety agency will submit annual reports to the Assistant Secretary for the duration of the grant award period with respect to—(A) the expenditure of grant funds; and (B) progress toward acquiring and deploying interoperable communications systems funded by the grant; and (3) agree to remit to the Assistant Secretary any grant funds that remain unexpended at the end of the 3-year period of the grant.

Grants under this section shall be awarded in the form of a single grant for a period of not more than 3 years. At the end of 3 years, any grant funds that remain unexpended should be remitted by the grantee to the Assistant Secretary, and, may be awarded to other eligible grant recipients. At the end of fiscal year 2010,

any such re-awarded grant funds that remain unexpended shall be remitted by the grantee to the Assistant Secretary and may not be re-awarded to other grantees.

In order to ensure consistency amongst various federal interoperable communications grant programs, the Managers expect the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, to administer the grant program in a manner consistent with the recommended guidance for public safety communications and interoperability grants established by the Office of Grant and Training of the Preparedness Directorate and the SAFECOM Program of the Office for Interoperability and Compatibility of the Science and Technology Directorate of the Department of Homeland Security. In addition, the Managers expect that the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, will ensure that the grants awarded under this program are utilized by public safety agencies in a manner which is consistent with applicable state interoperable communications plans, state and urban area homeland security strategies, and the National Preparedness Goal and accompanying guidance.

Moreover, in order to minimize the paperwork and administrative burden of public safety agencies applying for funds under this grant program, the Managers expect the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, to enable a public safety agency to utilize, to the maximum extent practicable, the identical application such public safety agency may have submitted to the Department of Homeland Security for any interoperable communications funding from the Department of Homeland Security and to take any other steps to minimize the administrative burden of public safety agencies that may be applying both for funds under this grant program and funds for interoperable communications from the Department of Homeland Security.

The Managers intend that grants under this section may be used for the acquisition costs associated with designing an interoperable communications system so that the system is properly engineered based upon the topography, population density, or other characteristics of the area in which the system will operate. The Managers note that there is a diverse array of technological and engineering solutions that enable interoperable communications systems.

The Managers encourage the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, to consider distributing a limited portion of grant funds under this section in a manner that gives priority to those public safety agencies in areas designated as at high risk for natural disasters and threats of terrorism to the agriculture, food, banking, and chemical industries; the defense industrial base; emergency services; energy; government facilities; postal, shipping, public health, health care, information technology, telecommunications, and transportation systems; water; dams; commercial facilities; and national monuments and icons.

Section 3007. NYC 9/11 digital transition

The funding provided under this section, \$30,000,000, would enable New York City broadcasters can build interim facilities to ensure that the New York metropolitan area could receive an adequate digital broadcast signal until the new facilities atop the Freedom tower can be completed. The Managers do not intend this program to alter or affect the FCC's authority with respect to licensing, interference, or other regulation.

Sec. 3008. Low-power television and translator digital to analog conversion

Section 3008 provides funding to facilitate continued service for the viewers of low power television stations over their analog TVs. The Assistant Secretary shall determine the maximum amount of compensation such a low-power television station may receive based on the average cost of such digital-to-analog conversion devices during the time period such low-power broadcast television station purchased the digital-to-analog conversion device, but in no case shall such compensation exceed \$1,000.

Section 3009. Low-power and translator upgrade program

The funding provided under this section would make available \$65,000,000 for a program to convert low-power television stations and television translator stations from analog to digital transmissions.

Sec. 3010. National alert and tsunami warning program

The funding provided under this section, \$156,000,000, will provide for a modern all hazards alert and warning program to provide alerts in response to natural disasters, man-made accidents, and terrorist incidents. The program will encourage, but not mandate, new technologies such as wireless communication devices, satellite radios, and personal computers to enhance the nation's current emergency warning capability. The goal of the program will be to help ensure that regardless of what communication technology an individual relies upon they will get an alert to a threat to public safety.

The funding will be used to develop technologies to allow emergency managers to precisely geographically target their alerts to only populations at risk. Research and development will be encouraged, but not mandated, to be conducted through a cooperative research program with the telecommunications industry. The funds should also be used to provide emergency managers with the tools necessary to input alerts into a national alerting system and have them retransmitted across all appropriate communication mediums. There should be established a procedure to provide credentials to emergency managers who wish to use the system to ensure the integrity of emergency alert communications to the public. The office responsible for managing the system should also ensure that personnel using the system are appropriately trained on how and when to use the system and understand that the system should only be used for grave threats to public safety. Personnel should also be trained to issue alerts that provide the public with information on what to do to protect themselves from the threat.

Section 3011. ENHANCE 911

The funding provided under this section would make available \$43,500,000 in grants to implement the ENHANCE 911 Act of 2004.

Section 3012. Essential air service program

The funding provided under this section would make \$30,000,000 in grants to the Essential Air Service program.

Section 3013. Supplemental license fees

This section provides for additional fees to be assessed by the Federal Communications Commission in the aggregate amount of \$10,000,000 during fiscal year 2006.

TITLE V—MEDICARE

Subtitle A—Part A

Hospital Quality Improvement (Section 5001 of the Conference Agreement, Section 6110 of the Senate Bill and no provision in the House Bill)

Current Law

Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected annual change in the hospital market basket (MB), a measure that estimates price inflation affecting hospitals. Congress establishes the update for Medicare's inpatient prospective payment system (IPPS) for operating costs in acute care hospitals, often several years in advance. Currently, through FY2007, the IPPS operating update has been established as the MB for hospitals that submit specific quality information and as the MB minus 0.4 percentage points for hospitals that do not provide such information. The required data are those ten quality indicators established by the Secretary of the Department of Health and Human Services (the Secretary) as of November 1, 2003. Starting in FY2008, the IPPS update will be the hospital MB. Any MB reduction does not apply when computing the applicable percentage increase in subsequent years.

Outlier payments are intended to protect IPPS hospitals from the risk of financial losses associated with patients with exceptionally high costs or unusually long stays. Medicare cases qualify for outlier payments if they exceed a threshold or fixed loss amount that is established each year. As directed by statute, the total amount of any outlier payments for any year should equal no less than 5 percent nor more than 6 percent of total projected operating diagnosis related group (DRG) payments. Outlier payments are financed by a reduction in the national average standardized amount, typically set at 5.1 percent.

For the purpose of establishing the correct IPPS payment, Medicare discharges are classified into diagnosis related groups (DRGs) primarily on the basis of the diagnosis and procedure code information included on the beneficiary's claim. The information includes the principal diagnosis (or main problem requiring inpatient

care), up to eight secondary diagnoses codes as well as up to six procedures performed during the stay. Medicare pays for inpatient hospital services using per discharge rates that will vary by the DRG (and its calculated weight) to which a patient's stay is assigned. Each DRG weight represents the average resources required to provide care for cases in that specific DRG relative to the average resources used to treat cases in all DRGs. The Center for Medicare and Medicaid Services (CMS) annually reviews the DRG definitions and relative weights to (1) reflect changes in treatment patterns and technology improvements and (2) ensure that cases with clinically similar conditions requiring comparable resources are grouped together.

Under the DRG classification system, certain secondary diagnoses are considered to be complications or comorbidities (CC). When present as a secondary condition (with a specific principal diagnosis), these diagnosis codes are considered to increase the length of stay by at least one day in at least 75 percent of the patients. In FY2006, there are 3,285 diagnosis codes on the CC list. 524 DRGs are used for Medicare payment purposes and 121 paired DRGs are split into higher and lower paid DRGs on the presence or the absence of a CC. CMS has added and deleted codes from the standard list of CCs, but has never conducted a comprehensive review of the list. It is planning to review systematically the CC list for FY2007 Medicare payments.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-2 which establishes the hospital value-based purchasing program for inpatient hospital services, starting FY2007. The program would make value-based payments to hospitals based on data reported under the quality measurement system established by the Secretary. Hospitals paid under Medicare's prospective payment system (PPS) that have substantially improved the quality of care over the prior year or exceeded an established quality threshold would receive a value-based payment as determined by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to hospitals that are receiving such payments for exceeding a quality threshold. Starting in FY2008, the percentage of the total amount for value-based payments in any fiscal year that is paid to such hospitals would be greater than the equivalent percentage paid in the previous year. Hospitals would be required to comply with all the quality data reporting requirements and attest to the accuracy of the data in order to be eligible for a value-based payment. The total amount of value-based payments in a fiscal year would equal the total amount of available funding for such payments for that year. The payments would be based on the methods determined by the Secretary and would be made to hospitals no later than the close of the following fiscal year. No later than January 1, 2007, the Secretary would provide each hospital with a description of how its payments for FY2006 would have been affected had the valuebased payment program been in effect that fiscal year.

Value-based payments in a fiscal year would be made from Medicare's Part A Trust fund and would equal specified reductions

in those trust fund expenditures as established in Section 6110(b) of the bill. Specifically, IPPS outlier payments would be established as no less than 5 percent and no more than 6 percent for fiscal years prior to 2007. In FY2007, outlier payments would be established as no less than 4 percent and no more than 5 percent. In FY2008, outlier payments would be established as no less than 3.75 percent and no more than 4.75 percent. In FY2009, outlier payments would be established as no less than 3.5 percent and no more than 4.5 percent. In FY2010, outlier payments would be established as no less than 3.25 percent and no more than 4.25 percent. In FY2011 and in subsequent years, outlier payments would be established as no less than 3 percent and no more than 4 percent.

The Secretary would be directed to reduce the average standardized amount by certain percentages to fund outlier payments and the hospital value-based purchasing program. The reduction factor would be equal to a calculation where the numerator is the sum of the additional outlier payments (as discussed in the preceding paragraph) plus a specified percentage of total projected DRG prospective payment rates divided by the total projected DRG prospective payment rates. The specific percentages would be 0 percent for fiscal years prior to 2007, 1 percent in FY2007, 1.25 percent in FY2008, 1.5 percent in FY2009, 1.75 percent in FY2010, and 2 percent in FY2011 and in subsequent years.

Acute care hospitals that do not submit required quality data would receive the MB minus 2 percentage points for FY2007 and each subsequent fiscal year. The reduction would apply only with respect to the fiscal year involved and would not be taken into account when computing subsequent updates. The required quality data would be that determined by the Secretary to be appropriate for the measurement of health care quality, including data necessary for the operation of the IPPS hospital value-based purchasing program.

House Bill

No provision.

Conference Agreement

Hospitals that do not submit the required data in FY2007 and each subsequent year will have the applicable MB percentage increase reduced by 2 percentage points. Each IPPS hospital is required to submit data on measures selected by the Secretary in the established form, manner, and specified time. Any reduction applies only to the fiscal year in question and does not affect subsequent fiscal years.

The conference agreement establishes that the Secretary will expand the number of quality indicators required to be reported by acute care hospitals. Beginning October 1, 2006 the Secretary will begin to adopt the baseline set of performance measures set forth in the November 2005 Institute of Medicine report that was required by section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Beginning October 1, 2007, the Secretary will add other measures that reflect consensus among the affected parties. To the extent feasible and practicable,

these measures will include those established by national consensus building entities. The Secretary is permitted to vary and replace any measures in appropriate cases, such as where all hospitals are effectively in compliance or where measures have been shown not to represent the best clinical practice.

The Secretary is required to establish procedures for making the submitted quality data available to the public. These procedures will ensure that a hospital has the opportunity to review the data before they are made available to the public. The Secretary is required to report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to inpatient services on the Internet website of CMS.

The Secretary is required to develop a plan to implement a value-based purchasing program for IPPS payments to acute care hospitals beginning with FY2009. The plan will include consideration of (1) the on-going development, selection, and modification process for measures of quality and resource use in hospital inpatient settings; (2) the reporting, collection, and validation of the data; (3) the structure of value-based payment adjustments such as the determination of thresholds for a payment adjustment, the size of the payment adjustment and the sources of funding for the value-based payments; and (4) the disclosure of information on hospital performance. The Secretary will consult with relevant affected parties and consider experience with applicable demonstration programs.

The Secretary is required to submit a report to Congress on the plan for the value-based purchasing program no later than August 1, 2007. The Medicare Payment Advisory Commission (MedPAC) is required to submit a report with detailed recommendations on the structure of the valued based payment adjustments no later than June 1, 2007. The report will include (1) a determination of thresholds, size of payments, sources of funds, and relationship of payments to quality measures; (2) analyses of hospital efficiency measures such as costs per discharge, related services (including physician services) within an episode of care; and (3) an identification of other changes that are needed within the IPPS payment structure.

Starting for discharges on October 1, 2007, hospitals are required to report any secondary diagnosis codes applicable to patients at their admission. By October 1, 2007, the Secretary is required to identify at least 2 high cost or high volume (or both high cost and high volume) diagnoses codes with a DRG assignment that has a higher payment weight when present with secondary diagnoses. These diagnoses codes represent conditions, including certain hospital acquired infections, that could reasonably have been prevented through the application of evidence-based guidelines. Starting for discharges on October 1, 2008, the DRG assigned to a discharge with the identified diagnosis codes will be the DRG that does not result in higher payments based on the presence of these secondary diagnosis codes. This assignment of the lower paid DRG applies to discharges, where, at the time of the patient's admission, the beneficiary had none of the identified diagnosis codes. Adjustments to the relative weight that occur because of this action are

not budget neutral. Specifically, aggregate payments for discharges in a fiscal year could be changed as a result of such adjustments.

The list of selected diagnosis may be revised from time to time as long as there are at least two conditions selected for discharges occurring during any fiscal year. The Secretary is required to consult with the Centers for Disease Control and Prevention and other appropriate entities when selecting and revising the identified diagnosis codes. The list of diagnosis codes and DRGs are not subject to judicial review.

Clarification of Determination of Medicaid Patient Days for DSH Computation (Section 5002 of the Conference Agreement, no provision in the Senate Bill and no provision in the House Bill)

Current Law

Hospitals that serve a certain number of low income Medicare and Medicaid beneficiaries will receive a disproportionate share hospital (DSH) adjustment that increases their Medicare IPPS payments. Most DSH hospitals receive the additional payments based on their DSH patient percentage which is the proportion of the hospital's total days provided to Medicaid recipients added to the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who are eligible for Part A and receive Supplemental Security Income). After a minimum threshold of 15 percent is met, a hospital's DSH adjustment will vary by the hospital's bed size or urban or rural location.

The policy of whether inpatient days provided to a patient covered under a demonstration project established by Section 1115 waivers could be included in the Medicare DSH calculation has changed over time. Prior to January 20, 2000, hospitals could not include the inpatient hospital days attributable to patients made eligible for Medicaid pursuant to a state's Social Security Act Section 1115 waiver. Starting on January 20, 2000, hospitals could include days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. This policy was corrected for discharge starting on October 1, 2003, when hospital inpatient days attributed to patients who do not receive coverage for inpatient benefits under Section 1115 demonstration projects could not be counted in the Medicare DSH calculation. These policies were established by regulation in January, 2000 and August, 2003.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement permits the Secretary to include inpatient hospital days of patients eligible for medical assistance under a Section 1115 demonstration waiver in the Medicare DSH calculation. These days will be counted as if they were provided to patients who were eligible for medical assistance under an ap-

proved Medicaid state plan. The existing regulations and their effective date are ratified. No hospital cost reports that are closed on the enactment date will be reopened to implement this provision.

Improvements to the Medicare-Dependent Hospital (MDH) Program (Section 5003 of the Conference Agreement, Section 6101 of the Senate Bill, and no provision in the House Bill)

Current Law

Certain rural hospitals with 100 beds or less that have at least 60 percent of its inpatient days or discharges during FY1987 or during two of the three most recently audited cost reporting periods (for which there is a settled cost report) are attributed to patients covered under Medicare qualify for special treatment under the inpatient prospective payment system as Medicare dependent hospitals (MDH). MDH hospitals are paid at national standardized rate or, if higher, 50 percent of their adjusted FY1982 or FY1987 hospital-specific costs. This special treatment will lapse for discharges starting on October 1, 2006.

Certain hospitals that serve a high proportion of Medicaid patients or poor Medicare beneficiaries qualify for a disproportionate share hospital (DSH) adjustment to their inpatient payments. Small urban and most rural hospitals (except for rural referral centers) have their DSH adjustment capped at 12 percent.

Senate Bill

The MDH status for qualifying rural hospitals would be extended through discharges occurring before October 1, 2011. Starting for discharges on October 1, 2006, a MDH would be able to elect payments based of its FY2002 hospital-specific costs if that would result in higher Medicare payments. MDH's payments would be based on 75 percent of their adjusted hospital-specific costs starting for discharges on October 1, 2006. MDH's that qualify for a disproportionate share hospital (DSH) adjustment would not have the adjustment capped at 12 percent.

House Bill

No provision.

Conference Agreement

The conference agreement adopts the Senate provision.

Reduction in Payments to Skilled Nursing Facilities for Bad Debt (Section 5004 of the Conference Agreement, Section 6102 of the Senate Bill, and no provision in the House Bill)

Current Law

Medicare pays for the costs of certain items outside of the Prospective Payment System on a reasonable costs basis. Section 1861(v)(1)(A)(I) of the Social Security Act states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. Under this authority, the Secretary adopted a bad debt policy in 1966. Under this policy, Medicare reimburses certain providers for

debt unpaid by beneficiaries for coinsurance and deductibles. Historically, CMS has reimbursed certain providers for 100 percent of this bad debt. SNFs are among the Medicare entities that are currently being reimbursed for 100 percent of beneficiary's bad debt.

Effective beginning with cost reports starting in FY2001, Medicare began reimbursing hospitals for 70 percent of the reasonable costs associated with beneficiaries' bad debt. In 2003, CMS issued a proposed rule (42 CFR Part 413, Medicare Program; Provider Bad Debt Payment) in which it described its intent to reduce reimbursement of bad debt for certain providers, including SNFs, by 30 percent. Within the rule, CMS explained that it believed that reducing the amount of Medicare debt reimbursement would encourage accountability and foster an incentive to be more efficient in bad debt collection efforts. It also stated that it believed that Medicare bad debt policy should be applied consistently and fairly among all providers eligible to receive bad debt reimbursement.

Senate Bill

The provision would amend Section 1861(v)(1) of the Social Security Act to reduce the payment for the allowable bad debts attributable to Medicare deductibles and coinsurance amounts by 30 percent for services furnished in SNFs on or after October 1, 2005.

House Bill

No provision.

Conference Agreement

The conference agreement reduces payments for allowable bad debts attributable to Medicare coinsurance by 30 percent for those individuals who are not dually eligible for Medicare and Medicaid. Bad debt payments for individuals who are dually eligible for Medicare and Medicaid remain at 100 percent.

Extended Phase-in of the Inpatient Rehabilitation Facility Classification Criteria (Section 5005 of the Conference Agreement, Section 6103 of the Senate Bill, and no provision in the House Bill)

Current Law

Inpatient rehabilitation facilities (IRFs) are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) used to pay short-term general hospitals. The Medicare statute gives the Secretary discretion to establish the criteria that facilities must meet in order to be considered an IRF. Since 1983, CMS has required that a facility must treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. The rule was suspended temporarily and reissued in 2004 with a revised set of qualifying conditions and a transition period for the compliance threshold as follows: at 50 percent from July 1, 2004 and before July 1, 2005; at 60 percent from July 1, 2005 and before July 1, 2006; at 65 percent from July 1, 2006 and before July 1, 2007; and at 75 percent from July 1, 2007 and thereafter. In April 2005, the Government Ac-

countability Office issued a final report recommending that the Centers for Medicare and Medicaid Services (CMS) refine the rule to describe more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors in addition to condition, to help ensure that IRFs can be classified appropriately and that only patients needing IRF services are admitted.

Senate Bill

The provision would establish the compliance threshold at 50 percent from July 1, 2005 through June 30, 2007. The Secretary would not be permitted to change the designation of an IRF that is in compliance with that threshold. The Secretary would be required to restore the status of a facility as an IRF from July 1, 2005 through the effective date of this provision because of not meeting the 60 percent threshold. The Secretary would be required to make appropriate payments to those facilities. IRFs that failed to meet the 50 percent compliance threshold would be deemed to meet that threshold while an additional 6 months of claims data is examined. If the review of the new data indicates that the IRF is not in compliance with the 50 percent threshold, the IRF's deemed status would be revoked retroactively to the beginning of the 6 month period. The Secretary would collect any overpayments made to the IRF. The Inspector General would be required to analyze the types of patients treated in IRFs that have a compliance rate between 50 percent and 60 percent. A report would be submitted to Congress and the Secretary by January 1, 2005. A Rehabilitation Advisory Council would be established until September 30, 2010 to provide advice and recommendations concerning coverage of rehabilitation services under the Medicare program.

House Bill

No provision.

Conference Agreement

The conference agreement establishes the compliance threshold at 60 percent during the 12-month period beginning on July 1, 2006; at 65 percent during the 12-month period beginning on July 1, 2007; and at 75 percent beginning on July 1, 2008 and subsequently. The conferees encourage CMS to conduct additional research and study on this issue.

Development of a strategic plan regarding physician investment in specialty hospitals (Section 5006 of the Conference Agreement, Section 6104 of the Senate Bill, and no provision in the House Bill)

Current Law

Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Section 507 of the

Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) established that the exception for physician investment and self-referral would not extend to specialty hospitals for a period of 18-months from enactment (or until June 8, 2004). In this instance, a specialty hospital is primarily or exclusively engaged in the care and treatment of patients with a cardiac condition, an orthopedic condition, those receiving a surgical procedure, or other specialized category of patient or cases that the Secretary designates as inconsistent with the purpose of permitting physician investment in a hospital. A specialty hospital does not include any hospital that is determined by the Secretary to be in operation or under development as of November 18, 2003, with the same number of physician investors as of such date that meets other specified requirements. For instance, an increase in the number of beds could only occur on the main campus of the hospital and could not exceed the greater of 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds. The Secretary was directed to consider the certain factors in determining whether a hospital is under development, such as the completion of architectural plans, and the status of funding, zoning requirements, and necessary approvals from State agencies.

Senate Bill

The prohibition on Medicare and Medicaid referrals to specialty hospitals by physician investors would be effective on and after December 8, 2003. The exception to the definition of specialty hospital would be modified to include those: (1) where the percent investment by physician investors is no greater than the percentage on June 8, 2005; (2) where the percent investment by any physician investor is no greater than the percentage on June 8, 2005; and (3) where the number of operating rooms is not greater than the number on June 8, 2005. The existing requirement concerning permissible changes in the number of beds in order to qualify for the specialty hospital exception would be modified. From December 8, 2003 through June 7, 2005, an acceptable increase in the number of beds would only occur on the main campus of the hospital and could not exceed the greater of 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds. After June 8, 2005, the number of beds at the specialty hospital would not be able to increase. These amendments would be effective on June 8, 2005.

House Bill

No provision.

Conference Agreement

The conference agreement directs the Secretary to develop a strategic and implementing plan regarding physician investment in specialty hospitals that addresses issues related to proportionality of investment return, bona fide investments, annual disclosure of investment information, and the provision of Medicaid and charity care by specialty hospitals. An interim report is due within three months and a final report no later than six months after date of enactment. The Secretary will continue the suspension on enroll-

ment of new specialty hospitals until the earlier of the date of submission of the report or 6 months after date of enactment. If the Secretary fails to comply with the statutory requirement to submit the final report within the six month time period, then the suspension on enrollment will be extended an additional two months. In developing the strategic and implementing plan the Secretary may waive certain requirements under the Administrative Procedures Act.

Medicare demonstration projects to permit gainsharing arrangements (Section 5007 of the Conference Agreement, no provision in the Senate Bill, and no provision in the House Bill)

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement establishes a gainsharing demonstration project to test and evaluate arrangements between hospitals and other providers, including physicians, and practitioners, that govern the utilization of inpatient hospital resources to improve the quality and efficiency of care provided to Medicare beneficiaries and to improve operational efficiency and performance. The Secretary will solicit applications 90 days after enactment, will approve not more than 6 demonstration projects with at least 2 of which will be in a rural area, and will begin on January 1, 2007.

The projects will meet certain requirements to maintain or improve quality while achieving cost savings. Such requirements include arrangements that provide remuneration as a share of savings, a written plan agreement, patient notification, quality and efficiency monitoring, independent review, and referral limitations. Restrictions on incentive payments in a project are waived, and similar protections extend to existing arrangements.

Not later than December 1, 2006, the Secretary will report to Congress on the number of demonstration projects. Not later than December 1, 2007, the Secretary will provide a project update to Congress including improvements toward quality and efficiency. By December 1, 2008, the Secretary will report to Congress on quality improvement and savings from the program. A final report will be submitted to Congress by May 1, 2010.

Post-acute care payment reform demonstration (Section 5008 of the Conference Agreement, no provision in the Senate Bill, and no provision in the House Bill)

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

By January 1, 2008, the Secretary shall establish a demonstration program to better understand costs and outcomes across different post-acute care sites. Under the program, for certain diagnoses specified by the Secretary, an individual receiving treatment for such diagnosis shall receive a comprehensive assessment on the date of discharge of clinical characteristics and patient needs, to determine appropriate placement of the patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute sites, to measure functional status and other factors during treatment and discharge from each provider. Participants shall provide information on the fixed and variable cost for each individual, and an additional comprehensive assessment shall be provided at the end of the individual's episode of care. The program will operate for a three year period, and shall be conducted with sufficient numbers to determine statistically reliable results.

No later than 6 months after the end of the program, the Secretary will submit a report to Congress on results and recommendations.

Subtitle B—Provisions Relating to Part B

CHAPTER 1—PAYMENT PROVISIONS

Beneficiary Ownership of Certain DME (Section 5101 of the Conference Agreement, Sections 6109 and Section 6116 of Senate Bill, no provision in the House Bill)

Current Law

Medicare Part B pays for certain items of durable medical equipment such as hospital beds, nebulizers and power-driven wheelchairs under the capped rental category. Most items in this category are provided on a rental basis for a period that cannot exceed fifteen months. After using the equipment for ten months, beneficiaries must be given the option of purchasing it effective thirteen months after the start of the rental period. If they choose the purchase option, the title to the equipment is transferred to beneficiaries. If the purchase option is not chosen, the supplier retains ownership of the equipment. Beneficiaries can continue to use it, but Medicare rental payments to the supplier are terminated. In the case of a power-driven wheelchair, the supplier must offer the beneficiary the option of purchasing the equipment when it is first furnished.

Medicare payments to suppliers for maintenance and servicing differ based on whether the beneficiary has purchased the equipment or whether the supplier continues to own it. In the case of a purchase agreement, payment for repairs and extensive maintenance recommended by the manufacturer is covered. When the

equipment remains in the ownership of the supplier and continues to be used by a beneficiary after the fifteen month rental period, Medicare makes a payment to the supplier every six months for servicing and maintenance regardless of whether any maintenance and servicing is performed.

Senate Bill

The Senate bill would require the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a thirteen month rental period. The option for a fifteen month rental period with the supplier retaining ownership of the item would be eliminated. The option for beneficiaries to purchase power-driven wheelchairs when initially furnished would be retained.

Automatic payments to the supplier every six months for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier's or manufacturer's warranty) would only be made if the Secretary determined them to be reasonable and necessary. This amendment would apply to items for which the first rental month occurred on or after January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill. The provisions apply to items for which the first rental month occurs on or after January 1, 2006.

The agreement further provides that rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after a 36 month rental period. After transfer of the title, monthly payments for oxygen contents (in the case of gaseous and liquid oxygen) will continue to be made, as provided for under current law, for the period of medical need. Payments for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) will be made if the Secretary determines them to be reasonable and necessary. The agreement specifies that the provision takes effect on January 1, 2006. In the case of an individual receiving oxygen equipment as of December 31, 2005, the 36-month period begins January 1, 2006.

Adjustments in Payments for Imaging Services (Section 5102 of the Conference Agreement, no provision in the Senate Bill and no provision in the House Bill)

Current Law

Medicare has a long-standing policy of reducing payment for multiple surgical procedures performed by the same physician, on the same patient on the same day. Full payment is made for the highest priced procedure, with any subsequent procedure paid at

50 percent. In 1995, the policy was extended to certain nuclear medicine diagnostic procedures.

Under the physician fee schedule, diagnostic imaging procedures are priced as follows: (1) the professional component (PC) represents the physician work, i.e. the interpretation; (2) the technical component (TC) represents practice expenses including clinical staff, supplies, and equipment; and (3) the global service which represents both the PC and TC. Diagnostic imaging services, even those paid on contiguous body parts, are generally paid at 100 percent for each procedure.

In its March 2005 report, Medicare Payment Policy, the Medicare Payment Advisory Commission recommended that CMS expand its coding edit policy to help the program pay more accurately for multiple imaging services performed during the same encounter. It noted that a number of private plans use coding edits to adjust payments for multiple imaging services performed on contiguous body parts. Private insurers usually pay the full amount for the first service but a reduced amount (usually half) for the technical component of any additional study that is of the same modality. This is based on the premise that there are savings in clerical time, preparation, and supplies.

In August 2005, CMS issued its proposed physician fee schedule for 2006 (Federal Register, vol. 70, no. 151, 45764–46064). CMS noted that its analysis supported a 50 percent reduction in the TC for the subsequent imaging procedure performed on contiguous body parts. It did not propose to apply the multiple procedure reduction to PC services because it believed that physician work is not significantly affected for multiple procedures. When a global service code is billed, the TC portion, but not the PC portion, would be reduced. CMS identified 11 families of imaging procedures by imaging modality. It recommended extending the multiple procedure TC payment reduction only to procedures involving contiguous body parts within a family of codes, not across families.

On November 21, 2005, CMS issued its final physician fee schedule regulation for 2006 (Federal Register, vol 70, no. 223, 70116–70476). It retained the proposed reduction with modifications. The payment reduction is to be phased in with a 25 percent reduction in 2006 and a 50 percent reduction in 2007. Further, the budget neutrality adjustment is to be applied only to practice expense relative value units rather than to both work and practice expense relative value units.

When the Secretary revises the relative values for the work, practice expense and malpractice components of physician payments, the revisions may not change the amount of physician expenditures by more than \$20 million. Thus, changes must be budget neutral. When reducing practice expenses for imaging, the Secretary is required to increase practice expenses for other physician services to maintain budget neutrality.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement specifies that, effective for fee schedules established beginning with 2007, the reduced expenditures attributable to the multiple procedure payment reduction for imaging (under the final rule published November 21, 2005) will not be taken into account for purposes of the budget neutrality calculation for fee schedules for 2006 and 2007.

The agreement further provides that for specified imaging services furnished on or after January 1, 2007, the technical component (including the technical component of the global fee) for a service will be reduced if it exceeds (without regard to the geographic wage adjustment factor) the outpatient department (OPD) fee schedule amount for the service established under the prospective payment system for hospital outpatient departments. In such cases, the Secretary will provide for the use of that OPD amount, adjusted by the geographic adjustment factor under the physician fee schedule. The services this policy applies to are: imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy. Not included are diagnostic and screening mammography. This change will not be taken into account for purposes of the budget neutrality calculation beginning in 2007.

This provision moves toward payment neutrality across sites of service delivery.

Limitation on Payments for Procedures in Ambulatory Surgical Centers (Section 5103 of the Conference Agreement, no provision in the Senate Bill, and no provision in the House Bill)

Current Law

Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ambulatory care surgery center (ASC). The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. CMS maintains a list of approved ASC procedures which is required to be updated every two years. The approved ASC procedures are categorized into one of nine payment groups that comprise the ASC facility fee schedule. The nine payment rates reflect the national median cost of procedures in that group adjusted to reflect geographic price variation.

The Secretary is required under the MMA to implement a new payment system for ASCs no later than January 2008.

Medicare reimbursement for hospital outpatient department (OPD) services is based on a fee schedule established by a separate prospective payment system (OPPS). Under OPPS, the unit of payment is the individual service or procedure as assigned to an ambulatory payment classification (APC). The payment rate for each service is determined by multiplying the relative weight for the service's APC by the conversion factor.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

Beginning on January 1, 2007, when the ASC facility payment (without application of any geographic price differences) is greater than the Medicare OPD fee schedule amount established under OPPS (without application of any geographic adjustment) for the same service, the ASC will be paid the OPD fee schedule amount. This adjustment applies to ASC payments until the revised ASC payment system is implemented. Total payments to ASCs will be held budget neutral between the year prior to implementation of the new payment system and the first year of the new payment system.

This provision moves toward payment neutrality across sites of service delivery.

Update for Physicians' Services for 2006 (Section 5104 of the Conference Agreement, Section 6105 of Senate Bill, and no provision in the House Bill)

Current Law

Medicare payments for services of physicians and certain non-physician 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 2005 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) 10-year rolling average change in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations.

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

occur in 2003 and 2004; however, the MMA prevented this from occurring through 2005. A negative 4.4 percent update is slated to occur in 2006.

Senate Bill

The Senate bill would specify that the update to the conversion factor in 2006 could not be less than one percent. The provision would further specify that these amendments would not be considered as a change in law for purposes of calculating the SGR.

House Bill

No provision.

Conference Agreement

The conference agreement specifies that the update for 2006 is zero percent. These amendments are not considered as a change in law for purposes of calculating the SGR.

MedPAC is required to report to Congress by March, 2007 on mechanisms to replace the Sustainable Growth Rate system.

Three-year Transition of the Hold Harmless Payments for Small Rural Hospitals Under the Prospective Payment System For Hospital Outpatient Department Services (Section 5105 of the Conference Agreement, Section 6106 of the Senate Bill, and no provision of the House Bill)

Current Law

The prospective payment system for services provided by hospital outpatient departments (OPD) was implemented in August 2000 for most acute care hospitals. Under hold harmless provisions, as modified by the MMA, rural hospitals with no more than 100 beds and sole community hospitals (SCH) located in rural areas are paid no less under this payment system than they would have received under the prior reimbursement system for covered OPD services provided before January 1, 2006.

Senate Bill

The hold harmless provisions governing OPD reimbursement for small rural hospitals and rural SCH would be extended to January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement establishes that small rural hospitals (with no more than 100 beds that are not SCHs) can receive additional Medicare payments, if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals will receive 95 percent of the difference between the prospective payment system and the prior reimbursement system. The hospitals will receive 90 percent of the difference in CY2007 and 85 percent of the difference in CY2008

On November 10, 2005, CMS issued its final hospital outpatient prospective payment system regulation for CY2006 (Federal Register, vol. 70, no. 217, 68516–68980). Under this rule, rural sole community hospitals will receive a 7.1 percent increase on January 1, 2006.

Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services (Section 5106 of the Conference Agreement, Section 6107 of the Senate Bill, no provision in the House Bill)

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 the Inspector General Report.

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.

Senate Bill

The provision would increase the composite rate component of the basic case-mix adjusted system for services beginning January 1, 2006 by 1.6 percent above the amount paid for such services furnished on December 31, 2005.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill.

Revisions to Payments for Therapy Services (Section 5107 of the Conference Agreement, Section 6108 of Senate Bill and no provision in the House Bill)

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 sec-

ond 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 are slated to go into effect beginning January 1, 2006. In the November 2005 final physician fee schedule regulation for 2006 CMS announced that the caps would be \$1,740 in 2006.

Senate Bill

The Senate bill would extend the moratorium for an additional year, through 2006.

House Bill

No provision.

Conference Agreement

The conference agreement would not extend the therapy cap moratorium. However, the Secretary would be required 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, may request an exception from the physical therapy/speech language pathology and occupational therapy caps. The individual may obtain such exception if the provision of services is determined medically necessary. If the Secretary does not make a decision on a request within 10 business days of receipt, the Secretary is deemed to have found the services medically necessary. The provision may be implemented by program instruction or otherwise. The agreement specifies that there can be no administrative or judicial review of the exceptions process (including establishment of the process).

The agreement requires the Secretary, by July 1, 2006, to implement clinically appropriate coding edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments. The edits are to include edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

CHAPTER 2—MISCELLANEOUS

Accelerated Implementation of Income-Related Reduction in Part B Premium Subsidy (Section 5111 of the Conference Agreement, no provision in the Senate Bill, no provision in the House Bill)

Current Law

The MMA increased the Part B premiums for higher income enrollees beginning in 2007. In 2007, individuals whose modified

adjusted gross income (AGI) exceeds \$80,000 and couples whose modified AGI exceeds \$160,000 will be subject to higher premium amounts. The increase will be phased-in over five years. During the first year, higher income enrollees will pay premiums ranging from 27 percent to 36 percent of the value of Part B. When fully phased-in, higher income individuals will pay premiums ranging from 35 percent to 80 percent of the value of Part B.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The agreement accelerates the phase-in period from five years to three years, with the provision fully effective in 2009. In 2007, higher income enrollees will pay total premiums ranging from 28 percent to 43 percent of the total value of Part B. In 2008, enrollees will pay total premiums ranging from 32 percent to 62 percent of the total value of Part B. When fully phased-in in 2009, higher income individuals will pay total premiums ranging from 35 percent to 80 percent of the total value of Part B.

Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (Section 5112 of the Conference Agreement, Section 6117 of the Senate Bill and no provision in the House Bill)

Current Law

Medicare provides coverage for services which are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. In addition, Medicare covers certain preventive services specified in law.

Senate Bill

The Senate bill would authorize Medicare coverage of ultrasound screening for abdominal aortic aneurysms for individuals who: (1) received referrals for such screenings as a result of an initial preventive physical exam performed for new Medicare enrollees; (2) who had not previously had such a test covered by Medicare; and (3) who had a family history of abdominal aortic aneurysms or who manifested risk factors included in a beneficiary category (not related to age) identified by the United States Preventive Services Task Force.

An ultrasound screening for abdominal aortic aneurysms would be defined as a procedure using sound waves provided for the early detection of abdominal aortic aneurysms. The Secretary could specify other procedures using alternative technologies which were of commensurate accuracy and cost. The term would include the physician's interpretation of the results of the procedure. Ultrasound screening for abdominal aortic aneurysms would be included in the package of services (including related education, counseling and referral) provided in the initial preventive service exam offered to new Medicare enrollees.

Payment for services would be made under the physician fee schedule. The provision would specify that payment would not be made for screenings performed more frequently than specified above. The Part B deductible would not apply to these services.

The Secretary would be required to establish quality assurance standards, in consultation with national medical, vascular technologist and sonographer societies, with respect to individuals (other than physicians) performing ultrasound screening for abdominal aortic aneurysms and diagnostic laboratories. Such standards would specify that the individual or laboratory was certified by the appropriate state licensing or certifying agency or (in the case of a state which did not license or certify such individuals or laboratories) by a national accreditation agency recognized by the Secretary. Medicare payment would not be made where individuals or laboratories performing the screening did not meet the quality assurance standards.

The bill would require the Secretary (after consultation with national medical, vascular technologist and sonographer societies) to conduct a national education and information campaign to promote awareness among health care practitioners and the general public with respect to the importance of early detection and treatment of abdominal aortic aneurysms. The section would authorize the appropriation of such funds as may be necessary, beginning in FY 2006 and each fiscal year thereafter. The Secretary could use such amounts to make grants to national medical, vascular technologist and sonographer societies to enable them to educate practitioners and providers about matters relating to such aneurysms. Such grants would be made in accordance with procedures and criteria specified by the Secretary.

The amendments would apply to ultrasound screenings for abdominal aortic aneurysms performed on or after January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill with modifications. The agreement does not specify that beneficiary categories recommended for screening cannot include categories related to age. The agreement does not provide for the development of quality assurance standards. Further, it does not include the national education and information campaign.

Improving Patient Access to, and Utilization of, Colorectal Cancer Screening Under Medicare (Section 5113 of the Conference Agreement, Section 6118 of the Senate Bill and no provision in the House Bill)

Current Law

Medicare covers certain cancer screening tests, subject to coverage limitations based on the type of test and the individual's level of risk. Covered tests are fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy, and barium enema. Payments for services are made under the physician fee schedule

which assigns relative values to services based on physician work, practice expense costs, and malpractice costs. The relative values are then adjusted for geographic variations in costs. These adjusted relative values are converted into dollar payment amounts by a conversion factor.

The Secretary is required to review and adjust relative values for specific services periodically, and has established a process for this review and adjustment.

Senate Bill

The Senate bill would require the Secretary to establish minimum payment amounts for CPT codes 45378 (diagnostic colonoscopy), 45380 (colonoscopy and biopsy), and 45385 (lesion removal, colonoscopy) and HCPCS codes G0105 (colorectal screen, high risk individual) and G0121 (colon cancer screen, not high risk individual) for items and services furnished after January 1, 2007. The amounts would reflect a 5 percent increase above the relative value units in effect as the non-facility rates for such codes on December 31, 2006; the revised payment levels would apply to items and services furnished in non-facility settings. Similarly, the provision would require the Secretary to establish minimum payment amounts for the same CPT and HCPCS codes for items and services furnished after January 1, 2007 which would reflect a 5 percent increase above the relative value units in effect as the facility rates for such codes on December 31, 2006; the revised payment levels would apply to items and services furnished in facility settings. The payment amounts would be adjusted annually in accordance with the payment update rules under the fee schedule. The Secretary would not take into account the revised payment amounts in determining the amount of payment under the prospective payment system for covered hospital outpatient department services.

The bill would also authorize Medicare coverage for an office visit or consultation prior to a screening colonoscopy or in connection with a beneficiary's decision to obtain such a screening. The visit or consultation would be for the purpose of beneficiary education, assuring selection of the proper screening test, and securing information relating to the procedure and sedation of the beneficiary. The visit or consultation would be covered regardless of whether the screening was medically indicated for the beneficiary. Payments would equal 80 percent of the lesser of the actual charge or the amount established under the physician fee schedule. Payment amounts established under the fee schedule would be consistent with those established for CPT codes 99203 (office/outpatient visit, new patient) and 99243 (office consultation). The provision would apply to services furnished on or after January 1, 2007.

The Part B deductible would not apply to colorectal cancer screening tests, effective January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement only includes the Senate provision waiving the Part B deductible.

Delivery of Services at Federally Qualified Health Centers (Section 5114 of the Conference Agreement, Section 6115 of the Senate Bill, and no provision in the House Bill)

Current Law

The Omnibus Budget Reconciliation Act (OBRA) of 1989 amended the Social Security Act (SSA) to create a new category of facility under Medicare and Medicaid known as a federally qualified health center (FQHC). An FQHC is required to provide certain primary care services by physicians and appropriate mid-level practitioners as well as other preventive health services including those required under certain sections of the Public Health Service (PHS) Act (specifically Sections 329, 330, and 340 of the PHS).

Prior to the enactment of MMA, FQHC services were covered by a skilled nursing facility's (SNF) consolidated billing requirement. FQHC services were bundled into the SNF comprehensive per diem payment for the covered stay and not separately billable. MMA specified that a SNF Part A resident who receives FQHC services from a physician or appropriate practitioner would be excluded from SNF consolidated billing and be paid separately.

Senate Bill

The provision would add diabetes self-management training and nutrition therapy benefits, as covered under Medicare, as additional services that may be covered under the all-inclusive per visit payment rate for FQHCs. It would allow FQHCs to receive payments for services provided through a health care professional who contracts with the center and would remove restrictions on receipt of homeless grants.

House Bill

No provision.

Conference Agreement

The conference agreement adopts the Senate provision.

Waiver of Part B Late Enrollment Penalty for Certain International Volunteers (Section 5115 of the Conference Agreement, Section 6114 of the Senate Bill and no provision in the House Bill)

Current Law

Medicare Part B is a voluntary program. Individuals generally enroll in Part B when they turn 65. Individuals who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10 percent of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of the surcharge that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B. The law establishes

certain exceptions to the delayed enrollment penalty. One exception applies to the “working aged.” Delayed enrollment is also permitted for certain disabled persons who have group health insurance coverage based on their own or a family member’s current employment with a large group health plan.

Individuals who are permitted to delay enrollment have their own special enrollment periods. A special enrollment period begins when current employment ends or when coverage under the plan ends. The special enrollment period ends eight months later. Individuals who fail to enroll in this period are considered to have delayed enrollment and could become subject to the penalty.

Senate Bill

The Senate bill would permit certain individuals to delay enrollment in Part B without a delayed enrollment penalty. Those individuals who volunteer outside of the United States for at least 12 months through a program sponsored by a tax-exempt organization defined under section 501(c)(3) of the Internal Revenue Code would be permitted to delay enrollment under Medicare Part B. They would have a 6 month special Part B enrollment period beginning on the first day of the month the individual was no longer in the program. Coverage would begin the month after the individual enrolled. This section would apply to months and special enrollment periods beginning January 2007.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill with a modification. The provision applies to individuals who can demonstrate health insurance coverage while volunteering outside the United States..

Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services Under Part B of the Medicare Program (No provision in the Conference Agreement, Section 6119 of the Senate Bill and no provision in the House Bill)

Current Law

Medicare provides coverage for mental health services, subject to certain limitations. Medicare Part B will make direct payments to physicians, psychologists, and clinical social workers for such services. Medicare does not make direct payments for services provided by marriage and family therapists and mental health counselors. Their services are generally paid as incident to a physician’s professional services. They may also be included as part of covered facility services such as those provided by a skilled nursing facility.

Senate Bill

The Senate bill would include “marriage and family therapist services” and “mental health counselor services” within the definition of “medical and other health services” covered under Medicare Part B. The term marriage and family therapist services would be

defined as services performed by marriage and family therapists for the diagnosis and treatment of mental illnesses. Such services would be those which the individual was legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which the services were performed. Such services would also have to be of the type which would otherwise be covered if furnished by a physician or as incident to a physician's professional services. Payment would only be made if no facility or other provider charged or was paid for such services.

The term marriage and family therapist would be defined as an individual who: (1) possessed a master's or doctoral degree which qualified the individual for licensure or certification as a marriage and family therapist pursuant to state law; (2) performed at least 2 years of clinical supervised experience in marriage and family therapy after obtaining the degree; (3) was licensed or certified as a marriage and family therapist in the state if such state provided for licensure and certification of marriage and family therapists.

The provision would define mental health counselor services as services performed by mental health counselors for the diagnosis and treatment of mental illnesses. Such services would be those which the individual was legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which the services were performed. Such services would also have to be of the type which would otherwise be covered if furnished by a physician or as incident to a physician's professional services. Payment would only be made if no facility or other provider charged or was paid for such services.

The term mental health counselor would be defined as an individual who: (1) possessed a master's or doctoral degree in mental health counseling or a related field; (2) performed at least 2 years of supervised mental health counselor practice after obtaining the degree; (3) was licensed or certified as a mental health counselor or professional counselor in the state if such state provided for licensure and certification of mental health counselors or professional counselors.

Payment for covered services would be made under Medicare Part B. Payment would equal the lesser of 80 percent of the actual charge for the service or 75 percent of the amount paid to a psychologist for such services. All services provided by marriage and family therapists and mental health counselors would be paid on an assignment basis. Further, services provided by marriage and family therapists and mental health counselors would be added to the list of services excluded from payment as part of the skilled nursing facility prospective payment system.

The bill would include services provided by marriage and family therapists and mental health counselors in the definition of covered rural health clinic services. It would modify the definition of the required interdisciplinary team for a hospice program to permit a marriage or family therapist to be on the team instead of a social worker.

The provision would apply to services provided on or after January 1, 2007.

House Bill

No provision.

Conference Agreement

No provision.

Subtitle C—Provisions Relating to Parts A and B

Home Health Payments. (Section 5201 of the Conference Agreement, Section 6110 of the Senate Bill—with respect to quality of home health services, and no provision in the House Bill)

Current Law

The Medicare home health prospective payment system, which was implemented on October 1, 2000, provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index.

Each year Medicare's payment to home health agencies is updated by the projected annual change in the home health market basket (HHMB), with specified reductions in some years. For the last three calendar quarters of 2004 through 2006, the home health update is the HHMB minus 0.8 percentage points. In 2007 and subsequent years, the payment update for home health agencies is equal to the full HHMB.

The Medicare Prescription Drug Improvement and Modernization act of 2003 provided for a one-year 5 percent additional payment for home health services furnished in rural areas. The temporary payment began for episodes and visits ending on or after April 1, 2004 and before April 1, 2005. It was made without regard to certain budget neutrality provisions and was not included in the base for determination of payment updates.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-6 which establishes the Home Health Agency Value-Based Purchasing Program. In 2008 and in subsequent years, the Secretary would make value-based payments to those home health agencies that, based on data submitted under the quality measurement system, have either substantially improved quality of care over the prior year, or exceed a threshold established by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to home health agencies that qualify for payments because they exceed a quality threshold. Starting in 2009 and in each subsequent year, the percentage of total value-based payments made to agencies that exceed the quality threshold would be greater than the percentage made in the previous year. To be eligible for a value-based payment, home health agencies would be required to submit the required quality data and attest that it is complete and accurate.

The total amount of value-based payments made in a year would equal the total funds available for such payments. The Secretary would determine the most appropriate method for making

payments. Payments for a year would be required to be made no later than December 31 of the subsequent year. By January 1, 2008, the Secretary would be required to provide each home health agency with a description of how its payments for 2007 would have been affected had the value-based purchasing system been in effect that year.

Value-based payments would be made from Part A and Part B in the same proportion as payments for home health services are made.

In 2007 and subsequent years, a home health agency that does not submit to the Secretary the required quality data would receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. For 2007 and subsequently, each home health agency would be required to submit data necessary for a value-based purchasing system in the form, manner, and time period specified by the Secretary. Procedures for making the data available to the public would be established.

To fund the program, spending under the trust funds for home health services would be reduced by a percent applied to the standard prospective payment amount made to all agencies that comply with the data submission requirements. The percent reduction would be 1 percent in 2008, 1.25 percent in 2009, 1.5 percent in 2010, 1.75 percent in 2011, and 2 percent in 2012 and subsequent years.

House Bill

No provision.

Conference Agreement

The conference agreement eliminates the update for home health payments in 2006. It also provides for a one-year 5 percent additional payment for home health episodes or visits furnished in a rural area during calendar year 2006.

The Conference agreement accepts the Senate language with respect to (1) the collection of health care quality data, as determined appropriate by the Secretary, (2) procedures for making the data available to the public, and (3) the reduction of payments to home health agencies that do not submit quality data in 2007 and beyond. The reduction in payments is equal to the market basket minus two percentage points. However the reduction will not be taken into account for calculation of the payment rate in subsequent years.

The conference agreement directs the Medicare Payment Advisory Commission to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services. The report is to include recommendations on the structure of the program, the determination of thresholds, the size of value-based payments, sources of funds, and the relationship of payments for improvements in health care quality.

Revision of Period for Providing Payment for Claims that are not Submitted Electronically (Section 5202 of the Conference Agreement, no provision in the Senate Bill, and no provision in the House Bill)

Current Law

Mandatory electronic claims submission went into effect on July 1, 2005 for all providers, with a few exceptions. The exceptions include: (1) small providers with fewer than 25 full-time equivalent (FTEs) employees and physicians, practitioners, or suppliers with fewer than 10 FTEs, (2) dentists, and (3) other providers as specified by the Centers for Medicare and Medicaid Services (CMS). Medicare contractors must pay 95 percent of all “clean” paper claims within 27–30 days of receipt.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The Conference agreement directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors are directed to pay 95 percent of all “clean” claims within 29–30 days of receipt for paper claims.

Timeframe for Part A and B Payments (Section 5203 of the Conference Agreement, Section 6112(b) of the Senate Bill, and no provision in the House Bill)

Current Law

Medicare contractors accept, process and pay claims submitted by providers for Medicare-covered services. Medicare contractors must pay interest on claims that are not promptly paid. The contractors must pay 95 percent of all “clean” claims within 14–30 days of receipt for electronically submitted claims, or within 27–30 days of receipt for paper claims. If the payment is not made within that time, interest begins accruing on the day after the required payment date and ends on the date on which the payment is made. The interest rate is set at the higher of the “private consumer rate,” or the “current value of the funds.”

Senate Bill

The Senate bill would delay Medicare Part A and B payments by 9 days. Claims that would otherwise be paid on September 22, 2006, through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individuals for any delay in a payment during the period.

House Bill

No provision.

Conference Agreement

The conference agreement accepts the Senate provision.

Medicare Integrity Program Funding (Section 5204 of the Conference Agreement, no provision in the Senate Bill and no provision in the House Bill)

Current Law

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress acted to increase and stabilize federal funding for anti-fraud activities. As required by Section 1817(k) of the Medicare law, an expenditure account was established within the Federal Hospital Insurance Trust Fund (the HCFAC account). Certain amounts were appropriated from the Trust Fund for specific activities, including the Medicare Integrity Program (MIP). These amounts have been established as not less than \$710 million and not more than \$720 million for FY2002 and subsequently.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement would increase MIP funding amounts by \$100 million for FY2006.

Subtitle D—Provisions Relating to Part C

Phase-out of risk adjustment budget neutrality in determining the amount of payments to Medicare Advantage organizations. (Section 5301 of the Conference Agreement, Section 6111 of the Senate Bill, and no provision in the House Bill)

Current Law

Medicare Advantage payment rates are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. Rates are adjusted by demographic and health status indicators. In the report language to the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Congress urged the Secretary to implement a more clinically-based risk adjustment methodology without reducing overall payments to plans. To keep payments from being reduced overall, the Secretary applied a budget neutrality adjustment to the risk adjusted rates. However, the Secretary has proposed to phase-out the budget neutrality adjustment citing studies that show a difference in the reported health status of Medicare Advantage enrollees compared to the reported health status of beneficiaries in traditional Medicare.

Senate Bill

Beginning in 2007, this section would specify an adjustment to the benchmarks to phase-out overall increases in MA rates that result from the budget neutral implementation of risk adjustment. In

2007, if the Secretary does not rebase rates to 100 percent of per capita fee-for-service costs, the MA benchmarks would be equal to the 2006 rates as announced by the Secretary on April 4, 2005, with four adjustments—(1) exclusion of any national adjustments for coding intensity, (2) exclusion of risk adjustment budget neutrality, (3) increase based on the national per capita MA growth percentage, and (4) omission of any adjustments to account for errors in previous years' projections of the national per capita MA growth percentage. If the Secretary does rebase the rates in 2007, the MA benchmark would be set at the greater of either the rate calculated above, or 100 percent of per capita fee-for-service spending in the area. After 2007, if the Secretary does not rebase rates, the MA benchmarks would be the previous year's benchmark increased by the national per capita MA growth percentage without adjusting for errors in the estimation of the growth percentage for a year before 2004. After 2007, if the Secretary rebases rates, the benchmark would be equal to the greater of either the rate calculated above, or 100 percent of per capita fee-for-service spending.

The benchmarks described above would be free of the budget neutral risk adjustment. However, the benchmarks would be adjusted so that budget neutrality would be phased-out over 4 years. The applicable phase-out factors would be equal to .55 in 2007, .40 in 2008, .25 in 2009 and .05 in 2010. This means that in 2007, 55 percent of the payment to plans would be based on payment rates including the budget neutral risk adjustment, and 45 percent of the payment to plans would be based on a rate without the budget neutral adjustment. The budget neutrality factor is calculated through a formula that equals the Secretary's estimate of the total amount of payments that would have been made to plans under the demographic risk adjustment system, minus the Secretary's estimate of the payments that would have been made to plans under the health status risk adjustment system without the budget neutrality adjustment, divided by the Secretary's estimate of the total amount of payments that would be made under the health status risk adjustment system without the budget neutrality adjustment. When making this calculation, the Secretary would (a) use a complete set of the most recent and representative MA risk scores available, (b) adjust the risk scores to reflect changes in treatment and coding practices in fee-for-service, and (c) adjust the risk scores for differences in coding patterns under Medicare Part A and B compared to Medicare Part C, to the extent the Secretary has identified differences and (d) as necessary, adjust for late data submissions, lagged cohorts, and changes in MA enrollment. The Secretary could take into account estimated health risk of enrollees in preferred provider organizations (including MA regional plans) for the year. The Secretary would be required to conduct an analysis of differences in coding patterns between MA plans and providers under Parts A and B of Medicare using data starting in 2004, and incorporate, to the extent such differences are identified, the findings into calculations of MA benchmarks no later than 2008. Adjustments would be terminated if the total amount of payments adjusted for health status exceeded payments adjusted for demographics.

The Secretary could not make any adjustments to the budget neutrality factor, other than those specified above. The Secretary's authority to risk adjust MA benchmarks based on 100 percent of per capita fee-for-service spending would not be limited by these changes.

This section also refines adjustments for health status when plans are paid based on their bid amounts (rather than the benchmark). The Secretary would ensure that such risk adjustments reflect changes in the treatment and coding practices between Medicare Part A and Part B relative to Medicare Part C to the extent that the Secretary has identified differences.

House Bill

No provision.

Conference Agreement

The conference agreement accepts the Senate language in part, with modifications. The conference agreement codifies the phase-out of the budget neutrality factor over 2006 to 2010 and outlines the adjustments that can be made to that factor. Under the agreement, the Secretary must conduct an analysis to identify differences in coding patterns between Medicare Advantage plans and fee for service. To the extent that the Secretary identifies any differences, they are to be incorporated into calculations of the risk rates and the budget neutrality factor in 2008, 2009, and 2010. The conferees intend that any adjustments made for differences in coding patterns be made for differences resulting from inaccurate coding. The conference agreement makes no permanent change to Medicare Advantage payment calculations.

Rural PACE Provider Grant Program (Section 5302 in the Conference Agreement, Section 6113 of the Senate Bill, and no provision in the House Bill)

Current Law

PACE is a program providing comprehensive Medicare and Medicaid services under a managed care arrangement to individuals over age 55 who are eligible for a nursing home level of care. PACE organizations, which are public or private non-profit entities, receive a fixed monthly Medicare and Medicaid payment to cover a comprehensive set of services for PACE participants. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.

Senate Bill

This provision would create site development grants, provide technical assistance to established rural PACE providers, and establish a fund to reimburse rural PACE providers for certain outlier costs. A rural area would be a county that is not part of a Metropolitan Statistical Areas (as defined by the Office of Management and Budget) as established for Medicare IPPS payments to acute care hospitals. The Secretary would establish a procedure to award site development grants to be used for expenses incurred in

relation to establishing or delivering services in rural areas. Up to 15 qualified PACE providers that serve a rural area, in whole or in part can receive a grant not to exceed \$750,000. The Secretary would be appropriated \$7.5 million in FY2006 and FY2007 out of the Treasury for these development grants. The appropriated funds would remain available for expenditure until FY 2010. The Secretary would establish a technical assistance program to provide (1) outreach and education to specified entities interested in starting rural PACE programs, and (2) technical assistance necessary to support rural PACE pilot sites. The Secretary would establish an outlier fund for inpatient and related physician and ancillary costs incurred for an eligible participant within a given 12-month period. Outlier costs would be those costs for inpatient and related physician and ancillary services in excess of \$50,000 incurred within a given 12-month period for an eligible participant who resides in a rural area. For the first 3 years of its operation, a rural PACE site would receive 80 percent of the outlier costs in excess of \$50,000 for that period. Total outlier payments for an eligible participant could not exceed \$100,000 for the 12-month period used to calculate the payment. No site may receive more than \$500,000 in total outlier expense payments in a 12-month period. A rural PACE pilot site would be required to access and exhaust risk reserves held or arranged for the provider and any working capital established through a site development grant prior to receiving any payment from the outlier fund. The Secretary would be appropriated \$10 million for FY2006 and FY2007 for the outlier fund. These outlier appropriations would remain available for expenditure through FY2010. The Secretary would be required to submit a report to Congress on the evaluation of the rural PACE pilot sites no later than 60 months from the date of enactment. Any amount paid under this authority would be in addition to Medicare PACE funds paid under Section 1894 of the Social Security Act or Medicaid PACE funds paid for under Section 1934 of the same act.

Conference Agreement

The conference agreement adopts the Senate provision with certain exceptions. The Secretary is required to establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area. The Secretary is appropriated \$7.5 million for FY2006 for the rural site development grants. These appropriated funds would remain available for expenditure through FY2008. The Secretary is appropriated \$10 million for FY2006 for the outlier funds. These appropriated funds would remain available for expenditure through FY2010. Rural PACE pilot sites must apply to receive outlier funds and document their incurred costs for the outlier participant in a manner specified by the Secretary.

Elimination of Medicare Advantage Regional Plan Stabilization Fund (No provision in Conference agreement, Section 6112(a) of the Senate Bill, and no provision in the House Bill)

Current Law

The Secretary must establish an MA Regional Plan Stabilization Fund to provide incentives for plan entry in each region and plan retention in certain MA regions with below average MA penetration. Initially, \$10 billion will be available for expenditures from the Fund beginning on January 1, 2007 and ending on December 31, 2013. Additional funds will be available in an amount equal to 12.5 percent of average per capita monthly savings from regional plans that bid below the benchmark.

Senate Bill

The Senate bill would repeal the stabilization fund retrospectively as of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

House Bill

No provision.

Conference Agreement

No provision.

Establishment of Medicare Value-based Purchasing Programs. (No provision in the Conference Agreement, Section 6110 of Senate Bill and no provision in the House Bill)

Subsection (a) Establishment of Medicare Value-Based Purchasing Programs Part E Value-Based Purchasing Programs—Quality Measurement Systems for Value-Based Purchasing Programs. (No provision in the Conference Agreement, Section 6110 of the Senate Bill and no provision in the House Bill)

Current Law

No provision.

Senate Bill

Section 6110 would amend the Medicare statute by redesignating the existing Section 1860E as Section 1860F and by adding a new Section 1860E which requires the Secretary to establish value-based purchasing systems for different providers.

Subsection (a) of Section 6110 would create Section 1860E–1 in the Medicare statute and would require the Secretary to develop provider-specific quality measurement systems for making value-based payments to hospitals, physicians and practitioners, Medicare Advantage (MA) and Part D prescription drug plans, end stage renal disease providers and facilities, and home health agencies. Measures for each quality system would be required to (1) be evidence-based; (2) be easy to collect and report; (3) address process, structures, outcomes, beneficiary experience, efficiency, equity, and overuse and underuse of health care; and (4) include at least one measure of health information technology infrastructure during the first year of implementation. Additional measures would be added

in subsequent years. Measures would include those that assess the quality of care furnished to older, frail individuals and those with multiple complex chronic conditions. By 2008, hospital quality systems would be required to include at least 5 measures that take into account the unique characteristics of small hospitals located in rural areas and frontier areas.

Before a measure would be used to determine whether a provider receives a value-based payment, data on the measure must have been collected for at least a twelve month period. Each set of quality measures selected for specific categories of providers would be able to vary in their application to an individual or entity depending on the type, size, scope and volume of services provided by the individual or entity.

The Secretary would be required to establish risk adjustment procedures to control for differences in beneficiaries' health status and characteristics and to assign weights to measures used by each quality system. If appropriate, measures of clinical effectiveness would be weighted more heavily than measures of beneficiary experience; and measures of risk adjusted outcomes would be weighted more heavily than measures of process. The Secretary would be required to update the quality measurement system, but not more often than every twelve months. The update would permit a comparison of data from one year to the next. The Secretary would be required to use the most recent quality data for a provider type. However, if the Secretary determines that there is insufficient data because of the low service volume, the Secretary would be able to aggregate data across more than one fiscal or calendar year.

In developing and updating each quality measurement system, the Secretary would be required to consult with provider-based groups and clinical specialty societies. The Secretary would also take into account quality measures developed by nationally recognized entities, existing quality measurement systems, reports by MedPAC required by this Act, results of relevant demonstrations, and the report on Health Care Performance Measures being developed by the Institute of Medicine under section 238(b) of the MMA. In implementing each quality measurement system, the Secretary would be required to consult with entities that have developed strategies for quality measurement and reporting as well as a wide range of stakeholders.

By July 1, 2006, the Secretary would be required to have in place an arrangement with an entity that will provide the Secretary with advice and recommendations about the development and updating of the quality measurement systems established by this Act. This arrangement, with a private nonprofit entity, would meet a specific set of requirements. For FY2006 and FY2007, \$3,000,000 is authorized for this purpose, with the amount in subsequent years increased by the Consumer Price Index for urban consumers.

House Bill

No provision.

Conference Agreement

No provision.

Physician and practitioner value-based purchasing program

Current Law

No provision.

Senate Bill

A new Section 1860E–3 would direct the Secretary to establish a program under which value-based payments are provided each year to physicians and practitioners that demonstrate the provision of high quality health care to individuals enrolled under part B. In addition, MedPAC would be required to conduct five studies evaluating the new program.

The first study would examine how the Medicare value-based purchasing programs under this section will affect Medicare beneficiaries, Medicare providers, and Medicare financing, including the impact of these programs on the access of such beneficiaries to items and services, the volume and utilization of such items and services, and low-volume providers. The initial report would be due to Congress and the Secretary no later than March 1, 2008, and a final report due no later than June 1, 2012.

The second study would examine the advisability and feasibility of establishing a value-based purchasing program for critical access hospitals (CAHs). This report would be due to Congress and the Secretary no later than March 1, 2007.

The third study would address the advisability and feasibility of including renal dialysis facilities in the value-based purchasing program described in this section or establishing a separate value-based purchasing program for renal dialysis facilities under this title. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2007.

The fourth study would be a report on the implementation of an end-stage renal disease (ESRD) provider and facility value-based purchasing program. This report would take into account the results to date of the demonstration of bundled case-mix adjusted payment system for ESRD services under Section 623(e) of MMA and would include issues for the Secretary to consider in operating the ESRD provider and facility value-based purchasing program as well as recommendations on such issues. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2008.

The fifth study, due to Congress and the Secretary by June 1, 2007, would report on the advisability and feasibility of establishing a value-based purchasing program for skilled nursing facilities (SNFs).

The value-based purchasing program would be established so that value-based payments will be made initially in 2009 and in each subsequent year. The definition of a physician would not be changed as a result of this section and would remain as given in current law (section 1861(r)). The term ‘practitioner’ would mean: (i) a practitioner defined under current law; (ii) a physical therapist; (iii) an occupational therapist; and (iv) a qualified speech-language pathologist. The Secretary would be charged with establishing procedures for the identification of physicians and practi-

tioners for payment purposes under this section, such as through physician or practitioner billing units or other units.

The value-based payments would be based on either relative or absolute standards. The Secretary would be able to make a value-based payment to a physician or a practitioner if both the quality and efficiency of care to an individual enrolled under Part B has improved substantially or has exceeded an established threshold. In determining which physicians and practitioners would qualify for a value-based payment, the Secretary would be required to use both the quality measurement system developed for this section with respect to the quality of the care provided by the physician or practitioner and the comparative utilization system developed under this section with respect to the efficiency of such care.

In determining the amount of award and the allocation of awards under the value-based purchasing program, the Secretary would determine both the amount of a value-based payment provided to a physician or a practitioner and the allocation of the total amount available for value-based payments for any year between payments with respect to physicians and practitioners that meet the quality threshold requirements described above.

In determining the amount and allocation of the value-based payments for physicians and practitioners who exceed the threshold that allows them to receive such payments, the Secretary would ensure that a majority of the total amount available for value-based payments for any year is provided to physicians and practitioners who meet the threshold for receiving such payments. Additionally, the percentage of value-based payments would not be able to decrease. For every year beginning in 2010, the Secretary would be required to ensure that the percentage of the total amount available for value-based payments for any year that is used to make payments to physicians and practitioners is greater than the previous year's percentage.

In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner would be required to submit quality data with respect to that year, and provide the Secretary (under procedures established by the Secretary) with an attestation that the data submitted is complete and accurate.

The Secretary would be required to establish value-based payments such that the estimated total amount of the value-based payments is equal to the total amount of available funding for value-based payments for the year. The payment of value-based payments would be based on such a method as the Secretary determines appropriate, and the Secretary would ensure that value-based payments with respect to a year are made by not later than December 31 of the subsequent year.

The Secretary, in consultation with relevant unnamed stakeholders, would develop a comparative utilization system for purposes of providing value-based payments. The resulting comparative utilization system would measure the efficiency of the care provided by a physician or practitioner. Under this comparative utilization system, the Secretary would select the measures of efficiency and review the most recent claims data with respect to services furnished or ordered by physicians and practitioners to determine

utilization patterns and efficiency. The Secretary would establish risk adjustment procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics.

Beginning in 2007, the Secretary would provide physicians and practitioners with annual reports on the utilization of items and services under this title based upon the review of claims data. The 2007 and 2008 reports would be confidential and not be made available to the public. Not later than March 1, 2009, the Secretary would provide each physician and practitioner with a description of the Secretary's estimate of how payments to the physician or practitioner would have been affected with respect to items and services furnished in 2008 if the value-based payment program had been in effect in 2008.

Payments to physicians and practitioners under the value-based payment program would be made from the Federal Supplementary Medical Insurance (Part B) Trust Fund. The total amount available for value-based payments with respect to a year would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the amendments made by Section 6110(c)(2) of the bill, as estimated by the Secretary.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (c) physicians and practitioners

(1) *Voluntary submission of physician and practitioner quality data*

Current Law

No provision.

Senate Bill

In 2007 and in subsequent years, physicians and providers who do not submit the required quality data would receive an update to the conversion factor minus two percentage points. This reduction would only apply to the fiscal year in question. In 2007 and subsequently, physicians and practitioners would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. Procedures for making the data available to the public would be established. These procedures would be required to provide the physicians and practitioners with an opportunity to review the data before it is released to the public. The Secretary would be allowed to make exceptions to the requirement for making data available to the public and would take into account the size and specialty representation of the practice involved when providing such exceptions.

House Bill

No provision.

Conference Agreement

No provision.

(2) *Reduction in conversion factor for physicians and practitioners that submit quality data in order to fund program*

Current Law

Medicare payments under Part B are based on a fee schedule. The fee schedule reflects a set of weights that vary across the many procedures that encompass the range of activities and services that physicians and practitioners provide. These relative weights are converted to dollar amounts for payment under Medicare by applying a multiplicative conversion factor. The conversion factor is updated each year according to a formula that aims to place a restraint on overall increases in Medicare spending for Part B services.

Senate Bill

To fund the value-based purchasing program for physicians and practitioners, the conversion factor would be reduced as follows: 1.0 percent in 2009, 1.25 percent in 2010, 1.5 percent in 2011, 1.75 percent in 2012, and 2.0 percent in 2013 and subsequent years.

House Bill

No provision.

Conference Agreement

No provision.

ESRD provider and facility value-based purchasing program

Current Law

No provision.

Senate Bill

Section 1680E–5. Beginning in 2007, the Secretary would establish a program under which value-based payments are provided each year to providers of services and renal dialysis facilities that provide services to ESRD individuals enrolled under part B and that demonstrate the provision of high quality health care. Facilities with at least 50 percent of their patients under the age of 18, as well as those providers and facilities currently participating in the bundled case-mix demonstration are excluded from this program.

Value-based payments would be made to a provider or facility, if the Secretary determines that the quality of care in that year has substantially improved over the prior year or exceeds a threshold established by the Secretary, using the quality measurement system.

The Secretary would determine the amount of a value-based payment and the allocation of the total amount available for all such payments, subject to certain requirements. The Secretary would ensure that the majority of the total amount available is awarded to those providers of services and renal dialysis facilities who provide high quality services. For 2007, the entire amount would be available for those who meet the requirements. Beginning in 2009, the percentage of the total amount available would be provided to those who improved in meeting such requirements relative to the previous year.

Beginning in 2007, each provider of services and renal dialysis facility would be required to submit data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the program. A provider or facility would be required to submit this data, in order to be eligible for a value-based payment for a year. The Secretary would establish procedures for making submitted data available to the public in a clear and understandable form and would ensure that a provider or facility first has the opportunity to review the data. The provider or facility would be required to provide an attestation that the data is complete and accurate.

The Secretary would establish payment amounts so that, as estimated by the Secretary, the total amount of value-based payments made in a year is equal to the total amount available. The payment of the awards would be based on a method as determined by the Secretary and must be paid no later than December 31 of the subsequent year. The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance (SMI) Trust Fund, as estimated by the Secretary. Payments to providers of services and renal dialysis facilities, under this section, would be made from the Federal SMI Trust Fund.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (e) ESRD

Providers and facilities

Current Law

No provision.

Senate Bill

No later than July 31, 2006, the Secretary would establish procedures for providers of services and renal dialysis facilities, who are paid based on the case-mix adjusted prospective payment system, to submit data that permits the measurement of health outcomes and other indices of quality.

In the case of any payment for an item or service furnished on or after January 1, 2007, the case-mix adjusted prospective pay-

ment amount would be reduced by the applicable percent, but only for those providers of services or renal facilities included in the value-based program. The applicable percent would be 1 percent for 2007, 1.25 percent for 2008, 1.5 percent for 2009, 1.75 percent for 2010, and 2 percent for each year thereafter.

Beginning January 1, 2007, the Secretary would implement a value-based purchasing program for providers and facilities participating in the bundled case-mix demonstration (as established under Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), in a manner similar to the value-based program established under Section 1860E-5 of this bill, including the funding of the program.

House Bill

No provision.

Conference Agreement

No provision.

PPS Hospital value-based purchasing program

Current Law

No provision.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-2 which establishes the hospital value-based purchasing program for inpatient hospital services, starting FY2007. The program would make value-based payments to hospitals based on data reported under the quality measurement system established by the Secretary. Hospitals paid under Medicare's prospective payment system (PPS) that have substantially improved the quality of care over the prior year or exceeded an established quality threshold would receive a value-based payment as determined by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to hospitals that are receiving such payments for exceeding a quality threshold. Starting in FY2008, the percentage of the total amount for value-based payments in any fiscal year that is paid to such hospitals would be greater than the equivalent percentage paid in the previous year. Hospitals would be required to comply with all the quality data reporting requirements and attest to the accuracy of the data in order to be eligible for a value-based payment. The total amount of value-based payments in a fiscal year would equal the total amount of available funding for such payments for that year. The payments would be based on the methods determined by the Secretary and would be made to hospitals no later than the close of the following fiscal year. No later than January 1, 2007, the Secretary would provide each hospital with a description of how its payments for FY2006 would have been affected had the value-based payment program been in effect that fiscal year.

Value-based payments in a fiscal year would be made from Medicare's Part A Trust fund and would equal specified reductions

in those trust fund expenditures as established in Section 6110(b) of the bill.

House Bill

No provision.

Conference Agreement

See Section 5001 of the Conference Agreement.

Plan value-based purchasing program

Current Law

No provision.

Senate Bill

A new Section 1860E–4 would require the Secretary to establish a program to award value-based payments to Medicare Advantage (MA) organizations that provide high quality health care. Payments would start in 2009, and continue each year thereafter. The program would apply to both MA regional and local plans. It also would apply to reasonable cost contract plans, except for provisions that would require plans to submit data two years prior to the start of the program, and provisions relating to plan bids.

The Secretary would make payments for each plan offered by an MA organization if the plan substantially improved over the prior year, or exceeded a minimum threshold. The Secretary would use measures of quality developed for the plan value-based payments system (Section 1860E–1) and ensure that awards are based on data from a full 12 months when making a comparison against a threshold, and 24 months when measuring improvement over a prior year.

The Secretary would determine the amount of the value-based payments, but must ensure that the majority of funds go to plans that receive a payment because their health measures exceeded a threshold. In 2010 and each subsequent year, the percentage of the total amount available is greater than the percentage in a previous year.

Value-based payments may only be used to invest in quality improvement programs or to enhance beneficiary benefits.

To be eligible for value-based payments, an MA plan or reasonable cost contract would be required to have collected, analyzed and reported the required data for the two previous years. Also, an MA plan would be required to provide the Secretary with an attestation that the value-based payment program including payment adjustments made by reason of Section 6110(d)(2)(A) had no effect on the integrity and actuarial soundness of the plan's bid.

The Secretary would ensure that the total of value-based payments is equal to the amount made available for those payments. Payments for a particular year would be required to be made not later than March 1 of the subsequent year, in a manner determined by the Secretary.

By March 1, 2009, the Secretary would provide each MA organization with an estimate of how plan payments would have been

affected if the value-based payment system had been in effect in 2008.

The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as a result of amendments to fund the value-based payment system, as estimated by the Secretary. Payments to MA organizations would be drawn from the two trust funds in proportion to the relative weight that part A and part B benefits represent of the total actuarial value of Medicare benefits.

House Bill

No provision.

Conference Agreement

No provision.

Home Health Agency Value-based Purchasing Program

Current Law

No provision.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-6 which establishes the Home Health Agency Value-Based Purchasing Program. In 2008 and in subsequent years, the Secretary would make value-based payments to those home health agencies that, based on data submitted under the quality measurement system, have either substantially improved quality of care over the prior year, or exceed a threshold established by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to home health agencies that qualify for payments because they exceed a quality threshold. Starting in 2009 and in each subsequent year, the percentage of total value-based payments made to agencies that exceed the quality threshold would be greater than the percentage made in the previous year. To be eligible for a value-based payment, home health agencies would be required to submit the required quality data and attest that it is complete and accurate.

The total amount of value-based payments made in a year would equal the total funds available for such payments. The Secretary would determine the most appropriate method for making payments. Payments for a year would be required to be made no later than December 31 of the subsequent year. By January 1, 2008, the Secretary would be required to provide each home health agency with a description of how its payments for 2007 would have been affected had the value-based purchasing system been in effect that year.

Value-based payments would be made from Part A and Part B in the same proportion as payments for home health services are made.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (b).—Hospitals

(1) Voluntary submission of hospital quality data

Current Law

Each year, Medicare's operating payments to acute general hospitals are increased or updated by a factor that is determined, in part, by the projected annual change in the hospital market basket (MB). Congress establishes the update for Medicare's inpatient prospective payment system (IPPS) for operating costs, often several years in advance. An IPPS hospital will receive an operating update of the MB from FY2005 through FY2007 if it submits data on the 10 quality indicators established by the Secretary as of November 1, 2003. The Secretary will specify the form, manner, and time of the data submission. A hospital that does not submit data to the Secretary will receive an update of the MB minus 0.4 percentage points for the fiscal year in question. The Secretary will not take into account this reduction when computing the applicable percentage increase in subsequent years. For FY2008 and subsequent fiscal years, hospitals will receive an update of the MB.

Senate Bill

In FY2007 and subsequent years, an IPPS hospital that does not submit the required quality data would receive an update of the MB minus two percentage points. This reduction would only apply to the fiscal year in question. In FY2007 and subsequently, an IPPS hospital would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. Procedures for making the data available to the public would be established. These procedures would be required to provide the hospitals with an opportunity to review the data before it is released to the public.

House Bill

No provision.

Conference Agreement

No provision.

(2) Reduction in outlier payments in order to fund program

Current Law

Outlier payments are intended to protect IPPS hospitals from the risk of financial losses associated with patients with exceptionally high costs or unusually long stays. Medicare cases qualify for outlier payments if they exceed a threshold or fixed loss amount that is established each year. As directed by statute, the total amount of any outlier payments for any year should equal no less

than 5 percent nor more than 6 percent of total projected operating diagnosis related group (DRG) payments. Outlier payments are financed by a reduction in the national average standardized amount, typically set at 5.1 percent.

Senate Bill

Outlier payments would be established as no less than 5 percent and no more than 6 percent for fiscal years prior to 2007. In FY2007, outlier payments would be established as no less than 4 percent and no more than 5 percent. In FY2008, outlier payments would be established as no less than 3.75 percent and no more than 4.75 percent. In FY2009, outlier payments would be established as no less than 3.5 percent and no more than 4.5 percent. In FY2010, outlier payments would be established as no less than 3.25 percent and no more than 4.25 percent. In FY2011 and in subsequent years, outlier payments would be established as no less than 3 percent and no more than 4 percent.

The Secretary would be directed to reduce the average standardized amount by certain percentages to fund outlier payments and the hospital value-based purchasing program. The reduction factor will be equal to a calculation where the numerator is the sum of the additional outlier payments (as discussed in the preceding paragraph) plus a specified percentage of total projected DRG prospective payment rates divided by the total projected DRG prospective payment rates. The specific percentages would be 0 percent for fiscal years prior to 2007, 1 percent in FY2007, 1.25 percent in FY2008, 1.5 percent in FY2009, 1.75 percent in FY2010, and 2 percent in FY2011 and in subsequent years.

House Bill

No provision.

Conference Agreement

No provision.

- (3) Value-based purchasing demonstration program for critical access hospitals

Current Law

No provision.

Senate Bill

The Secretary, within six months from enactment, would be required to establish a two-year value-based payment demonstration program at six representative CAHs, using such funds as are necessary from the Part A trust fund. The Secretary would be required to report to Congress with recommendations within six months of completing the demonstration.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (d)—Plans

(1) Submission of quality data

Current Law

Each Medicare Advantage (MA) organization has an ongoing quality improvement program. MA private fee-for-service plans, MSA plans and Medicare cost reimbursement plans are exempt from this requirement. Each MA organization collects, analyzes and reports health outcomes and quality data. The quality improvement program for local preferred provider organizations only applies to providers that have contracts with the organization. The Secretary can collect only the types of data that were collected by the Secretary as of November 1, 2003. The Secretary can collect other types of data only after consulting with MA organizations and private accrediting bodies, and submitting a report to Congress.

Senate Bill

Beginning on or after January 1, 2006, the Secretary would also collect data necessary for the plan value-based purchasing program (Section 1860E-4). The Secretary would establish requirements for MA private fee-for-service plans and cost reimbursement plans with respect to the collection, analysis and reporting of data on health outcomes and quality. The Secretary would establish procedures for making health outcomes and quality data available to the public in a clear and understandable form. Prior to the data being made public, the Secretary would ensure that an MA organization has the opportunity to review the data for the plans it offers. The Secretary may change the type of data collected for the value-based purchasing program after complying with requirements for the development, update and implementation of the program.

The Secretary would take into account the data reporting requirements that plans must comply with under other federal and state programs and in the commercial market when establishing a time frame for data reporting requirements under the new program.

House Bill

No provision.

Conference Agreement

No provision.

(2) Reduction in payments to organizations in order to fund program

Current Law

No provision.

Senate Bill

For those providers included in the value-based program, including reasonable cost contracts, the monthly payment to plans would be reduced by 1 percent in 2009, 1.25 percent in 2010, 1.5 percent in 2011, 1.75 percent in 2012, and 2.0 percent for 2013 and

each subsequent year. These reductions would not have any effect on determining whether the risk adjusted benchmark exceeds a plan's risk adjusted bid, or the amount of the difference.

House Bill

No provision.

Conference Agreement

No provision.

- (3) Requirements for reporting on use of value-based payments

Current Law

No provision.

Senate Bill

Beginning on or after January 1, 2011, MA plans would submit information describing how the organization will use any value-based payments received under the program. This information would be submitted by plans at the same time they submit plan bids. Beginning in 2010, not later than July 1 of each year, any reasonable cost reimbursement contract that received a value-based payment would submit a report to the Secretary describing how the organization will use the value-based payment.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (f) Home Health Agencies

Value-based purchasing program for home health agencies

Current Law

No provision.

Senate Bill

In 2007 and subsequent years, a home health agency that does not submit to the Secretary the required quality data would receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. For 2007 and subsequently, each home health agency would be required to submit data necessary for a value-based purchasing system in the form, manner, and time period specified by the Secretary. Procedures for making the data available to the public would be established.

To fund the program, spending under the trust funds for home health services would be reduced by a percent applied to the standard prospective payment amount made to all agencies that comply with the data submission requirements. The percent reduction would be 1 percent in 2008, 1.25 percent in 2009, 1.5 percent in

2010, 1.75 percent in 2011, and 2 percent in 2012 and subsequent years.

House Bill

No provision.

Conference Agreement

See Section 5201 of the Conference Agreement.

Subsection (g) Skilled Nursing Facilities

- (1) Requirement for skilled nursing facilities to report functional capacity of medicare residents upon admission and discharge

Current Law

Medicare law requires nursing homes to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Under the law, this assessment must describe the resident's capability of performing daily life functions and significant impairments in functional capacity and be based on a uniform minimum data set specified by the Secretary, or specified by the state with the Secretary's approval. If specified by a state, it must be consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

As a result, the Minimum Data Set (MDS), designed by the Secretary, consists of a core set of screening, clinical and functional status elements, including common definitions and coding categories which form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. MDS is designed to facilitate and standardize resident assessments, which are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. These resident assessments help identify social, medical and psychological problems and form the basis for individualized care planning. MDS is also used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement.

In general, MDS resident assessments are conducted on the 5th, 14th, 30th, 60th, and 90th days of post-hospital SNF care. SNFS also conduct other assessments that may be needed to account for changes in patient care needs.

Senate Bill

This provision would amend section 1819(b) of the Social Security Act by adding a requirement that on or after October 1, 2006, a SNF would be required to submit a report to the Secretary on the functional capacity of each resident who is entitled to SNF ben-

efits at the time of his or her admission and discharge. This report would be required to be submitted within 10 days of the admission or discharge as the case may be.

House Bill

No provision.

Conference Agreement

No provision.

(2) Voluntary submission of skilled nursing facility data

Current Law

As described above, the MDS submitted to CMS by states is intended to provide information on the quality of care provided to residents in SNFs. In recent years, CMS has attempted to make available additional quality measures. CMS posts data on nursing home's care records from complaint surveys, staffing levels, and number and types of residents, facility ownership and 15 quality measure scores on a website entitled Nursing Home Compare. This site is available to the public and is intended to assist individuals in choosing a Medicare- and Medicaid-certified nursing home by state, county, city, zip code, or by facility name. Additional research into the development of quality measures, staffing, and best practices is currently underway through CMS contracts with Quality Improvement Organizations (QIOs).

Senate Bill

This provision would also require SNFs to submit quality data for the measurement of health outcomes and other indices of quality to the Secretary for FY 2009 and each subsequent fiscal year. Data required would be determined by the Secretary after conducting a study in consultation with certain nationally recognized quality measurement entities, researchers, health care provider organizations, and other appropriate groups and consult with, and take into account, recommendations of, the entity that the Secretary has an arrangement with based on criteria specified in section 6110(e) of this bill. The Secretary would also be required to consult with entities that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures and that involve representatives of health care providers, health plans, consumers, employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care.

For FY 2009 and each subsequent year, SNF market basket percentage changes would be reduced by two percentage points for SNFs that do not submit this data. Such reductions would apply only with respect to the fiscal year involved and the Secretary would be prohibited from taking into account a reduction in the Federal per diem rate.

The Secretary would be required to establish procedures for making this data available to the public in a clear and understandable form. Such procedures would be required to ensure that a fa-

cility has the opportunity to review the data that is be made public with respect to the facility prior to such data being made public.

House Bill

No provision.

Conference Agreement

No provision.

TITLE VI—MEDICAID AND SCHIP

Subtitle A—Medicaid

Chapter 1—Payment for Prescription Drugs

Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions (Section 6001 of the Conference Agreement, Section 6001 of the Senate Bill, and Section 3101 of the House Bill)

a. Modification of federal upper payment limit for multiple source drugs; definition of multiple source drugs

Current Law

States set the amounts to pay pharmacies for outpatient prescription drugs provided to Medicaid enrollees. States pay those amount to pharmacies and then seek reimbursement of the federal share of those payments. Federal reimbursements to states for state spending for certain outpatient prescription drugs are subject to ceilings called federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs—those that have at least three therapeutically equivalent drug versions. The Centers for Medicare and Medicaid Services (CMS) calculates the FUL to be equal to 150 percent of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating the FULs are the lowest of the average wholesale prices (AWP) for each group of drug equivalents. Brand name drugs are subject to an upper limit equal to the amount that pharmacists must pay to acquire the drug (the acquisition cost) as estimated by the states.

Pharmaceutical manufacturers whose drugs are available to Medicaid beneficiaries must provide state Medicaid programs with rebates. Rebates are calculated based on the average manufacturer's price (AMP) of each product, and for certain other products, the best price at which the manufacturers sell the drug. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation. Sales at prices that are "nominal" in amount are excluded from the computation of best price. CMS defines nominal prices to be those that are below 10 percent of the AMP.

Senate Bill

The Senate bill would specify that FULs for multiple source drugs provided in pharmacies that are not critical access pharmacies would be calculated to be equal to 115 percent of the weighted AMP for those drugs. The FULs for multiple source drugs provided in critical access pharmacies would be calculated to be equal to the lesser of 140 percent of the AMP or the wholesale acquisition cost (WAC) for the drug. The bill would establish FULs for single source drugs. For those single source drugs provided in pharmacies that are not critical access pharmacies, the FUL would be calculated to be equal to 105 percent of the AMP. FULs for those single source drugs provided in critical access retail pharmacies would be calculated to be equal to the lesser of 108 percent of the AMP or the WAC for the drug.

Exceptions to the FUL would be for drugs sold during an initial sales period in which data on sales for the drug are not sufficiently available from the manufacturer to compute the AMP or the weighted AMP, and for drugs for which alternatives would not be as effective. For drugs sold during an initial sales period, the Senate bill would establish a transitional upper payment limit to apply only during such period. For a period not to exceed 2 calendar quarters, the upper limit for single source drugs would be calculated to be equal to the wholesale acquisition cost (WAC) for the drug. The bill would define WAC—the definition would be identical to the current law Medicare definition. For first non-innovator multiple source drugs, the upper limit during the transition period would be equal to the AMP for the single source drug rated as therapeutically equivalent minus 10 percent. For subsequent non-innovator multiple source drugs, if the Secretary has sufficient data to determine AMP, the FUL during the transition period would be equal to the weighted AMP for the therapeutically equivalent and bioequivalent form of the drug. If the Secretary does not have sufficient data, the FUL would be the AMP for the single source drug that is therapeutically equivalent and bioequivalent minus 10 percent.

In the case of an innovator multiple source drug that a prescribing health care provider determines is necessary for treatment of a condition and that a non-innovator multiple source drug would not be as effective for the individual or would have adverse effects for the individual or both, and for which the provider obtains prior authorization in accordance with the states' program, the upper payment limit for the innovator multiple source drug shall be equal to 105 percent of the AMP for such drug.

The Secretary would be required to update FULs on a quarterly basis, taking into account the most recent data collected for the purposes of determining such limits and the FDA's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations."

The Senate FUL provisions would become effective on the later of January 1, 2007 or the date that is 6 months after the close of the first regular session of the State legislature that begins after the date of enactment.

The Senate bill would establish interim FULs to apply during calendar year 2006, before the new FULs become effective. During

the period January 1, 2006 through the effective date of the FUL provisions, the Secretary would apply the FUL as under current law and regulations except that instead of limiting federal matching to 150 percent of AWP, it would be limited to 125 percent of AWP. In the case of covered outpatient drugs that are marketed as of July 1, 2005 and are subject to FULs under current law, the Secretary would be required to use the AWP, direct prices, and WACs as of that date to calculate the applicable FUL. New drugs first marketed between July 1, 2005 and January 1, 2007 would be subject to this interim FUL calculation.

House Bill

The House bill would specify that the FUL for the ingredient cost of a multiple source drug would be equal to 120 percent of the volume weighted average RAMP for that drug. The bill would establish upper limits for single source drugs as well. The FUL for the ingredient cost of a single source drug would be equal to the 106 percent of the RAMP for that drug. A drug product that is a single source drug and that becomes a multiple source drug would continue to be treated as a single source drug, with respect to the applicable FUL, until the Secretary determines that there is sufficient data to compile the volume weighted average RAMP.

The House bill would provide the Secretary with an option to develop an alternative methodology setting the FUL based on the most recently reported retail survey price instead of a percentage of RAMP or the volume weighted average RAMP. The House bill would allow the Secretary to use this methodology, in 2007, for a limited number of covered outpatient drugs, including both single source and multiple source drugs selected to be representative of the classes of drugs dispensed under Medicaid.

The House bill provides exceptions to the FULs for drugs sold during an initial sales period and for drugs dispensed by specialty pharmacies. For those drugs sold during an initial sales period for which data for computation of the RAMP may not be available, the House bill includes a provision similar to the Senate provision, except it would apply only to single source drugs sold during the initial sales period and the provision does not include any specification for first innovator multiple source drugs. The bill includes a definition of WAC, to be used during the initial sales period, that is identical to the definition of WAC in the Senate bill. The House bill would also allow a state to elect not to apply the new FUL to covered outpatient drugs dispensed by specialty pharmacies, such as those that dispense only immunosuppressive drugs, as defined by the Secretary, or drugs administered by a physician in a physician's office.

The House bill would require the Secretary to update the FULs at least on a quarterly basis. Otherwise, the provision regarding FUL updates is identical to the Senate provision.

The effective date for the House FUL provisions would be on the later of January 1, 2007 or the date that is 6 months after the close of the first regular session of the state legislature that begins after the date of enactment of this Act.

The House bill would provide the Secretary with the authority to delay the implementation of the new FUL limits for a period of

not more than 1 year, if the Comptroller General finds that the estimated average payment amount to pharmacies for covered outpatient drugs under the new FULs are below the average prices paid by pharmacies for acquiring such drugs. If the Secretary delays the implementation of the FULs then the Secretary would be required to transmit to Congress, prior to the termination of the period of delay, a report containing specific recommendations for legislation to establish a more equitable payment system.

The House bill would clarify that the FULs would not affect maximum allowable cost limits as established by states and rebates would continue to be paid without regard to whether or not states' payments are subject to such a limit. In addition, it would prohibit administrative and judicial reviews of the Secretary's determinations of FULs, RAMPs, volume weighted average RAMPs including the:

- assignment of National Drug Codes to billing and payment classes;
- Secretary's disclosure to states of AMP, RAMP, volume weighted average RAMP, and retail survey prices;
- determinations by the Secretary of covered outpatient drugs dispensed by specialty pharmacies or administered in physicians' offices;
- contracting and calculations under these provisions; and
- methods of allocating rebates, chargebacks, or other price concessions if specified by the Secretary.

The House bill would require the Comptroller General of the U.S. to provide a report to Congress no later than nine months after the date of enactment on the appropriateness of payment levels to pharmacies for dispensing fees under the Medicaid program and on whether the estimated average payment amounts to pharmacies for covered outpatient drugs under the new FUL method are below the average prices paid by pharmacies for acquiring such drugs. The bill would also require the Inspector General of HHS to provide a report to Congress, no later than two years after the date of enactment, on the appropriateness of using RAMP and retail survey prices rather than the AMP or other price measures, as the basis for establishing a FUL for reimbursement of outpatient drugs under Medicaid.

Conference Agreement

The conference agreement applies FULs to multiple source drugs for which the FDA has rated 2 or more products to be therapeutically and pharmaceutically equivalent. For those drugs, the FUL would be equal to 250 percent of the average manufacturer price computed without regard to prompt pay discounts for the lowest cost drug. Effective January 1, 2007.

The agreement modifies the definition of multiple source drug so that a drug qualifies as a multiple source drug if there is at least one other drug sold and marketed during the period that is rated as therapeutically equivalent and bioequivalent to it.

b. Disclosure of price information to states and the public

Current Law

AMP and best price data are required to be reported by manufacturers to CMS no later than 30 days after the date of entering into a rebate agreement and then no later than 30 days after the last day of each rebate period. Those prices are required to be kept confidential except for the purpose of carrying out the requirements of Medicaid rebates, or to permit the Comptroller General and the Director of the Congressional Budget Office to review the information.

Senate Bill

The Senate bill would modify the confidentiality requirements to allow states access to reported price information and would require the Secretary to make available to states, beginning with the first quarter of FY2006, the most recently reported AMP and weighted AMPs. The Secretary would be required to devise and implement a means of electronic distribution for these prices to state Medicaid agencies.

House Bill

The House bill would modify the confidentiality requirements to allow states access to reported price information. In addition, the bill would require the Secretary to devise and implement a means for electronic distribution to state Medicaid agencies, of retail survey prices.

Conference Agreement

The conference agreement would increase the required reporting of AMP and best prices. AMP would be reported and calculated on a monthly basis. In addition, the agreement allows states to have access to reported AMP data for multiple source drugs for the purpose of carrying out the Medicaid programs and would require the Secretary to disclose such information through a website accessible to the public. In addition, the provision requires the Secretary to provide AMPs to States on a monthly basis and to update information posted to the website on at least a quarterly basis.

c. Definition of average manufacturer price

Current Law

The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. CMS instructs manufacturers to exclude certain federal drug purchases as well as free goods from the computation of AMP. Sales at nominal prices are excluded from the best price computation. Manufacturers are required to report, for each rebate period, the AMP for all Medicaid covered outpatient drug products and the best price for single source and innovator multiple source drugs to CMS.

Senate Bill

The Senate bill would modify the definition of AMP and require the modified AMP to be used to calculate the FUL for single source drugs in addition to rebates, as under current law. The provision would specify that sales exempted from inclusion in the determination of best price, nominal price sales (except for those contingent on purchase requirements or agreements), and bona fide service fees would be exempted from the computation of the AMP. Computation of AMP would include cash and volume discounts; nominal price sales contingent on a purchase agreement or requirement; free goods; chargebacks or rebates to a pharmacy (excluding mail order, nursing home pharmacies and pharmacy benefit managers), or any other direct or indirect discounts; and any other price concessions which may be based on recommendations of the Inspector General of HHS. Bona fide user fees would be defined as expenses for a service actually performed by an entity for a manufacturer that would have generally been paid for by the manufacturer at the same rate had these services been performed by another entity.

The Senate bill would define the weighted AMP, to be used in calculating the FUL for multiple source drugs, with respect to the rebate period, as the volume-weighted average of manufacturers' reported prices for all drug products that are therapeutically equivalent and bioequivalent. It would be computed by summing, for all therapeutic equivalents and bioequivalent forms of the drug, the products of the AMP and the number of units sold. The sum of those amounts would be divided by the sum of all units sold for all NDCs assigned to such products. In cases in which there is a lag in the reporting of information on rebates and chargebacks so that adequate data are not available on a timely basis to update the weighted AMP for a multiple source drug, the manufacturer of such drug would apply a methodology based on a 12-month rolling average to estimate costs attributable to rebates and chargebacks for such drugs. For years after 2006, the Secretary would be required to establish a uniform methodology to estimate and apply such costs.

The Senate bill would modify the existing price reporting requirements so that manufacturers would be required to report the modified AMP and the weighted AMP to the Secretary of CMS as well as information and data on any sales made during the reporting period at a nominal price. The bill would provide the Secretary with the authority to enter into contracts with appropriate entities to determine AMP, prices, volume, and other data necessary to calculate the FUL and payment limits for covered drugs.

The Senate modifications to the definition of AMP would become effective as if enacted on July 1, 2005 except for the provisions related to the exclusion of nominal prices from AMP. Those provisions would become effective on the later of the expiration date of a contract in effect on the date of enactment or October 1, 2006 and would apply to sales made and rebate periods beginning on or after that date.

House Bill

The House bill would not change AMP. Instead it would establish a measure of price referred to as RAMP for the purpose of calculating the FUL for single source drugs. RAMP would be defined as the average price paid to a manufacturer for the drug in the U.S. in the quarter by wholesalers for drugs distributed to retail pharmacies, excluding service fees. For this purpose, retail pharmacies would be defined to exclude mail-order only pharmacies and pharmacies at nursing facilities and homes. Specified items to be excluded from RAMP are similar to those to be excluded from AMP in the Senate bill except that the House bill allows the Secretary to define nominal sales, and free goods contingent on purchase requirements would not be excluded from RAMP. In addition, service fees that represent fair market value for a bonafide service provided by the entity would be excluded from RAMP. Items to be included in RAMP are also similar to those included in AMP in the Senate bill except that RAMP includes free goods contingent upon a purchase requirement; and does not provide for an exception for mail order, nursing home pharmacies and pharmacy benefit managers.

The volume weighted average RAMP would be defined, for all drug products in the same multiple source drug billing and payment code (or other methodology as specified by the Secretary), as the volume weighted average of the reported RAMPs. It would be computed by summing the products of the RAMPs for all product with an NDC code and multiplying by the total number of units of the drug product sold. Those amounts would be summed together and divided by the total number of units sold for all NDC codes assigned to such products.

The House bill would establish reporting requirements of drug manufacturers. Manufacturers would be required, beginning after July 1, 2006, to submit the RAMP, the total number of units required to compute the volume weighted average RAMP, the WAC for drugs sold during an initial sales period, and information on nominal price sales. The reporting would be by National Drug Code (NDC). In addition, the bill would provide the Secretary with the authority to enter into contracts with appropriate entities to determine RAMPs and other data necessary to calculate the FULs and payment limits and would modify the confidentiality provisions allowing states access to reported price information.

Conference Agreement

The conference agreement amends the definition of AMP to exclude customary prompt pay discounts extended to wholesalers from those amounts. In addition, the agreement modifies the price reporting requirements so that manufacturers would be required to submit, not later than 30 days after the last day of each rebate period, the customary prompt pay discounts extended to wholesalers in addition to the AMP and best price reporting required under current law.

The conference agreement requires the Inspector General of the Department of Health and Human Services (HHS) to, no later than June 1, 2006, review the requirements for, and the manner in which AMP is determined and to submit to the Secretary and

Congress any recommendations for changes as determined to be appropriate.

The agreement also requires the Secretary of HHS to promulgate a regulation clarifying the requirements for and the manner in which AMPs are to be determined, taking into consideration the recommendations of the Inspector General.

d. Exclusion of sales at a nominal price from determination of best price

Current Law

In addition to the AMP, pharmaceutical manufacturers are required to report to the Secretary of HHS the “best price” at which the manufacturer sells each of its drug products to certain purchasers for the purpose of calculating the rebate amounts. Prices that are nominal in amount are excluded from best price reporting. Nominal prices are defined by CMS to be those that are below 10 percent of the average manufacturer’s price.

Senate Bill

The Senate bill would exclude, for the purposes of computing the AMP, sales by a manufacturer of covered outpatient drugs that are single source, innovator multiple source drugs, or are authorized generics that are made available at nominal prices to the following listed entities: (a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; (b) intermediate care facilities for the mentally retarded, (c) stateowned or operated nursing facilities, (d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area. The nominal price limitations would not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule. In addition, the bill would modify manufacturers’ price reporting requirements to include, for calendar quarters beginning on or after January 1, 2006 information on sales made at a nominal price.

House Bill

The House bill would exclude, for the purpose of computing the RAMP, sales as the Secretary identifies, that are nominal in amount. In addition, the bill would modify manufacturers’ price reporting requirements to include, for calendar quarters beginning on or after July 1, 2006 information on sales made at a nominal price.

Conference Agreement

The conference agreement modifies the manufacturer price reporting requirements so that for calendar quarters beginning on or after January 1, 2007, manufacturers would be required to report information on sales of Medicaid covered drugs that are made at a nominal price.

In addition, the agreement defines the sales are to be considered nominal for the purpose of reporting nominal price sales and

for computing and reporting the best price. (The agreement does not amend the AMP vis-a-vis nominal prices.) Nominal sales are those made by a manufacturer of covered drugs at nominal prices to (a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; (b) intermediate care facilities for the mentally retarded, (c) state-owned or operated nursing facilities, (d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area. The nominal price limitations do not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule.

e. Retail survey prices; state payment and utilization rates; and performance rankings

Current Law

No provision.

Senate Bill

No provision.

House Bill

The House bill would allow the Secretary to contract with a vendor to obtain retail survey prices for Medicaid covered outpatient drugs that represent a nationwide average of pharmacy sales costs for such drugs, net of all discounts and rebates. Such a contract would be awarded for a term of 2 years.

The Secretary would be required to competitively bid for an outside vendor with a demonstrated history in surveying and determining on a representative nationwide basis, retail prices for ingredient costs of prescription drugs; working with retail pharmacies, commercial payers, and states in obtaining and disseminating price information; and collecting and reporting price information on at least a monthly basis. The contract would include the terms and conditions specified by the Secretary and would include a requirement that the vendor monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug available nationwide; update the Secretary no less often than monthly on the retail survey prices for multiple source drugs and on the computed upper payment limit for those drugs; to independently confirm retail survey prices. Information on the retail survey prices obtained through this process, including information on single source drugs would be required to be provided to states on an ongoing and timely basis.

Conference Agreement

The conference agreement includes a provision similar to the House provision. The agreement allows the Secretary to contract for services for the determination of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs. The conference agreement adds a

provision allowing such a contract to include notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available. The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs. The contract shall be effective for a term of two years. If the Secretary were to be notified that such a product has become generally available, the Secretary would be required to make a determination within 7 days as to whether the drug meets the definition of a multiple source drug subject to the application of the FUL. The agreement allows the Secretary to waive those provisions the Secretary determines are appropriate to waive, of the Federal Acquisition Regulation, for the efficient implementation of the contract.

The agreement does not require the contractor to independently confirm retail survey prices, as in the House bill, and does not require the Secretary to provide for electronic distribution to states. On the other hand, the Secretary would be required to devise and implement a means for providing access to each state Medicaid agency of collected price information and to provide information on retail survey prices, including information on single source drugs, to states at least monthly.

The agreement requires an annual report from each state agency. States are required to provide to the Secretary, the payment rates for all covered drugs, dispensing fees and utilization of innovator multiple source drugs under the state Medicaid plan. The Secretary is required to compare, on an annual basis, for the 50 most widely prescribed drugs, the national retail sales price data for each state. In addition, the Secretary is required to submit full information regarding the annual rankings to Congress. The provision becomes effective on January 1, 2007.

(f) Miscellaneous amendments

Current Law

States are required to have in place a program of prospective drug review wherein before each prescription is filled, the use of the prescription is screened for potential drug therapy problems. The requirement includes language clarifying that nothing in the provision is intended to require a pharmacist to provide this consultation when a beneficiary refuses such a consultation.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement clarifies that the requirement to provide prospective drug reviews is not intended to require verifications that consultations were offered or refused.

Effective on the date of enactment.

(g) Effective date

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

Unless otherwise specified, the provisions in Section 6001 take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Collection and Submission of Utilization Data for Certain Physician Administered Drugs (Section 6002 of the Conference Agreement, Section 6004 of the Senate Bill, and Section 3102 of the House Bill)

Current Law

Manufacturers are required to provide rebates to states for all outpatient prescription drugs with some exceptions. Outpatient prescription drugs provided through managed care organizations are explicitly exempted from the rebate requirement. In addition, outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs are exempt from the rebate requirement. Certain drugs administered by physicians in their offices or in another outpatient setting, such as chemotherapy, have often been excluded from the drug rebate program although there is no specific statutory exclusion. This is because providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectible prescription drugs, including cancer drugs. The HCPCS J-codes do not, however, provide States with the specific manufacturer information necessary to enable them to seek rebates. The NDC number is necessary for the state to bill manufacturers for rebates. CMS has requested that states identify Medicaid drugs, specifically those using HCPCS J-codes, by their NDC codes so that rebates can be collected for these drugs (Letter to State Medicaid Director, SMDL #03-002, dated March 14, 2003). CMS has concluded that because of this coding, many state Medicaid programs have not collected rebates on these drugs, resulting in millions of dollars in uncollected rebates.

Senate Bill

As a condition of receiving Medicaid payment, states would be required to submit, to the Secretary of HHS, utilization data and coding information for physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required. The reporting would include J-codes and National Drug Code numbers. The purpose of the reporting would be to allow the Secretary to secure rebates for such drugs.

Effective upon enactment.

House Bill

As a condition of receiving Medicaid payment, and in order to secure rebates for physician administered drugs states would be required to submit:

—No later than January 1, 2006, utilization data and coding information for single source drugs or biologicals that are physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required.

—No later than January 1, 2007, utilization data and coding information by NDC (unless the Secretary identifies an alternative coding system) for multiple source drugs.

—No later than January 1, 2008, utilization and coding information for those drugs on the list of 20 high volume physician administered drugs.

—No later than January 1, 2007, the Secretary would be required to publish a list of the 20 physician administered multiple source drugs that have the highest volume of physician administered dispensing under Medicaid. The Secretary would be able to modify such list from year.

The Secretary would be permitted to delay the application of the reporting requirements in the case of a State to prevent hardship to States that require additional time to implement such a reporting system.

Conference Agreement

The agreement includes a provision similar to the House provision. For drugs administered on or after January 1, 2006, states are required to provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered. For drugs administered on or after January 1, 2008, states are required to provide for the collection and submission of utilization and coding information for each Medicaid multiple source drug that is physician administered. Submissions from states will be based on National Drug Codes unless the Secretary specified an alternative coding system. All other provisions are identical to the House bill.

Improved Regulation of Drugs Sold Under a New Drug Application Approved Under Section 505(c) of the Federal Food, Drug, and Cosmetic Act (Section 6003 of the Conference Agreement, Section 6003 of the Senate Bill, and Section 3103 of the House Bill)

Current Law

Prescription drug manufacturers participating in the Medicaid program are required to report, to the Secretary of HHS, the AMP for each pharmaceutical product offered under Medicaid and, for each brand name drug product, the best price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or governmental entity. The term 'best price' is defined in the Medicaid statute but only with respect to single source and innovator multiple source drugs since the best

price is part of the rebate computation for only those drugs. These reported prices are used to calculate rebates—which are generally calculated separately for brand name drug products and for generics.

Sometimes manufacturers produce both a brand name version of a prescription drug and also sell or license a second manufacturer (or a subsidiary) to produce some of the same product to be sold or re-labeled as a generic. These generics, called “authorized generics,” are subject to a separate rebate calculation. Rebates for brand name products, take into account the best price reported for each drug. Such price often does not include the price of the product sold as the authorized generic.

Current law defines best price with respect only to a single source drug or innovator multiple source drug, as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, HMO, nonprofit entity, or governmental entity within the U.S. excluding prices charged to specified governmental purchasers. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation.

Senate Bill

The Senate bill would modify the existing drug price reporting requirements to include, for single source drugs, innovator multiple source drugs, authorized generic drugs, and any other drugs sold under a new drug application approved (under Section 505c of the Federal Food, Drug and Cosmetic Act, FDCA) by FDA, both the average manufacturer’s price and the manufacturer’s best price for such drugs. An authorized generic drug would be defined as a listed drug that has been approved by the FDA under Section 505(c) of such Act and is marketed, sold or distributed directly or indirectly to retail class of trade under a different labeling, packaging (other than repackaging the listed drug for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.

The definition of best price would be modified so that, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug to be sold under an NDA, it is inclusive of the lowest price such drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity. The definition of AMP would be modified to include, in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA to be inclusive of the average price paid for such drugs. The provision would become effective on January 1, 2006.

House Bill

The provision would modify the existing drug price reporting requirements for pharmaceutical manufacturers. No later than 30 days after the last day of each rebate period, manufacturers would be required to report,

- for each covered outpatient drug, including those sold under a new drug application approved by the FDA, the average manufacturer's price for such drugs; and,
- for single source drugs, innovator multiple source drugs, and any other drug sold under a new drug application approved by the FDA, the manufacturers best price for such drugs during the applicable rebate period.

Not later than 30 days after the date of entering into a drug rebate agreement, manufacturers would be required to report on the average manufacturer price for each of the manufacturer's covered outpatient drugs, including those sold under a new drug application approved by the FDA.

The definition of best price would be changed to apply, not only to each single source drug and innovator multiple source drug, but also to drugs sold under a new drug application (NDA) approved by (under Section 505c of FFDCA) FDA. In addition, the definition would be modified so that the best price, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA, is inclusive of the lowest price such authorized generic or other drug is sold to any wholesaler, retailer, provider, HMO, non-profit or governmental entity except for those entities excluded under current law. The provision would modify the current law definition of AMP to include, in the case of a manufacturer that approves, allows, or otherwise permits a drug of the manufacturer to be sold under an NDA to be inclusive of the average manufacturer price paid for such drugs. The provision would become effective on January 1, 2006.

Conference Agreement

The agreement includes a provision similar to the Senate provision. The provision is different from the Senate provision in that it does not refer to the affected drugs as "authorized generics". Instead, the agreement uses the phrase "any drug of the manufacturer sold under a new drug application approved under section "505(c) of the Federal Food, Drug, and Cosmetic Act" to include authorized generics. The conference agreement does not include a definition of "authorized generics." In addition, the definition of best price would be modified so that it is inclusive, in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the FFDCA, of the lowest price for an authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the U.S. The effective date would be January 1, 2007.

Children's Hospital Participation in Drug Discount Program (Section 6004 of the Conference Agreement, no provision of the Senate Bill, and Section 3104 of the House Bill)

Current Law

Section 340(B) of the Public Health Service Act allows certain health care providers, including community health centers and dis-

proportionate share hospitals, access to prescription drug prices that are similar to the prices paid by Medicaid agencies after being reduced by manufacturer rebates.

Senate Bill

No provision.

House Bill

The House bill would include a provision adding Children's Hospitals to the list of providers that may have access to 340(B) discounted prices. The provision would become effective for drugs purchased on or after the date of enactment.

Conference Agreement

The conference agreement includes the House provision.

Dispensing Fees (No provision in the Conference Agreement, Section 6001 of the Senate Bill, and Section 3101 of the House Bill)

Current Law

States are allowed to pay pharmacies reasonable dispensing fees.

Senate Bill

The Senate bill would require states to establish dispensing fees that are (a) greater for noninnovator multiple source drugs than those for innovator multiple source drugs that are therapeutically equivalent and bioequivalent; and (b) that take into account requirements established by the Secretary to include reasonable costs associated with a pharmacist's time checking an individual's coverage or performing quality assurance; measuring or mixing of a drug; filing the container; providing the completed prescription; delivery; special packaging; physical overhead and salaries of pharmacists and other pharmacy workers; geographic factors that impact costs; patient counseling; and drugs requiring specialty pharmacy management services.

The Senate bill would require, no later than 15 months after the date of enactment, with quarterly updates thereafter, the Secretary to establish of list of covered outpatient drugs requiring specialty pharmacy care management services. The list would include only those drugs for which the Secretary determines that access to the drug would be seriously impaired without the provision of such care management services. Specialty pharmacy care management services would be defined as those services provided in connection with the dispensing of a covered drug that requires:

- significant caregiver contact, education about the disease state, prevention, treatment, drug indications, benefits, risks, complications, pharmacy counseling and explanation;
- patient compliance services including coordination of provider visits with drug delivery, compliance with dosing regimen, mailing or telephone call reminders, compiling compliance data, assistance providers with compliance programs;

- tracking services, referral processes, screening referrals, and tracking patient weight for dosage.

In addition, the Senate bill would require states to consider, in establishing dispensing fees, the costs associated with operating a critical access retail pharmacy.

House Bill

The House bill would require states to pay a dispensing fee for each covered outpatient drug. States would be allowed to vary dispensing fees to take into account the special circumstances of pharmacies serving rural and underserved areas and sole community pharmacies. Dispensing fees for drugs defined as multiple source drugs under the FUL policy would be required to be no less than \$8 per prescription unit. The Secretary would be required to define what constitutes a prescription unit for this purpose.

Conference Agreement

No provision.

Increase in rebates for covered outpatient drugs (No provisions of the Conference Agreement, Sections 6001, 6002 and 6039D of the Senate Bill, and no provisions of the House Bill)

Current Law

Basic Medicaid rebates for single source and innovator multiple source drugs are equal to the greater of 15.1 percent of the AMP or the difference between the reported AMP and best price for each drug. In addition, if the prices of single source or innovator multiple source drugs rise faster than inflation, additional rebates are due. Rebates for all other multiple source drugs is equal to 11 percent of the AMP.

Senate Bill

The Senate bill would modify the formulas for prescription drug rebates under the Medicaid program. Beginning on January 1, 2006, rebates for single source and innovator multiple source drugs would be equal to the greater of 18.1 percent of the AMP or the difference between the reported AMP and the best price for each drug. (Sections 6002(a)(3) and 6001(b)(2).)

Rebates for single source and innovator multiple source drugs equal to 17.8 percent of the AMP or the difference between the reported AMP and the best price for each drug. (Section 6039D.)

Rebates for all other drugs would be equal to 17 percent. Changes to the rebate formula would begin on January 1, 2006.

House Bill

No provision.

Conference Agreement

No provision.

Extension of rebates to Medicaid MCOs (No provisions of the Conference Agreement, Sections 6001 and 6038 of the Senate Bill, and no provisions of the House Bill)

Current Law

Rebates are not required for drugs dispensed by Medicaid managed care organizations (MCO) when the drugs are paid as part of the MCO capitation rate, to drugs provided in hospitals, and sometimes in physicians', or dentists' offices.

Senate Bill

Section 6001(a)(5) of the Senate bill would establish rebates for drugs dispensed by Medicaid MCOs. States would have the option of collecting rebates directly from manufacturers or allowing the MCO to collect the rebates in exchange for a reduction in the pre-paid payment made to the entity for Medicaid enrollees. The provision would become effective on the date of enactment and would apply to Medicaid rebate agreements entered into or renewed on or after that date.

Section 6038 would establish rebates for drugs dispensed by Medicaid MCOs except for those drugs purchased at discounted prices under the Public Health Service Act Sec. 340B drug discount program.

House Bill

No provision.

Conference Agreement

No provision.

Improving Patient Outcomes (No provision of the Conference Agreement, no provision of the Senate Bill, and Section 3105 of the House Bill)

Current Law

States may establish a prior authorization program as long as the system provides a response for a request for approval within 24 hours, and as long as the program allows for a dispensing of at least a 72 hour supply of a covered drug in an emergency situation. Other restrictions may be imposed if they are necessary to discourage waste, fraud or abuse.

Senate Bill

No provision.

House Bill

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

scription is transmitted. The provision would be effective on January 1, 2007.

Conference Agreement

No provision.

Chapter 2—Long-Term Care Under Medicaid

SUBCHAPTER A—REFORM OF ASSET TRANSFER RULES; LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY

Lengthening Look-back Period for all Disposals to 5 years (Section 6011(a) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(a) of the House Bill)

Current Law

Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

Ineligibility for Medicaid coverage is limited to only certain long-term care services, not all services covered under the program. The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations. States may choose to apply this ineligibility period to other state plan long-term care services. (They also currently apply to home and community care for functionally disabled elderly individuals under section 1929 of the Act. This is an optional coverage group which operates only in Texas.) In general, states do not extend the penalty to Medicaid's acute care services.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to 5 years, or 60 months, for all income and assets disposed of by the individual after this Act's date of enactment. For income and assets disposed of prior to the enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would

apply. The House bill would become effective on the date of the enactment of this Act.

Conference Agreement

The conference agreement includes the House provision.

Change in Beginning Date for Period of Ineligibility (Section 6011(b) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(b) of the House Bill)

Current Law

The period of ineligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period. Some penalties imposed on applicants who made improper transfers within the look-back period and prior to the date of Medicaid application may expire before the date of Medicaid application. For example, an improper transfer of \$100,000 made 2 years prior to Medicaid application could result in a 20-month penalty period (\$100,000 divided by the private rate for a nursing home state in a state of \$5,000). Since the individual applies to Medicaid two years, or 24 months, after having made the transfer, the penalty has already expired before the individual applies to Medicaid. However, if the transfer of \$100,000 is made one year prior to Medicaid application, the penalty of 20 months would not have expired before the applicant needed Medicaid coverage, but rather would continue for eight months after Medicaid application.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917(c)(1)(D) of the Social Security Act by changing the start date of the ineligibility period for all transfers made on or after the date of the enactment, to the first day of a month during or before which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and is receiving certain long-term care services, whichever is later and which does not occur during any period of ineligibility as a result of an asset transfer policy. For transfers made prior to this Act's enactment, current law applies.

Conference Agreement

The conference agreement includes the House provision but specifies that the start date begins on the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy.

Effective Date (Sections 6011(c) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(c) of the House Bill)

Current Law

Currently effective.

Senate Bill

No provision.

House Bill

The amendments made by this section would apply to transfers made on or after the date of enactment.

Conference Agreement

The conference agreement includes the House provision.

Availability of Hardship Waivers (Sections 6011(d) and (e) of the Conference Agreement, Section 6011(f) of the Senate Bill, and Sections 3111(d) and (e) of the House Bill)

Current Law

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

CMS guidance requires that state procedures, at a minimum, provide for and discuss: (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Senate Bill

The Senate bill would amend Section 1917(c) of the Social Security Act by adding a requirement that states establish undue hardship procedures (in accordance with standards specified by the Secretary) that would provide for: (1) a notice that an undue hardship exception exists before the imposition of a penalty period to an applicant for Medicaid who would be subject to such a penalty; (2) a timely process before the imposition of a penalty determining whether an undue hardship waiver will be granted for the individual; (3) a process under which an adverse determination can be appealed; and (4) an application of criteria that specifies that undue hardship exists when application of the ineligibility period or counting of trusts would deprive the individual of medical care

so that the individual's health or life would be endangered or when it would deprive the individual of food, clothing, shelter, or other necessities of life.

House Bill

The House bill would amend section 1917(c)(2)(D) of the Social Security Act to specify the criteria by which an application for an undue hardship waiver would be approved. Approval would be subject to a finding that the application of an ineligibility period would deprive the individual of medical care such that the individual's health or life would be endangered, or that the individual would be deprived of food, clothing, shelter, or other necessities of life. States would also be required to provide for: (A) notice to recipients that an undue hardship exception exists; (B) a timely process for determining whether an undue hardship waiver will be granted; and (C) a process under which an adverse determination can be appealed.

This provision would also amend section 1917(c)(2) of the Social Security Act to permit facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or the consent of his or her guardian. If the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Conference Agreement

The conference agreement includes the House provision.

Disclosure and Treatment of Annuities and of Large Transactions
(Section 6012 of the Conference Agreement, Section 6011(d) of the Senate Bill, and Section 3112 of the House Bill)

Current Law

Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary of DHHS defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal). If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place. The State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound.

States and courts interpret this guidance differently. In *Mertz v. Houston*, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the

court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. In a recent case in Ohio, a state court ruled that it was proper to look at the intent of asset transfers, even if the annuity was actuarially sound. (*Bateson v. Ohio Dept. of Job and Family* (Ohio Ct. Appl., 12th, No. CA2003-09-093, Nov. 22, 2004).

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

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state probate law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. Thus assets such as living trusts, life insurance policies, certain annuities, which may pass to heirs outside of probate, would be subject to Medicaid recovery only if a state expanded its definition of "estate."

Senate Bill

The Senate bill would amend section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The Senate bill would amend section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the

second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

The Senate bill would amend Section 1917(b)(4) of the Social Security Act to include an annuity in the definition of estate that is subject to estate recovery unless the annuity was purchased from a financial institution or other business that sells annuities in the state as part of its regular business.

House Bill

The House bill would amend section 1917 of the Social Security Act by adding a new subsection that would require individuals, at the initial application or recertification for certain Medicaid long-term care services, to disclose to the state the following:

(A) A description of any interest the individual has in an annuity (or similar financial instrument which provides for the conversion of a countable asset to a noncountable asset, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset;

Applications or recertification forms shall include a statement that designates the state as the remainder beneficiary under such an annuity or similar financial instrument, subject to the following provisions:

(A) For institutionalized individuals who receive certain Medicaid-covered long-term care services, the state would become the remainder beneficiary in the first position of an annuity (in which he or she has an interest) for the total amount paid by Medicaid on behalf of the individual; the state becomes the remainder beneficiary in the second position when there is a spouse, minor, or disabled child as a named beneficiary.

(B) In the case of disclosure concerning an annuity, the state would notify the annuity's issuer of the state's right as a preferred remainder beneficiary in the annuity for Medicaid services furnished to the individual. This provision would not prevent the issuer from notifying persons with any other remainder of the state's interest in the remainder.

(C) The state may require an issuer to notify when there is a change in the amount of income or principal being withdrawn from the amount being withdrawn at the time of the most recent disclosure, as specified above. A state would take such information into account when determining the amount of the state's obligations for Medicaid or the individual's eligibility. Such a change in amount would be deemed as a transfer of an asset for less than fair market value unless the individual demonstrates, to the state's satisfaction, that the asset transfer was for fair market value.

The Secretary may provide guidance to states on categories of arm's length transactions (such as the purchase of a commercial annuity) that could be generally treated as an asset transfer for fair market value.

The House bill would not prevent a state from denying Medicaid eligibility for an individual based on the income or resources derived from an annuity.

The House bill would apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment.

Conference Agreement

The conference agreement requires individuals, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form includes a statement naming the state as the remainder beneficiary. In the case of disclosure concerning an annuity, the state notifies the annuity's issuer of the state's right as a preferred remainder beneficiary for Medicaid assistance furnished to the individual. Issuers may notify persons with any other remainder interest of the state's remainder interest.

States may require an issuer to notify the state when there is a change in the amount of income or principal withdrawn from the amount withdrawn at the point of Medicaid application or recertification. States take this information into account when determining the amount of the state's financial share of costs or in the individual's eligibility for Medicaid.

The Secretary may provide guidance to states on categories of transactions that may be treated as a transfer of asset for less than fair market value. States may deny eligibility for medical assistance for an individual based on the income or resources derived from an annuity.

The conference agreement amends section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

The conference agreement amends section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for a Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in subsection (b) and (q) of section 408 of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in subsections (a), (c), and (p) of section 408 of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The amendments apply to transactions, including the purchase of annuity, occurring on or after the date of this Act's enactment.

Application of Income-First Rule in Applying Community Spouse's
Income Before Assets in Providing Support of Community
Spouse (Section 6013 of the Conference Agreement, no provi-
sion in the Senate Bill, and Section 3113 of the House Bill)

Current Law

Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services. These provisions were added by the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the situation that would otherwise leave the spouse not receiving Medicaid (community spouse) with little or no income or assets when the other spouse is institutionalized or, at state option, receives Medicaid's home- and community-based services. Before MCCA, states could consider all of the assets of the community spouse, as well as the spouse needing Medicaid coverage, to be available to pay for care for the spouse needing Medicaid coverage. These rules created hardships for the spouse living in the community who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the other spouse could qualify for coverage. MCCA established new rules for the treatment of income and assets of married couples, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules.

Regarding income, current law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, section 1924(d) of the Social Security Act provides for the establishment of a minimum monthly maintenance needs allowance for each community spouse to try to ensure that the community spouse has sufficient income to meet his or her basic monthly needs. (The community spouse's minimum monthly maintenance needs allowance is set at a level that is higher than the official federal poverty level.) Once income is attributed to each of the spouses according to their ownership interest, the community spouse's monthly income is compared against the minimum monthly maintenance needs allowance. If the community spouse's monthly income amount is less than the minimum monthly maintenance needs allowance, the institutionalized spouse may choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e. the difference between the community spouse's monthly income and the state-specified minimum monthly maintenance needs allowance). This transfer allows more income to be available to the community spouse, while Medicaid pays a larger share of the institutionalized spouse's care costs. Within federal limits, states set the maximum monthly income level that community spouses may retain. Federal requirements specify that this amount may be no greater than \$2,377.50 per month, and no less than \$1,561.25 per month in 2005.

Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. This amount is referred to as the community spouse resource al-

lowance (CSRA). Federal requirements specify that this amount may be no greater than \$95,100 and no less than \$19,020 in total countable assets in 2005. When determining eligibility, all assets of the couple are combined, counted, and split in half, regardless of ownership. If the community spouse's share of the assets is less than the state-specified maximum, then the Medicaid beneficiary must transfer his or her share of the assets to the community spouse until the community spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid.

States have some flexibility in the way they apply these rules at the time in which a person applies through the fair hearing process to raise his or her minimum maintenance needs allowance. At this point, a state may decide to allocate more income or resources from the institutionalized spouse to the community spouse. In doing so, states have employed two divergent methods. Under the method used by most states, known as the "income-first" method, the state requires that the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet or, if approved by the state, exceed the minimum monthly maintenance needs allowance; the remainder, if any, is applied to the institutionalized spouse's cost of care. Under this method, the assets of an institutionalized spouse (e.g. an annuity or other income producing asset) cannot be transferred to the community spouse to generate additional income for the community spouse unless the income transferred by the institutionalized spouse would not enable the community spouse's total monthly income to reach the state-approved monthly maintenance needs allowance. This method generally requires a couple to deplete a larger share of their assets than the resources-first method.

In contrast, under the other method, known as the "resources-first" method, the couple's resources can be protected first for the benefit of the community spouse to the extent necessary to ensure that the community spouse's total income, including income generated by the CSRA, meets or, if approved by the state, exceeds the community spouse's minimum monthly maintenance needs allowance. Additional income from the institutionalized spouse that may be, but has not been, made available for the community spouse is used toward the cost of care for the institutionalized spouse. This method generally allows the community-spouse to retain a larger amount of assets than the income-first method.

On September 7, 2001, the Secretary issued a proposed rule (Federal Register Vol. 66, No. 174) that would have codified state practices. The proposed rule would have allowed states to choose between using either the income-first or resources-first method when determining whether the community spouse has sufficient income to meet the minimum monthly maintenance needs allowance. Under the proposed rule, states would not have been able to apply different rules to different individuals, on a case-by-case basis. The Secretary has not issued a final rule.

Senate Bill

No provision.

House Bill

The House bill would amend section 1924(d) of the Social Security Act to require that any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a community spouse's monthly income allowance be first made from income of the institutionalized spouse. Only when sufficient income is not available, could resources of the institutionalized spouse be transferred or allocated.

The House bill would apply to transfers and allocations made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Conference Agreement

The conference agreement amends section 1924(d), and therein sections (c) and (e), of the Social Security Act to require that states consider that all income of the institutionalized spouse that could be made available to the community spouse, in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing, has been made before states allocate the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse. These amendments apply to transfers and allocations made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity (Section 6014 of the Conference Agreement, no provision in the Senate Bill, and Section 3114 of the House Bill).

Current Law

Within federal law, states set asset standards that applicants must meet to qualify for Medicaid coverage. Among other things, these standards specify a limit on the amount of countable assets a person may have to qualify, as well as define which types of assets are counted and not counted. In general, countable assets cannot exceed \$2,000 for an individual applicant. States generally follow SSI rules for computing both countable and non-countable assets.

Under Medicaid and SSI rules, the value of an item may be totally or partially excluded when calculating countable resources. For example, the entire value of a car, regardless of its worth, is excluded, but life insurance is counted to the extent that the cash surrender value exceeds \$1,500 (if the total value of all life insurance policies on any person does not exceed \$1,500, no part of the cash surrender value of such life insurance will be counted for eligibility purposes).

Current Medicaid and SSI asset counting practices generally exclude the entire value of an applicant's home. A home is defined as any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and re-

lated outbuildings. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. However, if an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than \$750,000. (The Secretary would establish a process to waive application of this provision for demonstrated cases of hardship.) This amount would be increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest \$1,000.

Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The House bill would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Conference Agreement

The Conference agreement amends section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than \$500,000. A state may elect an amount that exceeds \$500,000, but does not exceed \$750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest \$1,000.

Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The House bill would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-

term care services based on an application filed on or after January 1, 2006.

Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts (Section 6015 of the Conference Agreement, no provision in the Senate Bill, and Section 3115 of the House Bill)

Current Law

Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay entrance fees and who often reside in such CCRCs throughout their older years. The services generally offered include meals, transportation, emergency response systems, and on-site nursing and physician services. Many also offer home care, maid services and laundry. CCRCs were developed, in large part, in response to an interest among many elderly persons to age-in-place. CCRCs can be either for-profit or not-for-profit CCRCs. They are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Although the majority of CCRC residents do not meet the financial criteria for Medicaid, some do. Under current law, section 1919(c)(5)(A)(i)(II) of the Social Security Act prohibits Medicaid-certified nursing facility from requiring that individuals provide them with oral or written assurance that they are not eligible for, or will not apply for, Medicaid or Medicare benefits.

Senate Bill

No provision.

House Bill

The House bill would amend section 1919(c)(5)(A)(i)(II) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) that are certified to accept Medicaid and/or Medicare payment to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for community spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid.

The House bill would also amend section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination. For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered in the computation of the spousal share available to Medicaid. Entrance fees that would be considered a resource available to the individual would meet the following criteria:

(A) the individual would have the ability to use the entrance fee, or the contract provides that the entrance fee could be used, to pay for care should other resources or income of the individual be insufficient to pay for care;

(B) the individual would be eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community

Conference Agreement

The conference agreement includes the House provision except that a CCRC or life care community cannot retain a portion of an entrance fee, otherwise made available to spend on care before applying for Medicaid, on account of a community spouse's resource allowance.

Additional Reforms of Medicaid Asset Transfer Rules

Requirement to Impose Partial Months of Ineligibility (Section 6016(a) of the Conference Agreement, Section 6011 (a) of the Senate Bill, and no provision in the House Bill)

Current Law

Current law requires states to impose penalties on individuals applying for Medicaid who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for individuals receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The look-back date is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

The length of the delay is determined by dividing the total cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth \$60,000, divided by a \$5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

When calculating the length of the penalty period when assets are transferred for less than fair market value, current law allows states to "round down," or not include in the ineligibility period the quotient amounts (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month. For example, in a

state with an average private stay in a nursing home of \$4,100, an ineligibility period for an improper transfer of \$53,000 could be 12.92 months (i.e. $\$53,000/\$4,100=12.92$). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31 day month), other states may round down the quotient to an ineligibility period of 12 months only.

Senate Bill

The Senate bill would amend Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Authority for States to Accumulate Multiple Transfers into One Penalty Period (Section 6016(b) of the Conference Agreement, Section 6011(b) of the Senate Bill, and no provision in the House Bill)

Current Law

Current law and additional CMS guidance provides that when a number of assets are transferred for less than fair market value on or after the look-back date during the same month, the penalty period is calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or individual's spouse) divided by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. When a number of assets are transferred during different months, then the rules vary based upon whether the penalty periods overlap. If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision but refers to the disposal of multiple fractional transfers of assets instead of multiple assets.

Inclusion of Transfer of Certain Notes and Loans Assets (Section 6016(c) of the Conference Agreement, Section 6011(c) of the Senate Bill, and no provision in the House Bill)

Current Law

Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed \$2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets.

Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Under Medicaid and SSI rules, non-countable assets include an individual's primary place of residence, one automobile, household goods and personal effects,¹ property essential to income-producing activity, up to \$1,500 in burial funds, life insurance policies whose total face value is not greater than \$1,500, and miscellaneous other items.

Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender.

¹Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 Federal Register 6340, no. 24, Feb. 7, 2005.

In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Inclusion of Transfers to Purchase Life Estates (Section 6016(d) of the Conference Agreement, Section 6011(e) of the Senate Bill, and no provision in the House Bill)

Current Law

Current law does not specify whether life estates should be treated as countable or noncountable assets for purposes of applying the Medicaid asset transfer rules. In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets. The guidance also explains that a transfer for less than fair market value occurs whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate. According to CMS, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act to add a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Effective Date (Section 6016(e) of the Conference Agreement, Section 6011(g) of the Senate Bill, and no provision in the House Bill)

Current Law

No provision.

Senate Bill

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act's enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act. In the case of a state that has a two-year legislative session, each year of the session would be considered to be a separate regular session of the state legislature. This amendment applies to provision under section 6011 of the Senate bill.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision with respect to amendments made by section 6016.

Subchapter B—Expanded Access to Certain Benefits

Expansion of State Long-Term Care Partnership Program (Section 6021 of the Conference Agreement, and Section 6012 of the Senate Bill, and Section 3133 of the House Bill)

Current Law

Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.

In general, states allow individuals to retain no more than \$2,000 in countable assets and exempt certain non-countable assets such as an individual's primary place of residence, one automobile, household goods and personal effects. Under section 1902 of the Social Security Act, a state may request the Secretary's permission to amend its Medicaid state plans to allow certain applicants to retain greater amounts of countable assets than other applicants and still qualify for Medicaid. Specifically, states that obtain the Secretary's approval may disregard some or all of the assets of persons apply-

ing for Medicaid who have purchased long-term care insurance policies.

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

The four partnership states with active programs have different models for determining the amount of assets that an eligible participant may protect. Connecticut and California use a dollar-for-dollar model, in which the amount of the assets protected is equivalent to the value of the benefit package paid by the policy purchased (e.g., \$100,000 of nursing-home or assisted living benefits paid enables that individual to retain up to \$100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a total asset protection model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

Federal oversight of long-term care insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–191). HIPAA established new rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy. LTC insurance products are largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including the following.

Model Regulations:

- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Requirements to deliver shopper's guide.

Model Act:

- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary;
- Accelerated death benefits; and
- Incontestability period.

HIPPA also includes requirements that tax-qualified policies comply with consumer protections regarding the delivery of policies, information on denials of claims, and disclosure. While many

state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards. As a result, there is significant variation in regulatory practices across states.

National Clearinghouse for Long-Term Care. No provision in current law requires the establishment of a long-term care consumer clearinghouse.

In related activities, DHHS has funded some states to establish state-based consumer-friendly access to information about long-term care services. In FY2003 and FY2004, the Centers for Medicare and Medicaid (CMS) and AoA awarded approximately \$19 million in grants to states for the purpose of assisting their efforts to create a single, coordinated system of information and access for all persons seeking long term care to minimize confusion, enhance individual choice, and support informed decision-making. In FY2005, \$15 million was awarded. A total of 43 states have received grants for this purpose. Some of the common activities under this grants program include information and referral, outreach, counseling about public benefits and long-term care options, and case management. States' methods for implementing the grant may vary; some states have established an actual physical location, and other states have established a statewide clearinghouse through a toll-tree number or a web-based information site.

In addition, CMS has made available to the public, via its website, a comparison of Medicare and Medicaid-certified nursing homes and home health agencies. The information provides detailed facility and agency information and characteristics, and contains several measures of quality (e.g., improvement in mobility). This website does not cover assisted living facilities, group homes and other residential facilities that are not nursing facilities; nor does it cover non-medical, non-certified, home and community-based long-term care services.

Senate Bill

The Senate bill would exempt an additional group of persons with certain long-term care insurance plans from Medicaid estate recovery. This group would include individuals who received Medicaid under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below. The provision would also require that existing LTC insurance partnership programs satisfy requirements B through G below for LTC insurance policies sold on or after 2 years after enactment.

The Senate bill would define LTC insurance policies as including, but not be limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term "Qualified State LTC Insurance Partnership," would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another states' Qualified LTC In-

insurance Partnership” or a long-term care insurance policy, the same as the state treats benefits paid under such a policy under the state’s plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed \$250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest \$100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold;

(F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and

(G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective.

LTC insurance policies would be required to meet the following requirements specified in the National Association of Insurance Commissioner’s (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). The requirements include the following topics described below.

Model Regulations:

- Guaranteed renewal or noncancellability;
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;
- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;

- Standards for marketing, including inaccurate completion of medical histories;
- Suitability;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Standard format outline of coverage; and
- Deliver shopper's guide.

Model Act:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act would be treated as including any other provision the Regulation or Act necessary to implement the provision. The determination of whether any requirement under the Model Act or Regulation have been met would be made by the Secretary.

No later than one year after enactment, the Secretary, in consultation with the NAIC, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies would be required to develop uniform standards for:

- Reciprocity. These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such-LTC insurance partnerships;
- Minimum reporting requirements. These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;
- Suitability. These standards would be for determining whether a long-term care insurance policy is appropriate for the needs of an applicant (based on guidance of the NAIC regarding suitability).

The Secretary, in consultation with those listed above, would also be required to submit recommendations to Congress with respect to the following:

- Incontestability. Recommendations regarding whether the requirements relating to incontestability for LTC insurance policies

sold under a state partnership program should be modified based on NAIC guidance;

- **Nonforfeiture.** Recommendations regarding whether requirements relating to nonforfeiture for issuers of LTC insurance policies under a state LTC insurance partnership program should be modified to reflect changes in an insured's financial circumstances;

- **Independent certification for benefits assessment.** Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be conducted by independent entities should be established for issuers of LTC insurance policies under such a state partnership program, and if so, what such standards should be;

- **Rating requirements.** Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for LTC insurance policies sold under such a state partnership program should be established and if so, what such standards should be; and

- **Dispute Resolution.** Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under LTC insurance policies sold under such a state partnership program and the delivery of the benefits promised under such policies.

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures and federal Medicare expenditures.

Effective Date. These amendments would become effective on October 1, 2007 and apply to long-term care insurance policies sold on or after that date.

House Bill

The House bill would amend section 1917(b)(1)(C)(ii) of the Social Security Act to allow additional groups of individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. The term "Qualified State LTC Insurance Partnership," would mean a Medicaid State plan amendment that provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. (In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged);

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued on or after the first day of the first

calendar quarter in which the plan amendment was submitted to the Secretary;

(III) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection;

(IV) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(V) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (promulgated after consultation with the states), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the Secretary determines appropriate to the administration of such partnerships;

(VI) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Secretary, as appropriate, would provide copies of the state reports to the state involved and would promote the education of consumers regarding qualified state long-term care insurance partnerships. In addition, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, the Secretary would develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary may develop, in consultation with the states and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships.

Effective Date. A state plan amendment that provides for a qualified state long-term care insurance partnership would be effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

Conference Agreement

The conference agreement amends section 1917(b)(1)(C)(ii) of the Social Security Act to: (1) require that existing partnership programs not allow consumer protection standards, as defined in a

Medicaid state plan amendment, to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and (2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a long-term care insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;

(III) The policy meets the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000).

Model Regulations relating to:

- Guaranteed renewal or noncancellability (including some sections of the Model Act);
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;
- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing, including inaccurate completion of medical histories;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Delivery of shopper's guide.

Model Act relating to:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;

- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act are treated as including any other provision of the Regulation or Act necessary to implement the provision. Long-term care insurance policies issued in a state shall be deemed as meeting the requirements of the model regulation or the Model Act if the state plan amendment provides that the State insurance commissioner for the state certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection.

(V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, states with experience with long-term care insurance partnership plans, other states, and representatives of consumers of long-term care insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the data format and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved;

(VII) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, state insurance commissioners, states with experience with long-term care insurance partnership plans, other states, and representatives of consumers of long-term care insurance policies, the Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mecha-

nism that State, the Secretary, and other Federal agencies can access.

Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update or other modification of a model regulation or model act provision listed above or substantially related those listed above, the Secretary reviews these changes, determines whether incorporating such changes into the corresponding provision would improve qualified state long-term care insurance partnerships, and, if so, incorporate the changes into the provision.

States may require issuers of long-term care insurance policies sold in that state (regardless of whether the policy is issued under a qualified state long-term care insurance partnership) to report additional information or data to the state.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary develops no later than January 1, 2007, in consultation with the National Association of Insurance Commissioners, states with experience with long-term care insurance partnership plans, other state, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships which have benefits paid under such policies will be treated the same by all such states, and states with such partnerships shall be subject to such standards unless the state notifies the Secretary of the State's election to be exempt from such standards.

The Secretary annually reports to Congress on the long-term care insurance partnerships. Such reports would include analyses of the extent to which partnership programs expand or limit access of individuals to long-term care and the impact of such partnerships on federal and state expenditures under Medicare and Medicaid. Nothing in this provision shall require the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with a state partnership program.

A state plan amendment that provides for a qualified state long-term care insurance partnership may provide that the amendment be effective for long-term care insurance policies issued on or after a date that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

With respect to policy exchanges, Conferees expect existing policy holders will be able to exchange existing policies for Partnership policies in accordance with policy provisions and state law after a State's plan amendment is effective.

National Clearinghouse for Long-Term Care. The Secretary establishes a National Clearinghouse for Long-Term Care Information (this may be done through a contract or interagency agreement). The National Clearinghouse for Long-Term Care: (1) educates consumers with respect to the availability and limitations of Medicaid long-term care coverage, including state Medicaid eligibility and estate recovery requirements; (2) provides objective information to assist consumers with the decision-making process for determining whether to purchase long-term care insurance or to

pursue other private market alternatives for purchasing long-term care; (3) provide contact information for additional objective sources on planning for long-term care services needs; and (4) maintain a list of states with state long-term care insurance partnerships.

In providing information to consumers on long-term care, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out for the National Clearinghouse for Long-Term Care \$3 million for each of fiscal years 2006 through 2010.

Expanded Access to Home and Community-based Services for the Elderly and Disabled (Section 6022 of the Conference Agreement, no provision in the Senate Bill, and Section 3131 of the House Bill)

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. HCBS waiver services can include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state and approved by the Secretary. As part of the waiver, states may define the services that will be offered, target a specific population (e.g., individuals with developmental disabilities) or a specific geographic region, and limit the number of waiver participants (resulting in a waiting list for services in many states).

Approval for a HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if, on average, the per person cost under the HCBS waiver is no higher than the cost if the person were residing in one of the three types of institutions identified in Medicaid law, (hospital, nursing facility or ICF-MR). The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

A HCBS waiver is generally approved for a 3- or 5-year time period and is subject to additional oversight from the Centers for Medicare and Medicaid Services (CMS). In July 2003, there were 275 HCBS waivers nationwide in all states (except Arizona which offers HCBS services under a Section 1115 waiver).

Senate Bill

No provision.

House Bill

The House bill would allow states to cover a broad range of home and community-based services (HCBS) as an optional benefit under the state Medicaid plan without requiring a waiver. States

would be able to define which HCBS services will be covered and could include any service authorized by federal law for existing HCBS waiver programs (as defined in Section 1915(c)(4)(B) of the Social Security Act). Similar to the existing HCBS waiver program, paying for an individual's room and board would not be permitted under this new benefit.

To qualify for this benefit the individual must meet the following criteria: (1) Age 65 or older or disabled (as defined under the Medicaid state plan) but who is not an individual with a developmental disability, mental retardation or a related condition; (2) have had a determination that, but for the provision of such services, the individual would require the level of care provided in a hospital or nursing facility (the cost of which could be reimbursed under Medicaid); and (3) meet the Medicaid eligibility standards in effect in the state (which may include an approved Medicaid waiver) as of the date of enactment of this provision.

A state would be able to cover this benefit under the Medicaid state plan if certain conditions are met: (1) Any state waiver or demonstration under Sections 1915 or 1115 of the Social Security Act with respect to such services for individuals described in this provision must have expired; and (2) the state must monitor and report to the Secretary of the Department of Health and Human Services (DHHS) on a quarterly basis the enrollment and expenditures for services provided under this option.

A state would not be required to comply with existing Medicaid requirements regarding the statewide availability of the service, the comparability of services, and the income and resource rules applicable in the community. A state may also limit the number of individuals who are eligible for services, establish waiting lists for the receipt of these services, and limit the amount, duration, and scope of services.

This section would be effective for home and community-based services furnished on or after October 1, 2006.

Conference Agreement

The conference agreement establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150 percent of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve, and would not include an individual's room and board. The state may provide this option to individuals without determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR.

States are required to establish needs-based criteria for determining an individual's eligibility for the HCBS option established by this provision, and the specific HCBS the individual will receive. The State must also establish needs-based criteria for determining whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision.

The state is also required to submit to the Secretary a projection of the number of individuals to be served under the option, and may limit the number of individuals who are eligible for such services.

The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.

A state is allowed to modify the needs-based criteria described above in the event that enrollment of individuals for the HCBS option exceeds projected enrollment. The state is not required to seek prior approval of the Secretary if the state wishes to modify the needs-based criteria, but must give the Secretary and the public at least 60 days notice of the proposed modification. If a state modifies the needs-based criteria, existing recipients of the HCBS optional state plan services will continue to be eligible to receive those services for at least 12 months beginning on the date the individual first received medical assistance for HCBS services. After such a modification, the state, at a minimum, must apply the level of care determination for hospitals, nursing facilities, and ICF-MRs that were in effect prior to the application of more stringent criteria.

The state is required to use an independent evaluation for determining an individual's eligibility for HCBS. The independent evaluation must include an assessment of the needs of the individual to: (1) determine a necessary level of services and supports consistent with the individual's physical and mental capacity; (2) prevent unnecessary or inappropriate care, and (3) establish an individualized care plan for the individual.

The assessment must include: (1) an objective evaluation of an individual's inability or need for significant assistance to perform two or more activities of daily living as defined in the Internal Revenue Service code; (2) a face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for HCBS; (3) where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual; (4) consultation with all treating and consulting health and support professionals caring for the individual; (5) an examination of the individual's relevant history and medical records, and care and support needs guided by best practices and research on effective strategies that result in improved health and quality of life outcomes. The assessment must also evaluate the ability of the individual or individual's representative to self-direct the purchase and control of HCBS if he/she elects this option, and if such an option is covered by the state.

The independent evaluation is to establish a written individualized plan of care. The plan must be developed in consultation with the individual, the individual's treating physician, health care or support professionals, or other appropriate individuals, and the

family caregiver or individual representative if appropriate; (2) to take into account the extent, and the need for, any family or other supports for the individual; (3) to identify the HCBS services to be provided (or purchase, if the individual elects to self-direct his/her care); (4) to be reviewed at least annually or as needed when there is a significant change in circumstances.

States may allow individual (or the individual's representative) to elect to self-direct the purchase and control of state plan HCBS. Under the self-directed option, the individual's needs, preferences, and capabilities are assessed, and based on the assessment, a service plan is developed jointly with the individual (or representative) that is approved by the state. The service plan must include certain activities such as a person-centered planning process and risk management techniques. States may also include an individualized budget that identifies a dollar value for the services and supports under the control and direction of the individual or his or her representative. States are required to provide information in the state plan amendment about how an individualized budget is developed and implemented.

The state must ensure that the provision of home and community-based services meets federal and state guidelines for quality assurance. The state must establish standards for the conduct of the independent evaluation to prevent conflicts of interest, and must allow for at least annual redetermination of eligibility and appeals using the process for appeals under the State Plan.

States may elect to provide for a period of presumptive eligibility (not to exceed 60 days) for individuals that the state has reason to believe may be eligible for home and community-based services. The covered activities include carrying out the independent evaluation and assessment and, if eligible, the specific services the individual will receive.

In covering this benefit, a state may elect not to comply with existing Medicaid requirements related to statewideness and the income and resource rules applicable in the community, but only for purposes of providing home and community-based services in accordance with this benefit. This option should not be construed as applying to those receiving Medicaid in an institution as a result of a determination that the individual requires the level of care in a hospital, nursing facility or ICF/MR.

Federal Medicaid funding will continue to be available for individuals who are receiving Medicaid in an institution or home and community-based setting (under a HCBS waiver program or Section 1115 demonstration) as of the effective date of the Medicaid state plan amendment, without regard to whether the individuals satisfy the more stringent eligibility criteria established under that paragraph until the individual is discharged from the institution or waiver program, or no longer requires such level of care.

The provision requires the Secretary acting through the Director of the Agency for Healthcare Research and Quality, to consult with consumers and health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction regarding HCBS offered under Medicaid.

The Secretary is required to use the indicators and measures to assess HCBS and outcomes, particularly with respect to a recipient's health and welfare, and the overall system for RCBS under Medicaid. The Secretary is also required to make best practices and comparative analyses of system features available to the public.

This provision will be effective on January 1, 2007.

Optional Choice of Self-directed Personal Assistance Services (Cash and Counseling) (Section 6023 of the Conference Agreement, and no provision in the Senate Bill, and Section 3132 of the House Bill)

Current Law

Under current law, state Medicaid programs offer several types of long-term care services to individuals who, because of disability or chronic illness, need assistance with activities such as eating, bathing, and dressing. Medicaid programs have the option of covering personal care services and may also cover a broad set of other services through a home and community-based services (HCBS) waiver authorized under Section 1915(c) of the Social Security Act. To qualify for a HCBS waiver, the individual must require the level of care of a hospital, nursing facility or intermediate care facility for persons with mental retardation (ICF/MR).

Traditionally, Medicaid personal care and other related services have been provided to individuals through local public or private agencies. However, in the last decade, Medicaid beneficiaries with disabilities or chronic conditions and federal and state policymakers have been increasing the discretion that beneficiaries have over key elements of the service (e.g., what time a personal care worker comes to the home to help the beneficiary, who provides the service, etc.) These types of programs are broadly known as "self-directed" or "consumer-directed" programs. The specific elements that a Medicaid beneficiary can control vary widely depending upon the state and the type of service covered. Currently, Medicaid law allows certain types of self directed programs to be implemented through the normal Medicaid state plan and HCBS waiver process. Other types of self-directed programs require a research and demonstration waiver under Section 1115 of the Social Security Act.

Under the Medicaid personal care benefit, the Centers for Medicare and Medicaid Services (CMS) explicitly permits self-direction of personal care services. The CMS State Medicaid Manual specifies, "Medicaid beneficiaries may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider." However, the state Medicaid agency maintains responsibility for monitoring service delivery and ensuring that qualified providers are delivering the personal care services. The state is not permitted to provide Medicaid funds directly to a consumer to pay for the personal care services.

Generally, CMS policy has been that payments for personal care (or similar) services delivered by legally responsible individuals (e.g., the parent of a minor child or a spouse) are not eligible for federal Medicaid matching funds. However, CMS has recently amended its policy so that under a HCBS waiver (though not the

Medicaid personal care benefit), states have the option of paying legally responsible relatives in extraordinary circumstances when the provision of personal care services is determined to be necessary to ensure the health and welfare of the waiver participant and so long as the parent or spouse meets the Medicaid provider requirements established by the state.

Senate Bill

No provision.

House Bill

This proposal would allow a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self-directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The Secretary must not approve a state's self-directed personal assistance services program unless the state assures that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and that financial accountability exists for funds expended for these services.

The state must also evaluate the need for personal care under the Medicaid state plan or personal services under a HCBS waiver for individuals who (1) are entitled to Medicaid personal care under the state plan or receive HCBS waiver services; (2) may require self-directed personal assistance services; and (3) may be eligible for self-directed personal assistance services. If covered by the state and at the choice of the individual, those who are likely to require personal care or HCBS waiver services must be informed of the feasible alternatives in the provision of Medicaid personal care services or personal assistance services under a HCBS waiver. The state must also provide a support system that ensures participants in the program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

The state will be required to submit an annual report to the Secretary which includes the number of individuals served and total expenditures on their behalf, in the aggregate. The state must also provide an evaluation of overall impact on the health and welfare of participants compared to non-participants every three years.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Under this provision, the term “self-directed personal assistance services” means personal care and related services, or HCBS waiver services that are provided to an eligible participant. Individuals participating in such services will be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services.

At the election of the state, a participant will be allowed to (1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and (2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

An approved self-directed services plan and budget under this provision must meet the following requirements: (1) The participant (or his/her guardian or authorized representative if appropriate) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider and location of service provision; (2) There is an assessment of the needs, strengths, and preferences of the participants for such service; (3) An individual’s plan for self-directed services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant’s capacity to engage in activities that promote community life; respects the participant’s preferences, choices and abilities; and involves families, and professionals in the planning or delivery of services or supports as desired or required by the participant.

The budget for self-directed services and supports must be developed and approved by the state based on the assessment and plan (described above), and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the state but not included in the budget.

In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual’s resources and capabilities.

A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity will be reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50 percent, though certain activities may be eligible for 75 percent reimbursement).

This provision will apply to services furnished on or after January 1, 2006.

Conference Agreement

The conference agreement follows the House provision except that the effective date has been changed to January 1, 2007.

Authority to continue providing certain adult day health care services or medical adult day care services (No provision in Conference Agreement, Section 6039B of Senate Bill, and no provision in the House Bill)

Current Law

Most states currently offer adult day care services to Medicaid beneficiaries through either the rehabilitation or clinic benefits of the Medicaid state plan (in about 8 states), or through a home and community-based (HCBS) waiver under Section 1915(c) of Medicaid law (in about 44 states through 102 separate HCBS programs).

Senate Bill

The Senate bill would prohibit the Secretary of HHS from denying federal Medicaid funding or withdrawing federal approval for adult day health care services or medical adult day care services under the Medicaid state plan, as defined by the state and approved by the Secretary on or before 1982.

House Bill

No provision.

Conference Agreement

No provision.

Chapter 3—Eliminating Fraud, Waste, and Abuse in Medicaid

Limitation on Use of Contingency Fee Arrangements (Section 6031 of the Conference Agreement, Section 6022 of the Senate Bill, and no provision in the House Bill)

Current Law

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or human resources umbrella agency, will often contract with other public or private entities (e.g., other state agencies or departments, consulting firms) to perform various administrative functions. In some cases, contingency fee arrangements are used to pay contractors based on Medicaid dollars saved, recovered, or otherwise obtained for the state (e.g., a fee equal to 10 percent of third party liability collections). The federal reimbursement rate for most Medicaid administrative costs is 50 percent.

In determining the amount of administrative costs—including contingency fees—that may be eligible for federal reimbursement, states must comply with a number of federal statutes and regulations. In general, federal Medicaid law requires states to use methods of administration that are found by the Secretary of HHS to be necessary for the proper and efficient operation of their Medicaid programs. With regard to contingency fee contracts, guidance issued by the Centers for Medicare and Medicaid Services (CMS)

to its regional offices in 2002 notes that in order to be eligible for federal reimbursement, contingency fees must: (1) be based on Medicaid cost avoidance savings or recoveries in which the federal government shares, (2) be intended to produce Medicaid program savings, not additional expenditures reported for federal reimbursement, and (3) not be contingent upon recoveries from the federal government. CMS guidance also notes that states may not claim federal reimbursement for contingency fee payments made to another government unit for Medicaid administrative activities.

Additional federal guidance is contained in Office of Management Budget (OMB) Circular A-87, which establishes principles and standards for determining allowable costs for states (and other governmental units) under federal grant programs such as Medicaid. The circular specifies that the cost of professional and consultant services are allowable when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the federal government.

Senate Bill

Under the Senate bill, states would not be eligible for federal reimbursement of amounts expended in connection with a contract or agreement (other than a Medicaid managed care contract) between the state Medicaid agency (or any state or local agency that administers a portion of the Medicaid program) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet standards established by the Inspector General (IG) of HHS.

Such standards would be designed by the IG to ensure prudent purchasing and program integrity with respect to federal funds. The IG would annually review the standards and revise them as necessary to promptly address new compensation arrangements that may present a risk to Medicaid program integrity. The standards would be issued no later than six months after enactment of the provision.

The provision would be effective January 1, 2007, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

No provision.

Conference Agreement

The conference agreement follows the House bill.

Encouraging the Enactment of State False Claims Acts (Section 6032 of the Conference Agreement, Section 6023 of the Senate Bill, and no provision in the House Bill)

Current Law

Under the federal False Claims Act, anyone who knowingly submits a false claim to the federal government is liable for damages up to three times the amount of the government's damages plus mandatory penalties of \$5,500 to \$11,000 for each false claim submitted. Under *qui tam* (whistleblower) provisions of the act, private citizens with knowledge of potential violations ("relators") may file suit on behalf of the government and are entitled to receive a share of the proceeds of the action or settlement of the claim (ranging from 15 percent to 30 percent, depending on whether or not the government elects to participate in the case).

States may have a variety of laws in place to facilitate prosecution of Medicaid fraud, and some have established their own versions of a false claims act. With limited exceptions, a state must repay the federal share (generally determined by the federal medical assistance percentage, or FMAP) of any provider overpayment within 60 days of discovering the overpayment, regardless of whether or not the state has recovered the overpayment.

Senate Bill

Under the Senate bill, if a state has in effect a law relating to false or fraudulent claims that meets certain requirements (described below), the federal medical assistance percentage, with respect to any amounts recovered under a state action brought under such a law, would be decreased by 10 percentage points.

The state law relating to false and fraudulent claims must be determined by the Inspector General of HHS, in consultation with the Attorney General, to: (1) establish liability to the state for false or fraudulent claims described in the federal False Claims Act, with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal False Claims Act, (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act, (5) contain provisions that are designed to prevent a windfall recovery for a *qui tam* relator that files a federal and state action for the same false or fraudulent claim.

The provision would be effective January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but excludes language regarding windfall recoveries for *qui tam* relators.

Employee Education About False Claims Recovery (Section 6033 of the Conference Agreement, Section 6024 of the Senate Bill, and no provision in the House Bill).

Current Law

No provision.

Senate Bill

Under the Senate bill, a state would be required to provide that any entity that receives annual Medicaid payments of at least \$1 million, as a condition of receiving such payments, must: (1) establish written policies, procedures, and protocols for training of all employees of the entity, and of any contractor or agent of the entity, that includes a detailed discussion of the federal False Claims Act, federal administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, (2) include in such written materials detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (4) require mandatory training for all employees of the entity and of any contractor or agent of the entity, at the time of hiring, with respect to such laws and the entity's policies and procedures for detecting fraud, waste, and abuse.

The provision would be effective January 1, 2007, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but applies only to entities receiving annual Medicaid payments of at least \$5 million and does not require the establishment of protocols and procedures for training of employees (i.e., only written policies are required).

Prohibition on Restocking and Double Billing of Prescription Drugs (Section 6034 of the Conference Agreement, and Section 6025 of the Senate Bill, and no provision in the House Bill)

Current Law

No provision.

Senate Bill

The Senate bill would prohibit federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable restocking fee). It would become effective on the first day of the first fiscal quarter beginning after enactment.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Medicaid Integrity Program (Section 6035 of the Conference Agreement, Section 6026 of the Senate Bill, and no provision in the House Bill)

Current Law

States and the federal government share in the responsibility for safeguarding Medicaid program integrity. States must comply with federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare and Medicaid Services (CMS) is the primary federal agency responsible for providing oversight of states' activities and facilitating their program integrity efforts. The HHS Office of Inspector General (OIG) also plays a role in Medicaid fraud and abuse detection and prevention efforts through its investigations, audits, evaluations, issuances of program recommendations, and other activities.

As part of its program integrity activities, CMS operates a Medicare-Medicaid (MediMedi) data match project that analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation (e.g., providers submitting claims to both programs for procedures that add up to more than 24 hours of patient care in a single day). The Medi-Medi project began with one state in 2001, and was subsequently expanded to include eight others. It is primarily supported by "wedge" funds from the Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (Medicare Part A) trust fund. HCFAC wedge funds are divided between the Department of Justice, the HHS Office of Inspector General, CMS, and other HHS agencies. The HCFAC account also funds the Medicare Integrity Program and activities of the Federal Bureau of Investigation related to health care fraud. Annual minimum and maximum HCFAC appropriations are specified in statute.

Senate Bill

The Senate bill would establish a Medicaid Integrity Program under title XIX. The Secretary of HHS would enter into contracts with eligible entities to carry out the program's activities, which would include: (1) review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, (2) audit of claims for payment for items or services fur-

nished or for administrative services rendered, (3) identification and recovery of overpayments to individuals or entities receiving federal funds under Medicaid, (4) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

An entity would be eligible to enter into a contract to carry out Medicaid Integrity Program activities if it meets eligibility and contracting requirements similar to those under the Medicare Integrity Program. Beginning in FY2006 and every five years, the Secretary of HHS—in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of HHS, and state officials with responsibility for controlling provider fraud and abuse under Medicaid—would establish a comprehensive plan for ensuring Medicaid program integrity by combating fraud, waste, and abuse.

Appropriations for the Medicaid Integrity Program would total \$50 million in FY2006, \$49 million in each of FY2007 and FY2008, \$74 million in each of FY2009 and FY2010, and \$75 million in FY2011 and each fiscal year thereafter. No later than 180 days after the end of each fiscal year (beginning with FY2006), the Secretary of HHS would submit a report to Congress that identifies the use and effectiveness of the use of such funds.

A Medicaid Chief Financial Officer (CFO) and Medicaid Program Integrity Oversight Board would also be established under title XIX. The Medicaid CFO would be appointed by and would report directly to the Administrator of CMS. The duties and authority of the Medicaid CFO would be comparable to those of other CFOs with respect to the management and expenditure of federal funds under federal health care programs. A Medicaid Program Integrity Oversight Board would also be established by the Secretary of HHS. The duties and authority of the board would be comparable to those of the Medicare Contractor Oversight Board, and would include responsibility for identifying vulnerabilities and developing strategies for minimizing integrity risks to state Medicaid programs.

States would be required to comply with any requirements determined by the Secretary of HHS to be necessary for carrying out the Medicaid Integrity Program, or the duties of the Medicaid CFO and the Medicaid Program Integrity Oversight Board.

In each of fiscal years 2006 through 2010, \$25 million would be appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended). No later than 180 days after the end of each fiscal year (beginning with FY2006), the Inspector General of HHS would submit a report to Congress that identifies the use and effectiveness of the use of such funds.

The Secretary of HHS would significantly increase the number of full-time equivalent CMS employees whose duties consist solely of ensuring the integrity of the Medicaid program.

House Bill

No provision.

Conference Agreement

The conference agreement generally follows the Senate bill, but excludes recovery of overpayments from the list of Medicaid Integrity Program activities and does not establish a Medicaid CFO or oversight board. It appropriates \$5 million in FY2006, \$50 million in each of FY2007 and FY2008, and \$75 million in each fiscal year thereafter for Medicaid Integrity Program activities.

The conference agreement also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program under Title XVIII of the Social Security Act. The Secretary of HHS shall enter into contracts with eligible entities to ensure that the Medi-Medi Program is conducted for the purpose of: (1) identifying program vulnerabilities in Medicare and Medicaid through the use of computer algorithms to look for payment anomalies, (2) working with states, the Attorney General, and the Inspector General of HHS to coordinate appropriate actions to protect Medicare and Medicaid expenditures, and (3) increasing the effectiveness and efficiency of both programs through cost avoidance, savings, and recoupment of fraudulent, wasteful, or abuse expenditures. At least quarterly, the Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of HHS, and the states.

In addition to HCFAC appropriations for the Medicare Integrity Program (which have a statutory floor and ceiling), the Medi-Medi Program would receive \$12 million in FY2006, \$24 million in FY2007, \$36 million in FY2008, \$48 million in FY2009, and \$60 million in FY2010 and each fiscal year thereafter.

Enhancing Third Party Identification and Payment (Section 6036 of the Conference Agreement, Section 6021 of the Senate Bill, and Section 3144 of the House Bill)

Current Law

Third-party liability (TPL) refers to the legal obligation of third parties—individuals, entities, or programs—to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. In general, federal law requires Medicaid to be the payor of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered medical support (including health insurance) from noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (with certain exceptions, such as the Indian Health Service).

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. To this end, they must: (1) collect health insurance information from individuals at the time of initial application for Medicaid and during any subsequent redeterminations of eligibility, (2) match data provided by Medicaid

applicants and recipients to certain files maintained by government agencies (e.g., state wage and income, Social Security Administration wage and earnings, state workers' compensation, state motor vehicle accident reports), (3) identify claims with diagnosis codes that would indicate trauma-related injury for which a third party may be liable for payment, and (4) follow up on TPL leads identified through these information-gathering activities.

If the state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

As a condition of eligibility for Medicaid, individuals are required to assign to the state Medicaid agency their rights to medical support and payment for medical care from any third party. This assignment of rights facilitates TPL recovery by allowing the state to collect, on behalf of Medicaid enrollees, amounts owed by third parties for claims paid by Medicaid.

Senate Bill

The Senate bill would amend the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include: (1) self-insured plans, (2) pharmacy benefit managers, and (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It would also amend that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual.

In addition, it would require a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state, to: (1) provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid, (2) accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the state, (3) respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided, and (4) agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim.

The provision would be effective January 1, 2006, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to

meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

The House bill is similar to the Senate bill.

Conference Agreement

The conference agreement generally follows the Senate and House bills, but substitutes the term “managed care organization” for “health maintenance organization” in Section 1902(a)(25) of the Social Security Act and specifies that states must require parties legally responsible for payment of a claim to provide, upon request of the state, information to determine during what period an individual or their spouses and dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary of HHS.

Chapter 4—Flexibility in Cost Sharing and Benefits

State Option for Alternative Medicaid Premiums and Cost Sharing
(Section 6041 of the Conference Agreement, no provision in the Senate Bill, and Sections 3121 and 3126 of the House Bill)

Current Law

With some exceptions, premiums and enrollment fees are generally prohibited under Medicaid. When applicable, nominal amounts for such charges are between \$1 and \$19 depending on family income. States are allowed to establish nominal service-related cost-sharing requirements that are generally between \$0.50 and \$3, depending on the cost of the service provided. The regulations that specify nominal premium and service-related cost-sharing amounts were published and amended in the late 1970s and the early 1980s. These amounts are not adjusted by any factor. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules.

Under certain circumstances, families qualifying for transitional Medicaid, pregnant women and infants with income over 150 percent FPL, medically needy groups, and workers with disabilities may be charged premiums for Medicaid coverage.

All service-related cost-sharing is prohibited for: (1) children under 18 years of age; (2) pregnant women for any services that relate to the pregnancy or to any other medical condition which may complicate pregnancy; (3) services furnished to individuals who are inpatients in a hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care; (4) services furnished to individuals receiving hospice care; (5) emergency services; and (6) family planning services and supplies. For most other beneficiaries and services, states may impose nominal service-related cost-sharing (described above). For workers with disabilities, service-related cost-sharing may be required that exceeds nominal amounts as long as they are set on a sliding scale based on income.

Under the state Medicaid plan, providers must not deny care or services to Medicaid beneficiaries due to the individual's inability to pay a cost-sharing charge. However, this requirement does not eliminate the beneficiary's liability for payment of such charges. For certain groups of pregnant women and infants for which monthly premiums may be charged, states must not require prepayment and must not terminate Medicaid eligibility for failure to pay such premiums until such failure continues for at least 60 days. States may waive those premiums when such payments would cause undue hardship.

States may offer Medicaid to certain uninsured women who are under age 65, and are in need of treatment for breast or cervical cancer based on screening services provided by an early detection program run by the CDC. This group has access to the same Medicaid services offered to the categorically needy in a given state, and are subject to Medicaid's nominal cost-sharing rules.

Senate Bill

No provision.

House Bill

The House Bill would allow states to impose premiums and cost-sharing for any group of individuals for any type of service, through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing imposed under this option would be allowed to vary among classes or groups of individuals, or types of service, including through the use of tiered cost-sharing for prescription drugs. Generally, the total amount of annual cost-sharing for all individuals in a family would be capped at 5 percent of family income for all families regardless of income. Individuals in families with income below 100 percent FPL would not be subject to premiums but could be subject to nominal service-related cost-sharing. Individuals in families with income exceeding 100 percent FPL may be subject to premiums and higher than nominal cost-sharing amounts.

Premiums would not be permitted for: (1) mandatory groups of children under 18, including individuals receiving adoption or foster care assistance under Title IV-E regardless of age; (2) pregnant women; (3) terminally ill persons receiving Medicaid hospice care; (4) individuals in institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs. States may exempt additional groups from premiums.'

Service related cost-sharing would not be permitted for: (1) services provided to mandatory groups of children under 18, including individuals receiving adoption or foster care assistance under Title IV-E regardless of age; (2) preventive services provided to children under 18 regardless of family income; (3) services provided to pregnant women that relate to pregnancy or to other medical conditions that may complicate pregnancy; (4) services provided to individuals receiving Medicaid hospice services; (5) services provided to individuals in institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs; (6) emergency services; and (7) family planning services and

supplies. States may exempt additional individuals or services from service-related cost-sharing.

In applying limits on cost-sharing amounts under this option that states may impose on individuals under 100 percent FPL, beginning with 2006, the Secretary would be required to increase nominal amounts of service-related cost-sharing by the annual percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

The bill further specifies that these provisions would not prevent states from further limiting cost-sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect waivers in effect before the date of enactment.

The bill would allow states 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 would allow states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition for the provision of care or services. Providers would also be allowed to reduce or waive cost-sharing amounts.

The Government Accountability Office (GAO) would be required to conduct a study of the impact of premiums and cost-sharing under Medicaid on access to and utilization of services. The report would be required to be submitted to Congress no later than January 1, 2008.

These provisions would apply to cost-sharing for items and services furnished on or after January 1, 2006. The House bill also specifies that none of the proposed cost-sharing (or benefit) provisions described above would apply to women who qualify for Medicaid under the breast and cervical cancer eligibility group.

Conference Agreement

The conference agreement includes the House bill, with modifications. It clarifies that rules with respect to optional cost sharing for prescribed drugs (see below) are separate from the rules for other optional cost sharing. Explicit cost sharing limits for individuals in families with income under 100 percent FPL are dropped in the conference agreement. For individuals in families with income between 100 and 150 percent FPL: (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10 percent of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5 percent of family income as applied on a quarterly or monthly basis as specified by the state. For individuals in families with income above 150 percent FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5 percent of family income as applied on a quarterly or monthly basis as specified by the state, and

(2) cost-sharing for any item or service cannot exceed 20 percent of the cost of the item or service.

Two groups are added to the list of those exempt from paying premiums and cost-sharing under the House bill. In the conference agreement, these additional groups include (1) children in foster care who receive aid and assistance under Part B of Title IV (Child and Family Services) of the Social Security Act; and (2) women who qualify for Medicaid under the breast and cervical cancer eligibility group (a technical change from the House bill).

In addition, the agreement clarifies that providers could reduce or waive cost-sharing on a case-by-case basis.

Under the conference agreement, increases in the nominal cost-sharing amounts follow the House bill (i.e., annual adjustments using the medical CPI), but apply more broadly to existing cost-sharing provisions in statute (Section 1916) as well as to the new cost-sharing provisions in the House bill specific to prescription drugs and non-emergency care provided in an emergency room (described below).

Special Rules for Cost Sharing for Prescription Drugs (Section 6042 of the Conference Agreement, no provision in the Senate Bill, and Section 3122 of the House Bill)

Current Law

States are allowed to establish nominal service-related cost-sharing requirements (defined in regulation) that are generally between \$0.50 and \$3, depending on the cost of the service provided. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules. As with other Medicaid benefits, nominal cost-sharing may be imposed on prescribed drugs, and states may vary nominal cost-sharing amounts for preferred and non-preferred drugs. States may also implement prior authorization for prescribed drugs.

Senate Bill

No provision.

House Bill

The House bill would allow states to impose cost-sharing amounts that exceed the proposed state option limits described above for certain state-identified non-preferred drugs if the cost sharing plan meets the following characteristics. Under this option, states may impose higher cost-sharing amounts for non-preferred drugs within a class; waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class; and must not apply such cost-sharing for preferred drugs to persons exempt from cost-sharing (identified above).

Cost-sharing for non-preferred drugs would be based on multiples of the nominal amounts based on family income. For persons with family income below 100 percent of FPL, nominal cost sharing would apply. For those with family income at or above 100 percent but below 150 percent of FPL, the multiple is equal to two times the applicable nominal amount, and for those with income equal to or exceeding 150 percent of FPL, the multiple is equal to three

times the applicable nominal amount. For persons generally exempt from cost-sharing (identified above), cost-sharing for non-preferred drugs may be applied. Such cost-sharing may not exceed nominal amounts, and aggregate caps on cost-sharing (in terms of nominal amounts and maximum cost-sharing based on the specified percentage of family income identified above) would still apply.

For Medicaid purposes, states would not be allowed to treat a preferred drug under the TRICARE pharmacy benefit program as a non-preferred drug, nor could states impose cost-sharing that exceeds the standards under this program that are in effect on the date of enactment for this provision.

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

The House bill would not prevent states from excluding specified drugs or classes of drugs from these special cost-sharing rules.

States would be prohibited from implementing these special cost-sharing rules for prescription drugs unless the state has instituted a system for prior authorization and related appeals processes for outpatient prescription drugs.

These provisions would become effective for cost-sharing imposed for items and services furnished on or after October 1, 2006.

Conference Agreement

The conference agreement includes the House bill, with modifications. Cost-sharing for non-preferred drugs may not exceed: (1) nominal amounts for individuals in families with income below or equal to 150 percent FPL, and (2) 20 percent of the cost of the drug for individuals in families with income above 150 percent FPL.

The conference agreement also drops both the TRICARE and the prior authorization/appeals process provisions in the House bill. It also changes the effective date of these provisions to January 1, 2007.

Emergency Room Copayments for Non-Emergency Care (Section 6043 of the Conference Agreement, no provision in the Senate Bill, and Section 3123 of the House Bill)

Current Law

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

Senate Bill

No provision.

House Bill

The House bill would allow states, through a state plan amendment, to impose increased cost-sharing on state-specified groups for non-emergency services provided in an ER, when certain

conditions are met. First, alternative non-emergency providers must be available and accessible to the person seeking care. Second, after initial screening but before the nonemergency care is provided at the ER, the beneficiary must be told: (1) the hospital can require a higher copayment, (2) the name and location of an alternative non-emergency provider and that this provider and that a lower copayment may apply, and (3) the hospital can provide a referral. When these conditions are met, states could apply or waive cost-sharing for services delivered by the alternate provider.

For persons with income below 100 percent FPL, cost-sharing for non-emergency services in an ER could not exceed twice the nominal amounts. Individuals exempt from premiums or service-related cost-sharing under other provisions of this bill may be subject to nominal copayments for non-emergency services in an ER, only when no cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers in the area served by the hospital ER. Aggregate caps on cost-sharing established under this bill (described in Sec. 3121(a)) would still apply.

These provisions would have no impact on a hospital's obligations with respect to screening and stabilizing emergency medical conditions, nor would they modify the application of the prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization. In addition, no hospital or physician that makes a cost-sharing determination would be liable in any civil action or proceeding, absent a finding by clear and convincing evidence of gross negligence. Liabilities related to the provision of care (or failure to do so) would not be affected by these provisions.

"Non-emergency services" would mean any care or services furnished in an ER that the physician determines does not constitute an appropriate medical screening examination or stabilizing examination and treatment screening required for hospitals under Medicare law (regarding examination and treatment for emergency medical conditions and women in labor). "Alternative non-emergency services provider" would mean a Medicaid-participating health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider that provides clinically appropriate services for such diagnosis or treatment of the condition within a clinically appropriate time of the provision of such non-emergency services.

The Secretary would be required to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. The House bill also authorizes and appropriates \$100 million for paying such providers for the 4-year period beginning with 2006. The Secretary would be required to give a preference to states that establish or provide for alternate non-emergency services providers (or networks) that serve rural or underserved areas where beneficiaries may have limited access to primary care providers, or in partnership with local community hospitals. To access these funds, states would be required to file an application meeting requirements set by the Secretary.

These amendments would apply to non-emergency services furnished on or after the date of enactment of this Act.

Conference Agreement

The conference agreement includes the House bill, with modifications. This provision allows states to permit a hospital to impose cost sharing for non-emergency care delivered in an ER under the same conditions identified in the House bill. But the conditions defining the beneficiary notification process are expanded to explicitly include a medical screening examination for emergency medical conditions as defined in Medicare law and a determination that such an emergency does not exist, prior to the delivery of non-emergency care in the ER. In addition, the hospital (not the physician or hospital) is responsible for the notification process.

The conference agreement clarifies that no hospital or physician can be held liable in any civil action or proceeding for the imposition of cost sharing under this new option, absent a finding of gross negligence by the hospital or physician. This provision does not affect liability with respect to examination and treatment for emergency medical conditions (including women in labor) as specified in Medicare law or otherwise applicable under state law based on the provision of (or failure to provide) care.

The conference agreement also slightly modifies the definition of an alternative nonemergency services provider by specifying that such providers be able to diagnose or treat a condition contemporaneously with (rather than within a clinically appropriate time of) the provision of similar non-emergency services that would be provided in an ER.

The conference agreement also changes the effective date of these provisions to January 1, 2007.

Use of Benchmark Packages (Section 6044 of the Conference Agreement, no provision in the Senate Bill, and Section 3124 of the House Bill)

Current Law

Categorically needy (CN) eligibility groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. Some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

As described above, some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, FQHC services, nursing facility care for persons

age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid children in CN groups are guaranteed access to all federally coverable routine and follow-up dental services necessary to treat a dental problem. EPSDT may be offered to MN children.

Both the services provided by rural health clinics (RHCs) and federally qualified health services (FQHCs) are required benefits for CN groups under Medicaid. Among other mandatory benefits for MN groups, states must offer ambulatory services for persons under 21 and those entitled to institutional services. Such ambulatory services may include RHC and FQHC services at state option. In general, RHCs and FQHCs are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services.

Senate Bill

No provision.

House Bill

The House bill would give states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage (described below). States could only apply this option to eligibility categories established before the date of enactment of this provision. States may choose to provide wrap-around and additional benefits.

Enrollment in benchmark and benchmark-equivalent coverage could be required for "full benefit eligible individuals," including persons eligible for all services covered for the CN, or any other category of eligibility for all covered services as determined by the Secretary. Certain individuals would be excluded from the definition of a full-benefit eligible, including (1) the MN; (2) CN individuals in certain states who are required to pay for medical expenses from their income until their remaining net income meets SSI financial standards in effect in 1972; and (3) other individuals who qualify for Medicaid when costs incurred for medical expenses or other remedial care are subtracted from income to meet financial eligibility requirements (also known as spend-down populations).

The House bill would require that specified groups be exempted from this option, including: (1) mandatory pregnant women and children; (2) dual eligibles (i.e., Medicaid beneficiaries also entitled to benefits under Medicare); (3) terminally ill persons receiving

Medicaid hospice services; (4) individuals in medical institutions who are required, as a condition of receiving institutional care, to pay for costs of medical care except for a minimal amount retained from their income for personal needs; (5) individuals who are medically frail or who have special medical needs, as identified in accordance with regulations of the Secretary; and (6) individuals who qualify for Medicaid long-term care services (i.e., nursing facility services, a level of care in any institution equivalent to nursing facility services, home and community-based waiver services, home health services, home and community-care for functionally disabled elderly individuals, personal care, and other optional long-term care services offered by the state).

Benchmark and benchmark-equivalent packages would be nearly identical to those offered under SCHIP, with some additions. Benchmark coverage would include: (1) the standard Blue Cross/Blue Shield preferred provider plan under FEHBP; (2) health coverage for state employees; and (3) health coverage offered by the largest commercial HMO. Benchmark-equivalent coverage would have the same actuarial value as one of the benchmark plans. Such coverage would include: (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) well child care, including immunizations, and (5) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75 percent of the actuarial value of coverage under the benchmark plan for: (1) prescribed drugs, (2) mental health services, (3) vision care, and (4) hearing services. Determination of actuarial value would follow generally accepted actuarial principles and methodologies and would be conducted by a member of the American Academy of Actuaries.

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

States could only enroll eligible beneficiaries in benchmark and benchmark-equivalent coverage if such persons have access to services provided by RHCs and FQHCs, and the Medicaid prospective payment system for both types of providers remains in effect.

These provisions would be effective upon the date of enactment.

Conference Agreement

The conference agreement includes the House bill, with modifications. For any child under age 19 in one of the major mandatory and optional eligibility groups (defined in Section 1902(a)(10)(A)) under the state Medicaid plan, wrap-around benefits to the benchmark or benchmark-equivalent coverage consists of early and periodic screening, diagnostic and treatment services as defined in current Medicaid law. The agreement drops benchmark dental coverage and accompanying provisions defining the children who would qualify for such benchmark dental coverage.

Also, under the conference agreement, states may exercise this option only for eligibility groups that were established under the state plan before the date of enactment of this option.

The conference agreement drops mandatory children under 18 (under Section 1902(a)(10)(A)(i)) from the list of groups exempted from this option.

The conference agreement also expands the list of specified groups that would be exempted from benchmark coverage to include: (1) individuals who qualify for Medicaid under the state plan on the basis of being blind or disabled regardless of whether the individual is eligible for SSI on such basis, including children with disabilities that meet SSI disability standards who require institutional care, but for whom care is delivered outside the institution, and the cost of that care does not exceed the otherwise applicable institutional care (also known as Katie Beckett or TEFRA children); (2) children in foster care receiving child welfare services (under Part B of Title IV) and children receiving foster care or adoption assistance under Part E of Title IV without regard to age; (3) individuals who qualify for Medicaid on the basis of receiving assistance under TANF (as in effect on or after the welfare reform effective date); (4) women in the breast and cervical cancer eligibility group (a technical change from the House bill); and (5) other "limited services beneficiaries," including certain tuberculosis-infected individuals, and legal and undocumented non-citizens who meet the financial and categorical requirements for Medicaid eligibility without regard to time in the U.S. and are eligible only for emergency medical services.

The conference agreement also adds to the set of three benchmark benefit packages, a fourth option called "secretary approved coverage" which may include any other health benefits coverage that the Secretary determines will provide appropriate coverage for the population targeted to receive such coverage.

Finally, the conference agreement changes the effective date of these provisions to January 1, 2007.

Chapter 5—State Financing Under Medicaid

Managed Care Organization Provider Tax (Section 6051 of the Conference Agreement, and Section 6033 of the Senate Bill, and Section 3142 of the House Bill)

Current Law

States' ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25 percent of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be "broad-based." A broad-based tax is a tax that is uniformly applied to all providers or services within the provider class. The federal statute identifies each of the classes of providers or services for the purpose of determining whether a tax is broad-based.

Medicaid managed care organizations (MCOs) are identified as a separate class of providers for the purposes of determining if a tax is broad-based. This class is unlike all of the other classes of providers or services because it is limited to only Medicaid providers. Other classes of providers or services identified in statute, such as inpatient hospital services, outpatient hospital services, physicians—are not restricted to Medicaid providers or Medicaid services.

Senate Bill

The Senate bill would expand the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. This would make the MCO provider class more consistent with the other provider classes for purposes of determining if a provider tax is broad-based.

The provision would become effective on January 1, 2006 except in states that have, as of December 31, 2005, a tax on the Medicaid MCO class of providers as defined under current law. The provision would not apply to those states.

House Bill

Similar to Senate provision except the provision would become effective upon enactment except for in states with taxes based on the current law Medicaid MCO provider class. For those states, the prohibition would become effective on October 1, 2008 and the reduction in Medicaid reimbursement due to this provision would be 50 percent for the fiscal year beginning on that day.

Conference Agreement

The conference agreement expands the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. The provision becomes effective upon enactment except in states with taxes based on the current law Medicaid MCO provider class as of December 8, 2005. In those states, the provision becomes effective on October 1, 2009.

Reforms of Case Management and Targeted Case Management Services (Section 6052 of the Conference Agreement, and Section 6031 of the Senate Bill, and Section 3146 of the House Bill)

Current Law

Under current Medicaid law (Section 1915(g)(2) of the Social Security Act), case management is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. Case management services are an optional benefit under the Medicaid state plan. The term "targeted case management" (TCM) refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of Medicaid eligible individuals as defined by the state (e.g., those with chronic mental illness), or persons who reside in a specific area.

Several states extend the Medicaid TCM benefit to individuals who may also be receiving case management services as a component of another state and/or federal program. For example, a state may provide TCM services for Medicaid beneficiaries in foster care—defined in the Medicaid state plan as “children in the state’s custody and who are placed in foster homes.” As part of the foster care program, children receive certain case management services regardless of whether or not they are a Medicaid beneficiary.

In addition, the existing federal guidance is conflicting with respect to the process states should follow to claim Medicaid reimbursement for TCM services when another program also covers case management services for the same beneficiary. The State Medicaid Manual (Section 4302.2) states that claims for targeted case management services must be fully documented for a specific Medicaid beneficiary in order to receive payment. In addition, documentation that includes time studies and cost allocation plans “are not acceptable as a basis for Federal participation in the costs of Medicaid services.” Cost allocation plans are a narrative description of the procedures that a state agency uses in identifying, measuring, and allocating the state agency’s administrative costs incurred for supervising or operating programs. Per federal regulations (45 CFR 95.505), the cost allocation plan does not include payments for services and goods provided directly to program recipients. However, a State Medicaid Director’s (SMD) letter dated January 19, 2001, which discusses targeted case management services for children in foster care under the federal Title IV–E program, requires states to “properly allocate case management costs between the two programs in accordance with OMB Circular A–87 under an approved cost allocation program.” Thus, this letter extended the application of cost allocation plans to claim reimbursement for case management services when a child is receiving these services under both the Title IV–E (foster care) and Medicaid programs.

Senate Bill

This proposal would further define the Medicaid TCM benefit under Section 1915(g)(2) of the Social Security Act, and would codify the ability of states to use an approved cost allocation plan (as outlined under OMB Circular A–87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.

Specifically, the proposal would clarify that the TCM benefit includes the following: (1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual’s needs and completing related documentation, and if needed, gathering information from other sources; (2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual’s needs; (3) referral and related activities to help an individual obtain needed services; and (4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual’s needs.

The proposal would also specify certain activities that are not reimbursable as TCM services. First, the TCM benefit would not include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. In addition, with respect to the direct delivery of foster care services, the TCM benefit would not cover: research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the eligible individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.

Finally, consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

This provision would take effect January 1, 2006.

House Bill

Same as Senate provision.

Conference Agreement

The conference agreement modifies the Senate and House bills to differentiate between case management and targeted case management services. It would define case management services in federal law as services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services including: (1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; (2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; (3) referral and related activities to help an individual obtain needed services; and (4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The conference agreement also establishes those activities that are not reimbursable as case management services including the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. With respect to the direct delivery of foster care services, case management would not include research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving

legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

The term “targeted case management services” is defined as case management services that are provided to specific classes of individuals or to individuals who reside in specific areas.

In cases where a case management provider contacts individuals who are not Medicaid eligible, or who are not part of the TCM target population, the activity could be billed as case management services if the purpose of the contact is directly related to the management of the eligible individual’s care. If the contact is related to the identification and management of the non-eligible or non-targeted individual’s needs and care, the activity may not be billed as case management services.

Consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for case management (or TCM) services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. If case management (or TCM) services are reimbursable by another federally-funded program the state would be required to allocate the costs of these services using OMB Circular A-87 (or any related or successor guidance or regulations).

Finally, the conference agreement established that (1) nothing in the provision would affect the application of rules with respect to third party liability under programs or activities carried out under Title XXVI of the Public Health Service Act (the HIV Health Care Services Program) or the Indian Health Service; and (2) the Secretary would be required to promulgate regulations to carry out the changes made by this provision. The effective date of this provision would be January 1, 2006.

Additional FMAP Adjustments (Section 6053 of the Conference Agreement, Sections 6032 and 6037 of the Senate Bill, and Sections 3148 and 3205 of the House Bill)

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50 percent and maximum of 83 percent. An enhanced FMAP is available for both services and administration under the State Children’s Health Insurance Program (SCHIP), subject to the availability of funds from a state’s SCHIP allotment. In addition to Medicaid and SCHIP, the FMAP is used in determining federal reimbursement for a number of other programs, including foster care and adoption assistance under Title IV-E of the Social Security Act.

When state FMAPs are calculated by HHS for an upcoming fiscal year, the state and U.S. amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce’s Bureau of Economic Analysis (BEA). For example, to calculate FMAPs for FY2006, HHS used per capita personal income

data for 2001, 2002, and 2003 that became available from BEA in October 2004.

BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised Census Bureau population figures and newly available source data. It also undertakes a comprehensive data revision—reflecting methodological and other changes—every few years that may result in upward and downward revisions to each of the component parts of personal income, which include: wages and salaries, supplements to wages and salaries (such as employer contributions for employee pension and insurance funds), proprietors' income, and dividends, interest, and rent.

As a result of these annual and comprehensive revisions, it is often the case that the value of a state's per capita personal income for a given year will change over time. For example, the 2001 per capita personal income data published by BEA in October 2003 (used in the calculation of FY2005 FMAPs) differed from the 2001 per capita personal income published in October 2004 (used in the calculation of FY2006 FMAPs).

P.L. 106-554 (Consolidated Appropriations Act, 2001), provided that for fiscal years 2001 through 2005, the Medicaid and SCHIP FMAPs for Alaska would be calculated using the state's per capita income divided by 1.05. Dividing by 1.05 lowered the state's per capita income, thereby increasing its FMAP.

Senate Bill

Under the Senate bill, FY2006 FMAPs for Medicaid and SCHIP would be re-computed for all states so that no FY2006 FMAP would be less than the greater of: (1) a state's FY2005 FMAP minus 0.5 percentage points (0.1 in the case of Delaware and Michigan, 0.3 in the case of Kentucky) or (2) the FY2006 FMAP that would have been determined for a state if per capita incomes for 2001 and 2002 that were used to calculate the state's FY2005 FMAP were used.

In a separate provision, if Alaska's calculated FY2006 or FY2007 FMAP for Medicaid or SCHIP is less than its FY2005 FMAP, the FY2005 FMAP would apply.

House Bill

Under the House bill, for purposes of computing Medicaid FMAPs beginning with FY2006, employer contributions toward pensions that exceed 50 percent of a state's total increase in personal income for a period would be excluded from the per capita income of a state, but not from U.S. per capita income.

In a separate provision, for purposes of computing Medicaid and SCHIP FMAPs for any year after 2006 for a state that the Secretary of HHS determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary would disregard such evacuees and their incomes.

Conference Agreement

The conference agreement follows the Alaska provision in the Senate bill and the Katrina provision in the House bill.

DSH Allotment for the District of Columbia (Section 6054 of the Conference Agreement, and Section 6035 of the Senate Bill, and no provision in the House Bill)

Current Law

States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under broad federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment.

Senate Bill

The Senate bill would raise the allotments for the District of Columbia for FY 2000, 2001, and 2002 from \$32 million to \$49 million. The higher allotments would be used to calculate DSH allotments beginning with FY 2006 amounts. The provision would take effect as if enacted on October 1, 2005 and would apply to expenditures made on or after that date.

House Bill

No provision.

Conference Agreement

The conference agreement includes a provision similar to the Senate provision. The agreement clarifies that the increased amounts calculated based on the modified allotments for FY 2000, 2001, and 2002 only apply to DSH expenditures applicable to fiscal year 2006 and subsequent fiscal years that are paid on or after October 1, 2005.

Increase in Medicaid Payments to Insular Areas (Section 6055 of the Conference Agreement, no provision in the Senate Bill, and Section 3141 of the House Bill)

Current Law

In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. For fiscal year 1999 and subsequent fiscal years, these caps are increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics). The federal Medicaid matching rate, which determines the share of Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent of the territories. Therefore, the federal government pays 50 percent of the cost of

Medicaid items and services in the territories up to the spending caps.

Senate Bill

No provision.

House Bill

For each of fiscal years 2006 and 2007, the House bill would increase the total annual cap on federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa. Puerto Rico would not receive additional federal Medicaid funding from this provision.

For the Virgin Islands and Guam, the FY2006 total annual Medicaid caps would be increased by \$2.5 million and the FY2007 caps would be increased by \$5.0 million. For the Northern Marianas, the FY2006 total annual Medicaid cap would be increased by \$1.0 million and the FY2007 cap would be increased by \$2.0 million. For American Samoa, the FY2006 total annual Medicaid cap would be increased by \$2.0 million and the FY2007 cap would be increased by \$4.0 million. For fiscal year 2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be calculated by increasing the FY2007 ceiling, as modified by this provision, by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics).

Conference Agreement

The conference agreement follows the House bill.

Demonstration Project Regarding Medicaid Coverage of Low-income HIV-infected individuals (no provision in the Conference Agreement, Sec. 6039(c) of the Senate Bill, and no provision in the House Bill)

Current Law

Section 1115 gives the Secretary of HHS authority to modify virtually all aspects of the Medicaid (and SCHIP) programs. Among other projects, the Secretary has used the Section 1115 waiver authority to approve benefit-specific demonstrations that provide targeted services to certain individuals. For example, under existing Medicaid HIV/AIDS Section 1115 demonstration waivers, the Secretary approved programs that provide a limited set of Medicaid benefits (e.g., case management, and pharmacy services) to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid. Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or SCHIP) state plan for purposes of federal reimbursement. Project costs associated with waiver programs granted under the Medicaid (or SCHIP) programs are subject to that state's FMAP (or enhanced-FMAP). Unlike regular Medicaid (or SCHIP), CMS waiver guidance specifies that costs associated with waiver programs must be budget neutral (or allotment neutral) to the federal government over the life of the waiver program whereby the

federal and state government negotiate a spending cap beyond which the federal government has no fiscal responsibility.

Senate Bill

The Senate Bill would require the Secretary of HHS to allow states to seek approval for time limited (i.e., 5-year) Section 1115 demonstration projects that provide full Medicaid coverage to specified HIV-infected individuals. For fiscal years 2006 through 2010, \$450,000,000 in federal funds would be appropriated for such demonstrations. From this amount, the Secretary would allocate money to states and territories (without regard to existing federal Medicaid spending caps applicable in the territories) with approved HIV Section 1115 demonstrations based on the availability of such funds. Allotment of funds among states (or territories) with approved demonstrations would be based on an amount equal to the state's SCHIP Enhanced Federal Medical Assistance Percentage (Enhanced-FMAP) for quarterly expenditures associated with medical assistance provided to individuals under the waiver up to the specified cap. The Secretary would be required to submit a program evaluation to Congress not later than December 31, 2010. This provision would be effective on January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement does not include the Senate bill.

Inclusion of Podiatrists As Physicians (no provision in the Conference Agreement, Section 6034 of the Senate Bill, and no provision in the House Bill)

Current Law

Under Medicaid, services provided by podiatrists may be covered under the optional "other practitioners" benefit category. "Physician services" are a mandatory Medicaid benefit.

Senate Bill

The Senate bill would treat podiatrists as physicians, as is the case under Medicare. Thus, states would be required to cover the medical services of podiatrists (i.e., doctors of podiatric medicine) under Medicaid. This provision would apply to all such services furnished on or after January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Demonstration Project Regarding Medicaid Reimbursement for Stabilization of Emergency Medicaid Conditions by Non-Publicly Owned or Operated Institutions for Mental Diseases (no provision in the Conference Agreement, Section 6036 of the Senate Bill, and no provision in the House Bill)

Current Law

An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The 1950 amendments to the Social Security Act established the prohibition of federal assistance for IMD residents as well as for patients diagnosed with a psychosis found in other medical institutions. When Medicaid was established in 1965, the law included a state option to allow Medicaid funding for inpatient psychiatric care rendered in general hospitals as well as funding for specific services provided to residents age 65 years and older in IMDs. The 1972 amendments allowed for optional coverage, under certain circumstances, for IMD residents under age 21 or, in some cases, under age 22. In general, reimbursement for services obtained in IMDs by Medicaid beneficiaries ages 22 to 64 years remains prohibited. The term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Under Medicare, "emergency medical condition" means a medical condition with acute symptoms of sufficient severity such that the absence of immediate medical attention could result in (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any organ. Under Medicare, the term "stabilize" means medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Senate Bill

The Senate bill would require the Secretary to establish a 3-year demonstration project in eligible states to provide Medicaid coverage for certain IMD services (not publicly-owned or operated) for Medicaid eligible individuals who are between the ages of 21 and 64, and who require IMD services to stabilize an emergency medical condition. Upon approval of an application, eligible states would include Arizona, Arkansas, Louisiana, Maine, North Dakota, Wyoming, and four additional states to be selected by the Secretary to provide geographic diversity. The provision would appropriate \$30 million for FY2006 for the demonstration which would be available through December 31, 2008. The Secretary would allocate funds to eligible states based on their applications and the availability of funds. Payments to states would be drawn from these allocations, based on the federal matching rate (FMAP) for benefits.

For purposes of the demonstration, the Secretary would be required to waive current law limitations on payments for services delivered to persons under 65 who are patients in an IMD. The

Secretary would have the option to also waive other requirements in Sections XI and XIX, including requirements relating to statewideness and comparability of benefits, only to the extent necessary to carry out the demonstration project. The terms “emergency medical condition” and “stabilize,” as defined under Medicare, would apply to the demonstration described in this provision.

The Senate bill would also require the Secretary to submit annual reports to Congress on the progress of the demonstration project. No later than March 31, 2009, the Secretary would submit to Congress a final report describing whether the demonstration: (1) resulted in increased access to Medicaid inpatient mental health services, (2) produced a significant reduction in the use of higher cost emergency room services for Medicaid beneficiaries, (3) impacted the costs of providing Medicaid inpatient psychiatric care, and (4) should be continued after December 31, 2008, and expanded nationwide.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Chapter 6—Other Provisions

Subchapter A—Family Opportunity Act

Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children (Section 6062 of the Conference Agreement, Section 6042 of the Senate Bill, and no provision in the House Bill)

Current Law

For children with disabilities, there are a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. For some of these groups, disability status or medical need is directly related to Medicaid eligibility (e.g., children receiving SSI with family income below 75 percent FPL). But there are other pathways through which such children may qualify for Medicaid coverage for which disability status and/or medical need are irrelevant (e.g., children under age 6 with family income below 133 percent FPL). All of the Medicaid eligibility pathways for children require income levels that are generally below 300 percent of the federal poverty level (FPL) with some state-specific exceptions.

States may require Medicaid beneficiaries to apply for coverage in certain employer-sponsored group health plans (in which such persons are eligible) when it is cost-effective to do so (defined below). This requirement may be imposed as a condition of continuing Medicaid eligibility, except that failure of a parent to enroll a child must not affect the child’s continuing eligibility for Medicaid. If all members of the family are not eligible for Medicaid, and the group health plan requires enrollment of the entire family, Medicaid will pay associated premiums for full family coverage if doing so is cost-effective. Medicaid will not pay deductibles, coinsurance or other cost-sharing for family members ineligible for

Medicaid. Third party liability rules apply to coverage in a group health plan; that is, such plans, not Medicaid, must pay for all covered services under the plan. Cost-effectiveness means that the reduction in Medicaid expenditures for Medicaid beneficiaries enrolled in a group health plan is likely to be greater than the additional costs for premiums and cost-sharing required under the group health plan.

For certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. States are specifically prohibited from requiring payment of deductions, cost-sharing or similar charges for services furnished to children under 18 (up to age 21; or reasonable subcategories, at state option). Also, in certain circumstances, states may impose monthly premiums for Medicaid. For example, states may require certain workers with disabilities to pay premiums and cost-sharing set on a sliding scale based on income. For one of these groups, states may require those with income between 250 percent and 450 percent FPL to pay the full premium. But the sum of such payments may not exceed 7.5 percent of income. For other groups, states may not require prepayment of premiums and may not terminate eligibility due to failure to pay premiums, unless such failure continues for at least 60 days. States may also waive premiums when such payments would cause undue hardship.

Unless otherwise specified for a given coverage group, Medicaid eligibility for children is limited to those in families with income up to $133\frac{1}{3}$ percent of the applicable AFDC payment standard in place as of July 16, 1996. In addition, targeted low-income children under SCHIP statute are defined as those who would not qualify for Medicaid under the state plan in effect on March 31, 1997. Payments for services provided to children who receive Medicaid benefits through an expansion of eligibility under SCHIP authority are reimbursed by the federal government at the enhanced federal medical assistance percentage (E-FMAP) rate, and funds based on this rate are drawn from annual SCHIP allotments. The SCHIP E-FMAP builds on the Medicaid FMAP. The FMAP formula is designed to provide a higher federal matching rate for states with lower average per capita income, compared to the national average.

Senate Bill

The Senate bill would create 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 (SSI) program with family income that exceeds SSI financial standards but is below 300 percent FPL. Medicaid coverage would be phased in by age group, beginning with children through age 6 in the second through fourth quarters of FY2008, then covering children through age 12 beginning in FY2009, and finally, covering children through age 18 during FY2010 and thereafter.

The Senate bill would require states to require certain parents of children eligible for Medicaid under the new optional coverage group to enroll in family coverage through employer-sponsored insurance (ESI) if certain conditions are met. When the employer offers family coverage, the parent is eligible for such coverage, and

the employer contributes at least 50 percent of the total cost of annual premiums for such coverage, states must require participation in such coverage as a condition of continuing Medicaid eligibility for the child. Also, if such coverage is obtained, states must reduce premiums by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability. States could pay any portion of required premiums on behalf of eligible children under such plans. Medicaid would be the secondary payer to these ESI plans. Benefits offered by Medicaid but not offered by the ESI plans would be covered under Medicaid.

States would be permitted, within certain limits, to require families with children that qualify for Medicaid under the new optional eligibility category to pay monthly premiums on a sliding scale based on income, but only if specific caps on aggregate payments for cost-sharing (premiums plus other charges) for employer-sponsored family coverage are met. These caps specify that cost-sharing would not exceed 5 percent of income for families with income up to 200 percent FPL, and would not exceed 7.5 percent of income for families with income between 200 percent and 300 percent FPL. States could not require prepayment of premiums, nor would states be allowed to terminate eligibility of an enrolled child for failure to pay premiums unless lack of payment continues for a minimum of 60 days beyond the due date. States could waive payment of premiums when such payment would cause undue hardship.

The Senate bill would permit the income level for the new optional coverage group (set at 300 percent FPL) to exceed the otherwise applicable AFDC-related income standard for children under Medicaid. This section also stipulates that children with disabilities made eligible for Medicaid through the new optional coverage group would not be considered to be targeted low-income children as defined under SCHIP. Thus, the regular Medicaid FMAP, rather than the higher SCHIP E-FMAP, would apply for determining the federal share of Medicaid expenditures for the new optional coverage group. In addition, federal payments would be drawn from the open-ended Medicaid account and not the capped SCHIP account.

These provisions would be effective for items and services furnished on or after January 1, 2008.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill, with modifications. First, the agreement defines qualifying children as those considered disabled under the SSI program without regard to any income or asset eligibility requirements that apply under SSI for children and whose family income does not exceed 300 percent FPL. In addition, the agreement moves up the start date by one year for phasing in Medicaid coverage for this new group. That is, Medicaid coverage would be phased in, beginning with children through age 6 in the second through fourth quarters of FY2007

(rather than FY2008), then covering children through age 12 beginning in FY2008 (rather than FY2009), and finally, covering children through age 18 beginning in FY2009 (rather than FY2010) and thereafter.

As under the Senate bill, the conference agreement allows states to impose income-related premiums under this option. But the agreement changes the aggregate amount of cost sharing for families based on income levels.

For children in families with income that does not exceed 200 percent FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing cannot exceed 5 percent of family income. For children in families with income between 200 percent FPL and 300 percent FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost sharing cannot exceed 7.5 percent of family income.

Finally, the conference agreement changes the effective date of these provisions to January 1, 2007.

Demonstration Projects Regarding Home and Community-based Alternative to Psychiatric Residential Treatment Facilities for Children (Section 6063 of the Conference Agreement, Section 6043 of the Senate Bill, and no provision in the House Bill)

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allows states to provide a broad range of home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation (ICF-MR). Federal approval for these waivers is contingent on the state's documentation of the waiver's cost-neutrality. Cost-neutrality is met if, on average, the per person cost with the HCBS waiver is no higher than the cost if the person were residing in a hospital, nursing home, or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

For children with psychiatric disabilities, many states provide Medicaid funding for inpatient psychiatric residential treatment facilities. However, because the waiver cost-neutrality calculation does not allow a comparison of HCBS waiver expenditures to expenditures in these psychiatric residential treatment facilities, most states have had difficulty covering HCBS waiver services for children with psychiatric disabilities. Four states (Indiana, Kansas, New York and Vermont) have been able to offer HCBS waiver services for children with psychiatric disabilities by documenting the cost-neutrality of the waiver compared to the state's hospital expenditures. However given the cost-neutrality requirement, those states that have limited the use of hospitals for children with psychiatric disabilities may be unable to develop HCBS waivers for this population.

Senate Bill

The Senate bill would authorize the Secretary to conduct demonstration projects in up to 10 states during the period from FY2007 through FY2011 to test the effectiveness of improving or maintaining the child's functional level, and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment, for children enrolled in Medicaid. These demonstration projects will develop home and community-based services as an alternative to a psychiatric residential treatment facility. However, these projects must also follow the requirements of the HCBS waiver program. Specifically, demonstration participants would be required to meet the level of care of a psychiatric residential treatment facility, and the average, per-person project expenditures may not exceed the average, per-person cost of a psychiatric residential treatment facility.

The demonstration states would be selected through a competitive bidding process. At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project.

As part of the demonstration, the following conditions would apply: (1) projects must meet the same terms and conditions that apply to all HCBS waivers; (2) the Secretary must ensure that the projects are budget neutral; that is, total Medicaid expenditures under the demonstration projects will not be allowed to exceed the amount that the Secretary estimates would have been paid in the absence of the demonstration projects; and (3) applications for a demonstration project must include an assurance to conduct an interim and final evaluation by an independent third party and any reports that the Secretary may require.

This proposal would appropriate \$218 million for FY2007 through FY2011 for the state demonstration projects and the federal evaluations and report. Total expenditures for state demonstration projects would not be allowed to exceed \$21 million in FY2007, \$37 million in FY2008, \$49 million in FY2009, \$53 million in FY2010, and \$57 million in FY2011. Funds not expended in a given fiscal year would continue to be available in subsequent fiscal years. An additional \$1 million would be available to the Secretary to complete a required interim and final evaluation of the project and report the conclusions of the evaluations to the President and Congress within 12 months of completing these evaluations.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision.

Development and Support of Family-to-Family Health Information Centers (Section 6064 of the Conference Agreement, Section 6044 of the Senate Bill, and no provision in the House Bill)

Current Law

Family-to-family health centers provide information and assistance to help families of children with special health care needs navigate the system of care and make decisions about the needs and available supports for their child. No provision in current law specifically authorizes a dedicated amount of funds for these family-to-family health information centers. However, since 2002, the Department of Health and Human Services (HHS) has awarded approximately \$6.9 million to develop these information centers in 36 states under various program authorities including: (1) Special Projects of Regional and National Significance Program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) operated by the Health Resources Services Administration (HRSA); (2) the Real Choice Systems Change grant program operated by the Centers for Medicare and Medicaid Services (CMS); and (3) a one-year direct Congressional appropriation to an organization in Iowa. Federal funding for these projects is time-limited. Except for the one-year direct appropriation, state projects have generally been funded for a three- or four-year period. HRSA intends to fund additional family-to-family health information centers awarding up to \$2.4 million to six projects for a four-year period starting in FY2006.

Senate Bill

The Senate bill would increase funding under the SPRANS program of Title V of the Social Security Act for the development and support of new family-to-family health information centers (described below). This proposal would appropriate an additional \$3 million for FY2007, \$4 million for FY2008, and \$5 million for FY2009 for this new purpose. For each of fiscal years 2010 and 2011, the bill would authorize to be appropriated to the Secretary \$5 million for this purpose. Funds would remain available until expended.

The family-to-family health information centers would: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health delivery models; (4) develop a model for collaboration between families of such children and health professionals; (5) provide training and guidance with regard to the care of such children; and (6) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals. The family-to-family health information center would be staffed by families who have expertise in public and private health care systems and by health professionals.

The Secretary would be required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision.

Restoration of Medicaid Eligibility for Certain SSI Beneficiaries (Section 6065 of the Conference Agreement, Section 6045 of the Senate Bill, and no provision in the House Bill)

Current Law

SSI and Medicaid eligibility is effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date that the individual is determined eligible.

Senate Bill

The Senate bill would extend Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application was filed, or (2) the date SSI eligibility was granted. This provision would be effective one year after the date of enactment.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill provision.

Subchapter B—Money Follows the Person Rebalancing Demonstration

Money Follows the Person Rebalancing Demonstration (Section 6071 of the Conference Agreement, Section 6061 of the Senate Bill, and no provision in the House Bill)

Current Law

Under Medicaid, states can offer a variety of home and community-based services to Medicaid beneficiaries who need long-term care. Some of these services may be offered statewide as part of the Medicaid state plan (e.g., home health services and personal care services). Other services may be offered through a home and community-based services (HCBS) waiver under Section 1915(c) of the Social Security Act. These waivers allow states to provide a broad range of home and community-based services to individuals who would otherwise require the level of care provided in certain types of institutions (i.e., a hospital, nursing facility or intermediate care facility for individuals with mental retardation (ICF-MR)). For example, HCBS waiver services could include respite, personal care, adult day care, or therapy. As part of the HCBS waiver, states have the ability to define the specific services that will be offered,

to target a specific population (e.g., elderly individuals) and to limit the number of individuals who can participate in the waiver.

Approval for an HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if the average per person cost under the HCBS waiver is no higher than the average per person cost of receiving care in a hospital, nursing facility or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

Under current law, Medicaid beneficiaries who are residents of an institution (such as a nursing home) and who would like to leave that institution would be entitled to receive those Medicaid services covered by the Medicaid state plan. However, individuals may not be able to access the broader range of services under an HCBS waiver because many states have waiting lists for the waiver.

Medicaid expenditures for services (including the Medicaid state plan and HCBS waiver) are generally shared between the federal and state governments. In FY2003 (the latest expenditure data available), the federal government covered 59 percent of the cost of services; states covered the remaining 41 percent of expenditures. The specific federal share of a state is based on the state's federal medical assistance percentage (FMAP) rate which can range from 50 percent to 83 percent.

Senate Bill

The Senate provision would authorize the Secretary to conduct a demonstration project in states to increase the use of home and community-based care instead of institutions. States awarded a demonstration would receive 90 percent of the costs of home and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant's transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community-based long-term care program, as described below.

Individuals will be eligible to participate in the demonstration if they meet the following criteria: they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); they are receiving Medicaid benefits for the services in this facility; and they will continue to require the level of care of the facility but for the provision of HCBS services.

The state's application for a demonstration project will be required to include, at a minimum, the following information: (1) assurance that the project was developed and will be operated through a public input process; (2) assurance that the project will operate in conjunction with an existing Medicaid home and community-based program; (3) the duration of the project, which must be for at least two consecutive fiscal years in a five-year period start-

ing in FY2009; (4) the service area, which may be statewide or less-than-statewide; (5) the target groups and the projected number to be enrolled and the estimated total expenditures for each fiscal year; (6) assurance that the project defers to individual choice and that the state will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible; (7) information on recent Medicaid expenditures for long-term care and home and community-based services and proposed methods to increase the state's investment in home and community-based services; (8) methods the state will use to eliminate barriers to paying for long-term care services for participants in the setting(s) of their choice; (9) assurance that the state will meet a maintenance of effort for Medicaid HCBS expenditures and will continue to operate a HCBS waiver that meets the statutory requirements for cost-neutrality.

A state will also be required to describe a plan for quality assurance and improvement of HCBS services under Medicaid; any requested waivers of Medicaid law; if applicable, the process for participants to self-direct his or her own services (meeting standards outlined in this proposal); and compliance with reports and evaluation, as required by the Secretary.

In addition to evaluating the merits of a state's application, in selecting demonstration projects, the Secretary will be required to consider a national balance of target groups and geographic distribution and to give a preference to states that cover multiple groups or offer project participants the opportunity to self-direct their services. The Secretary will be authorized to waive certain sections of Medicaid law to achieve the purpose of the demonstration.

To qualify for grant awards after year one, states will be required to meet numerical benchmarks measuring the increased investment in services under this proposal and the number of individuals transitioned into the community. States will also be required to demonstrate that they are assuring the health and welfare of project participants. For states that do not meet these requirements, the Secretary will be required to rescind the grant award for future grant periods and will be allowed to re-award unused funding.

The proposal would require the Secretary to provide technical assistance and oversight to state grantees and may use up to \$2.4 million of the amounts appropriated for the portion of fiscal year 2009 that begins on January 1, 2009, and ends on September 30, 2009, and for fiscal year 2010, to carry out these activities during the period beginning on January 1, 2009 and ending on September 30, 2013. The Secretary would also be required to conduct a national evaluation and report its findings to the President and Congress no later than September 30, 2012 and may use up to \$1.1 million each year from FY2010 through FY2013 to carry out these activities.

This proposal would appropriate \$250 million for the portion of FY2009 which begins on January 1, 2009, and ends on September 30, 2009; \$300 million in FY2010; \$350 million in FY2011; \$400 million in FY2012; and \$450 million in FY2013 to carry out the demonstration project. Funds not awarded to states in a given fis-

cal year would continue to be available in subsequent fiscal years through September 30, 2013.

Payments for home and community-based long-term care services under the demonstration project would be in lieu of payment with respect to expenditures that could otherwise be paid for by Medicaid. However, if a state exhausts its grant funding in a particular year, the state is not prevented from using Medicaid to pay for home and community-based long term care services. Finally, a state that does not use all of its funding in a given fiscal year will continue to have access to that funding for four subsequent fiscal years.

House Bill

No provision.

Confrence Agreement

The conference agreement follows the Senate provision, but makes several changes to the Senate bill. First, to be eligible an individual must continue to require the level of care in an institution. However, in any case where a state would apply a more stringent level of care standard as a result of implementing a Medicaid state plan option under section 1915(I), established under this conference agreement, the individual must continue to require the level of care which had resulted in admission to the institution.

A state must assure that it will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible. If the state chooses to apply a more stringent level of care as a result of covering the state plan option under Section 1915(I), established under this conference agreement, the individual must continue to meet the requirement for the level of care that had resulted in his or her admission to the institution.

In addition, those states awarded a demonstration would receive an enhanced FMAP rate (referred to as the “MFP-enhanced FMAP”) equal to the current FMAP rate for the state increased by a number of percentage points equal to 50 percent of the difference between 100 percent and the normal FMAP rate. However, in no case can the FMAP rate exceed 90 percent for a state. The state will receive the MFP-enhanced FMAP for the costs of home and community-based, long-term care services for 12 months following a demonstration participant’s transition from an institution into the community.

Finally, demonstration grants would be awarded starting in 2007, instead of 2009 which changes all relevant dates within this provision including:

- The duration of the project must be for at least two consecutive fiscal years in a five-year period starting in FY2007; and
- The Secretary would be able to use up to \$2.4 million of the amounts appropriated for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, to carry out technical assistance and quality assurance activities during the period beginning on January 1, 2007 and ending on September 30, 2011; and

- The Secretary will also be required to report evaluation and findings to the President and Congress no later than September 30, 2011 and may use up to \$1.1 million each year from FY2008 through FY2011 to carry out these activities; and
- The provision would appropriate \$250 million for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; \$300 million in FY2008; \$350 million in FY2009; \$400 million in FY2010; and \$450 million in FY2011 to carry out the demonstration project; and
- Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2011.

Subchapter C—Miscellaneous

Medicaid Transformation Grants (Section 6081 of the Conference Agreement, no provision in the Senate Bill, and Section 3143 of the House Bill)

Current Law

Section 1903(a) of the Social Security Act describes the level of federal reimbursement available to states for various Medicaid program functions. The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50 percent and maximum of 83 percent. The federal reimbursement rate for Medicaid administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions receive enhanced (usually 75 percent) reimbursement.

Senate Bill

No provision.

House Bill

Under the House bill, in addition to the normal federal Medicaid reimbursement received by states under section 1903(a), the Secretary of HHS would provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

Examples of innovative methods for which such funds may be used include: (1) methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs, (2) methods for improving rates of collection from estates of owed to Medicaid, (3) methods for reducing waste, fraud, and abuse under Medicaid, such as reducing improper payment rates as measured by the annual payment error rate measurement (PERM) project rates, (4) implementation of a medication risk management program as part of a drug use review program, and (5) methods for reducing, in clinically appropriate ways, Medicaid expenditures for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the

use of education programs and other incentives to promote greater use of generics.

No payments would be made to a state unless the state applied to the Secretary of HHS for such payments in a form, manner, and time specified by the Secretary. Payments would be made under such terms and conditions consistent with the subsection as the Secretary prescribes. Payment to a state under the subsection would be conditioned on the state submitting to the Secretary an annual report on the programs supported by such payment. The reports would include information on: (1) the specific uses of such payment, (2) an assessment of the quality improvements and clinical outcomes under such programs, and (3) estimates of the cost savings resulting from such programs.

Total payments would equal and not exceed \$50 million in each of FY2007 and FY2008. The Secretary would specify a method for allocating the funds among states. Such method would provide preference for states that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. The method would also allocate at least 25 percent of the funds among states whose populations as of July 1, 2004 were more than 105 percent of their populations as of April 1, 2000.

Conference Agreement

The conference agreement follows the House bill, but would increase total payments to equal and not exceed \$75 million in each of FY2007 and FY2008. The agreement also adds, as an additional option for use of funds, methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital clinic systems. Conferees believe that it is important to develop new models to meet the needs of the uninsured. University-based physicians are uniquely qualified to assume this task. Bringing the resources of academia and health care systems together to serve the poor and medically needy will create new opportunities to develop strategies that can be used on a broader scale.

Improved Enforcement of Documentation Requirements (Section 6082 of the Conference Agreement, no provision in the Senate Bill, and Section 3145 of the House Bill)

Current Law

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien (e.g., a legal permanent resident, refugee, alien granted asylum or related relief) who meets all other Medicaid program eligibility criteria. Non-qualified aliens (e.g., those who are unauthorized or illegally present, non-immigrants admitted for a temporary purpose such as education or employment, short-term parolees) who would otherwise be eligible for Medicaid except for their immigration status may only receive Medicaid care and services that are necessary for the treatment of an emergency medical condition and are not related to an organ transplant procedure.

As a condition of an individual's eligibility for Medicaid benefits, Section 1137(d) of the Social Security Act requires a state to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. If an individual declares that he or she is a citizen or national, the state is not required to obtain additional documentary evidence but may choose to do so. According to a 2005 report from the Department of Health and Human Services' Office of Inspector General, 46 states and the District of Columbia allow or sometimes allow self-declaration of United States citizenship, while four states require Medicaid applicants to submit documentary evidence to verify citizenship statements.

If an individual declares that he or she is not a citizen or national, the individual must declare that he or she is a qualified alien and must present: (1) alien registration documentation or other proof of immigration registration from the Department of Homeland Security's United States Citizenship and Immigration Services Bureau (DHS/USCIS, formerly the Immigration and Naturalization Service) or (2) other documents determined by the state to constitute reasonable evidence of satisfactory immigration status. If an individual presents DHS/USCIS documentation, the state must verify the individual's immigration status with DHS/USCIS through the automated Systematic Alien Verification for Entitlements (SAVE) system, or by using an alternative verification system approved by the Secretary of Health and Human Services. States receive 100 percent federal reimbursement for the operation of such systems.

Senate Bill

No provision.

House Bill

Under the House bill, states would be prohibited from receiving federal reimbursement for medical assistance provided under Medicaid to an individual who has not provided satisfactory documentary evidence of citizenship or nationality.

Such evidence would include one of the following documents:

- a United States passport;
- Form N-550 or N-570 (Certificate of Naturalization);
- Form N-560 or N-561 (Certificate of United States Citizenship);
- such other document that the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

Satisfactory documentary evidence would also include a document from each of the following lists:

- a certificate of birth in the United States;
- Form FS-545 or Form DS-1350 (Certificate of Birth Abroad);
- Form 1-97 (United States Citizen Identification Card);
- Form FS-240 (Report of Birth Abroad of a Citizen of the United States); or

- such other document as the Secretary may specify (excluding a document specified by the Secretary as described above) that provides proof of United States citizenship or nationality;

AND

- any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act; or
- any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

The documentary requirements would not apply to an alien who is: (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on the basis of receiving Supplemental Security Income benefits, or (3) eligible for Medicaid on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

The provision would apply to determinations of initial eligibility for Medicaid made on or after July 1, 2006, and to redeterminations made after such date in the case of individuals for whom the new documentary requirements were not previously met.

Conference Agreement

The conference agreement follows the House bill, but allows a state-issued driver's license or other identity document described in section 274(A)(b)(1)(D) of the Immigration and Nationality Act as satisfactory evidence, but only if the state issuing the license or such document requires proof of U.S. citizenship before issuance or obtains a Social Security number from the applicant and verifies before certification that such number is valid and assigned to an applicant who is a citizen.

Health Opportunity Accounts (Section 6083 of the Conference Agreement, no provision in the Senate Bill, and Section 3134 of the House Bill)

Current Law

Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income families, children, pregnant women, and individuals who are aged or disabled. To qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. The specific income and resource limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Each state designs and administers its own program under broad federal guidelines. Variation exists among states in eligibility, covered services, and the delivery of, and reimbursement for services. States that wish to experiment with new approaches for providing health care coverage that promote the objectives of the Medicaid program may seek approval for Section 1115 demonstration waivers.

Medicaid's basic benefits rules require all states to provide certain "mandatory" services as listed in Medicaid statute. Federal matching payments are also available for optional services if states choose to include them in their Medicaid plans. States define the

specific features of each service to be provided under that plan within broad federal guidelines including: (1) Amount, duration, and scope. Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose, (2) Comparability. With certain exceptions, services available to any categorically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state. Similarly, services available to any medically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other medically needy beneficiary in the state, (3) Statewideness. State plan services must be covered throughout an entire state, and (4) Freedom of choice. With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers or managed care entities participating in Medicaid.

States may generally impose nominal cost-sharing on beneficiaries, with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, services provided to nursing facility residents who are required to spend all of their income for medical care except for a personal needs allowance, and services furnished to individuals receiving hospice care. States may require nominal copayments, coinsurance, or deductibles within federal limits from other beneficiaries or for other services. Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts.

For the most part, states establish their own rates to pay Medicaid providers for services. By regulation these rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. All providers are required to accept payments under the program as payment in full for covered services except where states require nominal cost-sharing by beneficiaries.

Senate Bill

No provision.

House Bill

The House bill would require the Secretary of HHS to establish no more than 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2006. While demonstration programs described in the House bill have some of the elements of a Section 1115 demonstration waiver, "Health Opportunity Accounts," as defined by the provision, are not explicitly authorized under current law.

If successful during the initial 5-year test period, other demonstrations would be approved. HOAs would be used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise author-

ized providers as well as to items and services that are medically appropriate or necessary. Eligibility for HOAs would be determined by the state, though individuals age 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, would be among those who would be precluded from participating. Once account holders were no longer eligible for Medicaid they could continue to make HOA withdrawals under state-specified conditions, though accounts could then also be used to pay for health insurance or, at state option, for job training or education. Among other things, state demonstration programs would have to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.

Demonstration participants would have both an HOA and coverage for medical items and services that, after an annual deductible is met, were available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations. Including federal shares, state contributions generally could not exceed \$2,500 for each adult and \$1,000 for each child.

Demonstration participants would be required to meet an annual deductible before they would be permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible would have to be at least 100 percent, but no more than 110 percent, of the annual state contributions to the HOA. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

The House bill would require demonstration participants to be able to obtain services from Medicaid providers or managed care organizations at the same payment rates that would be applicable if the coverage deductible did not apply, or from any provider for payment rates not exceeding 125 percent of those rates.

Conference Agreement

The House bill is agreed to with the following modifications. The conference agreement requires the Secretary of HHS to establish no more than 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2007. If successful (based on cost-effectiveness, quality of care and other Secretary-specified criteria) during the initial 5-year test period, such demonstrations may be extended or made permanent, and other demonstrations may be approved. Not later than 3 months prior to the end of the initial 5-year test period, the conference agreement requires the Comptroller General of the United States to submit an evaluation of the demonstration programs to Congress.

HOAs are used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Eligibility for HOAs is determined by the state, though individuals age 65 or

older, or who are disabled, pregnant, or receiving terminal care or long-term care, are among those who are precluded from participating. Once account holders are no longer eligible for Medicaid they may continue to make HOA withdrawals under state-specified conditions for a period of three years, though no additional account contributions will be made and the account balances will be reduced by 25 percent. For ineligible individuals who participated in the demonstration program for at least one year, accounts could then also be used to pay for health insurance or, at state option, for additional expenditures such as job training or education. The conference agreement adds a 1-year moratorium for reenrollment, whereby eligible individuals disenrolled from the state demonstration programs are not permitted to reenroll for a full year from such individual's disenrollment date. Among other things, state demonstration programs are required to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.

The conference agreement requires demonstration participants have both an HOA and coverage for medical items and services that, after an annual deductible is met, are available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations as permitted under current law. Including federal shares, state contributions generally may not exceed \$2,500 for each adult and \$1,000 for each child.

The conference agreement requires demonstration participants to meet an annual deductible before they are permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible must be at least 100 percent, but no more than 110 percent, of the annual state contributions to the HOA without regard to state-specified limits on the HOA balance. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

The conference agreement requires demonstration participants to be able to obtain services from Medicaid providers, or Medicaid managed care organizations at the same payment rates that are applicable if the coverage deductible did not apply, or from any other provider or managed care organization at payment rates not exceeding 125 percent of such Medicaid provider payment rates. The conference agreement requires that the payment rates for Medicaid providers or managed care organizations be computed without regard to any cost sharing that are otherwise applicable under current law (as modified by the conference agreement).

State Option to Establish Non-emergency Medical Transportation Program (Section 6084 of the Conference Agreement, no provision in the Senate Bill, and Section 3125 of the House Bill)

Current Law

Federal regulations require states to ensure necessary transportation for beneficiaries to and from providers. When states offer transportation as an optional benefit, federal reimbursement uses the federal assistance medical percentage (FMAP) rate which var-

ies by state and ranges from 50 percent to 83 percent. FMAP reimbursement is only available if transportation is furnished by a provider to whom a direct payment can be made. Beneficiaries must have freedom of choice among transportation providers and such services must be equal in amount, duration and scope for all beneficiaries classified as categorically needy (CN). This comparability requirement also applies among medically needy (MN) groups. Other arrangements, such as payments to a broker who manages and pays transportation vendors, must be claimed as an administrative expense rather than as a benefit. Such costs are reimbursed by the federal government at 50 percent, and fewer federal requirements must be met.

Senate Bill

No provision.

House Bill

The House bill would allow states to establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care but have no other means of transportation. The state would not be required to provide comparable services for all Medicaid enrollees, nor freedom of choice among providers. The program would include wheelchair van, taxi, stretcher car, bus passes and tickets, and other transportation methods deemed appropriate by the Secretary, and could be conducted under contract with a broker who: (1) is selected through a competitive bidding process that assesses the broker's experience, references, qualifications, resources and costs; (2) has oversight procedures to monitor beneficiary access and complaints and to ensure that transport personnel are licensed, qualified, competent and courteous; (3) is subject to regular auditing by the state to ensure quality of services and adequacy of beneficiary access to medical care; and (4) complies with requirements related to prohibitions on referrals and conflict of interest established by the Secretary. These provisions would be effective upon enactment.

The Office of the Inspector General (OIG) of DHHS would be required to submit a report to Congress examining the non-emergency medical transportation brokerage program implemented under this provision no later than January 1, 2007. This report must include findings regarding conflicts of interest and improper utilization of transportation services under this program, as well as recommendations for improvements.

Conference Agreement

The conference agreement includes the House bill, and specifies that non-emergency medical transportation brokerage programs do not have to be available statewide.

Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program (Section 6085 of the Conference Agreement, no provision in the Senate Bill, no provision in the House Bill)

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 of benefits is known as transitional medical assistance (TMA). States are currently required to provide TMA to families losing eligibility for Medicaid under two scenarios: one related to child or spousal support, and one related to work.

First, under 1931(c) of the Social Security Act, states must provide four months of TMA coverage to families losing Medicaid eligibility due to increased child or spousal support. This is a permanent provision of law with no sunset date.

Second, states are required to provide TMA to families losing Medicaid eligibility for work-related reasons. While Section 1902(e)(1) of the Social Security Act permanently requires states to provide four months of TMA to families losing Medicaid eligibility due to an increase in hours of work or income from employment, the Family Support Act (FSA) of 1988 expanded state TMA requirements under Section 1925 of the Social Security Act. As a result, states are currently required to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards have the effect of increasing the income level at which a family may qualify for Medicaid). FSA originally authorized Section 1925 to replace the four-month requirement in Section 1902(e)(1) through FY1998. However, the sunset date for Section 1925 has been extended a number of times, most recently through December 31, 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 through December 31, 2005 by temporary extension measures.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement extends TMA under Section 1925 of the Social Security Act through December 31, 2006. It also extends the \$50 million annual appropriation for the abstinence education block grant program through fiscal year 2006 and provides an additional \$12.5 million for the program for the first quarter of fiscal year 2007 (i.e., through December 31, 2006).

Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Entities (Section 6086 of the Conference Agreement, no provision in the Senate Bill, and Section 3147 of the House Bill)

Current Law

Medicaid law provides certain protections for beneficiaries enrolled in managed care, including assuring coverage of emergency services under each managed care contract awarded by the state.

Senate Bill

No provision.

House Bill

A Medicaid provider that does not have a contract with a Medicaid managed care entity (MCE) that furnishes emergency care to a beneficiary enrolled with that MCO must accept as payment in full the amount otherwise applicable outside of managed care (e.g., in the fee-for-service setting) minus any payments for indirect costs of medical education and direct costs of graduate medical education. The effective date of this provision would be January 1, 2007.

Conference Agreement

The conference agreement includes the House bill, but clarifies that the fee-for-service rate is the maximum payment rate. Also, in a state where rates paid to hospitals under the state plan are negotiated by contract and not publicly released, the payment amount applicable under this provision must be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under the plan for tertiary hospitals.

Subtitle B—SCHIP

Additional allotments to eliminate fiscal year 2006 funding shortfalls (Section 6101 Subsection a of the Conference Agreement, Section 6051 Subsection a of the Senate Bill, and no provision in the House Bill)

Current Law

In general, funds for the SCHIP program are authorized and appropriated for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount determined by a formula set

in law. Federal funds not drawn from a state's allotment by the end of each fiscal year continue to be available to that state for two additional fiscal years. At the end of the three-year period, unspent funds from the original allotment are reallocated in ways that vary depending on the fiscal year. The original SCHIP law, (i.e., BBA97), specifies that only those states that spend all of their original allotment by the applicable three-year deadline would receive redistributed funds from the other states' unspent allotments, based on a process determined by the Secretary of Health and Human Services (HHS); and these redistributed funds would be available for one year. However, later laws (i.e., P.L. 106-554 and P.L. 108-74) overrode how the reallocation of unspent FY1998 to FY2001 original allotments would occur. The redistribution of unspent FY2002 SCHIP original allotments was determined by the Secretary of HHS in accordance with the default redistribution provision in BBA97.

Under current law, unspent original allotments from FY2003 forward are to be redistributed according to the original BBA97 methodology. That is, redistributed funds will go only to those states that spend all of their original allotments by the applicable three-year deadline, with the redistributed amounts determined by the Secretary of HHS and made available for one year only.

Senate Bill

In general, the Senate bill would reduce the period of availability of the FY2004 and FY2005 original allotments from three years to two, and would specify rules for the reallocation of unspent FY2003, FY2004, and FY2005 SCHIP original allotments. The reallocated FY2003 and FY2004 funds would be available in FY2006; the reallocated FY2005 funds would be available in FY2007.

In FY2006, the Senate bill would require that unspent FY2003 original allotments remaining at the end of FY2005 (after a set-aside of 1.05 percent of the total unspent FY2003 funds for the territories) would be redistributed to states with an initial projected FY2006 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures in FY2006 would exceed the amounts available from the state's FY2005 and FY2006 original allotments. Each state with an initial projected shortfall would receive a portion of the available unspent FY2003 original allotments in proportion to its contribution to the total pool of such shortfalls. From the 1.05 percent territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2003 original allotments for the territories.

Also in FY2006, the Senate bill would require that the territories receive a set-aside of 1.05 percent of the total unspent FY2004 original allotments available at the end of FY2005. Described states would be permitted to extend the use of their unspent FY2004 original allotments in an amount equal to the shortfall still remaining after receiving redistributed FY2003 funds. Described states would be defined as states that: (1) spent all FY2003 original allotments by the end of FY2005, (2) did not spend all of their FY2004 original allotment by the end of FY2005, and (3) reported an initial projected FY2006 shortfall. After the set-aside for the territories as well as the reduction of FY2004 ex-

tended funds for the described states, the remaining unspent FY2004 funds would be available to states with a net projected FY2006 shortfall, defined as each state's initial projected shortfall reduced by the redistributed FY2003 funds it received and by the extended FY2004 funds if it is a described state. Each state with a net projected shortfall would receive a redistribution of FY2004 funds to cover its net projected shortfall. Any remaining FY2004 unspent original allotments would then be extended proportionally to states that did not spend their FY2004 allotments by the end of the two-year period of availability. From the 1.05 percent territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2004 original allotments for the territories.

In FY2007, the Senate bill would require that the territories receive a set-aside of 1.05 percent of the total unspent FY2005 original allotments available at the end of FY2006. Described states would be permitted to extend the use of their unspent FY2005 original allotments in an amount equal to their initial projected FY2007 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures for FY2007 exceeds the amount available from the state's FY2006 and FY2007 original allotments. Described states would be defined as states that: (1) did not spend all of their FY2005 original allotment by the end of FY2006, and (2) reported an initial projected FY2007 shortfall. After the set-aside for the territories as well as the reduction of FY2005 extended funds for the described states, the remaining unspent FY2005 funds would be available to states with a net projected FY2007 shortfall, described as each state's initial projected shortfall reduced by the extended FY2005 funds for the described states. Each state with a net projected shortfall would receive a redistribution of FY2005 funds to cover its net projected shortfall or, if the remaining funds are inadequate to cover the FY2007 projected shortfalls, a portion of the available unspent FY2005 original allotments in proportion to the state's contribution to the total shortfall pool. If any FY2005 unspent original allotments remain, they would then be extended proportionally to states that did not spend their FY2005 allotments by the end of the two-year period of availability. From the 1.05 percent territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2005 original allotments for the territories.

To calculate the amounts available for redistribution and retention in each formula described above, the Secretary would use expenditures reported by states not later than November 30, 2005, for the FY2003 and FY2004 redistributions, and November 30, 2006, for the FY2005 redistribution. To calculate states with projected shortfalls in each formula described above, the Secretary would use projected expenditures reported by the states not later than September 30, 2005, for the FY2003 and FY2004 redistributions, and not later than September 30, 2006, for the FY2005 redistribution. This provision of the Senate bill would be effective upon enactment of this Act.

House Bill

No provision.

Conference Agreement

Out of money not otherwise available in the Treasury, the conference agreement authorizes and appropriates \$283 million for the purpose of providing additional SCHIP allotments to shortfall states in FY2006. The conference agreement defines shortfall states as those with an approved SCHIP plan for which (based on the most recent SCHIP data as of December 16, 2005) the Secretary estimates that such state's FY2006 projected expenditures exceed the sum of all funds available for expenditure by that state in FY2006 including: (1) the amount of such state's FY2004 and FY2005 original allotments that will not be expended in FY2005; (2) the amount, if any, that is redistributed to such state during FY2006; and (3) the amount of such state's FY2006 original allotment. From the additional SCHIP appropriation, each FY2006 shortfall state would receive an allotment to cover its projected shortfall or, if the appropriated funds are inadequate to cover the FY2006 projected shortfalls, the Secretary shall distribute the available funds on a pro rata basis based on each such state's estimated shortfall. Such additional SCHIP allotments are available for one year only. On October 1, 2006, any remaining unspent additional allotments will not be subject to redistribution, but will instead revert to the Treasury.

The conference agreement limits the types of payments that may be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the additional FY2006 appropriation available to shortfall states to include child health assistance payments made on behalf of targeted low-income children. The amendments made by this section of the conference agreement apply to items and services furnished on or after October 1, 2005, without regard to whether or not regulations implementing such amendments have been issued.

Prohibition against covering nonpregnant childless adults with SCHIP funds (Section 6102 of the Conference Agreement, and Section 6053 of the Senate Bill)

Current Law

Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under Section 1115, the Secretary may waive requirements in Section 1902 (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP.

With respect to SCHIP, the Clinton Administration issued a July 31, 2000, letter regarding treatment of adults. While this Administration was supportive of using the 1115 authority to expand SCHIP to parents of Medicaid or SCHIP-eligible children, as well as to certain pregnant women, it opposed coverage of childless adults. Under the Bush Administration, the Health Insurance

Flexibility and Accountability (HIFA) Initiative was implemented using the 1115 waiver authority. The initiative was created to encourage states to increase the number of individuals with health insurance coverage (including childless adults) within current program resources.

Senate Bill

The Senate bill would limit the Secretary of Health and Human Services's Section 1115 waiver authority by prohibiting the approval of new waiver, experimental, pilot, or demonstration projects that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The provision would allow the Secretary to continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible children (as defined under Section 1931 of Medicaid statute), and to pregnant adults. Finally, the provision would allow for the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to such projects) affecting federal SCHIP funds that had been approved under the Section 1115 waiver authority before the date of enactment of this Act. This provision would be effective upon the enactment of this Act.

House Bill

No provision.

Conference Agreement

The Senate bill is agreed to.

Continued authority for qualifying states to use certain funds for Medicaid expenditures. (Section 6103 of the Conference Agreement, Section 6054 of the Senate Bill, and no provision in the House Bill)

Current Law

Current law permits qualifying states (i.e., states that on or after April 15, 1997, had an income eligibility standard for children, other than infants, of at least 184 percent of the FPL.—Other qualifications also apply to states with statewide waivers under Section 1115 of the Social Security Act.) to receive the SCHIP enhanced federal matching rate for the coverage of certain children enrolled in regular Medicaid. Specifically, for services delivered to Medicaid beneficiaries under the age of 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150 percent of the FPL, federal SCHIP funds can be used to pay the difference between the SCHIP enhanced federal matching rate and the regular Medicaid federal matching rate. The maximum amount that qualifying states may claim under this allowance is the lesser of the following two amounts: (1) 20 percent of the state's available FY1998 through FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20 percent

spending. No 20 percent spending will be permitted in FY2006 or any fiscal year thereafter.

House Bill

No provision.

Senate Bill

The Senate bill would continue the authority for qualifying states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the bill would allow qualifying states to use any available FY2004 and FY2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds, as the case may be) for such Medicaid services made on or after October 1, 2005 under the 20 percent allowance. This provision of the Senate bill would be effective on or after October 1, 2005.

Conference Agreement

The Senate bill is agreed to.

Use of Redistributed Funds for Child Health Assistance for Targeted Low-income Children (No provision in the Conference Agreement, Section 6051—Subsection b of the Senate Bill, and no provision in the House Bill)

Current Law

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. The federal government contributes more toward the coverage of individuals in SCHIP than it does for those covered under Medicaid. All SCHIP assistance for targeted low-income children, including claims submitted to and approved by CMS for expenditures under the Section 1115 waiver authority, are matched at the enhanced federal medical assistance percentage (enhanced-FMAP).

Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

Senate Bill

The Senate bill would limit the types of payments that could be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the FY2003, FY2004, and FY2005 redistributed funds available to shortfall states. Specifically, the Senate bill would require the federal government to make matching payments at the SCHIP enhanced matching rate for child health assistance payments made on behalf of targeted low-income children.

However, expenditures drawn against the FY2003, FY2004, and FY2005 redistributed SCHIP funds would occur at the regular Medicaid FMAP rate for all other approved SCHIP expenditures, consisting of the following: (1) benefit expenditures for adults (other than pregnant women) approved under the Section 1115 waiver authority; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Authority to Use up to 10 Percent of Fiscal Year 2006 and 2007 Allotments for Outreach (No provision in the Conference Agreement, Section 6052 of the Senate Bill, and no provision in the House Bill)

Current Law

In general, Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate can be made for the following four specific health care activities: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for these four specific health care activities cannot exceed 10 percent of the total amount of expenditures for SCHIP insurance benefits and other specific health care activities combined. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) created a special rule for the redistribution of unspent FY1998 and FY1999 original allotments. Under BIPA, states that did not use all of their original allotments for the year were permitted to use up to 10 percent of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap, described above.

Senate Bill

The Senate bill would allow states to use up to 10 percent of their FY2006 and FY2007 original allotments for expenditures on outreach activities incurred during FY2006 and FY2007 respectively. This allowance would be over and above spending for such activities under the general administrative cap described under current law. Outreach activities would include: (1) activities to promote the coordination of the administration of SCHIP with other public and private health insurance programs; and (2) strategies to market the program to the target population and to simplify and

expedite the eligibility determination and enrollment process. This provision would be effective upon enactment of this Act.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Grants to Promote Innovative Outreach and Enrollment Under Medicaid and SCHIP (No provision in the Conference Agreement, Section 6055 of the Senate Bill, and no provision in the House Bill)

Current Law

The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. States are responsible for the nonfederal share, using state tax revenues, for example, but can also use local government funds to comprise a portion of the non-federal share. Generally, the non-federal share of costs under Medicaid and SCHIP cannot be comprised of other federal funds.

Under Medicaid, there are no caps on administrative expenses that may be claimed for federal matching dollars. Title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10 percent of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

Senate Bill

The Senate bill would establish a new grant program under SCHIP to (1) finance outreach and enrollment efforts to increase participation of eligible children in both SCHIP and Medicaid, and (2) promote understanding of the importance of health insurance coverage for prenatal care and children. The Secretary would be permitted to reserve a portion of the grant funds for the purpose of awarding performance bonuses to eligible entities (defined below) that meet enrollment goals or other criteria established by the Secretary.

In awarding grants, the Secretary would be required to give priority to: (1) entities that propose to target geographic areas with high rates of eligible but not enrolled children, or racial and ethnic minorities and health disparity populations, and (2) entities targeting the same populations that are federal health safety net organizations (defined below) or faith-based organizations or consortia. Of the funds appropriated for this grant program (see below), 10 percent would be set aside for grants to certain Indian health care

providers for outreach and enrollment of Indian children. These Indian health care providers would include the Indian Health Service (IHS) and Urban Indian Organization (UIO) providers that receive funds under Title V of the Indian Health Care Improvement Act.

The Senate bill would require entities seeking a grant to submit an application to the Secretary containing information on the quality and outcome performance measures to be used to evaluate the effectiveness of grant activities to ensure that these activities are meeting their goals. In addition, the application must provide assurances that the entity would: (1) conduct an assessment of the effectiveness using such performance measures, and (2) collect and report enrollment data and other information from these assessments to the Secretary in a form and manner as required by the Secretary.

The Senate bill would require the Secretary to disseminate to eligible entities and make publicly available the enrollment data and information collected and reported by grantees. The Secretary would also be required to submit an annual report to Congress on the funded outreach activities.

The Senate bill would require that federal funds awarded under this new grant be used to supplement, not supplant, non-federal funds that are otherwise available for these grant activities.

Specific definitions would be applicable to the new grant program. Five types of entities would be eligible to receive these grants, including: (1) state or local governments, (2) federal health safety net organizations, (3) national, local or community-based public or nonprofit private organizations, (4) faith-based organizations or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of Section 1955 of the Public Health Service Act (relating to grant awards to non-governmental entities), and (5) elementary or secondary schools. Federal health safety net organizations include a number of different types of entities, including for example: (1) Indian tribes, tribal organizations, UIOs and IHS providers, (2) federally qualified health centers, (3) hospitals that receive disproportionate share hospital (DSH) payments, (4) entities described in Section 340B(a)(4) of the Public Health Service Act (e.g., certain family planning projects, certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (5) any other entity that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

The Senate bill would appropriate \$25 million for fiscal year 2007 for these grants. These grants would be in addition to existing SCHIP appropriations, and would not be subject to restrictions on expenditures for outreach activities under current law.

These provisions would be effective with the FY2007 appropriation for this new grant program.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Subtitle C—Katrina Relief

Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations (Section 6201 of the Conference Agreement, Sections 6032 and 6071 of the Senate Bill, and Sections 3100 and 3201 of the House Bill)

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50 percent and maximum of 83 percent. An enhanced FMAP is available for both services and administration under SCHIP, subject to the availability of funds from a state's SCHIP allotment. In order for a state to receive federal Medicaid or SCHIP reimbursement, it must have in effect a state plan approved by the Secretary of HHS that meets requirements set forth in federal statute and regulations.

Using an application template developed by the Centers for Medicare and Medicaid Service within HHS, a number of states (17 as of December 15, 2005) have been granted waivers under Section 1115 of the Social Security Act to provide Medicaid and SCHIP services to certain individuals affected by Hurricane Katrina (these waivers are referred to as being part of a multistate demonstration project). For purposes of FMAP reimbursement, Section 1115 waivers are deemed to be part of a state's Medicaid or SCHIP state plan (i.e., its "regular" Medicaid or SCHIP program).

All of the waivers granted thus far under the Hurricane Katrina multi-state Section 1115 demonstration create a temporary eligibility period, not to exceed five months, during which certain Hurricane Katrina evacuees will be granted access to Medicaid and SCHIP services in the host state (i.e., the state that has been granted a Section 1115 waiver) based on simplified eligibility criteria. In addition to creating temporary Medicaid or SCHIP eligibility for evacuees, waivers for some states also create an uncompensated care pool that may be used through January 31, 2006, to augment Medicaid and SCHIP services for evacuees and to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP.

Disaster declarations were issued in the wake of Hurricane Katrina pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, which authorizes the President to issue such declarations to speed a wide range of federal aid—including individual assistance (e.g., housing for individuals and families) and public assistance (e.g., repair of community infrastructure)—to states determined to be overwhelmed by hurricanes or other catastrophes. The Federal Emergency Management Agency (FEMA) makes the decision as to when a major disaster or emergency is "closed out" for administrative purposes.

Senate Bill

Under the Senate bill, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100 percent FMAP reimbursement for Medicaid and SCHIP assistance provided to individuals who resided during the week preceding Hurricane Katrina in one of the parishes of Louisiana or counties of Mississippi and Alabama specified in the bill. Costs directly attributable to related administrative activities would also be reimbursed at 100 percent.

A separate provision would allow the state of Louisiana, Mississippi, or Alabama to elect to not have the Medicaid subtitle of the bill apply with respect to the state during any period for which a major disaster declared in accordance with the Stafford Act with respect to a parish (in the case of Louisiana) or a county (in the case of Mississippi or Alabama) as a result of Hurricane Katrina is in effect.

House Bill

Under the House bill, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100 percent FMAP reimbursement for Medicaid and SCHIP assistance provided to: (1) any individual residing in a parish of Louisiana, a county of Mississippi, or a major disaster county of Alabama and (2) individuals who resided during the week preceding Hurricane Katrina in a parish or county for which a major disaster has been declared as a result of the hurricane and for which the President has determined, as of September 14, 2005, warrants individual assistance under the Stafford Act. Costs directly attributable to related administrative activities would also be reimbursed at 100 percent.

A separate provision would allow the Medicaid subtitle of the bill to not apply during the 11-month period beginning September 1, 2005, to individuals entitled to Medicaid assistance by reason of their residence in a parish of Louisiana or a county of Mississippi or Alabama for which a major disaster has been declared as a result of Hurricane Katrina and for which the President has determined, before September 14, 2005, warrants individual and public assistance under the Stafford Act.

Conference Agreement

The conference agreement appropriates \$2 billion (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those who have provided care to affected individuals or evacuees under a Section 1115 project) for the following purposes:

- the non-federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Hurricane Katrina and continue to reside in the same state) and evacuees (affected individuals who have been displaced to another state) under approved multi-state Section 1115 demonstration projects;
- reasonable administrative costs related to such projects;

- the non-federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP state plans; and
- other purposes, if approved by the Secretary, to restore access to health care in impacted communities.

The non-federal share paid to eligible states shall not be regarded as federal funds for purposes of Medicaid matching requirements. No payment obligations may be incurred under approved multi-state Section 1115 projects for costs of: (1) health care provided as Medicaid or SCHIP medical assistance incurred after June 30, 2006 and (2) uncompensated care or services and supplies beyond those included as Medicaid or SCHIP medical assistance incurred after January 31, 2006.

State High Risk Health Insurance Pool Funding (Section 6202 of the Conference Agreement, no provision in the Senate Bill, and Section 3202 of the House Bill)

Current Law

A majority of states have established high-risk health insurance pool programs as one approach to reduce the number of uninsured persons. These programs target individuals who cannot obtain or afford health insurance in the private health insurance market, primarily because of pre-existing health conditions. Many states also use their high-risk pools to provide access to health insurance to individuals eligible under the guaranteed issue and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–191). In general, high-risk pools are operated through state-established nonprofit organizations that contract with private insurance companies to collect premiums, administer benefits, and pay claims. These programs tend to be small and enroll a small percentage of the uninsured. As of December 2004, 33 states operate high risk health insurance pool programs. Authorizing legislation for federal funding of these pools expired September 30, 2005.

Senate Bill

No provision.

House Bill

The House bill would amend the Public Health Service Act to reauthorize federal funding for state high risk health insurance pools. For FY2006, it would provide \$90 million in appropriations for grants to states to be used to cover up to 50 percent of operating expenses of existing state high risk pools.

Conference Agreement

The conference agreement would appropriate, for FY2006, \$75 million for the losses incurred by a State in connection with the operation of their qualified high risk pool. There is also \$15 million in FY2006 appropriated to fund seed grants to States to create, and initially fund, a high risk pool. This funding will also apply upon the enactment of the State High Risk Pool Funding Extension Act of 2005.

Recomputation of HPSA, MUA, and MUP Designations Within Hurricane Katrina Affected Areas (No provision in the Conference Agreement, no provision in the Senate Bill, and Section 3203 of the House Bill)

Current Law

The Public Health Service Act provides for the designation of areas underserved by healthcare personnel, providing federal loans, scholarships and grants to improve the distribution of health care workers. The program is authorized through 2006.

Senate Bill

No provision.

House Bill

The House bill would direct the Secretary of HHS to review all such shortage designations in Hurricane Katrina declared disaster areas (pursuant to the Stafford Act), considering potential new shortages of health care workers.

Conference Agreement

No provision.

Waiver of Certain Requirements Applicable to the Provision of Health Care in Areas Impacted by Hurricane Katrina (No provision in the Conference Agreement, no provision in the Senate Bill, and Section 3204 of the House Bill)

Current Law

The Public Health Service Act establishes requirements for federally qualified health centers and personnel in the National Health Service Corps. Programs are authorized through 2006.

Senate Bill

No provision.

House Bill

The House bill would direct the Secretary of HHS to relax certain requirements for the conduct of federally qualified health centers, and National Health Service Corps personnel staffing them, in areas directly affected by Hurricane Katrina, or indirectly affected by hosting large numbers of evacuees.

Conference Agreement

No provision.

House Bill

Section 7001 temporarily increases the vessel tonnage fees paid by vessels arriving in the United States. Specifically, section 7001 increases the vessel tonnage fees paid by vessels arriving in the U.S. from a place in North America, Central America, the West India Islands, the Bahama Islands, and Newfoundland, and by certain vessels returning from a "voyage to nowhere." The fees are increased from 2 cents per ton, not to exceed 10 cents per ton in a

single year, to 4.5 cents per ton, not to exceed 22.5 cents per ton in a single year. In addition, section 7001 increases the vessel tonnage fees paid by vessels arriving from a foreign port anywhere else in the world from 6 cents per ton, not to exceed 30 cents per ton, to 13.5 cents per ton, not to exceed 67.5 cents per ton in a single year. These increased rates will be in effect for fiscal years 2006 through 2010.

TITLE VII—HOUSE COMMITTEE ON WAYS AND MEANS

TANF—Temporary Assistance for Needy Families (Subtitle A)

Reauthorization of Grants

Current Law

The TANF block grant provides states with funding for a wide range of benefits and services to families with children, including cash welfare. Basic block grants are funded nationally at \$16.5 billion per year. The law also provides supplemental grants to certain states funded at \$319 million per year; performance bonus funds of \$200 million per year for meeting program goals and \$100 million per year for reducing out-of-wedlock pregnancies; contingency funds of \$2 billion for states experiencing economic downturns; and a loan fund. Funding authority for the program expires December 31, 2005.

Allows up to 30 percent of TANF block grants to be transferred to the Child Care and Development Block Grant (CCDBG) and Social Services Block Grant (SSBG), although limit on transfers to SSBG is set at 4.25 percent for FY2006 and later.

House Passed Bill

Extends TANF block grant at current level through FY2010 and TANF supplemental grants at current levels through FY2009. Eliminates all bonus funds and the loan fund. (Some of these savings are used to finance grants to promote healthy marriages and responsible fatherhood, see below.) Continues a \$2 billion contingency fund through FY2010.

Raises overall transfer authority to 50 percent of the TANF block grant, and increases maximum transfer to SSBG to 10 percent (level allowed in the original 1996 welfare law).

Senate Passed Bill

No provision.

Conference Report

Recede to the House, with the modification that TANF supplemental grants are authorized at their current level for three fiscal years (through FY2008). Recede to the Senate with regard to transfer authority.

Work Participation Requirements

Current Law

States are required to make an assessment of the work-readiness of TANF assistance recipients and may establish an Indi-

vidual Responsibility plan for them. States are required to sanction families with a recipient who does not comply with work.

Recipients are required to visit their children's schools twice per year.

Senate Passed Bill

No provision.

Conference Report

Recede to the Senate with respect to self-sufficiency plans, sanctions, and the increase in work participation standard to 70 percent.

Recede to the House with regard to the caseload reduction credit, with the modification that the base year for this credit is changed to FY2005, effective October 1, 2006. Adds that families receiving assistance under separate state programs are included in the calculation of work participation rates; and the Secretary of Health and Human Services is to provide additional direction to and oversight of states related to activities that may be counted as work activities, how to count and verify reported hours of work, and determining who is a work-eligible individual, with a new penalty for states that fail to establish and maintain such improved work participation verification procedures.

Recede to the Senate on additional credits for states with large past caseload declines, hours of work, partial credits, special allowances or requirements, and changes in list of work activities and extent to which such activities may be counted as work.

Healthy Marriage Promotion Grants

Current Law

No special grants. States may use TANF funds for activities to promote the formation and maintenance of two-parent families.

House Passed Bill

Establishes \$100 million per year in matching grants and \$100 million per year in demonstration grants to fund various activities to promote healthy marriages. Requires that marriage promotion activities be voluntary. Requires that grantees consult with organizations with experts in domestic violence.

Senate Passed Bill

No provision.

Conference Report

Recede to the House with the modification that the Secretary of HHS will award \$150 million per fiscal year in healthy marriage promotion, responsible fatherhood, and related grants in each of FYs 2006–2010. Of this amount, up to \$50 million per fiscal year may be awarded on a competitive basis for activities promoting responsible fatherhood, and up to \$2 million per fiscal year is available for demonstration projects for coordination of child welfare and TANF services to tribal families at risk of child abuse or neglect.

Conference Report

Recede to the House with the modification that total child care funding will increase by \$1 billion above the current level over five years, appropriating \$2.917 billion in mandatory child care funding for each of FYs 2006–2010.

Child Support Enforcement (Subtitle C)

Current Law

The Child Support Enforcement (CSE) program is a federal-state program that provides the following basic services to both welfare and nonwelfare families: parent location, review and modification of child support orders, collection of child support payments, establishment of medical child support, and distribution of child support payments. The CSE program is funded with both state and federal dollars. There are four funding mechanisms. First, states spend their own money to operate a CSE program. Second, the federal government reimburses each state 66 percent for most of its child support enforcement activities or services. The federal government reimburses states at a higher 90 percent matching rate for paternity determination expenditures. Third, states collect child support on behalf of families receiving welfare benefits to reimburse themselves (and the federal government) for the cost of welfare payments to the family. Fourth, an incentive payment is given to states for operating a good program (current law requires that states reinvest incentive payments back into the CSE program or related activities).

House Passed Bill

Revises some child support enforcement collection mechanisms and add others.

Provides financial incentives to states that send more child support collected on behalf of families on welfare to the families themselves (rather than retain funds as reimbursement for welfare costs). The federal government would pay for a share of support passed through to welfare families as long as that support did not reduce the family's welfare benefit. Also gives states financing incentives to send to former welfare families more of the child support payments collected on their behalf.

Includes a provision to gradually reduce (from FY2007–FY2010) the federal matching rate for child support administrative expenditures from its current 66 percent to 50 percent. Also, prohibits the federal government from matching child support incentive payments reinvested in the CSE program.

Senate Passed Bill

No provision.

Conference Report

Recede to the House with modifications that revise child support enforcement collection mechanisms, and provide financial incentives to states that pass through more child support to current and former TANF families. Recede to the House with respect to ending federal matching of state expenditure of federal child sup-

port incentive funds, effective in FY 2008. Recede to the Senate with regard to reducing the federal administrative matching rate. Includes provision changing to 66 percent the federal matching rate for laboratory costs incurred in determining paternity, effective October 1, of the Social Security Act and determinations regarding foster care placement, termination of parental rights, and recognition of adoptions. Courts can also use these grant funds to implement changes found necessary as a result of the assessments.

House Passed Bill

Restates the federal foster care eligibility rules to effectively nullify the *Rosales* decision. Restates adoption assistance eligibility to make the same clarification and to simplify the eligibility determination.

Senate Passed Bill

No provision.

Conference Report

Recede to the House, with the modification to include (1) new funds totaling \$100 million over the five-year period FY 2006–2010 for strengthening courts involved in child welfare proceedings, and (2) new funds for the Safe and Stable Families program, increasing mandatory funding to \$345 million in FY 2006 (and thus totaling \$200 million over the five-year period FY 2006–2010).

Limit Federal Foster Care Administrative Claims

Current Law

States may claim reimbursement for some administrative costs related to children who are at “imminent” risk of entering foster care. Some states, relying on prior HHS policy guidance, make additional administrative claims for children placed in unlicensed, or otherwise federally ineligible placement settings, provided the foster child meets all other federal foster care eligibility criteria.

House Passed Bill

Specifies in which cases, and for how long, states may seek reimbursement of foster care administrative costs only on behalf of otherwise federally eligible children who are living with unlicensed relatives, in another ineligible setting, or who have not yet entered foster care.

Senate Passed Bill

No provision.

Conference Report

Recede to the House.

Supplemental Security Income (Subtitle E)

Review of State Agency Blindness and Disability Determinations

Current Law

No provision.

Conference Report

Recede to the Senate.

STATEMENT OF MANAGERS

TITLE VIII—EDUCATION AND PENSION BENEFIT PROVISIONS

With respect to Section 2201(d) of the House amendment, the managers on the Part of the House agree to request a study by the Government Accountability Office regarding the effect of the premium as provided under Section 4006(a)(7) of ERISA on persons who are a contributing sponsor of the plan or a member of such sponsor's controlled group and who has filed or has had filed against such person a petition seeking reorganization in a case under title 11 of the United States Code, or under any similar law of a State or a political subdivision of a State (or a case described in section 4041(c)(2)(B)(i) filed by or against such person and report the same to the Committees on Education and the Workforce and the Committee on the Judiciary within 18 months of enactment of this Act.

STATEMENT OF MANAGERS

LIHEAP PROVISION

The Congress finds the following:

(1) Hurricanes Katrina and Rita severely disrupted crude oil and natural gas production in the Gulf of Mexico. The Energy Information Administration estimates that as a result of these two hurricanes, the amount of shut in crude oil production nearly doubled to almost 1,600,000 barrels per day, and the amount of natural gas production shut in also doubled to about 8,000,000,000 cubic feet per day. The hurricanes also initially shut down most of the crude oil refinery capacity in the Gulf of Mexico region. These disruptions led to significantly higher prices for crude oil, refined oil products, and natural gas expected to continue in the foreseeable future.

(2) These production and supply disruptions are expected to lead to significantly higher heating costs for consumers for the foreseeable future. These significant increases in home heating costs this winter and for the foreseeable future will particularly harm low-income consumers. The Low-Income Home Energy Assistance Program is designed to assist these low-income consumers in this situation. Accordingly, Congress seeks a one-time only supplement to the Low-Income Home Energy Assistance Program fund to assist low-income consumers with the additional home heating expenditures that they will face in the foreseeable future as a result of Hurricanes Katrina and Rita.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 9001 Funding Availability

This section appropriates to the Secretary of Health and Human Services for a 1-time only obligation and expenditure \$250,000,000 for fiscal year 2007 for allocation under section 2604(a) through (d) and \$750,000,000 for allotment of emergency

funds under section 2604(e) of the Low-Income Home Energy Assistance Act of 1981 (42 D.S.C. 8623(a) through (e)), for the sole purpose of providing assistance to offset the anticipated higher energy costs caused by Hurricane Katrina and Hurricane Rita.

This section sunsets after September 30, 2007, and no monies provided for under this section shall be available after such date.

P.L. 109-58, the Energy Policy Act of 2005, reauthorized annual regular LIHEAP funds at \$5.1 billion per year from FY2005 to FY2007. The LIHEAP appropriation for FY2005 was \$2.182 billion for allocation pursuant to the formula set forth by law. No funds were appropriated for allotment of emergency funds.

For consideration of the Senate bill, and the House amendment thereto, and modifications committed to conference:

JIM NUSSLE,
JIM RYUN,
ANDER CRENSHAW,
ADAM PUTNAM,
ROGER F. WICKER,
KENNY C. HULSHOF,
PAUL D. RYAN,
ROY BLUNT,
TOM DELAY,

From the Committee on Agriculture, for consideration of title I of the Senate bill and title I of the House amendment, and modifications committed to conference:

BOB GOODLATTE,
FRANK D. LUCAS,

From the Committee on Education and the Workforce, for consideration of title VII of the Senate bill and title II and subtitle C of title III of the House amendment, and modifications committed to conference:

JOHN BOEHNER,
HOWARD P. MCKEON,

From the Committee on Energy and Commerce, for consideration of title III and title VI of the Senate bill and title III of the House amendment, and modifications committed to conference:

JOE BARTON,
NATHAN DEAL,

From the Committee on Financial Services, for consideration of title II of the Senate bill and title IV of the House amendment, and modifications committed to conference:

MICHAEL G. OXLEY,
SPENCER BACHUS

(Provided that Mr. Ney is appointed in lieu of Mr. Bachus for consideration of subtitles C and D of title II of the Senate bill and subtitle B of title IV of the House amendment:),

From the Committee on the Judiciary, for consideration of title VIII of the Senate bill and title V of the House amendment, and modifications committed to conference:

F. JAMES SENSENBRENNER, Jr.,
LAMAR SMITH,

From the Committee on Resources, for consideration of title IV of the Senate bill and title VI of the House amendment, and modifications committed to conference:

RICHARD POMBO,
JIM GIBBONS,

From the Committee on Transportation and Infrastructure, for consideration of title V and division A of the Senate bill and title VII of the House amendment, and modifications committed to conference:

DON YOUNG,
FRANK LOBIONDO,

From the Committee on Ways and Means, for consideration of sections 6039, 6071, and subtitle B of title VI of the Senate bill and title VIII of the House amendment, and modifications committed to conference:

WILLIAM THOMAS,
WALLY HERGER,

Managers on the Part of the House.

JUDD GREGG,
PETE DOMENICI,
CHUCK GRASSLEY,
MICHAEL B. ENZI,
WAYNE ALLARD,
JEFF SESSIONS,
TED STEVENS,
RICHARD SHELBY,
ARLEN SPECTER,
SAXBY CHAMBLISS,
MITCH MCCONNELL,

Managers on the Part of the Senate.