Approved: March 17, 2006
Date

MINUTES OF THE HOUSE APPROPRIATIONS COMMITTEE

The meeting was called to order by Chairman Melvin Neufeld at 9:00 A.M. on March 9, 2006 in Room 514-S of the Capitol.

All members were present except:
Representative Shari Weber- excused

Committee staff present:
Alan Conroy, Kansas Legislative Research Department
J. G. Scott, Kansas Legislative Research Department
Becky Krahl, Kansas Legislative Research Department
Matt Spurgin, Kansas Legislative Research Department
Amy Deckard, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Susan Kannarr, Kansas Legislative Research Department
Jim Wilson, Office of Revisor of Statutes
Mike Corrigan, Office of Revisor of Statutes
Nikki Feuerborn, Administrative Assistant
Shirley Jepson, Committee Secretary

Conferees appearing before the committee:

Others attending:
See attached list.

- Attachment 1 — Budget Committee reports on Department of Administration, Division of Health Policy and Finance and Kansas Health Policy Authority
- Attachment 2 — Budget Committee reports on Capital Improvements for Department of Administration and Department of Social and Rehabilitation Services
- Attachment 3 — Budget Committee reports on Department on Aging, Division of Health Policy and Finance, Kansas Health Policy Authority, Department of Social and Rehabilitation Services
- Attachment 4 — Deficit Reduction Act of 2005 - Summary of Medicaid/Medicare/Health Provisions

Representative Wilk appeared before the Committee to request the introduction of legislation concerning health savings accounts and price transparencies questions - posting of prices so individuals with high deductibles are able to see the pricing of clinical care and hospital care.

Representative Bethell moved to introduce legislation regarding health savings accounts and price transparencies. The motion was seconded by Representative Feuerborn. Motion carried.

Representative Pottorff, Chair of the General Government and Commerce Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department of Administration for FY 2006 and moved for the adoption of the Budget Committee report for FY 2006 (Attachment 1). The motion was seconded by Representative Yoder. Motion carried.

Representative Pottorff, Chair of the General Government and Commerce Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department of Administration for FY 2007 and moved for the adoption of the Budget Committee report for FY 2007 (Attachment 1). The motion was seconded by Representative Lane.

Representative McCreary moved for a substitute motion to amend Item No. 4 of the Budget Committee report on the Department of Administration for FY 2007 by approving the expenditure of $325,000 from the State General Fund for Radio Kansas–Hutchinson; stipulate that if federal matching funds are not received, the $325,000 will be returned to the State General Fund (SGF); and further requested a review at Omnibus. The motion was seconded by Representative

Gatewood. Motion withdrawn with approval of the second.

Representative McCreary moved for a substitute motion to amend the Budget Committee report on the Department of Administration for FY 2007 by adding language to appropriate $325,000 from the State General Fund (SGF) for Radio Kansas-Hutchinson with a stipulation that if a federal grant to partially fund the project is not received, the $325,000 will be returned to the State General Fund (SGF) and further requested a review at Omnibus. The motion was seconded by Representative Gatewood. Motion carried.

Representative Pottorff moved to adopt the Budget Committee report on the Department of Administration for FY 2007 as amended. The motion was seconded by Representative Yoder. Motion carried.

Representative Bethell, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's recommendation for Capital Improvements for Department of Social and Rehabilitation Services (SRS) and Department of Administration for FY 2006 and FY 2007 and moved for the adoption of the Budget Committee Reports for FY 2006 and FY 2007 (Attachment 2). The motion was seconded by Representative Henry. Motion carried.

Representative Bethell, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department on Aging for FY 2006 and moved for the adoption of the Budget Committee report for FY 2006 (Attachment 3). The motion was seconded by Representative Henry. Motion carried.

Representative Bethell, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department on Aging for FY 2007 and moved for the adoption of the Budget Committee report for FY 2007 (Attachment 3). The motion was seconded by Representative Henry.

Representative Feuerborn moved to amend the Budget Committee report for the Department on Aging for FY 2007 by removing language in Item No. 6 stating "particularly in western Kansas". The motion was seconded by Representative Bethell. Motion carried.

Representative Bethell moved to amend the Budget Committee report on Department on Aging for FY 2007 by adding language for the Budget Committee to review before Omnibus the cost effectiveness of the Senior Care Act as compared to the PACE program. The motion was seconded by Representative Landwehr. Motion carried.

Representative Bethell moved to adopt the Budget Committee report on the Department on Aging for FY 2007 as amended. The motion was seconded by Representative Henry. Motion carried.

Representative Ballard, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department of Administration-Division of Health Policy and Finance (DHPF) for FY 2006 and moved for the adoption of the Budget Committee report for FY 2006 (Attachment 3). The motion was seconded by Representative Bethell. Motion carried.

Representative Ballard, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department of Administration-Division of Health Policy and Finance for FY 2007 and moved for the adoption of the Budget Committee report for FY 2007 (Attachment 3). The motion was seconded by Representative Bethell. Motion carried.

Representative Ballard, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Kansas Health Policy Authority (KHPA) for FY 2006 and moved for the adoption of the Budget Committee report for FY 2006 (Attachment 3). The motion was seconded by Representative Bethell. Motion carried.

Responding to questions from the Committee, Scott Brunner, Department of Administration,

Division of Health Policy and Finance, stated that the Healthy Kids pilot program covers children of state employees who would have otherwise been eligible for the State Children's Health Insurance Program (SCHIP). The pilot program was started at the beginning of the health insurance plan year in January with the state covering 90 percent of the cost and the employee paying the remaining 10 percent. Mr. Brunner indicated that the plan operates within state law and has no matching federal funds. To be eligible for the pilot program, the employee must fill out an application, similar to a Healthwave application, and report total income for employee and spouse to meet federal poverty guidelines before acceptance into the program.

Representative Bethell, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Kansas Health Policy Authority (KHPA) for FY 2007 and moved for the adoption of the Budget Committee report for FY 2007 (Attachment 3). The motion was seconded by Representative Landwehr.

Representative Landwehr moved to amend the Budget Committee report on the Kansas Health Policy Authority (KHPA) for FY 2007 by adding language requesting that the Division of Health Policy and Finance review the plan changes to the dental program under Title 19 and Title 21 and the impact the changes will have on the populations being served by these programs and requested that KHPA report their findings as well as the short term and long term policies regarding the Title 19 and Title 21 dental program to the Budget Committee before Omnibus .The motion was seconded by Representative Bethell. Motion carried.

Representative Landwehr moved to amend the Budget Committee report on the Kansas Health Policy Authority (KHPA) for FY 2007 by adding a proviso stating during fiscal year 2007 a school district shall encourage parents of pupils at risk to obtain an eye examination by an optometrist or an ophthalmologist to determine if such child suffers from conditions which impair the ability to read: provided, however, that the expense for such examination, if not reimbursed through medicaid, healthwave, private insurance, or other governmental or private program, shall be the responsibility of te child's parent. The motion was seconded by Representative Ballard. Motion carried.

Representative McLeland moved to amend the Budget Committee report on the Kansas Health Policy Authority for FY 2007 by adding a proviso to allow in-state pharmacies, who are at present only allowed to fill prescriptions for a 30-day supply according to the state employees health plan, to fill prescriptions with a 90-day supply at little or no additional cost as offered by out-of-state mail pharmacies. The motion was seconded by Representative Hutchins. Motion carried.

Representative Bethell moved to adopt the Budget Committee report on the Kansas Health Policy Authority for FY 2007 as amended. The motion was seconded by Representative Landwehr. Motion carried.

Representative Henry, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's budget recommendation for the Department of Social and Rehabilitation Services (SRS) for FY 2006 and moved for the adoption of the Budget Committee report for FY 2006 (Attachment 3). The motion was seconded by Representative Ballard. Motion carried.

The meeting was recessed at 11:00 a.m. and reconvened at 12:50 p.m.

Representative Ballard, member of the Social Services Budget Committee, presented the Budget Committee report on the Governor's recommendation for the Department of Social and Rehabilitation Services for FY 2007 and moved for the adoption of the Budget Committee report for FY 2007 (Attachment 3). The motion was seconded by Representative Bethell.

Representative Pilcher-Cook moved for a substitute motion to amend Item No. 24 of the Budget Committee report on the Department of Social and Rehabilitation Services for FY 2007 by deleting $1.5 million of funding recommended by the Governor for the Child Support Enforcement (CSE) customer service center. The motion was seconded by Representative Landwehr. Motion failed on a 8-9 vote. Representative Landwehr requested to be recorded as voting "yes".

Representative Ballard moved to adopt the Budget Committee report on the Department of Social and Rehabilitation Services for FY 2007 as amended. The motion was seconded by Representative Bethell. Motion carried.

Information provided by the National Conference on State Legislatures (NCSL) on the Deficit Reduction Act of 2005 - Summary of Medicaid/medicare/Health Provisions, updated on February 3, 2006, was distributed to the Committee (Attachment 4).

The meeting was adjourned at 1:50 p.m. The next meeting of the Committee will be held at 9:00 a.m. on March 10, 2006.

Melvin Neufeld, Chair

HOUSE APPROPRIATIONS COMMITTEE

March 9, 2006
9:00 a.m.

NAME	REPRESENTING
Tom Stratton	KS Legal Services
Rue Seeber	Hein Law Firm
Chad Austin	KS Hosp Assoc
Tom Bruns	EDS
Nancy Pierce	KHCA
Kevin J. Bacon	KCDC
Steve Solomon	TFI Family Services
Ka Mey	LCR

House Budget Committee Report

Kansas Department of Administration

March 9, 2006

Department of Administration – Regular

Division of Health Policy and Finance

Kansas Health Policy Authority

Senate Subcommittee Report

Agency: Department of Administration **Bill No.** 570 **Bill Sec.** 31

Analyst: Dunkel and Efird **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 456,716,994	$ 452,419,015	$ (950,173)
Other Funds	970,218,291	957,760,545	0
Subtotal–Operating	$ 1,426,935,285	$ 1,410,179,560	$ (950,173)
Capital Improvements:			
State General Fund	$ 5,706,944	$ 5,706,944	$ 0
Other Funds	147,732	147,732	0
Subtotal–Capital Improvements	$ 5,854,676	$ 5,854,676	$ 0
TOTAL–REPORTABLE	$ 1,432,789,961	$ 1,416,034,236	$ (950,173)
FTE Positions–Reportable	262.4	261.9	(6.0)

Agency Estimate

Operating Budget. The agency's revised estimate for the current fiscal year includes the initial payment of $10.0 million State General Fund for the KPERS debt service on pension obligation bonds. The 2005 Legislature approved this initial payment. The revised estimate includes $1.39 billion for the Division of Health Policy and Finance (DHPF).

Capital Improvements. The agency requests revised FY 2006 expenditures of almost $5.9 million all funds, including $5.7 million State General Fund financing, for debt service principal and capital improvement projects.

Governor's Recommendation

Operating Budget. The Governor concurs with the $10.0 million State General Fund amount for KPERS debt service and recommends supplemental financing of $500,000 State General Fund for the Long Term Care Ombudsman's Office to provide assistance with Medicare Part D enrollments. The recommendation includes $1.37 billion for DHPF and $950,173 for the transfer of the Kansas Health Policy Authority (KHPA) to DHPF.

Capital Improvements. The Governor concurs with the agency's revised estimate of funding for debt service principal and capital improvement projects.

House Committee Report

Agency: Department of Administration **Bill No.** 2958 **Bill Sec.** 31

Analyst: Dunkel and Efird **Analysis Pg. No.** Vol. I – 525 **Budget Page No.** 13

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	House Committee Adjustments
Operating Expenditures:			
State General Fund	$ 456,716,994	$ 452,419,015	$ (2,016,840)
Other Funds	970,218,291	957,760,545	0
Subtotal–Operating	$ 1,426,935,285	$ 1,410,179,560	$ (2,016,840)
Capital Improvements:			
State General Fund	$ 5,706,944	$ 5,706,944	$ 0
Other Funds	147,732	147,732	0
Subtotal–Capital Improvements	$ 5,854,676	$ 5,854,676	$ 0
Total – Reportable Expenditures	$ 1,432,789,961	$ 1,416,034,236	$ (2,016,840)
Nonreportable Operating Expenditures:	99,961,964	99,961,964	0
Nonreportable Capital Improvements:	2,917,395	2,917,395	0
GRAND TOTAL	$ 1,535,669,320	$ 1,518,913,595	$ (2,016,840)
Total FTE Positions	920.9	920.9	(6.0)
Non FTE Perm. Uncl. Pos.	32.3	32.3	0.0
Grand Total	953.2	953.2	(6.0)

Agency Estimate

Operating Budget. The agency's revised estimate for the current fiscal year includes the initial payment of $10.0 million from the State General Fund for the Kansas Public Employees Retirement System (KPERS) debt service on pension obligation bonds. The 2005 Legislature approved this initial payment. The revised estimate includes $1.39 billion for the Division of Health Policy and Finance (DHPF).

Capital Improvements. The agency requests revised FY 2006 expenditures of almost $5.9 million all funds, including $5.7 million from the State General Fund, for debt service principal and capital improvement projects.

Governor's Recommendation

Operating Budget. The Governor concurs with the $10.0 million from the State General

Fund for KPERS debt service and recommends supplemental financing of $500,000 from the State General Fund for the Long Term Care Ombudsman's Office to provide assistance with Medicare Part D enrollments. The Governor's recommendation includes $1.37 billion for DHPF and $950,173 for the transfer of the Kansas Health Policy Authority (KHPA) to DHPF.

Capital Improvements. The Governor concurs with the agency's revised estimate of funding for debt service principal and capital improvement projects.

Senate Subcommittee Report

Agency: Department of Administration **Bill No.** 573 **Bill Sec.** 19

Analyst: Dunkel and Efird **Analysis Pg. No.** Vol. I – 525 **Budget Page No.** 13

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 38,668,722	$ 453,611,756	$ (417,073,513)
Other Funds	8,378,590	964,326,737	(955,976,800)
Subtotal–Operating	$ 42,047,312	$ 1,417,938,493	$ (1,373,050,313)
Capital Improvements:			
State General Fund	$ 13,583,256	$ 4,742,000	$ 0
Other Funds	94,740	153,240	0
Subtotal–Capital Improvements	$ 13,677,996	$ 4,895,240	$ 0
TOTAL–REPORTABLE	$ 55,725,308	$ 1,422,833,733	$ (1,373,050,313)
FTE Positions–Reportable	128.0	258.9	(130.9)

Agency Request

Operating Budget. The request does not include funding for DHPF which is abolished when its programs are scheduled for transfer to the KHPA on July 1, 2006. The agency's request includes a $5.0 million State General Fund addition for KPERS debt service as the payments increase to $15.0 State General Fund million in FY 2007. The agency also requests an addition of $3.25 million State General Fund in FY 2007 for debt service on Statehouse bonds that will be used to fund Phase IV of the renovation project. Enhancement funding of $5,089,586, including $5,011,585 State General Fund, is requested.

Capital Improvements. The agency requests FY 2007 expenditures of over $13.7 million all funds, including almost $13.6 million State General Fund financing, for debt service principal and new capital improvement projects. The agency's request includes $7.8 million all funds for new projects, with almost $7.7 million State General Fund financing.

Governor's Recommendation

Operating Budget. The Governor's ion includes $1.37 billion for the delay of the transfer of the DHPF programs to the KHPA and $3.9 million for maintaining the KHPA and its programs in DHPF. The Governor concurs with the $5.0 million State General Fund increase for KPERS debt service and recommends almost $5.0 million State General Fund in FY 2007 for debt service on

$ 2.4 million of KDOT bonds for the Comprehensive Transportation Plan. The Governor does not include any additional debt service financing for the Statehouse bonds associated with Phase IV. The Governor recommends financing for a 2.5 percent salary plan adjustment that would be in addition to other enhancement funding of $5,827,623, including $5,749,623 State General Fund.

Capital Improvements. The Governor recommends $4.9 million all funds, including $4.7 million State General Fund. Financing for new projects is limited to $447,000 all funds by the Governor, who includes $352,000 State General Fund financing for new projects.

House Budget Committee Report

Agency: Department of Administration **Bill No.** 2968 **Bill Sec.** 19

Analyst: Dunkel and Efird **Analysis Pg. No.** Vol. I – 525 **Budget Page No.** 13

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Budget Committee Adjustments
Reportable Operating Expenditures:			
State General Fund	$ 33,668,722	$ 453,611,756	$ (417,627,414)
Other Funds	8,378,590	964,326,737	(955,976,800)
Subtotal–Operating	$ 42,047,312	$ 1,417,938,493	$ (1,373,604,214)
Reportable Capital Improvements:			
State General Fund	$ 13,583,256	$ 4,742,000	$ 0
Other Funds	94,740	153,240	0
Subtotal–Capital Improvements	$ 13,677,996	$ 4,895,240	$ 0
Total – Reportable Expenditures	$ 55,725,308	$ 1,422,833,733	$ (1,373,604,214)
Nonreportable Operating Expenditures:	80,547,822	103,735,746	(225,853,798)
Nonreportable Capital Improvements:	2,718,988	2,718,988	0
GRAND TOTAL	$ 138,992,118	$ 1,422,833,733	$ (1,599,458,012)
Total FTE Positions	751.5	921.8	(170.2)
Non FTE Perm. Uncl. Pos.	20.8	31.3	(10.5)
Grand Total	772.3	953.1	(180.7)

Agency Request

Operating Budget. The request does not include funding for the Division of Health Policy and Finance (DHPF) which is abolished when its programs are scheduled for transfer to the Kansas Health Policy Authority (KHPA) on July 1, 2006. The agency's request includes a $5.0 million from the State General Fund addition for the Kansas Public Employees Retirement System (KPERS) debt service as the payments increase to $15.0 from the State General Fund million in FY 2007. The agency also requests an addition of $3.25 million from the State General Fund in FY 2007 for debt service on Statehouse bonds that will be used to fund Phase IV of the renovation

project.

Capital Improvements. The agency requests FY 2007 expenditures of over $13.7 million all funds, including almost $13.6 million from the State General Fund, for debt service principal and new capital improvement projects. The agency's request includes $7.8 million all funds for new projects, with almost $7.7 million from the State General Fund.

Governor's Recommendation

Operating Budget. The Governor's recommendation includes $1.37 billion for the delay of the transfer of the DHPF programs to the KHPA and $3.9 million for maintaining the KHPA and its programs in DHPF. The Governor concurs with the $5.0 million State General Fund increase for KPERS debt service and recommends almost $5.0 million from the State General Fund in FY 2007 for debt service on $212.4 million of highway bonds for the Comprehensive Transportation Plan. The Governor does not include any additional debt service financing for the Statehouse bonds associated with Phase IV. The Governor recommends financing for a 2.5 percent salary plan adjustment.

Capital Improvements. The Governor recommends $4.9 million all funds, including $4.7 million from the State General Fund. Financing for new projects is limited to $447,000 all funds by the Governor, who includes $352,000 State General Fund financing for new projects.

HOUSE BUDGET COMMITTEE REPORT

Department of Administration – Regular

March 6, 2006

Representative JoAnn Pottorff, Chairperson

Representative Richard Carlson

Representative David Huff

Representative Annie Kuether

Representative Harold Lane

Representative Clark Shultz

Representative Kevin Yoder

Senate Subcommittee Report

Agency: Department of Administration–Regular **Bill No.** 570 **Bill Sec.** 31

Analyst: Efird **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 25,075,803	$ 25,575,803	$ 0
Other Funds	9,441,183	9,441,183	0
Subtotal–Operating	$ 34,516,986	$ 35,016,986	$ 0
Capital Improvements:			
State General Fund	$ 5,706,944	$ 5,706,944	$ 0
Other Funds	147,732	147,732	0
Subtotal–Capital Improvements	$ 5,854,676	$ 5,854,676	$ 0
TOTAL–REPORTABLE	$ 40,371,662	$ 40,871,662	$ 0
FTE Positions–Reportable	132.0	132.0	0.0

Agency Estimate

Operating Budget. The agency's revised estimate for the current fiscal year includes the initial payment of $10.0 million State General Fund for the KPERS debt service on pension obligation bonds. The 2005 Legislature approved this initial payment.

Capital Improvements. The agency requests revised FY 2006 expenditures of almost $5.9 million all funds, including $5.7 million State General Fund financing, for debt service principal and capital improvement projects.

Governor's Recommendation

Operating Budget. The Governor concurs with the $10.0 million State General Fund amount for KPERS debt service and recommends supplemental financing of $500,000 State General Fund for the Long Term Care Ombudsman's Office to provide assistance with Medicare Part D enrollments.

Capital Improvements. The Governor concurs with the agency's revised estimate of funding for debt service principal and capital improvement projects.

Senate Subcommittee Recommendation

The Subcommittee concurs with the Governor's FY 2006 recommendation with the following comment:

1. **Medicare Part D**. Review at Omnibus any developments on this topic. The

Subcommittee commends the Office of the Long-Term Care Ombudsman for seeking supplemental financing of $500,000 from the State General Fund to provide assistance with Medicare Part D prescription plan enrollments. The Subcommittee understands that the Office may be able to secure federal reimbursement for at least some administrative expenditures for this outreach effort. The Subcommittee believes securing federal funds is especially important should the program deadline for Medicare Part D enrollments be extended beyond May 15, 2006, and wishes to have a report on the latest developments during Omnibus.

Senate Committee Recommendation

The Committee concurs.

House Budget Committee Report

Agency: Department of Administration–Regular **Bill No.** 2958 **Bill Sec.** 31

Analyst: Efird **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 25,075,803	$ 25,575,803	$ 0
Other Funds	9,441,183	9,441,183	0
Subtotal–Operating	$ 34,516,986	$ 35,016,986	$ 0
Capital Improvements:			
State General Fund	$ 5,706,944	$ 5,706,944	$ 0
Other Funds	147,732	147,732	0
Subtotal–Capital Improvements	$ 5,854,676	$ 5,854,676	$ 0
TOTAL–REPORTABLE	$ 40,371,662	$ 40,871,662	$ 0
FTE Positions–Reportable	132.0	132.0	0.0

Agency Estimate

Operating Budget. The agency's revised estimate for the current fiscal year includes the initial payment of $10.0 million State General Fund for the KPERS debt service on pension obligation bonds. The 2005 Legislature approved this initial payment.

Capital Improvements. The agency requests revised FY 2006 expenditures of almost $5.9 million all funds, including $5.7 million State General Fund financing, for debt service principal and capital improvement projects.

Governor's Recommendation

Operating Budget. The Governor concurs with the $10.0 million State General Fund amount for KPERS debt service and recommends supplemental financing of $500,000 State General Fund for the Long Term Care Ombudsman's Office to provide assistance with Medicare Part D enrollments.

Capital Improvements. The Governor concurs with the agency's revised estimate of funding for debt service principal and capital improvement projects.

House Budget Committee Recommendation

The Budget Committee concurs with the Governor's FY 2006 recommendation.

Senate Subcommittee Report

Agency: Department of Administration–Regular **Bill No.** 573 **Bill Sec.** 19

Analyst: Efird **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 33,727,222	$ 35,996,073	$ 542,170
Other Funds	8,320,090	8,349,937	0
Subtotal–Operating	$ 42,047,312	$ 44,346,010	$ 542,170
Capital Improvements:			
State General Fund	$ 13,583,256	$ 4,742,000	$ 0
Other Funds	94,740	153,240	0
Subtotal–Capital Improvements	$ 13,677,996	$ 4,895,240	$ 0
TOTAL–REPORTABLE	$ 55,725,308	$ 49,241,250	$ 542,170
FTE Positions–Reportable	128.0	128.0	0.0

Agency Request

Operating Budget. The agency's request includes a $5.0 million State General Fund addition for KPERS debt service as the payments increase to $15.0 State General Fund million in FY 2007. The agency also requests an addition of $3.25 million State General Fund in FY 2007 for debt service on Statehouse bonds that will be used to fund Phase IV of the renovation project. The request does not include funding for DHPF which is abolished when its programs are scheduled for transfer to the KHPA on July 1, 2006. Enhancement funding of $5,089,586, including $5,011,585 State General Fund, is requested.

Capital Improvements. The agency requests FY 2007 expenditures of over $13.7 million all funds, including almost $13.6 million State General Fund financing, for debt service principal and new capital improvement projects. The agency's request includes $7.8 million all funds for new projects, with almost $7.7 million State General Fund financing.

Governor's Recommendation

Operating Budget. The Governor concurs with the $5.0 million State General Fund increase for KPERS debt service and recommends almost $5.0 million State General Fund in FY 2007 for debt service on $212.4 million of KDOT bonds for the Comprehensive Transportation Plan. The recommendation includes $1.37 billion for the delay of the transfer of the DHPF programs to the KHPA and $3.9 million for maintaining the KHPA and its programs in DHPF. The Governor does not include any additional debt service financing for the Statehouse bonds associated with Phase IV. The Governor recommends financing for a 2.5 percent salary plan adjustment that would be in addition to other enhancement funding of $5,827,623, including $5,749,623 State General Fund.

Capital Improvements. The Governor recommends $4.9 million all funds, including $4.7 million State General Fund. Financing for new projects is limited to $447,000 all funds by the Governor, who includes $352,000 State General Fund financing for new projects.

Senate Subcommittee Recommendation

The Subcommittee concurs with the Governor's FY 2007 recommendation with following comments and adjustment:

1. **Public Broadcasting**. Add a total of $542,170 from the State General Fund for operating expenses, tower construction, equipment purchases requested by public television and radio stations. The Subcommittee appreciates the Kansas Public Broadcasting Council's report on services provided to Kansas. The Subcommittee believes that investments in the future are needed to maintain high quality, accessible public broadcasting services. The following is a breakdown of the Subcommittee recommendation:

   a. **Add $25,000** from the State General Fund for enhanced operating support to provide stations with relief from higher costs related to the maintenance of both analog and digital broadcasting. This will increase the Governor's recommended enhancement funding of $100,000 to $125,000 in FY 2007 as requested by the Council.

   b. **Add $325,000** from the State General Fund for Radio Kansas -- Hutchinson to partially finance a new $1.1 million tower. The radio station has its antenna located on a commercial tower, but must remove it in the near future. The radio station indicates it will not be able to continue broadcasting unless a new tower is constructed. The $325,000 State General Fund financing will pay approximately 30 percent of total cost, with the federal Public Telecommunications Facilities Program providing approximately 63 percent. The balance, approximately $100,000, will come from private fund raising. The Subcommittee recommends further review during Omnibus regarding its suggestion for the station to report on how much additional expense would be involved in strengthening the proposed new tower to accommodate other users who would pay rent, how much revenue might be gained, and what obstacles must be addressed to build a stronger tower and allow additional users on the tower.

   c. **Add $192,170** from the State General Fund for KPTS TV – Wichita to upgrade analog studio production equipment that is no longer supported by now defunct manufacturers. This studio equipment is used weekly to produce public affairs programs and public pledge drives. This financing would provide the 50.0 percent match required in order to secure a federal Public Telecommunications Facilities Program grant for the other 50.0 percent.

   d. **Review at Omnibus** a request to add $602,125 from the State General Fund for KTWU TV – Topeka for the purchase of digital equipment.

2. **Capitol Complex Plan**. The Subcommittee notes a proposal to add $100,000 from the State General Fund for updating a long-range plan for the Capitol Complex. Funding was not included in the FY 2007 *Governor's Budget Report*. The Subcommittee wishes discussion to take place in the Senate Ways and

Means Committee about adding funds for the Capitol Area Plaza Authority's Master Plan to be updated by a consultant. The plan was last updated approximately 20 years ago.

3. **Motor Vehicles**. The Subcommittee notes the Governor's recommendation for FY 2007 includes $89,731 from all funds for the purchase of replacement vehicles. Of that amount, $11,731 is financed from the State General Fund for one vehicle in the Ombudsman's Office, and the remainder is financed in the nonreportable budget for $78,000. The nonreportable expenditures include $57,000 for three delivery vehicles that transport agency interoffice mail and $21,000 is the first-year cost of a three-year plan to acquire four automobiles under the Master Lease Purchase Program for use by Facilities Management.

4. **Statehouse Bonding**. The Subcommittee notes that 2006 SB 571 includes $16.2 million of additional bonding authority for the Statehouse renovation and that debt service for the bonds will start in FY 2008. The Legislative Coordinating Council at its meeting of December 19, 2005, approved a recommendation that the Governor include $16,227,091 in additional bonding authority or a direct appropriation in the FY 2007 Department of Administration budget for Statehouse renovation and restoration.

Senate Committee Recommendation

The Committee concurs.

House Budget Committee Report

Agency: Department of Administration–Regular **Bill No.** 2968 **Bill Sec.** 19

Analyst: Efird **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Budget Committee Adjustments*
Operating Expenditures:			
State General Fund	$ 33,727,222	$ 35,996,073	$ (11,731)
Other Funds	8,320,090	8,349,937	0
Subtotal–Operating	$ 42,047,312	$ 44,346,010	$ (11,731)
Capital Improvements:			
State General Fund	$ 13,583,256	$ 4,742,000	$ 0
Other Funds	94,740	153,240	0
Subtotal–Capital Improvements	$ 13,677,996	$ 4,895,240	$ 0
TOTAL–REPORTABLE	$ 55,725,308	$ 49,241,250	$ (11,731)
FTE Positions–Reportable	128.0	128.0	0.0

***Note**: There is an additional $21,000 reduction in the nonreportable budget.

Agency Request

Operating Budget. The agency's request includes a $5.0 million from the State General Fund addition for the Kansas Public Employees Retirement System (KPERS) debt service as the payments increase to $15.0 million from the State General Fund in FY 2007. The agency also requests an addition of $3.25 million from the State General Fund in FY 2007 for debt service on Statehouse bonds that will be used to fund Phase IV of the renovation project. The request does not include funding for the Division of Health Policy and Finance (DHPF) which is abolished when its programs are scheduled for transfer to the Kansas Health Policy Authority (KHPA) on July 1, 2006.

Capital Improvements. The agency requests FY 2007 expenditures of over $13.7 million all funds, including almost $13.6 million from State General Fund financing, for debt service principal and new capital improvement projects. The agency's request includes $7.8 million all funds for new projects, with almost $7.7 million from State General Fund financing.

Governor's Recommendation

Operating Budget. The Governor concurs with the $5.0 million State General Fund increase for KPERS debt service and recommends almost $5.0 million from the State General Fund in FY 2007 for debt service on $212.4 million in bonds for the Comprehensive Transportation Plan. The Governor does not include any additional debt service financing for the Statehouse bonds associated with Phase IV. The Governor recommends issuance of $16.2 million in Statehouse bonds for Phase III. The Governor also recommends financing for a 2.5 percent salary plan adjustment that would be in addition to other enhancement funding of $5,827,623 all funds, including $5,749,623 from the State General Fund.

Capital Improvements. The Governor recommends $4.9 million all funds, including $4.7 million from the State General Fund. Financing for new projects is limited to $447,000 all funds by the Governor, who includes $352,000 from State General Fund financing for new projects.

House Budget Committee Recommendation

The Budget Committee concurs with the Governor's FY 2007 recommendation with following comments and recommendations:

1. **FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System (KPERS) rates, KPERS death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

   For this agency, the FY 2006 approved budget totaled $33,639,111, including $24,933,009 from the State General Fund. The approved budget was increased

by a net total of $5,019,595, including $4,886,112 from the State General Fund to establish a baseline budget for FY 2007. The adjustments included $101,643 in salary adjustments and $21,792 in one-time reductions, offset by an increase of $4,939,741 for debt service payments.

2. **Comparison of FY 2007 Baseline Budget to Governor's Recommendation.** The table below reflects the difference between the Governor's recommendation and the baseline budget.

	SGF	All Funds
Governor's Recommendation	$ 35,996,073	$ 44,346,010
Baseline Budget	29,819,121	38,658,703
Dollar Difference	$ 6,176,952	$ 5,687,307
Percent Difference	*17.2%*	*12.8%*

The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	SGF	All Funds
Base Salary Adjustment	$ 90,813	$ 779,067
New Vehicle Purchase	11,731	11,731
Transportation Bonds	4,992,724	4,992,724
Chiller Tower	395,168	395,168
Gubernatorial Transition	150,000	150,000
Software Study	100,000	100,000
Public Broadcasting Grants	100,000	100,000
Other Net Adjustments	336,516	(841,383)
TOTAL	$ 6,176,952	$ 5,687,307

3. **Motor Vehicles**. Delete $32,731, including $11,731 from the State General Fund, for replacement vehicles recommended by the Governor, with $11,731 in the reportable budget and $21,000 in the nonreportable budget. Review the FY 2007 acquisitions at Omnibus.

4. **Public Broadcasting**. Review enhancement requests during Omnibus, including $325,000 from the State General Fund for Radio Kansas -- Hutchinson to partially finance a new $1.1 million tower; $192,170 from the State General Fund for KPTS TV – Wichita to upgrade analog studio production equipment that is no longer supported by now defunct manufacturers; and $602,125 from the State General Fund for KTWU TV – Topeka for the purchase of digital equipment.

House Budget Committee Reports

Capital Improvements

Department of Social and Rehabilitation Services
Department of Administration

March 9, 2006

HOUSE SOCIAL SERVICES BUDGET COMMITTEE

CAPITAL IMPROVEMENTS

Agency: Department of Social and Rehabilitation Services **Bill No.** 2957 **Bill Sec.** 3

Analyst: Kannarr **Analysis Pg. No.** Vol. II - Pg. 1342 **Capital Budget Page No.** 209

Project	Agency Est. FY 2006	Gov. Rec. FY 2006	JCSBC Rec. FY 2006	Budget Committee Rec. FY 2006
Projects:				
Institutional Rehabilitation and Repair	$ 2,248,264	$ 2,248,264	$ 2,248,264	$ 2,248,264
Chanute Service Center Office Rehabilitation and Repair	300,000	300,000	300,000	300,000
State Security Hospital	23,999	23,999	23,999	23,999
Sex Predator Capacity Expansion	15,598	15,598	15,598	15,598
TOTAL	$ 2,587,861	$ 2,587,861	$ 2,587,861	$ 2,587,861
Financing:				
State General Fund	$ 0	$ 0	$ 0	$ 0
State Institutions Building Fund	2,287,861	2,287,861	2,287,861	2,287,861
Other Funds	300,000	300,000	300,000	300,000
TOTAL	$ 2,587,861	$ 2,587,861	$ 2,587,861	$ 2,587,861
Debt Service Principal - State Inst. Bldg. Fund	$ 2,810,000	$ 2,810,000	$ 2,810,000	$ 2,810,000

Agency Estimate/Governor's Recommendation

The agency requests $2,587,861, including $2,287,861 from the State Institutions Building Fund, for FY 2006. The request includes: $2,248,264 for 1st Priority Rehabilitation and Repair Projects at the State Hospitals; $300,000 for window replacement at the Chanute Service Center; and $39,597 in re-appropriated funds for projects at Larned State Hospital.

The Governor concurs with the agency estimate.

Joint Committee on State Building Construction Recommendation

The Joint Committee on State Building Construction concurs with the Governor's recommendation.

House Budget Committee Recommendation

The House Budget Committee concurs with the Governor's recommendation.

HOUSE SOCIAL SERVICES BUDGET COMMITTEE ON

CAPITAL IMPROVEMENTS

Agency: Department of Social and Rehabilitation Services **Bill No.** 2957 **Bill Sec.** 3

Analyst: Kannarr **Analysis Pg. No.** Vol. II - Pg. 1342 **Capital Budget Page No.** 209

Project	Agency Est. FY 2007	Gov. Rec. FY 2007	JCSBC Rec. FY 2007	Budget Committee Rec. FY 2007
Projects:				
Institutional Rehabilitation and Repair	$ 8,768,200	$ 1,947,277	$ 8,768,200	$ 1,947,277
Chanute Service Center Office Rehabilitation and Repair	300,000	300,000	300,000	300,000
State Security Hospital	0	0	0	0
Sex Predator Capacity Expansion	0	0	0	0
TOTAL	$ 9,068,200	$ 2,247,277	$ 9,068,200	$ 2,247,277
Financing:				
State General Fund	$ 0	$ 0	$ 0	$ 0
State Institutions Building Fund	8,768,200	1,947,277	8,768,200	1,947,277
Other Funds	300,000	300,000	300,000	300,000
TOTAL	$ 9,068,200	$ 2,247,277	$ 9,068,200	$ 2,247,277
Debt Service Principal - State Inst. Bldg. Fund	$ 2,895,000	$ 2,895,000	$ 2,895,000	$ 2,895,000

Agency Request/Governor's Recommendation

The agency requests $9,068,200, including $8,768,200 from the State Institutions Building Fund, for FY 2007. The request includes: $1,418,300 for 1st Priority Rehabilitation and Repair projects at the State Hospitals; $300,000 for window replacement at the Chanute Service Center; and $7,349,900 for 2nd Priority Rehabilitation and Repair projects at the State Hospitals.

The Governor recommends $2,247,277, including $1,947,277 from the State Institutions Building Fund. The recommendation is a reduction of $6,820,923 (75.2 percent) below the agency request. The Governor concurs with the $300,000 requested for the Chanute Service Center but recommends only $1,947,277 for Rehabilitation and Repair projects at the State Hospitals.

Joint Committee on State Building Construction Recommendation

The Joint Committee on State Building Construction concurs with the Governor's recommendation.

House Budget Committee Recommendation

The House Budget Committee concurs with the Governor's recommendation.

HOUSE GENERAL GOVERNMENT AND COMMERCE BUDGET COMMITTEE

CAPITAL IMPROVEMENTS

Agency: Department of Administration **Bill No.** 2957 **Bill Sec.** 8

Analyst: Efird **Analysis Pg. No.** Vol. I-552 **Capital Budget Page No.** Vol. I-229

Project	Agency Est. FY 2006	Gov. Rec. FY 2006	JCSBC Rec. FY 2006	Budget Committee Rec. FY 2006
Projects:				
Statehouse/ Cedar Crest Rehabilitation/ Repair	$ 353,731	$ 353,731	$ 353,731	$ 353,731
Judicial Center Rehab. And Repair	163,213	163,213	163,213	163,213
Memorial Hall Entrance	200,000	200,000	200,000	200,000
Topeka State Hospital Cemetery Memorial	50,000	50,000	50,000	50,000
Parking Lot and Sidewalk Maintenance AOF	95,000	95,000	95,000	95,000
Rehabilitation and Repair Off–AOF	200,000	200,000	200,000	200,000
Eastman Building Renovation Off–AOF	350,000	350,000	350,000	350,000
TOTAL	$ 1,411,944	$ 1,411,944	$ 1,411,944	$ 1,411,944
Financing:				
State General Fund	$ 766,944	$ 766,944	$ 766,944	$ 766,944
All Other Funds	645,000	645,000	645,000	645,000
TOTAL	$ 1,411,944	$ 1,411,944	$ 1,411,944	$ 1,411,944

Agency Estimate

The agency requests revised FY 2006 expenditures for capital improvements totaling $1,411,944 all funds, including $766,944 State General Fund. The FY 2006 financing approved for the Statehouse and Cedar Crest was $200,000 State General Fund, and the additional amount of $153,731 State General Fund is reappropriated savings from last fiscal year. The Judicial Center financing was approved for $100,000 State General Fund and the additional $63,213 State General Fund is reappropriated savings from last fiscal year. The State Finance Council approved the sale of the Eastman Building on the old Topeka State Hospital grounds to the Department of Labor, and part of the agreement was to spend $350,000 all other funds on renovation of the facility.

Governor's Recommendation

The Governor recommends the revised FY 2006 estimate for capital improvement expenditures.

Joint Committee on State Building Construction Recommendation

The Joint Committee on State Building Construction concurs with the Governor's recommendation for FY 2006 revised expenditures.

House Budget Committee

The Budget Committee concurs with the Joint Committee and the Governor for FY 2006.

HOUSE GENERAL GOVERNMENT AND COMMERCE BUDGET COMMITTEE

CAPITAL IMPROVEMENTS

Agency: Department of Administration **Bill No.** 2957 **Bill Sec.** 8

Analyst: Efird **Analysis Pg. No.** Vol. I-552 **Capital Budget Page No.** Vol. I-229

Project	Agency Req. FY 2007	Gov. Rec. FY 2007	JCSBC Rec. FY 2007	Budget Committee Rec. FY 2007
Projects:				
Statehouse/ Cedar Crest Rehabilitation/ Repair	$ 200,000	$ 200,000	$ 200,000	$ 200,000
Judicial Center Rehab. And Repair	100,000	100,000	100,000	100,000
Parking Lot and Sidewalk Maintenance AOF	95,000	95,000	95,000	95,000
Rehabilitation and Repair Off–AOF	200,000	200,000	200,000	200,000
Printing Plant Renovation Off–AOF	75,000	75,000	75,000	75,000
Docking Cooling Tower Replacement	2,041,573	0	0	0
Docking Fire Alarm Upgrade	214,500	0	0	0
Docking Chiller Switch Replacement	58,500	0	0	0
Landon Chiller Switch Replacement	109,170	0	0	0
Docking Penthouse Roof Replacement	100,000	0	0	0
Landon Inspection and Facade Study	50,000	0	0	0
Landon Chiller System Repair	160,000	0	0	0
Eisenhower West Roof Replacement	85,000	0	0	0
Forbes 725 Building Roof	51,153	0	0	0
West Hall Boiler Replacement	180,000	0	0	0
Capitol Complex Tunnel Replacement	770,000	0	0	0
Judicial Center Exterior Step Repair	60,000	0	0	0
Eisenhower Data Center Cooling Redundancy	264,000	0	0	0
Landon Fire Pump Replacement	75,000	0	0	0
Judicial Center Fire Alarm Replacement	180,000	0	0	0
Landon Northwest Roof Repairs	35,000	0	0	0
Judicial Center Stone Facade Repair	500,000	0	0	0
Memorial Hall Window Replacements	283,360	0	0	0
Judicial Center Lighting Upgrades	180,000	0	0	0
Judicial Center Landscaping	18,000	0	0	0
Dillon House Renovation/ Roof Repair	1,705,000	52,000	52,000	52,000
Landon New Generator Exhaust System	333,000	0	0	0
TOTAL	$ 8,123,256	$ 722,000	$ 722,000	$ 722,000
Financing:				
State General Fund	$ 7,753,256	$ 352,000	$ 352,000	$ 352,000
All Other Funds	370,000	370,000	370,000	370,000
TOTAL	$ 8,123,256	$ 722,000	$ 722,000	$ 722,000

Agency Request

The agency requests enhancement financing of $7,453,256 from State General Fund for new reportable FY 2007 capital improvement projects. Absent the State General Fund enhancement financing, the **agency's** reportable FY 2007 capital improvements request for new projects is $395,000 all funds for various rehabilitation and repair projects, including $300,000 State General Fund.

Governor's Recommendation

2-6

The Governor recommends reportable expenditures $395,000 all funds in FY 2007, including $300,000 State General Fund, for various rehabilitation and repair projects and adds

$52,000 State General Fund for repair of the Dillon House roof. The **Governor** recommends replacement of the Docking Cooling Tower as multiyear capital outlay, rather than a capital improvement project, beginning in FY 2007 with a first-year payment of $395,000 State General Fund that is not reported in the above table. For the nonreportable expenditures, the **agency** requests $275,000 all other funds in FY 2007 for repair and rehabilitation projects. The **Governor** concurs with $275,000 all funds nonreportable expenditures in FY 2007.

Joint Committee on State Building Construction Recommendation

The Joint Committee on State Building Construction concurs with the Governor's recommendation for FY 2007 expenditures.

House Budget Committee Recommendation

The Budget Committee concurs with the Joint Committee and the Governor for FY 2007.

FY 2006 and FY 2007

Social Services Budget Committee

Department on Aging
Division of Health Policy and Finance
Health Policy Authority
Department of Social and Rehabilitation Services

Representative Brenda Landwehr, Chair

Representative Jerry Henry

Representative Barbara Ballard

Representative Peggy Mast

Representative Bob Bethell

Representative Louis Ruiz

Representative Willa DeCastro

Representative Arlen Siegfreid

Representative John Edmonds

HOUSE APPROPRIATIONS

DATE 3-09-2006

ATTACHMENT 3

Senate Subcommittee Report

Agency: Department on Aging **Bill No.** SB 570 **Bill Sec.** 42

Analyst: Deckard **Analysis Pg. No.** Vol. II-1438 **Budget Page No.** 37

Expenditure Summary	Agency Estimate FY 06	Governor's Recommendation FY 06	Senate Subcommittee Adjustments
All Funds:			
State Operations	$ 15,997,938	$ 15,923,194	$ 0
Aid to Local Units	6,572,136	6,572,136	0
Other Assistance	421,700,237	416,559,009	0
TOTAL	$ 444,270,311	$ 439,054,339	$ 0
State General Fund:			
State Operations	$ 6,258,491	$ 6,258,491	$ 0
Aid to Local Units	1,508,101	1,508,101	0
Other Assistance	162,597,599	160,569,910	0
TOTAL	$ 170,364,191	$ 168,336,502	$ 0
FTE Positions	208.0	208.0	0.0
Non FTE Uncl. Perm. Pos.	6.5	6.5	0.0
TOTAL	214.5	214.5	0.0

Agency Estimate

The **Department** estimates FY 2006 operating expenditures of $444,270,311, including $170,364,191 from the State General Fund, a decrease of $1,988,038 all funds or 0.4 percent below the approved amount. The Department includes in its estimate the lapse of $170,142 in State General Funds. Additionally, the Department reduced the amount budgeted for HCBS/FE waiver by $3.88 million to account for the fact that the revised estimated need for this program was not as large as originally budgeted. The Department indicated that the revised level is still anticipated to prevent the existence of a waiting list for HCBS/FE waiver services.

Governor's Recommendation

The **Governor** recommends FY 2006 operating expenditures of $439,054,339, including $168,336,502 from the State General Fund. The recommendation is a decrease of $7,204,010 or 1.6 percent below the approved amount and a reduction of $5,215,972 or 1.2 percent below the agency's request. The Governor recommends the reduction of $4.5 million, including $1.8 million from the State General Fund, to capture additional HCBS/FE waiver savings and the reduction of $685,464, including $270,347 from the State General Fund to reflect the amounts for nursing facilities arrived at during the concensus caseload process which were lower than the agency's estimate in its budget submission. Additionally, the recommendation includes a lapse of $4.3 million in reappropriated State General Fund moneys.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the recommendations of the Governor.

Senate Committee Recommendation

The Senate Committee concurs with the Subcommittee's recommendation.

House Budget Committee Report

Agency: Department on Aging **Bill No.** HB 2958 **Bill Sec.** 42

Analyst: Deckard **Analysis Pg. No.** Vol. II-1438 **Budget Page No.** 37

Expenditure Summary	Agency Estimate FY 06	Governor's Recommendation FY 06	House Budget Committee Adjustments
All Funds:			
State Operations	$ 15,997,938	$ 15,923,194	$ 0
Aid to Local Units	6,572,136	6,572,136	0
Other Assistance	421,700,237	416,559,009	0
TOTAL	$ 444,270,311	$ 439,054,339	$ 0
State General Fund:			
State Operations	$ 6,258,491	$ 6,258,491	$ 0
Aid to Local Units	1,508,101	1,508,101	0
Other Assistance	162,597,599	160,569,910	0
TOTAL	$ 170,364,191	$ 168,336,502	$ 0
FTE Positions	208.0	208.0	0.0
Non FTE Uncl. Perm. Pos.	6.5	6.5	0.0
TOTAL	214.5	214.5	0.0

Agency Estimate

The Department estimates FY 2006 operating expenditures of $444,270,311, including $170,364,191 from the State General Fund, a decrease of $1,988,038 all funds or 0.4 percent below the approved amount. The Department includes in its estimate the lapse of $170,142 in State General Funds. Additionally, the Department reduced the amount budgeted for HCBS/FE waiver by $3.88 million to account for the fact that the revised estimated need for this program was not as large as originally budgeted. The Department indicated that the revised level is still anticipated to prevent the existence of a waiting list for HCBS/FE waiver services.

Governor's Recommendation

The Governor recommends FY 2006 operating expenditures of $439,054,339, including $168,336,502 from the State General Fund. The recommendation is a decrease of $7,204,010 or 1.6 percent below the approved amount and a reduction of $5,215,972 or 1.2 percent below the agency's request. The Governor recommends the reduction of $4.5 million, including $1.8 million from the State General Fund, to capture additional HCBS/FE waiver savings and the reduction of $685,464, including $270,347 from the State General Fund to reflect the amounts for nursing facilities arrived at during the concensus caseload process which were lower than the agency's estimate in its budget submission. Additionally, the recommendation includes a lapse of $4.3 million in reappropriated State General Fund moneys.

House Budget Committee Recommendation

The House Budget Committee concurs with the recommendations of the Governor.

Senate Subcommittee Report

Agency: Department on Aging **Bill No.** SB 573 **Bill Sec.** 31

Analyst: Deckard **Analysis Pg. No.** Vol. II-1438 **Budget Page No.** 37

Expenditure Summary	Agency Request FY 07	Governor's Recommendation FY 07	Senate Subcommittee Adjustments
All Funds:			
State Operations	$ 16,039,918	$ 15,532,018	$ 0
Aid to Local Units	7,003,336	6,572,136	0
Other Assistance	456,804,787	429,307,947	0
TOTAL	$ 479,848,041	$ 451,412,101	$ 0
State General Fund:			
State Operations	$ 6,272,618	$ 5,830,979	$ 0
Aid to Local Units	1,939,301	1,508,101	0
Other Assistance	177,003,535	167,324,671	0
TOTAL	$ 185,215,454	$ 174,663,751	$ 0
FTE Positions	208.0	208.0	0.0
Non FTE Uncl. Perm. Pos.	6.5	6.5	0.0
TOTAL	214.5	214.5	0.0

Agency Request

The **Department** requests FY 2007 operating expenditures of $479,848,041, including $185,215,454 from the State General Fund. This is an increase of $35,577,730 from all funding sources or 8.0 percent above the FY 2006 revised estimate. The request includes thirteen enhancement packages totaling $26,702,951, including $11,299,940 from the State General Fund. Without the enhancement packages, the Department's request is an increase of $8,874,779 or 2.0 percent from the FY 2006 revised estimate.

Governor's Recommendation

The **Governor** recommends FY 2007 expenditures of $451,412,101, including $174,663,751 from the State General Fund. The recommendation is an increase of $12,357,762 or 2.8 percent above the FY 2006 recommendation and a decrease of $28,435,940 or 5.9 percent below the agency's request. The recommendation includes the addition of $9,080,463, including $4,811,645 from the State General Fund, in enhancement requests, and the addition of $221,072, including $87,576 from the State General Fund, for the 2.5 percent cost of living adjustment for state employees. The recommendation includes the reduction of $8,593,940, including $3,215,241 from the State General Fund, from the HCBS/FE waiver, the reduction of $2,076,984, including $822,278 from the State General Fund from the PACE program, and the reduction of $363,600, including $126,556 from the State General Fund, from Targeted Case Management.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the recommendations of the Governor with the following observations:

1. Review at Omnibus the addition of $4,127,400, including $1,627,847 from the State General Fund, to increase Home and Community Based Services for the Frail Elderly (HCBS/FE) waiver provider rates by six percent.

2. Review at Omnibus the addition of $396,216, including $156,268 from the State General Fund, to increase Targeted Case Management provider rates by six percent.

3. The Subcommittee notes that payments for individuals in nursing facilities are the largest single item in the agency's budget. Testimony indicated that the cost to provide this service continues to increase, but the number that is being served appears to have plateaued. Overall, the cost for this service is the main cost driver for this budget. Testimony as indicated that the severity level is increasing, as demonstrated by the change in the case mix seen in reimbursements to individual facilities. The Budget Committee notes that the addition of $8,413,678, including $4,246,074 from the State General Fund, for the increase in nursing facility expenditures, to reflect the amounts arrived at during the concensus caseload process.

4. The Subcommittee notes its concern that individuals in community settings may not be receiving sufficient assistance to met all of their needs. The Subcommittee received testimony that the average number of hours of service an individual on the HCBS/FE waiver received during FY 2005 was approximately two hours per day. The Subcommittee notes its concern that if needs are not being meet in the community, it may result in additional costs to the state for long term care in nursing facilities.

   The Subcommittee was informed that there is currently no waiting list for HCBS/FE waiver service, nor is it anticipated that there will be a waiting list during FY 2007. The Subcommittee notes the addition of $431,200 from the State General Fund to eliminate the waiting list for the Senior Care Act in FY 2007, and is encouraged that it appears there will not be a waiting list in FY 2007 for the services that this agency provides.

   The Subcommittee also notes that at the present time sufficient funding is available for nutrition funding for those in community settings, however, federal funding may be an issue for this program in the future.

5. The Subcommittee commends the Acting Secretary for her hard work during this transition period.

Senate Committee Recommendation

The Senate Committee concurs with the Subcommittee's recommendation with the following adjustment:

1. At Omnibus review the overall issue of PACE (Program of All Inclusive Care for the Elderly) including:

- the Wyandotte County expansion enhancement request;
- existing PACE programs; and
- the level of need for PACE programs.

The 2005 Legislature expanded the program by 150 slots, to be split between the existing program in Wichita and a new site to be established in Topeka. The expansion is not funded in the FY 2007 Governor's recommendation.

House Budget Committee Report

Agency: Department on Aging **Bill No.** HB 2968 **Bill Sec.** 31

Analyst: Deckard **Analysis Pg. No.** Vol. II-1438 **Budget Page No.** 37

Expenditure Summary	Agency Request FY 07	Governor's Recommendation FY 07	House Budget Committee Adjustments
All Funds:			
State Operations	$ 16,039,918	$ 15,532,018	$ (202,428)
Aid to Local Units	7,003,336	6,572,136	0
Other Assistance	456,804,787	429,307,947	0
TOTAL	$ 479,848,041	$ 451,412,101	$ (202,428)
State General Fund:			
State Operations	$ 6,272,618	$ 5,830,979	$ (101,214)
Aid to Local Units	1,939,301	1,508,101	0
Other Assistance	177,003,535	167,324,671	0
TOTAL	$ 185,215,454	$ 174,663,751	$ (101,214)
FTE Positions	208.0	208.0	0.0
Non FTE Uncl. Perm. Pos.	6.5	6.5	0.0
TOTAL	214.5	214.5	0.0

Agency Request

The Department requests FY 2007 operating expenditures of $479,848,041, including $185,215,454 from the State General Fund. This is an increase of $35,577,730 from all funding sources or 8.0 percent above the FY 2006 revised estimate. The request includes thirteen enhancement packages totaling $26,702,951, including $11,299,940 from the State General Fund. Without the enhancement packages, the Department's request is an increase of $8,874,779 or 2.0 percent from the FY 2006 revised estimate.

Governor's Recommendation

The Governor recommends FY 2007 expenditures of $451,412,101, including $174,663,751 from the State General Fund. The recommendation is an increase of $12,357,762 or 2.8 percent above the FY 2006 recommendation and a decrease of $28,435,940 or 5.9 percent below the agency's request. The recommendation includes the addition of $9,080,463, including $4,811,645 from the State General Fund, in enhancement requests, and the addition of $221,072, including $87,576 from the State General Fund, for the 2.5 percent cost of living adjustment for state employees. The recommendation includes the reduction of $8,593,940, including $3,215,241 from the State General Fund, from the HCBS/FE waiver, the reduction of $2,076,984, including $822,278 from the State General Fund from the PACE program, and the reduction of $363,600, including $126,556 from the State General Fund, from Targeted Case Management.

House Budget Committee Recommendation

The House Budget Committee concurs with the recommendations of the Governor, with the following adjustments and observations:

1. **FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System (KPERS) rates, KPERS death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

   For this agency, the FY 2006 approved budget totaled $446,258,349, including $171,096,825 from the State General Fund. The approved budget was increased by a net total of $5,443,077, including $3,081,526 from the State General Fund to establish a baseline budget for FY 2007. The reduction included $170,014 in salary adjustments, partially offset by an increase of $5,600,000 for caseload estimates.

2. **Comparison of FY 2007 Baseline Budget to Governor's Recommendation.** The table below reflects the difference between the Governor's recommendation and the baseline budget.

	SGF	All Funds
Governor's Recommendation	$ 174,663,751	$ 451,412,101
Baseline Budget	174,178,351	451,700,426
Dollar Difference	$ 485,400	$ (289,325)
Percent Difference	*0.3%*	*0.1%*

The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	SGF	All Funds
Base Salary Adjustment	$ 87,576	$ 221,072
Enhancements	565,571	666,785
Reduction HCBS/FE waiver	(1,730,511)	(5,490,299)
TCM adjustments	121,668	268,800
State Pharmacy Program	0	(1,066,196)
Loan Program	0	(500,000)
Federal Funding Changes	0	415,402
Civil Monetary Penalties	0	400,000
PACE	1,454,006	3,681,442
Meals on Wheels Checkoff	0	36,000
Non-Federal Grants	0	63,930
Other Administration Adjustments	(12,910)	13,739
TOTAL	$ 485,400	$ (289,325)

3. **Vehicle Purchase.** Delete $202,428, including $101,214 from the State General Fund, to remove funding recommended by the Governor to replace 18 high mileage vehicles. The Budget Committee recommends the agency's purchase of vehicles be reviewed at Omnibus.

4. The Budget Committee directs the agency to provide information relating to how the reduction in HCBS/FE waiver expenditures is impacting individuals on the waiver, and how such a large reduction is possible.

5. The Budget Committee is concerned at the level of funding provided for PACE in FY 2007 under the Governor's recommendation. The Budget Committee notes that funding for PACE was removed from the concensus caseload process starting in October 2005. The Budget Committee notes that the 2005 Legislature expanded the program by 150 slots, to be split between the existing program in Wichita and a new site to be established in Topeka. The expansion is not funded in the FY 2007 Governor's recommendation. The Budget Committee notes that a commitment was made to provide funding for this purpose and notes testimony indicated that private entities have already expended or contracted for over $2 million in expenditures related to the approved expansion. The Budget Committee requests that the Division of the Budget provide a clear accounting of the expansion issue prior to Omnibus. Additionally, the Budget Committee wishes to review the issue of PACE at Omnibus including: the Wyandotte County expansion enhancement request; existing PACE programs; and the level of need for PACE programs.

   Additionally, the Budget Committee requests that the Department on Aging continue to review the potential for a rural site for a PACE program especially the potential for additional federal funds for a pilot program and report to the Committee any progress.

6. The Budget Committee requests that the agency consider the formation of a rural long term care taskforce and include all interested parties in the discussion. The Budget Committee notes that long-term care facilities are crucial to small communities and their economies, particularly in western Kansas.

7. The Budget Committee notes its concern with the current rebasing reimbursement methodology utilized by the agency. The Budget Committee encourages the agency to continue to review the methodology and to consider adjusting the reimbursement rate for individuals with moderate to severe cognitive impairments.

8. The Budget Committee requests the agency to review information received during testimony that all Area Agencies on Aging (AAA) are currently losing money by providing targeted case management services. The Budget Committee requests that the agency report to the Committee prior to Omnibus with its findings.

9. Review at Omnibus the addition of $85,000 from the State General Fund for a mental health pilot project as requested in the agency's enhancement package. The Budget Committee requests that the agency engage in discussions with the AAA's and the Community Mental Health Centers (CMHC) regarding the need and the potential benefits of the project. The agency is directed to report to the Committee prior to Omnibus.

10. The Budget Committee notes the agency's recognition of the need to improve its programs and services to hard-to-reach populations, including those with language, location, literacy, culture, and other barriers. The Budget Committee is encouraged by the agency's efforts in developing literature in alternative languages and easy to read formats, and by the fact that the agency is pursing alternative distribution methods through partnerships in the community.

11. The Budget Committee notes that the Senior Health Insurance Counseling for Kansans (SHICK) program was moved from the Insurance Department to the Department on Aging several years ago. The Budget Committee wishes to review the placement of this program and the potential for a transfer back to the Insurance Department during Omnibus. The Budget Committee requests the agency respond prior to Omnibus.

12. The Budget Committee notes that the agency is attempting to address concerns raised with the Nursing Facility Inspection program. The agency indicated that its efforts include the following:

    - The Acting Secretary and new Licensure, Certification and Evalution Commissioner are making themselves available to provider associations and participating in listening sessions and exchanges of views.

    - The Commissioner has streamlined response to complaints and enforcement activities by reorganization, reducing layers of management and clarifying roles.

    - The agency is building relationships with federal Center for Medicare and Medicaid Services partners that promote the maintenance of high standards of protection for residents and value the essential role of long term care providers for residents of Kansas facilities

Senate Subcommittee Report

Agency: Department of Administration - Division of Health Policy and Finance **Bill No.** 570 **Bill Sec.** 35

Analyst: Dunkel **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Est. FY 06	Governor Rec. FY 06	Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 431,641,191	$ 426,843,212	$ (950,173)
Other Funds	960,777,108	948,319,362	0
TOTAL	$ 1,392,418,299	$ 1,375,162,574	$ (950,173)
FTE Positions–Reportable	130.4	129.9	(6.0)
Non-FTE Unclassified Perm.	10.0	10.0	0.0
TOTAL	140.4	139.9	(6.0)

Agency Estimate

The **agency** estimates FY 2006 expenditures of $1.4 billion, including $431.6 million State General Fund for the Division of Health Policy and Finance. The estimate is an increase of $12.5 million or 0.9 percent all funds and $1.6 million or 0.4 percent State General Fund from the amount approved by the 2005 Legislature. According to the agency the increase reflects the supplemental request for the SCHIP program, additional funding for HealthWave Administration to address program growth, and additional expenditures related to the Medicaid Management Information System.

Governor's Recommendation

The **Governor** recommends FY 2006 expenditures of $1.4 billion, including $426.8 million from the State General fund for the Division of Health Policy and Finance. The recommendation is a decrease of $4.7 million or 0.3 percent all funds and $3.2 million or 0.7 percent State General Fund below FY 2006 approved expenditures. The **Governor's** recommendation is a reduction of $17.3 million or 1.2 percent all funds and $4.8 million or 1.1 percent State General Fund and 0.5 FTE positions below the agency request. The Governor makes the following reductions:

- $17.9 million, including $6.0 million from the State General Fund for Fall Consensus Caseload adjustments;
- $568,151 from the State General Fund to bring expenditures to approved levels; and
- 6.5 FTE positions to bring FTE and Non-FTE positions numbers to the approved levels.

The **Governor** recommends the Health Policy Authority operate as a distinct program under the Division of Health Policy and Finance instead of operating as a new state agency and adds $950,173 State General Fund for Health Policy Authority operations.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation with the following adjustments:

1. Delete $950,173 from the State General Fund and 6.0 FTE positions for the Division of Health Policy and Finance that the Governor recommended to fund the Health Policy Authority within the Division of Health Policy and Finance.

House Budget Committee Report

Agency: Department of Administration - Division of Health Policy and Finance **Bill No.** 2958 **Bill Sec.** 31

Analyst: Dunkel **Analysis Pg. No.** Vol. I – 525 **Budget Page No.** 13

Expenditure	Agency Estimate FY 06	Governor Rec. FY 06	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 431,641,191	$ 426,843,212	$ (2,016,840)
Other Funds	960,777,108	948,319,362	0
TOTAL	$ 1,392,418,299	$ 1,375,162,574	$ (2,016,840)
FTE Positions	130.4	129.9	(6.0)
Non-FTE Unclassified Perm.	10.0	10.0	0.0
TOTAL	140.4	139.9	(6.0)

Agency Estimate

The **agency** estimates FY 2006 expenditures of $1.4 billion, including $431.6 million State General Fund for the Division of Health Policy and Finance. The estimate is an increase of $12.5 million or 0.9 percent all funds and $1.6 million or 0.4 percent State General Fund from the amount approved by the 2005 Legislature. According to the agency the increase reflects the supplemental request for the SCHIP program, additional funding for HealthWave Administration to address program growth, and additional expenditures related to the Medicaid Management Information System.

Governor's Recommendation

The **Governor** recommends FY 2006 expenditures of $1.4 billion, including $426.8 million from the State General fund for the Division of Health Policy and Finance. The recommendation is a decrease of $4.7 million or 0.3 percent all funds and $3.2 million or 0.7 percent State General Fund below FY 2006 approved expenditures. The **Governor's** recommendation is a reduction of $17.3

million or 1.2 percent all funds and $4.8 million or 1.1 percent State General Fund and 0.5 FTE positions below the agency request. The Governor makes the following reductions:

- $17.9 million, including $6.0 million from the State General Fund for Fall Consensus Caseload adjustments;
- $568,151 from the State General Fund to bring expenditures to approved levels; and
- 6.5 FTE positions to bring FTE and Non-FTE positions numbers to the approved levels.

The **Governor** recommends the Health Policy Authority operate as a distinct program under the Division of Health Policy and Finance instead of operating as a new state agency and adds $950,173 from the State General Fund for Health Policy Authority operations.

House Budget Committee Recommendation

The House Budget Committee concurs with the Governor's recommendation with the following adjustments:

1. Delete $950,173 from the State General Fund and 6.0 FTE positions for the Health Policy Authority which the Governor funded within the Division of Health Policy and Finance.

2. Delete $1,066,667 from the State General Fund for the Enhanced Care Management Project for review during Omnibus.

   The Enhanced Care Management Project is a pilot project in Sedgwick County. The goal of the project is to improve health outcomes by managing health benefit utilization through education, access to community services, and balanced advocacy for chronically ill Medicaid clients. The project, which began on March 1, 2006, is administered by Central Plains Regional Health Care Foundation, an extension of the Sedgwick County Medical Society. Trajectory HealthCare LLC has been contracted to provide external evaluation of the project throughout its five-year term.

   The Governor recommended $2.0 million from the State General Fund for this project in FY 2006. The Budget Committee, noting the late start of the project, recommended a reduction of the $1,066,667, leaving $400,000 in start-up costs and funding for four months of the program. The Budget Committee recommends Omnibus consideration of the item to give it an opportunity to review actual expenditures in FY 2006.

3. The Budget Committee notes that the Health Care Access Improvement Program (HCAIP) has received federal approval for the hospital provider assessment and is receiving revenue. The attached document provides an explanation and analysis of revenue from the program for both FY 2006 and 2007.

Attachment A

Hospital Provider Assessment

Health Care Access Improvement Program

2004 Senate Substitute for HB 2912 and House Substitute for SB 12 established the Health Care Access Improvement Program, which uses an annual assessment on inpatient services provided by hospitals and on non-Medicare premiums collected by health maintenance organizations (HMOs) to improve and expand health care in Kansas for low income persons. The assessment paid by hospitals and HMOs is used as state match to draw down additional federal funding of approximately 40.0 percent state dollars and 60.0 percent federal dollars.

The legislation also created the Health Care Access Improvement Panel to make recommendations on the distribution of assessment funds. The panel consists of three members appointed by the Kansas Hospital Association with the chairman selected from those three appointees, two members licensed to practice medicine and surgery appointed by the Kansas Medical Society, one representative of SRS—appointed by the Governor, one member appointed by an HMO, and one member appointed by the Kansas Association for the Medically Under Served. The panel reports annually to the Legislature.

Hospital Provider Assessment Revenues

Hospital providers that are state agencies, state educational institutions, or critical access hospitals are exempt from the assessment. The state mental health hospitals and developmental disability hospitals also are exempt. The assessment for eligible hospitals is 1.83 percent of net inpatient revenue for each hospital based on the hospital's 2001 fiscal year, due only after the hospital has received 150 days of increased rates. If the hospital did not have a complete 12 month 2001 fiscal year, the assessment amount is $200,000. The original estimates totaled $35.0 million each year in assessment revenue that could be matched with up to $52.5 million in federal Medicaid funds. The Health Care Access Improvement program required the approval of the Centers for Medicare and Medicaid Services (CMS) before it could be implemented.

The legislation specified how the assessment revenue would be dispersed among hospitals, physicians, and medical education programs.

- **Not less than 80.0 percent** of the funds collected from hospital assessments would be disbursed to hospital providers through a combination of Medicaid access improvement payments and increased Medicaid rates on designated diagnostic-related groupings, procedures, and codes.

- **Not more than 20.0 percent** of the funds collected from hospital assessments will be disbursed to doctors or dentists through increased Medicaid rates on designated procedures and codes.

- **Not more than 3.2 percent** of the funds collected from hospital assessments will be used to fund health care access improvement programs in undergraduate, graduate, or continuing medical education, including the Medical Student Loan Act.

3-14

Progress Report

The state plan amendment (SPA) to enact the hospital rate changes financed through the provider assessment was submitted on September 24, 2004, with an effective date of July 1, 2004. The plan amendment was approved by CMS on October 14, 2005. DHPF began implementation of the payment mechanisms and collection of the assessment revenues. Letters were sent to providers in November to provide notice that the state plan amendment was approved. A follow up letter was sent to hospitals on December 6 with the amount of the assessment and the proposed schedule for payments. The SPA submission allowed for payments to be made for dates of service retroactively to July 1, 2004, and hospitals had been notified with their assessment amounts for the FY 2005.

On December 22, 2005, DHPF paid out $67.0 million to 147 hospital providers. This first payment covered the dates of service between July 1, 2004 and June 30, 2005. This first payment also made all of the applicable access incentive payments allowed by the approved SPA.

A second payment will be made prior to March 31, 2006, and will include any remaining claims with service dates between July 1, 2004 and June 30, 2005 and claims for services provided after June 30, 2005. Changes have been made to the Medicaid payment system to pay the out patient and DRG rate increase on claims that processed since December 2005. The outpatient rate increase policy was effective with processing dates on or after December 1, 2005. The DRG rate increase for inpatient claims was effective with processing dates on or after January 1, 2006.

The rate increase shown for inpatient and outpatient services currently is 34.4 percent higher than the rates in effect on June 30, 2004. On March 1, 2006, the percentage will be reduced to 25.8 percent. This change was approved by the Health Care Access Improvement Panel to use some of the assessment funds to raise the rates paid through the managed care contract with FirstGuard Health Plans. The additional payments to FirstGuard will allow the in patient and out patient rates paid through the managed care organization to match the rates paid in the fee for service Medicaid program. The total payments to hospitals are expected to remain the same from this shift, but individual hospitals may receive more or less depending upon the volume of their claims with FirstGuard.

The amount of health care provider assessment for State Fiscal Year 2005 was $33,728,195. As of February 24, 2006, DHPF has collected $32,940,402 from 72 providers.

At this time DHPF is working to implement the physician rate increase. The methodology endorsed by the Kansas Medical Society, the Health Care Access Improvement Panel, and DHPF will raise physician rates to a higher percentage of the Medicare payment. With the amount of revenue available, DHPF plans to raise physician fees to approximately 87.0 percent of the Medicare payment. Medicaid physician rates that exceed 87.0 percent of Medicare currently will stay the same. Other rates will be raised to that benchmark percentage. This approach uses up the surplus assessment funds that were dedicated to physician rates, but could not be used because of the delays in approval of the SPA. DHPF expects to raise the physician rates by June 2006.

Below is a table that compares the estimated amounts of assessment revenues and projected expenditures to the actual collections and the proposed expenditures.

	FY 2005		FY 2006		FY 2007	
	Initial Estimate	Actual	Initial Estimate	Governor's Recommendation	Initial Estimate	Governor's Recommendation
Balance Forward						26,178,720
Assessment Revenue (FY 2005)	35,000,000	-		32,940,402		
Federal Matching	52,500,000	-		49,410,603		
Assessment Revenue (FY 2006)			35,000,000	*33,728,155*		
Federal Matching			52,500,000	*50,592,233*		
Assessment Revenue (FY 2007)					35,000,000	*33,728,155*
Federal Matching					52,500,000	*50,592,233*
Total Revenue	87,500,000	-	87,500,000	166,671,393	-	110,499,107
Hospital rates (FY 2005)	70,000,000	-		40,995,678		
Access Payments (FY 2005)				25,971,782		
Hospital rates (FY 2006)			70,000,000	*44,553,431*		
Acess Payments (FY 2006				*25,971,782*		
Hospital rates (FY 2007)					70,000,000	*44,553,431*
Acess Payments (FY 2007)						*25,971,782*
Physician rates	17,500,000	-	17,500,000	2,600,000	17,500,000	32,000,000
Graduate Medical Education		-		400,000		400,000
Total Expenditures	87,500,000	-	87,500,000	140,492,673	87,500,000	102,925,213
Carry Forward Revenue				26,178,720		7,573,894

Senate Subcommittee Report

Agency: Department of Administration - Division of Health Policy and Finance **Bill No.** 570 **Bill Sec.** 35

Analyst: Dunkel **Analysis Pg. No.** Vol. I-525 **Budget Page No.** 13

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Senate Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 0	$ 417,615,683	$ (417,615,683)
Other Funds	0	955,976,800	(955,976,800)
TOTAL	$ 0	$ 1,373,592,483	$ (1,373,592,483)
FTE Positions–Reportable	0.0	130.9	(130.9)
Non-FTE Other Unclassified	0.0	10.0	(10.0)
TOTAL	0.0	140.9	(140.9)
Operating Expenditures:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	0	22,532,798	(22,532,798)
TOTAL Non-Reportable	$ 0	$ 22,532,798	$ (22,532,798)
FTE Positions	0.0	39.3	(39.3)
Non-FTE Uncl. Perm. Pos.	0.0	0.5	(0.5)
TOTAL Non-Reportable	0.0	39.8	(39.8)

Agency Request

The **agency** requests no expenditures for FY 2007.

Governor's Recommendation

The **Governor** recommends expenditures of $1.4 billion, including $417.6 million from the State General Fund for the Division of Health Policy and Finance in FY 2007. The recommendation is a reduction of $1.6 million or 0.1 percent all funds and $9.2 million or 2.2 percent State General Fund below the FY 2006 recommendation. The all funds reduction reflects reduced expenditures for Medical Policy Administration and the State General Fund reduction reflects a shift of expenditures from the State General Fund to the Social Welfare Fund.

The **Governor's** recommendation includes the delay of the transfer of programs to the Health Policy Authority until FY 2008, and the continuation of the Authority as a distinct program in DHPF, instead of an independent state agency.

Senate Subcommittee Recommendation

The Senate Subcommittee makes the following recommendations:

1. Delete $1.4 billion, including $417.6 million from the State General Fund and 130.9 FTE positions for programs that shift from the Division of Health Policy and

Finance in the Department of Administration to the Health Policy Authority in FY 2007 as required in 2005 House Substitute for SB 272.

House Budget Committee Report

Agency: Department of Administration - Division of Health Policy and Finance **Bill No.** 2968 **Bill Sec.** 19

Analyst: Dunkel **Analysis Pg. No.** Vol. I – 525 **Budget Page No.** 13

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 0	$ 417,615,683	$ (417,615,683)
Other Funds	0	955,976,800	(955,976,800)
TOTAL Reportable	$ 0	$ 1,373,592,483	$ (1,373,592,483)
FTE Positions	0.0	130.9	(130.9)
Non-FTE Unclassified Perm.	0.0	10.0	(10.0)
TOTAL Reportable	0.0	140.9	(140.9)
Operating Expenditures:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	0	22,532,798	(22,532,798)
TOTAL Reportable	$ 0	$ 22,532,798	$ (22,532,798)
FTE Positions	0.0	39.3	(39.3)
Non-FTE Unclassified Perm.	0.0	0.5	(0.5)
TOTAL Reportable	0.0	39.8	(39.8)

Agency Request

The **agency** requests no expenditures for FY 2007.

Governor's Recommendation

The **Governor** recommends expenditures of $1.4 billion, including $417.6 million from the State General Fund for the Division of Health Policy and Finance (DHPF) in FY 2007. The recommendation is a reduction of $1.6 million or 0.1 percent all funds and $9.2 million or 2.2 percent State General Fund below the FY 2006 recommendation. The all funds reduction reflects reduced expenditures for Medical Policy Administration and the State General Fund reduction reflects a shift of expenditures from the State General Fund to the Social Welfare Fund.

The **Governor's** recommendation includes the delay of the transfer of programs to the Health Policy Authority until FY 2008, and the continuation of the Authority as a distinct program in DHPF, instead of an independent state agency.

3-18

House Budget Committee Recommendation

The House Budget Committee concurs with the Governor's recommendation with the following adjustments and observations:

1. **FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System (KPERS) rates, KPERS death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

   For this agency, the FY 2006 approved budget totaled $1.4 billion, including $430.1 million from the State General Fund. The approved budget was reduced by a net total of $1.4 billion, including $430.1 million from the State General Fund to establish a baseline budget for FY 2007. The reductions reflect the shift of program funding to the Health Policy Authority in FY 2007.

2. **Comparison of FY 2007 Baseline Budget to Governor's Recommendation**. The table below reflects the difference between the Governor's recommendation and the baseline budget.

	SGF	All Funds
Governor's Recommendation	$417,615,683	$1,373,592,483
Baseline Budget	0	0
Dollar Difference	$417,615,683	$1,373,592,483
Percent Difference		

   The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	SGF	*All Funds*
Funding for Health Policy Authority programs in the Division of Health Policy and Finance	*$ 417,615,683*	*$ 1,373,592,483*

3. Delete $1.4 billion, including $417.6 million from the State General Fund and 130.9 FTE positions for programs that shift from the Division of Health Policy and Finance in the Department of Administration to the Health Policy Authority in FY 2007.

Senate Subcommittee Report

Agency: Health Policy Authority **Bill No.** -- **Bill Sec.** --

Analyst: Dunkel **Analysis Pg. No.** Vol 1 - 562 **Budget Page No.** 187

Expenditure	Agency Req. FY 06	Governor Rec. FY 06	Senate Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 750,173	$ 0	$ 950,173
Other Funds	0	0	0
TOTAL	$ 750,173	$ 0	$ 950,173
FTE Positions	6.0	0.0	6.0
Non FTE Uncl. Perm. Pos.	0.0	0.0	0.0
TOTAL	6.0	0.0	6.0

Agency Estimate

For FY 2006, the **agency** estimates expenditures of $750,173 from the State General Fund. Expenditures are primarily for the Business Health Partnership ($500,000) and salaries and wages ($250,173).

Governor's Recommendation

For FY 2006, the **Governor** recommends that instead of operating as a separate program, the Health Policy Authority operate as a distinct program within the Department of Administration Division of Health Policy and Finance. The Governor's recommendation moves all expenditures from the Health Policy Authority to the Division of Health Policy and Finance.

Senate Subcommittee Recommendation

The Senate Subcommittee makes the following recommendation:

1. The Senate Subcommittee recommends $950,173 from the State General Fund for the Health Policy Authority. This recommendation restores the agency's requested $250,173 in operating expenditures and restores its status as a separate agency. The recommendation also includes $200,000 from the State General Fund for the generic drug program. This additional funding was recommended by the Governor in the Division of Health Policy and Finance in the Department of Administration.

House Budget Committee Report

Agency: Health Policy Authority **Bill No.** – **Bill Sec.** –

Analyst: Dunkel **Analysis Pg. No.** Vol 1 - 562 **Budget Page No.** 187

Expenditure	Agency Req. FY 06	Governor Rec. FY 06	House Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 750,173	$ 0	$ 450,173
Other Funds	0	0	0
TOTAL	$ 750,173	$ 0	$ 450,173
FTE Positions	6.0	0.0	6.0
Non FTE Uncl. Perm. Pos.	0.0	0.0	0.0
TOTAL	6.0	0.0	6.0

Agency Estimate

For FY 2006, the **agency** estimates expenditures of $750,173 from the State General Fund. Expenditures are primarily for the Business Health Partnership ($500,000) and salaries and wages ($250,173).

Governor's Recommendation

For FY 2006, the **Governor** recommends that instead of operating as a separate program, the Health Policy Authority operate as a distinct program within the Department of Administration Division of Health Policy and Finance. The Governor's recommendation moves all expenditures from the Health Policy Authority to the Division of Health Policy and Finance.

House Budget Committee Recommendation

The House Budget Committee makes the following adjustments:

1. Add $950,173 from the State General Fund to fund the Health Policy Authority as an independent state agency. The recommendation includes $200,000 from the State General Fund for the generic drug program. This additional funding was recommended by the Governor in the Division of Health Policy and Finance in the Department of Administration.

2. Delete $500,000 from the State General Fund for the Business Health Partnership and review during Omnibus. The purpose of the not-for-profit Business Health Partnership is to develop and market a low cost heath plan to small businesses. The Business Health Policy Committee was created by the

Legislature with the intent of providing small businesses (2-50 employees) access to health coverage at an affordable rate. The committee is comprised of business leaders and legislators.

The Budget Committee recognizes the importance of supporting health insurance for small business employees, but feels more information about the pilot project is necessary before it can approve the funding.

3. The Budget Committee notes HealthyKIDS is a pilot program for State Employees whose children would be eligible for SCHIP, if it was not prohibited by federal law. This means they have a household income below 200.0 percent of the Federal Poverty Level (FPL), which is $32,180 per year for a family of three. Under HealthyKIDS, the state covers 90.0 percent of the employees children's health insurance premium, and the employee pays the remaining 10.0 percent. Traditionally, the employee pays 45.0 percent of the premium. The pilot project covers 2,500 children of state employees, 550 of whom were not previously enrolled in the state employees health program.

   Expenditures for the HealthyKIDS program are reflected in the State Employees Health Insurance Program, which is not reflected in the state budget as an aggregate. Instead, each agency reflects the payment of state employee health benefits in its salaries and wages budget.

   The Budget Committee notes with concern that 1,950 children were already covered under the State Employees Health Insurance Program prior to implementation of the HealthyKIDS pilot. When these children shifted to HealthyKIDS, the cost previously paid by employees was shifted to the state. Only 550 children who did not previously have health insurance were included in this program. The cost of this program for FY 2006 is an estimated $900,000 from the Cafeteria Benefits Fund with $702,000 expended for children who were already covered under the state Employees Health Insurance Program.

Senate Subcommittee Report

Agency: Health Policy Authority **Bill No.** -- **Bill Sec.** --

Analyst: Dunkel **Analysis Pg. No.** Vol. I-562 **Budget Page No.** 187

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	Senate Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 445,193,727	$ 0	$ 417,615,683
Other Funds	975,928,412	0	955,976,800
TOTAL Reportable	$ 1,421,122,139	$ 0	$ 1,373,592,483
FTE Positions	144.4	0.0	130.9
Non FTE Uncl. Perm. Pos.	10.0	0.0	10.0
TOTAL Reportable	154.4	0.0	140.9
Operating Expenditures:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	22,481,911	0	22,532,798
TOTAL Non-Reportable	$ 22,481,911	$ 0	$ 22,532,798
FTE Positions	47.0	0.0	39.3
Non FTE Uncl. Perm. Pos.	0.5	0.0	0.5
TOTAL Non-Reportable	47.5	0.0	39.8

Agency Request

For FY 2007, the **agency** requests expenditures of $1.4 billion, including $445.2 million from the State General Fund. The request is an increase of $1.4 billion over the agency's FY 2006 estimate and reflects the transfer of the following programs from the Department of Administration Division of Health Policy and Finance to the Health Policy Authority:

Medical Policy Administration ($26.6 million all funds, $6.7 million State General Fund);
Medicaid Management Information System (MMIS) ($37.7 million all funds, $11.5 million State General Fund);
HealthWave Administration ($11.6 million all funds, $4.7 million State General Fund);
Ticket to Work ($662,882 all funds); and,
Regular Medical and the State Children's Health Insurance Program (SCHIP) ($1.3 billion all funds, $421.4 million State General Fund).

In addition, the request includes enhancement requests totaling $27.4 million, including $9.5 million from the State General Fund.

Governor's Recommendation

For FY 2007, the **Governor** proposes a change to the provision of 2005 House Substitute for SB 272. The Governor proposes a one-year delay, until July 1, 2007, of the transfer of health programs from the Division of Health Policy and Finance to the Health Policy Authority. In addition,

the Governor recommends the Health Policy Authority operate as a distinct program under the Department of Administration Division of Health Policy and Finance. The Governor's recommendation moves all expenditures from the Health Policy Authority to the Division of Health Policy and Finance.

Senate Subcommittee Recommendation

The Senate Subcommittee makes the following recommendation:

1. Add $1.4 billion, including $417.6 million from the State General Fund and 130.9 FTE positions for the reportable budget of the Health Policy Authority to fund the budget with the statutory shift of programs from the Division of Health Policy and Finance in the Department of Administration, in the amount recommended by the Governor for program expenditures, to the Health Policy Authority in FY 2007.

2. Add $22.5 million and 39.3 FTE positions for the non-reportable budget of the Health Policy Authority to fund the budget with the statutory shift of programs from the Division of Health Policy and Finance in the Department of Administration to the Health Policy Authority in FY 2007.

House Budget Committee Report

Agency: Health Policy Authority **Bill No.** -- **Bill Sec.** --

Analyst: Dunkel **Analysis Pg. No.** Vol 1 - 562 **Budget Page No.** 187

Expenditure	Agency Req. FY 07	Governor Rec. FY 07	House Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 445,193,727	$ 0	$ 412,019,868
Other Funds	975,928,412	0	956,208,115
TOTAL Reportable	$ 1,421,122,139	$ 0	$ 1,368,227,983
FTE Positions	144.4	0.0	130.9
Non FTE Uncl. Perm. Pos.	10.0	0.0	10.0
TOTAL Reportable	154.4	0.0	140.9
Operating Expenditures:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	22,481,911	0	22,532,798
TOTAL Non-Reportable	$ 22,481,911	$ 0	$ 22,532,798
FTE Positions	47.0	0.0	39.3
Non FTE Uncl. Perm. Pos.	0.5	0.0	0.5
TOTAL Non-Reportable	47.5	0.0	39.8

Agency Request

For FY 2007, the **agency** requests expenditures of $1.4 billion, including $445.2 million from the State General Fund. The request is an increase of $1.4 billion over the agency's FY 2006 estimate and reflects the transfer of the following programs from the Department of Administration Division of Health Policy and Finance to the Health Policy Authority:

Medical Policy Administration ($26.6 million all funds, $6.7 million State General Fund);
Medicaid Management Information System (MMIS) ($37.7 million all funds, $11.5 million State General Fund);
HealthWave Administration ($11.6 million all funds, $4.7 million State General Fund);
Ticket to Work ($662,882 all funds); and,
Regular Medical and the State Children's Health Insurance Program (SCHIP) ($1.3 billion all funds, $421.4 million State General Fund).

In addition, the request includes enhancement requests totaling $27.4 million, including $9.5 million from the State General Fund.

Governor's Recommendation

For FY 2007, the **Governor** proposes a change to the provision of 2005 House Substitute for SB 272. The Governor proposes a one-year delay, until July 1, 2007, of the transfer of health programs from the Division of Health Policy and Finance to the Health Policy Authority. In addition, the Governor recommends the Health Policy Authority operate as a distinct program under the Department of Administration Division of Health Policy and Finance. The Governor's recommendation moves all expenditures from the Health Policy Authority to the Division of Health Policy and Finance.

House Budget Committee Recommendation

The House Budget Committee makes the following observations and adjustments:

1. **FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System (KPERS) rates, KPERS death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

   For this agency, the FY 2006 approved budget totaled $1.6 million, including $1.45 million from the State General Fund. The approved budget was increased by a net total of $1.3 billion, including $434.3 million from the State General Fund to establish a baseline budget for FY 2007. The additions included $1.3 billion, including $435.8 million from the State General Fund for the shift of programs from the Division of Health Policy and Finance to the Health Policy Authority in FY

2007, $91,567 in salary adjustments, and $31.6 million in one-time adjustments for consensus caseloads.

Comparison of FY 2007 Baseline Budget to Governor's Recommendation. The table below reflects the difference between the Governor's recommendation and the baseline budget.

	SGF	All Funds
Governor's Recommendation	$ 0	$ 0
Baseline Budget	435,788,695	1,349,775,832
Dollar Difference	$ (435,788,695)	$ (1,349,775,832)
Percent Difference	--	--

The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	SGF	*All Funds*
Shift of Program funding from the Health Policy Authority to the Division of Health Policy and Finance	*$ (435,788,695)*	*$ (1,349,775,832)*

3. Add $1.4 billion, including $417.6 million from the State General Fund and 130.9 FTE positions for the reportable budget of the Health Policy Authority to fund the budget with the statutory shift of programs from the Division of Health Policy and Finance in the Department of Administration to the Health Policy Authority in FY 2007.

4. Add $22.5 million and 39.3 FTE positions for the non-reportable budget of the Health Policy Authority to fund the budget with the statutory shift of programs from the Division of Health Policy and Finance in the Department of Administration to the Health Policy Authority in FY 2007.

5. Delete $1.5 million from the State General Fund for the Business Health Partnership to be reviewed during Omnibus. The purpose of the not-for-profit Business Health Partnership is to develop and market a low cost heath plan to small businesses. The Business Health Policy Committee was created by the Legislature with the intent of providing small businesses (2-50 employees) access to health coverage at an affordable rate. The committee is comprised of business leaders and legislators.

   The Governor recommended $2.0 million from the State General Fund in FY 2007 for a pilot program in Sedgwick County to increase financial incentives for small businesses when they offer health insurance to their employees. The pilot targets employees with incomes below 200.0 percent of the Federal Poverty Level, working for firms with two to 25 employees. The pilot program will include the existing small business tax credit and additional credits to reduce company contributions to 30.0 percent of the premium and employee contributions to 10.0 percent of the premium. The pilot will provide insurance from a single carrier and will be coordinated with the Community RX Kansas program and the State

Children's Health Insurance Program (SCHIP).

The Budget Committee recognizes the importance of supporting health insurance for small business employees, but feels more information about the pilot project is necessary before it can approve the full funding.

6. Delete $3.5 million from the State General Fund for the Healthy Kansas First 5 program for review during Omnibus. Healthy Kansas First 5 expands eligibility under both Medicaid and the State Children's Health Insurance Program (SCHIP):

   - Medicaid eligibility for pregnant women and infants will be increased from 150% to 185% of the Federal Poverty Level (FPL)
   - SCHIP eligibility will be increased from 200% to 235% of FPL.
   - Families with children above 235% of FPL will be allowed to buy into the SCHIP benefit package if they meet the following criteria:
     - they do not have access to any employer based insurance
     - they have been without insurance for six months

   The Budget Committee notes with concern that this program expands eligibility for both Medicaid and SCHIP that may not be sustainable if another economic downturn occurs. In addition, federal matching dollars for SCHIP are limited and Kansas already uses all of its SCHIP, as well as SCHIP dollars unused by other states that are redistributed periodically by the federal government. If the Kansas SCHIP program exceeds the federal funds available, the additional cost must be paid from state dollars. Given the cut-backs that became necessary in Missouri and Tennessee when program expansion became unsustainable, the Budget Committee recommends review of this item during Omnibus when more detailed cost estimates will be available from the agency.

7. Delete $500,000 from the State General Fund for the Enhanced Care Management Project for review during Omnibus.

   The Enhanced Care Management Project is a pilot project in Sedgwick County. The goal of the project is to improve health outcomes by managing health benefit utilization through education, access to community services, and balanced advocacy for chronically ill Medicaid clients. The project, which began on March 1, 2006, is administered by Central Plains Regional Health Care Foundation, an extension of the Sedgwick County Medical Society. Trajectory HealthCare LLC has been contracted to provide an external evaluation of the project throughout its five-year term.

   The Governor recommended $2.0 million from the State General Fund for this project in FY 2007. The Budget Committee recommended a reduction of $500,000 from the State General Fund pending Omnibus consideration of the item to give it an opportunity to review actual expenditures in FY 2006.

8. Delete $250,000 from the State General Fund for the Presumptive Eligibility program for review during Omnibus. The Governor recommended $2.5 million from the State General Fund for the implementation of presumptive eligibility for

children ages 0 - 19. This would allow them to go to a hospital or clinic for services, where they would be screened to determine if they meet presumptive eligibility criteria for Medicaid or SCHIP. If they are presumed eligible for services, the health care provider can depend on payment for services while full eligibility is being determined (approximately a month).

The Budget Committee expresses concern regarding the burden this program will put on providers, who will have to implement the screening process after training from the agency, with no additional reimbursement. The Budget Committee asks that the agency report back during Omnibus with the number of other states that are using presumptive eligibility and whether or not providers are being reimbursed.

9. Add $385,500, including $154,185 from the State General Fund to restore the Governor's reduction for fragmentation of pills with an enhanced dispensing fee.

   According to the agency, mechanical fragmentation is accomplished with a special machine that can split one Lipitor 80mg tablet into 10 and 20mg fragments. The precision of the machine has been verified through assay of the fragmented tablets which comply with USP standards. The State would realize savings for each claim that is processed using fragmented Lipitor 80mg tablets in place of both 10 and 20mg tablets.

   The Budget Committee recommended restoration of funding for this item due to concerns over the efficacy and consistency of medication when split through mechanical fragmentation. In addition, there are concerns about requiring pharmacists to ignore package instructions for drugs - the package insert for Lipitor says "do not split" - as well as patient compliance.

10. The Budget Committee expresses concern about the implementation of presumptive disablity for the MediKan program.

    Currently, persons applying for Social security disability programs can receive a limited package of state-only funded medical benefits through MediKan. MediKan services are available for 24 months while the Social Security Administration (SSA) reviews the persons application. After 24 months, if the person does not meet SSA eligibility requirements and has exhausted their appeals, they are no longer eligible for services, except through limited hardship criteria.

    Beginning July 1, 2006, the state will begin a process of making a preliminary determination of disability that will result in immediate Medicaid benefits for the eligible person. This will allow the state to draw down the federal matching rate of 60.0 percent to pay for these services. A determination of presumptive disability will be made within 45 days. If the applicant is presumed disabled, they will begin to receive the full package of Medicaid services. If the applicant is not presumed disabled, they will not receive services.

    Once the determination of presumptive disability has been made, the applicant will submit a disability application to the SSA which will go through the usual process. Regardless of the final disability determination by the SSA, the state will not be required to return the federal matching funds for the services

provided under this program, as long as the State's presumptive disability criteria result in 50 percent or greater of the applicants receiving an SSA disability determination.

Persons in the MediKan program as of July 1, 2006 will be screened for presumptive disability in the month of his or her annual review. If they are not presumed disabled and have exhausted all SSA appeals, they will no longer receive medical benefits. There are no hardship criteria under presumptive disability.

The Budged Committee concerns regarding presumptive disability are threefold:

a. There is no process to address persons who may not qualify for presumptive disability, but may ultimately qualify as disabled under SSA requirements. The Budget Committee recommends the Division of Health Policy and Finance, the Health Policy Authority, and the Department of Social and Rehabilitation Services work together to address this issue and report to the Committee during Omnibus.

b. Only 25.0 percent of persons on MediKan ultimately qualify for SSA disability. Over 60.0 percent of persons currently on the MediKan program have a mental health diagnosis - resulting in mental health drugs being the largest cost driver for MediKan. Presumptive disability may shift people from MediKan services to the community mental health system, state hospitals, and jails. No additional funding provisions were made to address this possibility. The Budget Committee recommends the agency work with stakeholders to address this issue and report to the Committee during Omnibus.

c. The Governor's recommendation includes a savings of $7.0 million from the State General Fund for presumptive disability which may have to be restored if the presumptive disability criteria set by the state results in less than half of the persons presumed disabled qualifying for SSA disability.

11. The Budget Committee notes HealthyKIDS is a pilot program for State Employees whose children would be eligible for SCHIP, if it was not prohibited by federal law. This means they have a household income below 200.0 percent of the Federal Poverty Level (FPL), which is $32,180 per year for a family of three. Under HealthyKIDS, the state covers 90.0 percent of the employees children's health insurance premium, and the employee pays the remaining 10.0 percent. Traditionally, the employee pays 45.0 percent of the premium. The pilot project covers 2,500 children of state employees, 550 of whom were not previously enrolled in the state employees health program.

Expenditures for the HealthyKIDS program are reflected in the State Employees Health Insurance Program, which is not reflected in the state budget as an aggregate. Instead, each agency reflects the payment of state employee health benefits in its salaries and wages budget.

The Budget Committee notes with concern that 1,950 children were already covered under the State Employees Health Insurance Program prior to implementation of the HealthyKIDS pilot. When these children shifted to HealthyKIDS, the cost previously paid by employees was shifted to the state. Only 550 children who did not previously have health insurance were included in this program. The cost of this program in FY 2007 is an estimated $1.8 million from the Cafeteria Benefits Fund, with $1.4 million expended for children who were already covered by the State Employees Health Insurance Program.

12. The Budget Committee notes with concern the impact of Medicare Part D on the dual eligible population. The size and complexity of the program resulted in major issues for both recipients and providers. The Budget Committee notes that the state paid $3.5 million in pharmacy claims to help dual eligibles maintain access to their medications. The agency anticipates full reimbursement for these expenditures from the federal government, and does not anticipate the need for supplemental funding to address cash-flow issues related to Medicare Part D.

Senate Subcommittee Report

Agency: Social and Rehabilitation Services **Bill No.** 570 **Bill Sec.** 43

Analyst: Kannarr **Analysis Pg. No.** Vol. II-1342 **Budget Page No.** 367

Expenditure Summary	Agency Estimate FY 06	Governor's Recommendation FY 06	Senate Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 494,201,495	$ 493,794,613	$ 550,000
Other Funds	814,439,064	822,746,193	0
Subtotal - Operating	$ 1,308,640,559	$ 1,316,540,806	$ 550,000
Capital Improvements:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	5,397,861	5,397,861	0
Subtotal - Capital Improvements	$ 5,397,861	$ 5,397,861	$ 0
TOTAL	$ 1,314,038,470	$ 1,321,938,667	$ 550,000
FTE Positions	3,847.6	3,655.1	0.0
Non FTE Uncl. Perm. Pos.	91.1	91.1	0.0
TOTAL	3,938.7	3,746.2	0.0

Agency Estimate

The **agency** estimates FY 2006 operating expenditures of $1,308,640,559, including $494,201,495 from the State General Fund. The estimate is an all funds decrease of $8,274,614 (0.6 percent) and a State General Fund increase of $1,916,208 (0.4 percent) from the amount approved by the 2005 Legislature. Subsequent to the 2005 Session, adjustments and corrections were made to the approved amount. The result of these changes is an approved budget of $1,316,649,154, including $492,097,810 from the State General Fund. If these adjustments are accounted for the FY 2006 estimate is an all funds decrease of $8,008,595 (0.6 percent) and a State General Fund increase of $2,103,685 (0.4 percent) from the amended approved amount.

The FY 2006 estimate includes supplemental requests of $8,339,527, including $3,945,117 from the State General Fund and $1,818,647 from the Economic Development Initiatives Fund. Absent supplemental requests, the estimate is an all funds decrease of $16,348,122 (1.2 percent) and a State General Fund decrease of $1,841,432 (0.4 percent) from the 2006 amended approved expenditures.

The estimate includes operating expenditures of $33,977,233 ($16,010,421 SGF) for the **Administration Division**; $600,544,882 ($218,381,900 SGF) for **Integrated Service Delivery**; $670,423,982 ($259,809,174 SGF) for **Health Care Policy**; and $3,694,462 for Capital Improvements - Debt Service Interest payments.

Governor's Recommendation

The **Governor** recommends FY 2006 expenditures of $1,316,540,806 for the Department of Social and Rehabilitation Services, including $493,794,613 from the State General Fund and $28,340,350 from the Children's Initiatives Fund. The recommendation is an all funds increase of $7,900,247 (0.6 percent), a State General Fund decrease of $6,871,792 (1.4 percent) and a Children's Initiatives Fund decrease of $2,212 (0.0 percent) as compared to the agency's revised estimate. The recommendation includes $2,377,831 from special revenue funds for a portion of the agency's supplemental requests. In addition, the Governor's recommendation reflects October 2005 consensus caseload estimates for entitlement programs. The Governor adds $6,787,477 State General Fund to cover federal existing Medicaid deferrals related to child welfare.

The Governor deletes 192.5 vacant FTE positions. The funding of $5,462,187, including $2,078,817 from the State General Fund, associated with those positions is used to reduce agency shrinkage from 13.36 percent to 10.68 percent. Overall funding does not change as a result of this recommendation.

The recommendation includes operating expenditures of $30,436,039 ($13,876,872 State General Fund) for the **Administration Division**; $691,432,172 ($265,607,506 State General Fund) for **Health Care Policy**; $590,978,133 ($214,310,235 State General Fund) for **Integrated Service Delivery**; and $3,694,462 special revenue funds for debt service interest payments.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation with the following exceptions:

1. Add $500,000 from the State General Fund to increase funding for the Community Support Medication program which purchases atypical anti-psychotic medications for individuals with a mental illness who are at risk for hospitalization and who meet income requirements.

2. Add $50,000 from the State General Fund to fund increases in caseloads for the Funeral Assistance program which provides aid to families currently receiving public assistance to pay for funeral and cemetery expenses for a deceased family member.

Senate Committee Recommendation

The Senate Committee concurs with the Subcommittee recommendations.

Budget Committee Report

Agency: Social and Rehabilitation Services **Bill No.** 2958 **Bill Sec.** 43

Analyst: Kannarr **Analysis Pg. No.** Vol. II-1342 **Budget Page No.** 367

Expenditure Summary	Agency Estimate FY 06	Governor's Recommendation FY 06	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 494,201,495	$ 493,794,613	$ 255,000
Other Funds	814,439,064	822,746,193	0
Subtotal - Operating	$ 1,308,640,559	$ 1,316,540,806	$ 255,000
Capital Improvements:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	5,397,861	5,397,861	0
Subtotal - Capital Improvements	$ 5,397,861	$ 5,397,861	$ 0
TOTAL	$ 1,314,038,470	$ 1,321,938,667	$ 255,000
FTE Positions	3,847.6	3,655.1	0.0
Non FTE Uncl. Perm. Pos.	91.1	91.1	0.0
TOTAL	3,938.7	3,746.2	0.0

Agency Estimate

The **agency** estimates FY 2006 operating expenditures of $1,308,640,559, including $494,201,495 from the State General Fund. The estimate is an all funds decrease of $8,274,614 (0.6 percent) and a State General Fund increase of $1,916,208 (0.4 percent) from the amount approved by the 2005 Legislature. Subsequent to the 2005 Session, adjustments and corrections were made to the approved amount. The result of these changes is an approved budget of $1,316,649,154, including $492,097,810 from the State General Fund. If these adjustments are accounted for the FY 2006 estimate is an all funds decrease of $8,008,595 (0.6 percent) and a State General Fund increase of $2,103,685 (0.4 percent) from the amended approved amount.

The FY 2006 estimate includes supplemental requests of $8,339,527, including $3,945,117 from the State General Fund and $1,818,647 from the Economic Development Initiatives Fund. Absent supplemental requests, the estimate is an all funds decrease of $16,348,122 (1.2 percent) and a State General Fund decrease of $1,841,432 (0.4 percent) from the 2006 amended approved expenditures.

The estimate includes operating expenditures of $33,977,233 ($16,010,421 SGF) for the **Administration Division**; $600,544,882 ($218,381,900 SGF) for **Integrated Service Delivery**; $670,423,982 ($259,809,174 SGF) for **Health Care Policy**; and $3,694,462 for Capital Improvements - Debt Service Interest payments.

Governor's Recommendation

The **Governor** recommends FY 2006 expenditures of $1,316,540,806 for the Department of Social and Rehabilitation Services, including $493,794,613 from the State General Fund and $28,340,350 from the Children's Initiatives Fund. The recommendation is an all funds increase of $7,900,247 (0.6 percent), a State General Fund decrease of $6,871,792 (1.4 percent) and a Children's Initiatives Fund decrease of $2,212 (0.0 percent) as compared to the agency's revised estimate. The recommendation includes $2,377,831 from special revenue funds for a portion of the agency's supplemental requests. In addition, the Governor's recommendation reflects October 2005 consensus caseload estimates for entitlement programs. The Governor adds $6,787,477 State General Fund to cover federal existing Medicaid deferrals related to child welfare.

The Governor deletes 192.5 vacant FTE positions. The funding of $5,462,187, including $2,078,817 from the State General Fund, associated with those positions is used to reduce agency shrinkage from 13.36 percent to 10.68 percent. Overall funding does not change as a result of this recommendation.

The recommendation includes operating expenditures of $30,436,039 ($13,876,872 State General Fund) for the **Administration Division**; $691,432,172 ($265,607,506 State General Fund) for **Health Care Policy**; $590,978,133 ($214,310,235 State General Fund) for **Integrated Service Delivery**; and $3,694,462 special revenue funds for debt service interest payments.

House Budget Committee Recommendation

The Social Services Budget Committee concurs with the Governor's recommendation with the following exceptions:

1. Add $130,000 from the State General Fund to address caseload issues in the Funeral Assistance program which provides aid to families presently receiving services in paying for funeral and cemetery expenses for deceased family members. This amount brings total funding up to $600,000 for the program. The Committee notes a request by the Kansas Funeral Directors and Embalmers Association for additional funding for the Funeral Assistance Program and that it was included as an enhancement request by the agency which was not funded by the Governor. The Committee was informed that the program benefit was reduced from $1,150 to $550 in FY 1998 and that this amount does not cover the entire costs of burial. The additional expenses are either paid by the families or absorbed by the funeral home. Finally, the Committee notes that without the funeral assistance program, indigent burial costs would fall to county governments.

2. Add $125,000 from the State General Fund for the Community Support Medication Program and review information about potential program growth at Omnibus. This program was originally approved by the 1997 Legislature when $680,000 was appropriated from the State General Fund to provide atypical anti-psychotic medications to persons with mental illness who meet income requirements and are at risk of hospitalization. Funding has been increased to $800,000 but according to testimony, is still not adequate to meet the needs of consumers. In the last year, the agency has been required to implement restrictions on access to the program to keep the program within its budget.

Senate Subcommittee Report

Agency: Social and Rehabilitation Services **Bill No.** 573 **Bill Sec.** 32

Analyst: Kannarr **Analysis Pg. No.** Vol. I-1342 **Budget Page No.** 367

Expenditure Summary	Agency Request FY 07	Governor's Recommendation FY 07	Senate Subcommittee Adjustments
Operating Expenditures:			
State General Fund	$ 541,041,759	$ 510,666,852	$ 4,795,424
Other Funds	823,708,493	845,640,054	4,759,322
Subtotal - Operating	$ 1,364,750,252	$ 1,356,306,906	$ 9,554,746
Capital Improvements:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	11,963,200	5,142,277	0
Subtotal - Capital Improvements	$ 11,963,200	$ 5,142,277	$ 0
TOTAL	$ 1,376,713,452	$ 1,361,449,183	$ 9,554,746
FTE Positions	3,873.6	3,670.6	12.0
Non FTE Uncl. Perm. Pos.	64.1	64.1	0.0
TOTAL	3,937.7	3,734.7	12.0

Agency Request

The **agency** requests FY 2007 operating expenditures of $1,364,750,252, including $541,041,759 from the State General Fund. The request is an all funds increase of $56,109,693 (4.3 percent) and a State General Fund increase of $46,840,264 (9.5 percent) above the FY 2006 estimate.

Requested enhancements total $94,975,277, including $53,712,056 from the State General Fund and $3,425,250 from the Economic Development Initiatives Fund.

The request includes operating expenditures of $30,836,013 ($14,146,147 SGF) for **Administration**; $614,681,570 ($246,513,176 SGF) for **Integrated Service Delivery**; $715,633,506 ($280,382,436 SGF) for **Health Care Policy**; and $3,599,163 for debt service interest payments.

Governor's Recommendation

The **Governor** recommends operating expenditures of $1,356,306,906 for the Department of Social and Rehabilitation Services, including $510,666,852 from the State General Fund, $29,163,081 from the Children's Initiatives Fund, and $340,000 from the Economic Development Initiatives Fund. The recommendation is an all funds decrease of $8,443,346 (0.6 percent), a State General Fund decrease of $30,374,907 (5.6 percent) and a Children's Initiatives Fund increase of $1,800,000 (6.6 percent) as compared to the agency request. The recommendation reflects October 2005 consensus caseload estimates for entitlement programs. The Governor recommends

$44,848,410 ($15,089,610 State General Fund) for a portion of the agency's enhancement package and adds funding for new initiatives including Pre-Kindergarten, energy assistance, and a Grandparents as Caregivers program.

The Governor's recommendation includes funding of $3,385,572, including $1,803,522 from the State General Fund, for a 2.5 percent base salary adjustment. The remaining change in salaries and wages between FY 2006 and FY 2007 reflects the absence of the 27th payroll period that was funded in FY 2006.

The Governor deletes 203.0 FTE positions from the agency request as part of the recommendation to eliminate vacant positions and use the associated funding of $6,183,328 ($2,391,336 State General Fund) to decrease the agency shrinkage rate from 13.36 percent to 10.26 percent. This recommendation is a deletion of 10.5 additional FTE positions as compared to the Governor's FY 2006 recommendation.

The recommendation includes operating expenditures of $30,369,914 ($13,833,888 State General Fund) for **Administration**; $609,501,689 ($228,474,507 State General Fund) for **Integrated Service Delivery**; $712,836,140 ($268,356,457 State General Fund) for **Health Care Policy**; and $3,599,163 from the State Institutions Building Fund for debt service interest payments.

Senate Subcommittee Recommendation

The Senate Subcommittee concurs with the Governor's recommendation with the following exceptions:

1. Add $50,000 from the State General Fund to fund increases in caseloads for the Funeral Assistance program which provides aid to families currently receiving public assistance to pay for funeral and cemetery expenses for a deceased family member.

2. Add $250,000 from the State General Fund to increase funding for the Community Support Medication program which purchases atypical anti-psychotic medications for individuals with a mental illness who are at risk for hospitalization and who meet income requirements. This amount is in addition to the $250,000 added by the Governor for total increased funding of $500,000, the same as in FY 2006.

3. Add $2,500,000, including $1,000,000 from the State General Fund, to further reduce the waiting list for the Medicaid Home and Community Based Services waiver for the Developmentally Disabled (HCBS/DD).

4. Add $2,500,000, including $1,000,000 from the State General Fund, to increase salary rates for direct care workers in the community who provide services to individuals on the Medicaid HCBS/DD waiver. The Subcommittee requests that representatives of the community developmental disabilities organizations report back to the Senate Ways and Means Subcommittee reviewing the SRS budget in the 2007 Session with information about the impact of the additional funding that has been added on salaries for direct care workers in the community.

5. Add $1,250,000, including $500,000 from the State General Fund, to reduce the waiting list for the Medicaid Home and Community Based Services waiver for the Physically Disabled (HCBS/PD).

6. Add $500,000 from the State General Fund to increase funding for grants to Centers for Independent Living which provide services to persons with disabilities to help them live successfully in the community.

7. Add $210,000 from the State General Fund to continue the College of Direct Supports, a workforce development program for direct support professionals who provide services to disabled consumers in community-based settings.

8. Add $1,250,000, including $500,000 from the State General Fund, to increase the hourly rate for personal services provided to individuals on the Medicaid Home and Community Based Services waiver for persons with Physical Disabilities (HCBS/PD).

9. Add $200,000 from the State General Fund to expand domestic violence prevention services to persons receiving cash assistance by increasing the number of locations and increasing counselors in underserved areas.

10. Add $675,710, including $435,424 from the State General Fund, and 12.0 FTE to increase participation in the federal Food Stamp program by providing additional caseworkers and outreach staff in the regional offices. According to agency estimates, the additional staff will result in approximately 2,000 additional families receiving food stamp benefits of approximately $4.7 million which will then be spent in retail stores statewide.

11. Add $150,000 from the State General Fund to increase support for the contract with Kansas Legal Services (KLS) to assist Kansans seeking federal disability determinations. The Subcommittee was informed that based on performance for the first half of FY 2006, current funding will not be adequate to meet the needs of clients requiring assistance. In addition, the additional funding will result in federal reimbursements to the state of $639,000. The Subcommittee does note that uncertainty exists regarding the impact of the current implementation of presumptive disability determination on the number of people requiring assistance from KLS.

12. The Subcommittee expresses its concerns about the potential impact of the recent federal deficit reduction bill on various programs at the agency.

13. The Subcommittee notes the ongoing issues with funding for Level V and VI services. The Subcommittee received testimony requesting State General Fund support for services that Medicaid will no longer support in the future. In addition, the Subcommittee acknowledges the ongoing collaborative process to develop solutions to treat children needing Level V and VI services.

14. The Subcommittee notes testimony it received regarding the importance of crisis stabilization services for children and youth and addition of professional family services to the Severe Emotional Disturbance (SED) waiver. The Subcommittee was informed that the agency is pursuing the use of professional family homes, grants to Community Mental Health Centers and public/private partnerships for alternative service delivery.

15. The Subcommittee notes its full support for the interim study on mental health services that was recommended during the review of budgets for the state mental health institutions. The study is intended to examine the public mental health system to look at what has taken place since the original Mental Health Reform

legislation was passed in the early 1990s, the need for a process to address census increases at state hospitals and reimbursement for community hospitals for inpatient mental health treatment.

Senate Committee Recommendation

The Senate Committee concurs with the Subcommittee recommendations.

Budget Committee Report

Agency: Social and Rehabilitation Services **Bill No.** 2968 **Bill Sec.** 32

Analyst: Kannarr **Analysis Pg. No.** Vol. I-1342 **Budget Page No.** 367

Expenditure Summary	Agency Request FY 07	Governor's Recommendation FY 07	Budget Committee Adjustments
Operating Expenditures:			
State General Fund	$ 541,041,759	$ 510,666,852	$ 547,800
Other Funds	823,708,493	845,640,054	(108,658)
Subtotal - Operating	$ 1,364,750,252	$ 1,356,306,906	$ 439,142
Capital Improvements:			
State General Fund	$ 0	$ 0	$ 0
Other Funds	11,963,200	5,142,277	0
Subtotal - Capital Improvements	$ 11,963,200	$ 5,142,277	$ 0
TOTAL	$ 1,376,713,452	$ 1,361,449,183	$ 439,142
FTE Positions	3,873.6	3,670.6	0.0
Non FTE Uncl. Perm. Pos.	64.1	64.1	0.0
TOTAL	3,937.7	3,734.7	0.0

Agency Request

The **agency** requests FY 2007 operating expenditures of $1,364,750,252, including $541,041,759 from the State General Fund. The request is an all funds increase of $56,109,693 (4.3 percent) and a State General Fund increase of $46,840,264 (9.5 percent) above the FY 2006 estimate.

Requested enhancements total $94,975,277, including $53,712,056 from the State General Fund and $3,425,250 from the Economic Development Initiatives Fund.

The request includes operating expenditures of $30,836,013 ($14,146,147 SGF) for **Administration**; $614,681,570 ($246,513,176 SGF) for **Integrated Service Delivery**; $715,633,506 ($280,382,436 SGF) for **Health Care Policy**; and $3,599,163 for debt service interest payments.

Governor's Recommendation

The **Governor** recommends operating expenditures of $1,356,306,906 for the Department of Social and Rehabilitation Services, including $510,666,852 from the State General Fund, $29,163,081 from the Children's Initiatives Fund, and $340,000 from the Economic Development Initiatives Fund. The recommendation is an all funds decrease of $8,443,346 (0.6 percent), a State General Fund decrease of $30,374,907 (5.6 percent) and a Children's Initiatives Fund increase of $1,800,000 (6.6 percent) as compared to the agency request. The recommendation reflects October 2005 consensus caseload estimates for entitlement programs. The Governor recommends $44,848,410 ($15,089,610 State General Fund) for a portion of the agency's enhancement package and adds funding for new initiatives including Pre-Kindergarten, energy assistance, and a Grandparents as Caregivers program.

The Governor's recommendation includes funding of $3,385,572, including $1,803,522 from the State General Fund, for a 2.5 percent base salary adjustment. The remaining change in salaries and wages between FY 2006 and FY 2007 reflects the absence of the 27th payroll period that was funded in FY 2006. The Governor deletes 203.0 FTE positions from the agency request as part of the recommendation to eliminate vacant positions and use the associated funding of $6,183,328 ($2,391,336 State General Fund) to decrease the agency shrinkage rate from 13.36 percent to 10.26 percent. This recommendation is a deletion of 10.5 additional FTE positions as compared to the Governor's FY 2006 recommendation.

The recommendation includes operating expenditures of $30,369,914 ($13,833,888 State General Fund) for **Administration**; $609,501,689 ($228,474,507 State General Fund) for **Integrated Service Delivery**; $712,836,140 ($268,356,457 State General Fund) for **Health Care Policy**; and $3,599,163 from the State Institutions Building Fund for debt service interest payments.

House Budget Committee Recommendation

The Social Services Budget Committee concurs with the Governor's recommendations with the following adjustments and comments:

1. **FY 2007 Baseline Budget.** To establish a baseline FY 2007 budget, the FY 2006 budget, as approved by the 2005 Legislature, was adjusted to reflect salary adjustments (removal of the 27th payroll period funding included in FY 2006, annualization of the FY 2006 phased in 2.5 percent base salary adjustment and statutorily required adjustments for Kansas Public Employees Retirement System (KPERS) rates, KPERS death and disability insurance, and longevity). In addition, adjustments were made for required debt service payments, revenue transfers, and consensus items including school finance funding and caseload estimates for the Department of Social and Rehabilitation Services, the Department of Administration, the Department on Aging, and the Board of Indigents' Defense Services. Finally, adjustments were made for one-time items which impact specific agency budgets.

   For this agency, the FY 2006 approved budget totaled $1,310,495,781, including $490,238,437 from the State General Fund, after adjusting for a State Finance Council transfer to the Division of Health Policy and finance of $10,935,692

($2,046,850 State General Fund). The approved budget was increased by a net total of $45,910,671 including $12,333,998 from the State General Fund to establish a baseline budget for FY 2007. The adjustments included a reduction of $2,742,087 in salary adjustments, offset by increases of $6,494,163 for debt service payments, $36,952,306 for consensus caseloads, and $5,216,288 in other one-time adjustments.

2. **Comparison of FY 2007 Baseline Budget to Governor's Recommendation.** The table below reflects the difference between the Governor's recommendation and the baseline budget.

	SGF	All Funds
Governor's Recommendation	$ 510,666,852	$ 1,361,449,183
Baseline Budget	502,572,435	1,356,416,451
Dollar Difference	$ 8,094,417	$ 5,032,732
Percent Difference	*1.6%*	*0.4%*

The following table reflects items included in the Governor's recommendation which differ from the baseline budget.

	SGF	All Funds
Base Salary Adjustment	$ 1,803,522	$ 3,385,572
Trade reclassification	8,008	8,008
Child care increase	3,000,000	3,000,000
Shift child care funding	(8,985,760)	1,478,647
Community Support Med. Prog.	250,000	250,000
Adult Dental for HCBS Waivers	2,008,320	5,092,089
HCBS/DD waiting list reduction and rate increase	5,403,354	13,700,187
Grandparents as Caregivers	2,092,740	2,092,740
Early Health Start expansion	1,852,779	1,852,779
Increased energy assistance	1,000,000	1,000,000
Shift of CIF funding to Tiny-K	0	(200,000)
Adoption support increase	0	899,184
CSE Customer Service Center	0	2,000,000
Pre-K pilot	0	2,000,000
Decreased SIBF funding	0	(6,820,923)
Child care fee fund reduction	0	(3,994,735)
Foster care grants (TANF shortfall)	0	(10,099,708)
Contract adjustments	142,003	531,859
Mental health claiming adjustments	0	(3,563,801)
Federal grant adjustments	0	(3,186,696)
Miscellaneous funding shifts	153,541	0
Capital outlay reduction	(626,520)	(1,610,614)
Other adjustments	(7,570)	(2,781,856)
Total	$ 8,094,417	$ 5,032,732

3. Delete $292,488, including $183,830 from the State General Fund, to remove funding recommended to replace 20 high mileage vehicles for consideration at Omnibus.

3-40

4. Add $130,000 from the State General Fund to address caseload issues in the Funeral Assistance program which provides aid to families presently receiving services in paying for funeral and cemetery expenses for deceased family members. This amount brings total funding up to $600,000 for the program. The Committee notes a request by the Kansas Funeral Directors and Embalmers Association for additional funding for the Funeral Assistance Program and that it was included as an enhancement request by the agency which was not funded by the Governor. The Committee was informed that the program benefit was reduced from $1,150 to $550 in FY 1998 and that this amount does not cover the entire costs of burial. The additional expenses are either paid by the families or absorbed by the funeral home. Finally, the Committee notes that without the funeral assistance program, indigent burial costs would fall to county governments.

5. Add $201,630 from the State General Fund to provide statewide access to the College of Direct Supports program. This program provides internet based training for people who provide services to persons with disabilities in the community. This program was originally funded by a grant from the Kansas Council on Developmental Disabilities. The recommended amount represents the estimated cost of implementing the program, including an administrative fee for technical and other support for the program.

6. Add $400,000 from the State General Fund for the Community Support Medication Program and review information about potential program growth at Omnibus. This program was originally approved by the 1997 Legislature when $680,000 was appropriated from the State General Fund to provide atypical anti-psychotic medications to persons with mental illness who meet income requirements and are at risk of hospitalization. Funding has been increased to $800,000 but according to testimony, is still not adequate to meet the needs of consumers. In the last year, the agency has been required to implement restrictions on access to the program to keep the program within its budget. Additionally, the Committee notes that this program could be impacted by people with mental illness who are not determined presumptively eligible for MediKan (discussed in Item 8) and who will need to access medications.

7. The Committee requests that SRS, Department on Aging, Division of Health Policy and Finance, Kansas Health Policy Authority, and the Department of Health and Environment report at Omnibus on the anticipated impacts on each agency from the federal Deficit Reduction Act of 2005 enacted this year.

   The Committee notes information it received from SRS regarding potential impacts of the Deficit Reduction bill and expresses concern over several reductions in funding and changes in policy that will impact the agency. The agency highlighted items of particular concern including a repeal of authority to use Child Support Enforcement incentives as state match to draw down additional federal dollars; reduced matching rates for Child Support paternity testing; restriction on the use of federal foster care (Title IV-E) administrative funding for children in unlicensed relative and other placements; and a reduction in vocational rehabilitation supported employment grants. The bill also contained increased funding for child care assistance. The agency also informed the Committee that there are other potential areas of concern that may or may not develop depending on program performance including the elimination of high performance bonuses in the Temporary Assistance for Needy Families (TANF) program, increased work

requirements and penalties for failure to meet the work requirement; and penalties for failure to comply with TANF work activity verification requirements.

8. The Committee requests definitive answers at Omnibus regarding plans for implementation of a presumptive disability determination process at the Division of Health Policy and Finance (DHPF), particularly as it relates to addressing the needs of people with mental illness who are not presumed eligible under the new system. The Committee is concerned that these individuals may increase demand for services in the public mental health system, managed by SRS, or seek treatment in emergency rooms because they cannot otherwise access medications. The Committee notes that approximately 60 percent of people receiving MediKan benefits suffer from mental illness and that mental health medications are cost drivers in the MediKan program currently. The Committee directs SRS and DHPF to assess the impact of the presumptive disability process on the mentally ill and develop a plan to address the needs of this population. The Omnibus response should also include information on the impact of the initiative on the General Assistance program and the current process for receiving federal disability determinations.

9. The Committee requests information at Omnibus from SRS and DHPF on the flow of federal reimbursements for services provided to MediKan and General Assistance clients and how the funding is being used. Prior to the separation of medical assistance program to DHPF, federal reimbursements were used, in part, to pay for the contract with Kansas Legal Services (KLS) to assist clients in receiving a federal disability determination and thus Social Security Disability payments. The Committee understands that a majority of this funding now flows to DHPF and is no longer available to fund the contract with KLS.

   The Committee is concerned about the effect of the reduced receipts in the SRS budget and the overall impact of the presumptive eligibility process on the KLS contract. The Committee notes that the services provided brings in money to the state in the form of federal reimbursement for services provided to the client during determination. Additionally, the Committee notes the complexity of the federal disability determination process and the assistance KLS provides in navigating the process in order to access federal disability payments. Finally, the Committee notes that KLS has requested an additional $150,000 in FY 2006 and FY 2007 from reimbursements collected by the state from the federal government to fund the contract increases. According to information from KLS, funding for the contracts is not adequate to complete existing cases under the contract and a similar experience is expected in FY 2007.

10. The Committee recommends a review at Omnibus of issues concerning the "Money Follows the Person" proviso which redirects funding for nursing facilities into home and community based services waivers when a person with physical disabilities or a frail elderly person leaves a nursing facility and returns to the community. This proviso has been included in the appropriations bill for several years. In particular, the Committee wants to look at issues regarding limitation on the number of people for whom this shifting is required and the fiscal impact of this policy over the last several years. The Committee notes that the budget bill for FY 2007 submitted by the Governor includes a proviso identical to the one approved by the 2005 Legislature. The Committee also notes that SB 218, which would place this provision into statute, is currently under consideration in the Senate Ways and Means Committee.

11. The Committee requests information at Omnibus on the agency's progress towards compliance with the federal requirement that Medicaid beneficiaries have access to any willing, qualified provider to receive mental health services. The Committee is concerned that not all beneficiaries have appropriate access to services, particularly in some areas of the state, and that additional providers would help alleviate this situation. The agency indicated during testimony that a system is now being developed that can resolve access issues if all parties are willing to negotiate.

    According to testimony, the agency is in negotiations with the community mental health system to allow access to providers outside the Community Mental Health Center (CMHC) system for youth in the child welfare system through the use of the youth's medical card. The agency believes progress made in this area will allow the agency to move to this concept in non-custody cases. It was noted that the CMHC system which was previously resistant is now involved in the development process but there is still negotiation that needs to occur around reimbursement and other issues. In addition, the Committee was informed that masters level social workers are not included as providers at this point. Finally, the Committee notes that a past concern with opening up the medical card to additional types of providers has been about costs to the Medicaid program and a loss of control over spending in the mental health system. One option to address this issue is a requirement that providers must affiliate with CMHCs to be able to participate which would allow the CMHCs to manage the mental health system. According to the agency, current thinking is that this may require a federal Medicaid waiver.

    Information provided at Omnibus should include an update on what efforts have been made to resolve these issues and where the development process stands. In addition, the information should contain suggestions from the agency on what tools the Legislature or the agency needs to re-enforce the message to the community mental health system that the Legislature wants to see progress on the issue of access to services which has been under discussion for a number of years.

    Finally, the Committee recommends that this issue be addressed early in the 2007 Legislative session by the Social Services Budget Committee and recommends that a proviso be added to the appropriations bill directing SRS to report progress to the Joint Committee on Children's Issues during the 2006 interim.

12. The Committee recommends Omnibus consideration of a parenting education program proposed by the Savannah Family Institute for the juvenile offender population. The Committee is interested in looking at this program for its potential to be used with the child welfare population to reinforce family relationships and assist with reintegration.

13. The Committee recommends Omnibus review of funding for child welfare services. This review would include looking at information on the potential impacts from federal budget activity, the structure of payments under new contracts effective July 1, 2005, and information on the potential impact of federal deferrals currently in process or being considered.

14. The Committee recommends Omnibus review of the Temporary Assistance for Needy Families (TANF) block grant. Specifically, the review is to include an

analysis of spending from this source over the last five years, the potential impact of federal budget activities and a forecast for spending in the future.

15. The Committee notes that a special Subcommittee has been formed to look at issues concerning the funding of Level V and Level VI services and recommends any recommendations and conclusions from the Subcommittee be reviewed by this Committee during Omnibus.

16. The Committee requests that the agency provide information at Omnibus on hourly rates for direct care staff who provide services to developmentally disabled persons living in the community. In particular, the information provided should include amounts of funding added in the last five years and how that money was incorporated into the formula used to distribute funds. The Committee notes that funding is recommended by the Governor for FY 2007 to fund the second half of the most recent rate study performed in 2004, as required by the Developmental Disability Reform Act. Additionally, the Committee notes that community providers may pay direct care workers hourly rates above what is in this formula calculated by the agency. Consequently, the dollar amount used in the formula does not directly correlate to the wages received by direct care workers in the community.

17. The Committee discussed funding of $2,092,740 from the State General Fund added by the Governor for the Grandparents as Caregivers program contained in 2005 SB 62. The dollars provide funding for the second half of FY 2007 as the program would become effective January 1, 2007. The Committee notes that because this is a new program, it is difficult to estimate the full cost of the program. The funding in the FY 2007 budget is only for half a year so that it could double to $4.2 million for FY 2008 depending on how many people access the program. The Committee also notes that there could be a potential offset for these expenditures due to fewer children being served in the foster care system. The Committee notes that the bill does contain reporting requirements that will allow the agency and the Legislature to track the program's performance and make necessary adjustments. The Committee recommends that the 2007 Legislature review program performance but notes that significant program data will not be available until the 2008 Legislature because it goes into effect midway through FY 2007. Finally, the Committee discussed the contrasts between the benefits provided in SB 62 to grandparents with amounts of money provided to other families with young children at similar income levels.

18. The Committee notes the Governor's deletion of 203.0 vacant FTE positions from the agency's budget in FY 2007 and use of funding associated with those positions to decrease shrinkage. In response to Committee questions, the agency noted that they have carried approximately 600 vacant FTE positions in recent years, largely in regional offices where the bulk of the agency's positions are located. The Committee expresses concern about the impact vacant positions have on staff morale and on the delivery of services.

19. The Committee notes that fees collected from parents of children receiving medical services from the agency totaled $262,850 in FY 2005. In addition, the Committee notes that the agency has been informally notified by the federal Centers for Medicare and Medicaid Services that it may require the state to pay a share back to the federal government for their participation in paying for the services provided.

20. The Committee notes information it received from the agency on activities related to addressing possible conflicts of interest in areas where the Community Developmental Disability Organization (CDDO) was also a provider of direct services. According to agency information, a strategic planning committee was formed to address issues related to CDDO management of services. The planning committee determined that documentation was needed about the community developmental disabilities system to evaluate the CDDOs' various "gatekeeping" functions assigned by statute, regulation and contracts. The outcome of this process is the development of a tool to evaluate management of conflict of interest; education of consumers regarding choice, quality assurance processes, handling of grievances and complaints, the affiliation process for direct service providers and leadership and management of the CDDO. The process of measuring consumer satisfaction and implementation of a compliance review process for CDDOs is expected to be implemented by July 1, 2006 at an estimated cost of $55,280 annually. The Committee recommends further monitoring of the progress made on this issue.

21. The Committee notes the waiting lists for services on the Home and Community Based Services (HCBS) waivers for the Developmentally Disabled (DD) and Physically Disabled (PD). The Committee was informed that as of January 2006 approximately 1,225 individuals with developmental disabilities have been determined eligible and are on the waiting list for services. The Committee was also informed that a rolling waiting list was started on January 16, 2006 for the HCBS PD waiver. A rolling waiting list means that new persons may be added only when another person leaves the waiver resulting in additional people being served but no increase in the total persons on the waiver. There are currently 33 persons on the PD waiting list.

22. The Committee notes information received on issues related to the Attendant Care for Independent Living (ACIL) program. In particular, the Committee received information, contained in Attachment 1, describing the status of overpayment and case management issues which are currently involved in court proceedings. The Committee notes that services for children in the program have not been disrupted by these activities.

23. The Committee recommends that the agency and the Legislature continue to monitor budget changes, interpretations and rulings from the federal government regarding the Medicaid program which may affect the state's use of these funds.

24. The Committee notes that a roundtable on Child Support Enforcement (CSE) issues was held in February 2006 and notes funding in the Governor's budget for a new CSE customer service center. The roundtable covered a number of issues including the potential to draw down additional federal funds if financial institution data match processes are implemented. The Governor recommended $2,000,000, including $340,000 from the Economic Development Initiatives Fund, to establish a statewide customer service center to handle child support telephone contacts, other than contacts related to payment processing by the Kansas Payment Center. The agency anticipates a contract will be negotiated to site the center at a location in rural Kansas. The center will combine a staff of trained customer service representatives, available during daytime hours, with an interactive voice response system to respond 24x7 using automation. The agency estimates that this center will free up enforcement staff, resulting in increased child support collections.

25. The Committee notes a request in the agency's requested budget for funding to support domestic violence prevention efforts for women in the cash assistance population. According to agency information, as many as 50 percent of women in this population experience domestic violence creating barriers to employment and other problems. In addition, the Committee notes the detrimental impact of violence in the home on the brain development of young children and the long term effect it has on children who grow up in violent homes.

Attachment 1

KANSAS

SOCIAL AND REHABILITATION SERVICES
GARY J. DANIELS, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

March 7, 2006

The Honorable Brenda Landwehr
House of Representatives
Statehouse, Room 115S
300 SW 10th
Topeka, KS 66612

Dear Rep. Landwehr:

This is in reply to your inquiry requesting an update on the status of the alleged overpayment involving Kid-Screen, LC.

The Surveillance and Utilization Review Section of EDS, the fiscal agent for Medicaid, determined that Kid-Screen, LC had been overpaid approximately $1.3 million based on several different issues. Kid-Screen, LC filed a request for an administrative hearing with the Department of Administration's Hearing Office challenging this determination and that appeal is currently pending.

Additionally, Kid-Screen, LC filed actions in the Shawnee County District Court seeking Restraining Orders and Temporary Injunctions to prevent the state from recovering the overpayment, and to allow it to continue providing services in the same manner it was using prior to the SURS' review until the appeal process is concluded. The Court granted these Restraining Orders maintaining the status quo, and requiring defendant to continue to authorize full payment under contract between plaintiffs and the state for any and all case management services provided by Kid-Screen, LC. Those orders remain in place pending a full hearing on the merits.

Sincerely,

Gary J. Daniels

Gary J. Daniels
Secretary

3-47

DOCKING STATE OFFICE BUILDING, 915 S.W. HARRISON ST., ROOM 603-N TOPEKA, KS 66612-1570
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NATIONAL CONFERENCE OF STATE LEGISLATURES

Washington Office: 444 N. Capitol Street, N.W. Suite 515 Washington, DC 20001 202/624-5400

DEFICIT REDUCTION ACT OF 2005
SUMMARY OF MEDICAID/MEDICARE/HEALTH PROVISIONS

(Updated February 3, 2006)

Prepared by: Joy Johnson Wilson, Health Policy Director

4-2

TABLE OF CONTENTS

H-3

NATIONAL CONFERENCE OF STATE LEGISLATURES

Washington Office: 444 N. Capitol Street, N.W. Suite 515 Washington, DC 20001 202/624-5400

deficit reduction act of 2005 – summary of conference agreement

Prepared by: Joy Johnson Wilson, Health Policy Director

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
MEDICAID PRESCRIPTION DRUG REFORMS		
Federal Upper Payment Limit (FUL) for Ingredient Cost of Covered Outpatient Drugs (Sec. 6001)	***Federal Upper Payment (FUL) Limit*** ▪ The FUL, the ceiling up to which federal reimbursements for outpatient prescription drug are available, applies to multiple source drugs — those that have at least three therapeutically equivalent drug versions sold by at least three suppliers. The FUL is calculated by the Centers for Medicare and Medicaid Services (CMS) to be equal to 150% 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. ▪ The FUL amounts are calculated and published in regulations by CMS. CMS periodically updates the FUL list and re-publishes those amounts. A state's aggregate payment for all Medicaid prescription drugs with a FUL must not exceed, in the aggregate, the payment levels established by the FUL program. The aggregate cap allows states to increase or decrease the cost of individual prescription drugs in	***Federal Upper Payment Limit*** ▪ Applies FULs to multiple source drugs for which the FDA has rated two or more products to be therapeutically and pharmaceutically equivalent. For those drugs, the FUL would be equal to 250% of the average manufacturer price (AMP) computed without regard to prompt pay discounts for the lowest cost drug. Applies to ingredient costs, but not to dispensing fees. ▪ 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. ▪ Effective January 1, 2007. *(The Congressional Budget Office(CBO) assumes that states will raise dispensing fees to mitigate the effect of this provision on pharmacists, to ensure that a sufficient number of pharmacists and retail pharmacies participate in the Medicaid program to assure adequate access)*

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	accordance with state or local markets while maintaining the overall savings created by the FUL program. ▪ States may exceed the FUL price for individual prescription drugs as long as their aggregate expenditures do not exceed the amounts that would have otherwise been spent by applying the FUL limit plus a reasonable dispensing fee. ***Disclosure of Price Information to States and to the Public*** ▪ 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. ***Definition of Average Manufacturer Price*** ▪ 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. ***Exclusion of Sales at a Nominal Price from Determination of Best Price*** ▪ 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% of the average	***Disclosure of Price Information to States and to the Public*** ▪ Increases the required reporting of AMP and best prices. AMP would be reported and calculated on a monthly basis. ▪ Allows states to have access to reported AMP data for multiple source drugs for the purpose of carrying out the Medicaid programs and requires the Secretary to disclose the information through a website accessible to the public. ▪ 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. ***Definition of Average Manufacturer Price*** ▪ Amends the definition of AMP to exclude customary prompt pay discounts extended to wholesalers from those amounts. ▪ 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. ▪ 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. ▪ Requires the HHS Secretary 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. ***Exclusion of Sales at a Nominal Price from Determination of Best Price*** ▪ Modifies the manufacturer price reporting requirements so

4-7

OVERVIEW: DEFICIT REDUCTION ACT OF 2005 (S. 1932)

The final vote on S. 1932 is scheduled to occur in the House of Representatives on February 1, 2006. Below is a brief chronology of recent actions on this budget reconciliation bill.

The House agreed to the Conference Report (H. Report 109-362) on December 19, 2005, by recorded vote 212 yeas – 206 nays. The Senate approved the Conference Report, with some changes, on December 21, 2005, by recorded vote 51 yeas – 50 nays. Vice President Dick Cheney cast the tie-breaking vote. The Senate struck three provisions from the House-passed Conference Report using a provision called the "Byrd Rule," which makes extraneous provisions, usually provisions that don't create budget savings, subject to a point of order. Efforts to waive the point of order, which requires 60 votes, failed. As a result, the House will have to consider the Senate-approved Conference Report and adopt it or go back into conference with the Senate to resolve the differences.

One Medicaid provision and two Medicare provisions were dropped:

- Section 6043 – Limited the liability of hospitals and physicians who require individuals to pay certain costs as a condition of receiving non-emergency care in hospital emergency rooms.
- Section 5001(b)(3) – Required the HHS Secretary to report to Congress on the Medicare value-based purchasing program established in the bill.
- Section 5001 (b)(4) - Required the HHS Secretary to report to Medicare Payment Advisory Commission (MedPAC) on the Medicare value-based purchasing program established in the bill.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	manufacturer's price. ***Retail Survey Prices; State Payment and Utilization Rates, and Performance Rankings*** ▪ No provision in current law. ***Prospective Drug Review*** ▪ 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 a consultation.	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. ▪ 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; and (d) any other facility or entity that the Secretary determines is a safety net provider to which sales of prescription 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. ***Retail Survey Prices; State Payment and Utilization Rates, and Performance Rankings*** ▪ 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 the drugs. ▪ Adds a provision allowing a contract to include notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available. ▪ Requires the vendor to update the Secretary no less often than

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		monthly on the retail survey prices for covered outpatient drugs. ▪ Provides that the contract will be effective for a term of two years. ▪ If the Secretary were to be notified that 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. ▪ Allows the Secretary to waive provisions of the Federal Acquisition Regulation[1], the Secretary determines are appropriate to waive for the efficient implementation of the contract. ▪ Requires the Secretary 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. ▪ Requires an annual report from each state agency. ▪ Requires states 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. ▪ Requires 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. ▪ Requires the Secretary to submit full information regarding

1 The Federal Acquisition Regulation (FAR) was established to codify uniform policies for acquisition of supplies and services by executive agencies. It is issued and maintained jointly, pursuant to the OFPP Reauthorization Act, under the statutory authorities granted to the Secretary of Defense, Administrator of General Services and the Administrator, National Aeronautics and Space Administration. Statutory authorities to issue and revise the FAR have been delegated to the Procurement Executives in DOD, GSA and NASA.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		the annual rankings to Congress. The provision becomes effective January 1, 2007. ***Prospective Drug Review*** ▪ 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. ***Effective Date*** ▪ 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 the amendments have been promulgated by that date. *(Federal savings - $3.6 billion over five years; $11.8 billion over 10 years)*
Collection and Submission of Utilization Data for Certain Physician Administered Drugs (Sec. 6002)	▪ Requires manufacturers 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. ▪ Because providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectible prescription drugs, including cancer drugs, 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. 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 concluded that because of this coding, many state Medicaid programs do not collect rebates on these drugs, resulting in millions of dollars in uncollected rebates. As a result, CMS requested states to	▪ Requires states, for physician administered, covered outpatient single source drugs administered on or after January 1, 2006, to provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered. ▪ Requires the HHS Secretary, no later than January 1, 2007, to publish a list of the 20 physician administered multiple source drugs that the Secretary determines has the highest dollar volume of physician administered drugs dispensed under the Medicaid program. ▪ Requires states, for physician administered, covered outpatient multiple source drugs administered on or after January 1, 2008, 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 specifies an alternative coding system.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	identify Medicaid drugs, specifically those using HCPCS J-codes, by their NDC codes so that rebates could be collected (Letter to State Medicaid Director, SMDL #03-002, dated March 14, 2003).	▪ Authorizes the Secretary to delay the application of the reporting requirements to prevent hardship to states that require additional time to implement the reporting system. *(Federal savings - $70 million over five years; $155 million over 10 years)*
Improved Regulation of Drugs Sold Under a New Drug Application Approved Under the Food, Drug and Cosmetic Act (Sec. 6003)	▪ Prescription drug manufacturers participating in the Medicaid program are required to report, to the HHS Secretary, 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. This 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	▪ Modifies the existing drug price reporting requirements to include, for single source drugs, innovator multiple source drugs, and any other drugs sold under a new drug application approved (under Section 505c of the Federal Food, Drug and Cosmetic Act, FFDCA) by FDA, both the average manufacturer's price and the manufacturer's best price for such drugs.[2] ▪ 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. ▪ Effective January 1, 2007. *(Federal savings $150 million over five years; $565 million over 10 years)*

[2] 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," includes authorized generics. The conference agreement does not include a definition of authorized generics.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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.	
Children's Hospital Participation in Section 340B Drug Discount Program (Sec. 6004)	▪ Under current law, children's hospitals are not a covered entity, eligible to participate in the 340B drug discount program.[3]	▪ Permits children's hospitals to participate in the 340B program. ▪ Effective upon enactment. *(Federal savings - $50 million over five years; $150 over ten years)*
Prohibition on Restocking and Double Billing Prescription Drugs (Sec. 6033)	▪ The practice, referred to as "restocking," occurs when a pharmacy resells drugs returned by hospitals or nursing homes. The medications often were for patients who had died and for whom the state had already been billed. The restocked drugs are then re-dispensed and Medicaid is billed a second time.[4]	▪ Prohibits federal matching payments for the ingredient costs of a covered outpatient drug claim if the claim has already been submitted and for which the pharmacy has already received payment. ▪ Effective on the first day of the first fiscal quarter beginning after enactment. *(Federal savings between $0 -$500, 000 over five years; federal savings between $0 -$500, 000 over ten years)*

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3 The "340B Program" was established by Section 602 of the Veterans Health Care Act of 1992 (P.L. 102-585), which put Section 340B of the Public Health Service Act into place. The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to certain covered entities specified in the statute 42 U.S.C. 340B(a)(4)at a reduced price, also defined in the statute. These covered entities are Health Resources and Service Administration (HRSA) grantees, Federally Qualified Health Centers (FQHCs) and FQHC look-alikes, family planning clinics, HIV/Ryan White clinics, state-operated AIDS drug assistance programs, black lung clinics, hemophilia treatment centers, urban Indian organizations, Native Hawaiian health centers, sexually transmitted disease and tuberculosis clinics, and disproportionate share hospitals. The 340B price defined in the statute is a ceiling price, meaning it is the highest price a covered entity would have to pay for a given outpatient drug. Entities can negotiate below ceiling prices with manufacturers. As a result, 340B prices have been found to be roughly 50% of the Average Wholesale Price (AWP).

4 In the case U.S. ex rel. Quinn v. Omnicare, Inc., 382 F. 3d 432 (3rd Cir. 2004), the Third Circuit held that the Medicaid statute does not explicitly prevent pharmacists from billing the Medicaid program twice for selling the same drugs.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		(Federal savings -
Special Rules for Cost-Sharing for Prescription Drugs (Sec. 6042)	▪ 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 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.	▪ Allows states to impose cost-sharing amounts for certain state-identified non-preferred drugs that exceed current law limits if the cost sharing plan meets certain requirements. Under this option, states may: (a) impose higher cost-sharing amounts for non-preferred drugs within a class; (b) waive or reduce the cost sharing otherwise applicable for preferred drugs within a class; and (c) not apply such cost sharing for preferred drugs to persons exempt from cost-sharing. ▪ Cost-sharing for non-preferred drugs would be based on multiples of the nominal amounts based on family income. For persons with family income at or below 150% of FPL, nominal cost sharing would apply. For those with family income at or above 150% of FPL, cost sharing cannot exceed 20% of the cost of the drug. ▪ 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. States may exclude specified drugs or classes of drugs from these special cost-sharing rules. ▪ Effective for cost-sharing imposed for items and services furnished on or after January 1, 2007. *(Federal savings - $960 million over five years; $5.4 billion over ten years)*
LONG TERM CARE REFORMS /TRANSFER OF ASSETS		
Lengthen Look Back Period (Sec. 6011)	▪ Current law requires states to review the assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." ▪ Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility.	▪ Lengthens the look-back date to five years, or 60 months, for all income and assets disposed of by an individual. The look back periods of 36 months for income and assets and 60 months for certain trusts would apply for income and assets disposed of prior to the enactment date. ▪ Effective upon enactment, but applies to asset transfers that occur after the date of enactment. As a result, the impact of

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	Transfers made before the look back period are not reviewed. ▪ Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. ▪ If a state eligibility screener finds a non-allowed transfer, current law requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. ▪ The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.	the longer look back period will not be felt until 2009. *(Federal savings - $1.5 billion over five years; $4 billion over ten years. Includes all provisions of Sec. 6011)*
Change in "Look Back" Penalty (Sec. 6011(b))	▪ Under current law, the penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.	▪ Changes the start date of the ineligibility period for all transfers made on or after the date of enactment to 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 upon enactment.
Protection Against Undue Hardship (Sec. 6011(d and e))	▪ 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,	▪ Codifies a modified version of the CMS guidance on hardship waivers. ▪ Provides that approval of a hardship waiver would be subject

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. [5]	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. ▪ Requires states to provide for: (A) notice to recipients that an undue hardship exception 18 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. ▪ Permits 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. These payments cannot not be made for longer than 30 days.
Treatment of Annuities (Sec. 6012)	▪ 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 HHS Secretary 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. The	▪ 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. ▪ Includes in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an

[5] 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound. 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. [6]	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 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 State as the Remainder Beneficiary (Sec. 6012(b))*** ▪ The 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

[6] 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).

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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. ▪ Provides that the purchase of an annuity will 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. ▪ Provisions apply to transactions, including the purchase of annuity, occurring on or after the date of enactment. *(Federal savings - $277 million over five years; $697 million over ten years)*
Application of "Income First" Rule in Applying Community Spouses Income Before Assets in Providing Support of Community Spouse (Sec. 6013)	▪ 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, the 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. ▪ 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	▪ Codifies the "income first" methodology. ▪ Effective upon enactment. *(Federal savings - $88 million over five years; $188 million over ten years)*

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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, 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 allowance (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	

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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 when 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	

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	care for the institutionalized spouse. This method generally allows the community-spouse to retain a larger amount of assets than the income-first method.	
Disqualification for Long Term Care Assistance for Individuals with Substantial Home Equity (Sec. 6014)	▪ Under current law, the value of an individual's home[7] is not included in the determination of Medicaid eligibility.	▪ Excludes 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. Permits a state to 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, 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. ▪ Applies 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. *(Federal savings - $298 million over five years; $878 million over ten years)*

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7 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 related 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
Enforcement of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts (Sec. 6015)	▪ No provision.	▪ Provides that contracts for admission to a state licensed, registered, certified, or equivalent continuing care retirement community or life care community, including a nursing facility that is part of the community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance. ▪ Provides that for determining eligibility for Medicaid nursing facility services, an individual's entrance fee in a continuing care community will be considered a resource available to the individual to the extent that: (1) 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 be insufficient to pay for care; (2) the individual is eligible for a refund of any remaining entrance fee when the individual dies, terminates the CCRC contract, or leaves the community; and (3) the entrance fee does not confer an ownership interest in the CCRC. ▪ To the extent the entrance fee is determined to be an available resource to an individual applying for medical assistance, and the individual has a community spouse, the entrance fee will be considered in the computation of the spousal share. *(Federal savings - $78 million over five years; $208 million over ten years)*
Requirement to Impose Partial Months of Ineligibility (Sec. 6016 (a))	▪ 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)[8]	▪ Amends current law by prohibiting states from rounding down, or otherwise disregarding any fractional period of

[8] 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, 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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."[9] ▪ 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.[10] 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.[11]	ineligibility when determining the ineligibility period. *(Federal savings - $181 million over five years; $476 million over ten years. Includes all of Sec. 6016)*
Authority for States to Accumulate Multiple Transfers into One Penalty (Sec. 6016 (b))	▪ 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,	▪ Amends current law by providing 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

9 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.

10 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.

11 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 31day month), other states may round down the quotient to an ineligibility period of 12 months only.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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.	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 the penalty periods on the earliest date which would apply to the transfers.
Inclusion of Transfer of Certain Notes and Loans Assets (Sec. 6016 (c))	▪ 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	▪ Amends current law to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. ▪ These 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. ▪ In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value must be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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. ▪ 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.	
Inclusion of Transfers to Purchase Life Estates (Sec. 6016 (d))	▪ 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.[12]	▪ Amends current law 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.
LONG TERM CARE REFORMS /HOME AND COMMUNITY BASED CARE		
State Long Term Care Partnerships (Sec. 6021)	▪ The program is a joint Medicaid/private long-term care insurance venture designed to encourage individuals to purchase long term care insurance and to save both state and federal government's money by substituting private insurance for Medicaid. Under the program, once private insurance benefits are exhausted, special Medicaid eligibility rules are applied if additional coverage is necessary. ▪ The Omnibus Reconciliation Act (OBRA) of 1993 contained language with both indirect and direct impact on the expansion of partnership programs. Indirectly, the Act provides further incentives for persons to purchase private insurance for long-term care by closing several loopholes in the Medicaid eligibility process (transfer of asset provisions).	***General Provisions*** ▪ Amends the Medicaid statute to reinstate the Long Term Care Partnership program to permit new states to enter into the partnership program and imposes additional requirements on those states with approved programs. ▪ For existing state partnership programs, the consumer protection standards for private long-term care policies (including a certificate issued under a group insurance contract) may not be less stringent than the standards that were in effect under the state's plan as of December 31, 2005. ▪ For state partnership programs approved after May 14, 1993 (essentially all new programs), individuals may be exempt

[12] 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	▪ The Act also makes specific mention of Partnership programs. The language indirectly recognized the four initial states now in operation plus a future program in Iowa and a modified program in Massachusetts. These states were allowed to operate their partnerships as planned, because they had a HHS approved state plan amendment before May 14, 1993. ▪ States obtaining a state plan amendment after this date were permitted to proceed with partnership programs, however, they would be required to recover from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the partnership is in effect only while the insured is alive. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets. As a result, only the four grandfathered states (California, Connecticut, Indiana and New York) continued their programs.	from estate recovery procedures if the state program provides for the disregard of any assets in an amount equal to the private long-term care insurance benefits paid on behalf of the individual. ▪ Under the program, private long-term care policies and partnership programs must meet the following requirements: (1) the covered individual is a resident of the state when private coverage begins; (2) the policy meets IRS requirements; (3) the policy meets NAIC model LTC insurance act and regulations (adopted October 2000);[13] (4) the policy provides compound inflation protection for purchasers under age 61, some level of inflation protection for purchasers between age 61 and 75, and may provide some inflation protection for purchasers age 76 and older; (5) the state Medicaid agency provides technical assistance related to the training of individuals selling these policies; (6) the issuer of the policy reports to the Secretary the amount of benefits paid, and when the policy terminates; and (7) the state applies any requirements affecting the terms or benefits of these policies to all long-term care policies sold in the state. ***Reporting Requirements*** ▪ Directs the HHS Secretary, in consultation with other appropriate governmental agencies, the NAIC, and consumer representatives, to develop recommendations to Congress to fund a uniform minimum data set to be supplied electronically by all policy issuers qualified for a partnership

[13] The NAIC model LTC insurance act provisions that apply include: (a) preexisting conditions; (b) outline of coverage; (c) prior hospitalization; (d) certification under group plans; (e) contingent nonforfeiture benefits; (f) policy summary; (g) right of return; and (h) monthly reports on accelerated death benefits. The NAIC model LTC insurance regulation provisions that apply include: (a) guaranteed renewal/noncancellability; (b) prohibitions on limitations/exclusions; (c) extension of benefits; (d) continuation or conversion of coverage; (e) discontinuation/replacement of policies; (f) unintentional lapse; (g) disclosure; (h)required disclosure of rating practices to consumers; (i) prohibition of post-claims underwriting; (j) minimum standards; (k) application forms and replacement coverage; (l) reporting requirements; (m) filing requirements for marketing; (n) standards for marketing (including inaccurate completion of medical histories); (o) prohibition of preexisting conditions/probationary periods in replacement policies; (p) contingent nonforfeiture for those who decline offer of nonforfeiture protection; (q) appropriateness of recommended purchase; (r) standard format outline of coverage; and (s) delivery of shopper's guide. If the state insurance commissioner certifies that the LTC insurance policies offered in a partnership program meet the above requirements, the policies will be deemed to meet the applicable requirements of the NAIC model act and regulation.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		program and to be maintained in a secure, centralized data bank that is accessible to states, HHS, and other federal agencies. ***Changes to the NAIC Model Act or Regulation*** ▪ When the NAIC adopts changes to the model act or regulation, the HHS Secretary is directed to determine whether or not the changes should be incorporated into the requirements for policies available in partnership programs, within one year of any change issued by the NAIC. ***State Plan Amendments*** ▪ A state plan amendment may be made effective in a state no earlier than the first day of the calendar quarter in which the amendment is submitted to the Secretary. ***Portability*** ▪ To ensure portability of LTC insurance policies purchased under a partnership program, the Secretary will develop (in consultation with the NAIC, states, and consumer representatives) standards for uniform reciprocal recognition of such policies in states with qualified partnership programs by January 1, 2007. ▪ States with partnership programs will be subject to meeting these standards unless the state elects to be exempt. ***Reports*** ▪ Requires the Secretary to report to Congress annually on the partnership program and its impact on access to long-term care and on federal and state Medicare and Medicaid expenditures. ***National Clearinghouse for Long-Term Care Information*** ▪ Directs the HHS Secretary to establish a National Clearinghouse for Long-term Care Information by contract or interagency agreement. The Clearinghouse will provide education on Medicaid long-term care benefits and eligibility

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		requirements, objective information regarding the purchase of long-term care insurance, contact information on objective counseling services to assist in planning for long-term care needs, and a list of states with approved partnership programs. ▪ Prohibits the Clearinghouse from recommending a specific long-term care insurance product or provider. *(Federal costs - $26 million over five years; $86 million over ten years)*
Expanded Access to Home and Community-Based Services for the Elderly and the Disabled (Sec. 6086)	▪ Medicaid home and community-based service (HCBS) waivers 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.	***General Provisions*** ▪ Establishes home and community-based services as an optional Medicaid benefit for certain individuals with incomes at or below 150% of the federal poverty level. ▪ Permits the state to provide this option to individuals *without* determining that but for the provision of the services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR. ▪ The scope of services may include any services permitted under the Home and Community Based (HCB) waiver which the Secretary has the authority to approve, and but would not include an individual's room and board. ▪ 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	▪ 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).	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 that level of care. ***State Requirements*** ▪ 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 services the individual will receive. ▪ Requires states to 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. ▪ Requires the state 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. ***Needs-Based Criteria*** ▪ 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		risk factors determined to be appropriate by the state. ▪ Permits states 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 was in effect prior to the application of more stringent criteria. ***Independent Evaluation and Assessment*** ▪ Requires states 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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 the option is covered by the state. ▪ The independent evaluation is to establish a written individualized plan of care. The plan must be developed to, 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; (1) to take into account the extent, and the need for, any family or other supports for the individual; (2) to identify the HCBS services to be provided (or purchase, if the individual elects to self-direct his/her care); (3) to be reviewed at least annually or as needed when there is a significant change in circumstances. ▪ Requires the state to 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 Medicaid plan. ***Self-Directed Option*** ▪ Permits states to allow individuals (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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		services and supports under the control and direction of the individual or his or her representative. ▪ Requires states to provide information in the state plan amendment about how an individualized budget is developed and implemented and to ensure that the provision of home and community-based services meets federal and state guidelines for quality assurance. ***Development of Program Performance Measures*** ▪ Requires the Secretary acting through the Director of the Agency for Healthcare Research and Quality (AHRQ), 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. ▪ Requires the Secretary 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 HCBS under Medicaid. ▪ Requires the Secretary to make best practices and comparative analyses of system features available to the public. ***Effective Date*** ▪ Effective January 1, 2007. *(Federal costs - $766 million over five years; $2.6 billion over ten years)*
Cash and Counseling (Sec. 6087)	▪ 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, while other services may be offered through a home and community-based services (HCBS) waiver.	▪ Allows 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	▪ 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.	services under a HCBS waiver. ▪ Provides that 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. ***State Assurances*** ▪ The HHS 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. ▪ 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. ▪ Requires the state to 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. ▪ Requires the state 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		Exemptions from Current Law Requirements ▪ Permits a state to provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness, and to limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability. ***Definition of Self-Directed Care*** ▪ 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 the 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. ***Service Plan and Service Budget*** ▪ 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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, friends, 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. ***Application of Quality Assurance and Risk Management*** ▪ 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. ***Financial Management*** ▪ 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%, though certain activities may be eligible for 75% reimbursement). ***Effective Date***

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		▪ Applies to services furnished on or after January 1, 2007. *(Federal costs - $100 million over five years; $360 million over ten years)*
ELIMINATING FRAUD, WASTE AND ABUSE		
Encouraging the Enactment of State False Claims Acts (Sec. 6032)	▪ Under the federal False Claims Act, anyone who knowingly submits a false claim (whether directly or indirectly) 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 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 to the provider. ▪ Currently 15 states and the District of Columbia have state false claims acts.[14]	***In General*** ▪ Provides that if a state has in effect a law relating to false or fraudulent claims that meets certain requirements, the federal medical assistance percentage (FMAP), with respect to any amounts recovered under a state action brought under such a law, will be decreased by 10 percentage points. ▪ The state law relating to false and fraudulent claims must be determined by the HHS Inspector General, 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, and (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act. ***Effective Date*** ▪ Effective January 1, 2007. *(Federal costs - $25 million over five years; $334 million over ten years)*
Employee Education about False Claims Recovery (Sec. 6033)	▪ No provision.	***In General*** ▪ Requires a state to provide that any entity that receives annual Medicaid payments of at least $5 million, as a condition of receiving the payments, must: (1) establish written policies,

[14] The following states have state false claims acts: California, Delaware, Florida, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Michigan, New Hampshire, New Mexico, Nevada, Tennessee, Texas, and Virginia. The laws in Louisiana, Tennessee and Texas apply only to Medicaid. The website for Taxpayers Against Fraud (http://www.taf.org/statefca.htm) provides additional information about state False Claims Acts, including legislative citations and text.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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, and (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. ***Effective Date*** ▪ Effective January 1, 2007, except that in the case 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. *(Federal costs - $7 million over five years/$70 million over ten years)*
Prohibition on Restocking and Double Billing Prescription Drugs (Sec. 6033)	▪ The practice, referred to as "restocking," occurs when a pharmacy resells drugs returned by hospitals or nursing homes. The medications often were for patients who had died and for whom the state had already been billed. The restocked drugs are then re-dispensed and Medicaid is billed a second time.[15]	▪ Prohibits federal matching payments for the ingredient costs of a covered outpatient drug claim if the claim has already been submitted and for which the pharmacy has already received payment. ▪ Effective on the first day of the first fiscal quarter beginning

[15] In the case U.S. ex rel. Quinn v. Omnicare, Inc., 382 F. 3d 432 (3rd Cir. 2004), the Third Circuit held that the Medicaid statute does not explicitly prevent pharmacists from billing the Medicaid program twice for selling the same drugs.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		after enactment. *(Federal savings between $0 -$500, 000 over five years; federal savings between $0 -$500, 000 over ten years)*
Medicaid Integrity Program (Sec. 6034)	▪ 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 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.	***Establishes a Medicaid Integrity Program.*** ▪ Directs the HHS Inspector General to 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 furnished or for administrative services rendered, (2) audit of claims for payment for items or services furnished or for administrative services rendered, and (3) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues. ▪ Beginning in FY 2006 and every five years thereafter, 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 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 $5 million in FY 2006, $50 million in FY 2007 and in FY 2008, and $75 million in FY 2009 and in each fiscal year thereafter. Amounts appropriated remain available until expended. ▪ Requires the Secretary, no later than 180 days after the end of each fiscal year (beginning with FY 2006), to submit a report to Congress that identifies the use and effectiveness of the use of funds appropriated for the program. ***State Requirement to Cooperate with Integrity Program Efforts*** ▪ Requires states to comply with any requirements determined

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		by the Secretary to be necessary for carrying out the Medicaid Integrity Program. ***Increased Funding for Medicaid Fraud and Abuse Control Activities*** ▪ In each of FY 2006 - FY 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). ***Increase in CMS Staffing Devoted to Ensuring Medicaid Program Integrity.*** ▪ Directs the Secretary to significantly increase the number of full-time equivalent employees whose duties consist solely of ensuring the integrity of the Medicaid program by providing states with support and assistance to combat provider fraud and abuse. ***Expansion of the Medicare-Medicaid Date Match Program (Medi-Medi Program).*** ▪ Establishes a national expansion of the Medicare- Medicaid data match project. ▪ Requires the HHS Secretary to 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 HHS Secretary is required to make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of HHS, and the states. ▪ In addition to Health Care Fraud and Abuse Control (HCFAC) program appropriations for the Medicare Integrity Program (which have a statutory floor and ceiling), the Medi-Medi Program would receive $12 million in FY 2006, $24 million in FY 2007, $36 million in FY 2008, $48 million in FY 2009, and $60 million in FY 2010 and in each fiscal year thereafter. ***Delayed Effective Date*** ▪ In the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance with the Medicaid state plan requirements of this chapter, the plan 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 this act. *(Federal costs - $528 million over five years/$1.2 billion over ten years)*
Enhancing Third Party Recovery (Sec. 6035)	▪ 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. ▪ 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	***Clarification of Right of Recovery Against Any Third Party Legally Responsible for Payment of a Claim for a Health Care Item or Service*** ▪ Amends the list of third parties 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. ▪ Also amends the law 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. ***Requirement for Third Parties to Provide the State with***

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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.	***Coverage Eligibility and Claims Data*** ▪ Requires states to provide assurances, satisfactory to the Secretary, 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. ***Effective Date*** ▪ Effective January 1, 2006 (except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance). *(Federal savings - $570 million over five years/$1.7 billion over ten years)*
Certification of Citizenship or Nationality (Sec. 6036)	▪ 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, nonimmigrants 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	▪ Prohibits states from receiving federal reimbursement for medical assistance provided under Medicaid to an individual who has not provided satisfactory documentary evidence of citizenship or nationality. ▪ Satisfactory evidence of citizenship includes: (1) a United States passport; (2) Form N-550 or N-570 (Certificate of Naturalization); (3) Form N-560 or N-561 (Certificate of United States Citizenship); (4) a state-issued driver's license or other identity document described in the Immigration and Nationality Act as satisfactory evidence, but only if the state issuing the license or the document requires proof of U.S.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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, states are required 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 HHS Secretary. States receive 100% federal reimbursement for the operation of these systems.	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; and (5) any 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 I-97 (United States Citizen Identification Card); ▪ Form FS-240 (Report of Birth Abroad of a Citizen of the United States); or ▪ 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 immigrant who is: (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		the basis of receiving Supplemental Security Income benefits, or (3) eligible for Medicaid on specified by the Secretary under which satisfactory documentary evidence of citizenship or nationality had been previously presented. ▪ Applies to eligibility determinations for medical assistance made on or after July 1, 2006 and to redeterminations made on or after that date in the case of individuals who were not previously asked to present documents. *(Federal savings - $220 million over five years; $735 million over ten years)*
FLEXIBILITY IN COST-SHARING AND BENEFITS		
Cost-Sharing Flexibility (Sec. 6041)	▪ Federal statute limits the amount of co-payments that can be charged. In most cases, co-payments up to $3 can be imposed for prescription drugs, physician visits, and outpatient hospital visits. However, certain categories of beneficiaries, such as children under 18, pregnant women, and the institutionalized cannot be charged co-payments. Co-pays are also prohibited for some services, including hospice care, emergency care, and family planning services and supplies.	***Modifies current law cost-sharing provisions*** ▪ Allows states to impose premiums and cost-sharing through Medicaid state plan amendments, rather than waivers. ▪ For individuals in families with incomes between 100% and 150% of FPL, premiums are not permitted, and cost-sharing would be allowed, but capped at 5% of total family income on a quarterly or monthly basis, as specified by the state; and cost-sharing for any item or service cannot exceed 10% of the cost of the item or service. ▪ For individuals in families with incomes above 150% of FPL, cost-sharing and premiums would be allowed, but capped at 5% of family income, on a quarterly or monthly basis as specified by the state; and cost-sharing for any item or service cannot exceed 20% of the cost of the item or service. ***Exemptions (Premiums)*** ▪ No premiums can be imposed on: (1) children under age 18 and children, regardless of age receiving adoption assistance or foster care assistance; (2) pregnant women; (3) individuals receiving hospice care; (4) any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, if the individual is required, as a condition of receiving assistance, to spend for costs of medical care all but a minimal amount of their income

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		required for personal needs. ***Exemptions (Cost-Sharing)*** ▪ No cost-sharing can be imposed: (1) on children under age 18 and children, regardless of age receiving adoption assistance or foster care assistance; (2) for preventive services provided to children under age 18, regardless of family income; (3) services furnished to pregnant women, if the services are pregnancy-related or related to other medical conditions that may complicate the pregnancy; (4) services provided to individuals receiving hospice care; (4) services provided to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, if the individual is required, as a condition of receiving assistance, to spend for costs of medical care all but a minimal amount of their income required for personal needs; (5) emergency services; and (6) family planning services and supplies. ***Exemption (Cost-Sharing, Premium Requirements and Benefit Package Flexibility)*** ▪ Exempts women who qualify for Medicaid under the breast or cervical cancer eligibility group, and children in foster care who receive child welfare services. ***Enforceability of Premium and Cost-Sharing Requirements*** ▪ Permits states to condition the provision of medical assistance upon prepayment of a premium. States may waive this provision for some or all groups of beneficiaries and may waive premium payments in cases where the payments would be an undue hardship. ▪ Permits states to permit a participating provider to deny services to a beneficiary who fails to pay cost-sharing. Participating providers may reduce or waive the co-payment requirements. ▪ Provides that these provisions do not prevent states from further limiting cost-sharing, affect the authority of the HHS

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		Secretary to waive limits on premiums or cost-sharing, or affect waivers in effect prior to the date of enactment of this Act. ***Indexing Cost-Sharing Amounts*** ▪ Directs the HHS Secretary to increase nominal cost-sharing (regular items and services, prescription drug services, and non-emergency care provided in an emergency room) amounts annually, beginning in 2006, using the medical consumer price index (CPI). The previous law nominal cost-sharing amounts were established in 1982. ***Studies*** ▪ Directs the GAO to conduct a study of the impact of cost-sharing and premiums on access and utilization of services and to report to Congress no later than January 1, 2008. ***Effective Date*** ▪ Applies to cost-sharing imposed for items and services furnished on or after March 31, 2006. *($960 million over five years/$4.4 billion over ten years)*
Special Rules for Cost-Sharing for Prescription Drugs (Sec. 6042)	▪ 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.	▪ Allows states to impose cost-sharing amounts that exceed the proposed state option limits for certain state-identified non-preferred drugs if the cost sharing plan meets certain characteristics. ▪ Under this option, states may: (a) impose higher cost-sharing amounts for non-preferred drugs within a class; (b) waive or reduce the cost-sharing otherwise applicable for preferred drugs within a class; and (c) must not apply cost-sharing for preferred drugs to persons exempt from cost-sharing. ▪ Cost-sharing for non-preferred drugs may not exceed: (1) nominal amounts for individuals in families with income below or equal to 150% FPL, and (2) 20% of the cost of the drug for individuals in families with income above 150% FPL.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		▪ Applies to cost-sharing imposed for items and services furnished on or after March 31, 2006. *($960 million over five years/$5.4 billion over ten years)*
Emergency Room Copayments for Non-emergency Care (Sec. 6043)	▪ No provision.	▪ Allows states, through a state plan amendment, to impose increased cost-sharing on state-specified groups for non-emergency services[16] provided in an emergency room (ER), when certain conditions are met. First, alternative non-emergency providers[17] must be available and accessible to the person seeking care. Second, after initial screening but before the non-emergency care is provided at the ER, the beneficiary must be told: (1) the hospital can require a higher 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% 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 Act may be subject to nominal co-payments 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.

16 "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).

17 Defines an "Alternative non-emergency services provider" as 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 can provides clinically appropriate services for such diagnosis or treatment of a condition contemporaneously with the provision of non-emergency services that would be provided in an emergency department of a hospital for the diagnosis and treatment of a condition.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		▪ Aggregate caps on cost-sharing established under other sections of this Act apply. ▪ These provisions of this section 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. *Note: A provision that would have provided that 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 and that liabilities related to the provision of care (or failure to do so) would not be affected by these provisions, was removed by the Senate during consideration of the Conference Report. A point of order was raised under the "Byrd Rule.".* ***Grant Funds for Establishment of Alternate Non-Emergency Services Providers*** ▪ Requires the HHS Secretary to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. ▪ Authorizes and appropriates $100 million to pay providers for the 4-year period beginning with 2006. ▪ Requires the HHS Secretary 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. ***Effective Date***

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		▪ Applies to non-emergency services furnished on or after January 1, 2007. *(Federal savings - $10 million over five years/$140 million over ten years)*
Benefit Package Flexibility (Sec. 6044)	▪ Limited flexibility available through the waiver process.	▪ Allows states to provide medical assistance through enrollment that provides benchmark coverage or benchmark equivalent coverage.[18] ▪ Permits a state to provide wraparound benefits or additional benefits. ***State Option to Provide Benchmark Benefit Packages*** ▪ 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; (3) health coverage offered by the largest commercial HMO; and (4) Secretary-approved coverage. ***Exemptions*** ▪ Excludes certain individuals from the definition of a full-benefit eligible, including (1) the medically needy (MN); (2) categorically needy 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). ▪ Provides that certain groups be exempted from this option,

[18] A qualifying child is a child under age 18 with a family income below 133% of the federal poverty level.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		including: (1) mandatory pregnant women; (2) blind or disabled individuals;[19] (3) dual eligibles; (4) terminally ill hospice patients; (5) individuals eligible on the basis of institutionalization; (6) the medically frail and individuals with special needs; (7) beneficiaries qualifying for long-term care services; (8) children in foster care receiving child welfare and or adoption assistance services; ; (9) individuals who qualify for Medicaid on the basis of receiving assistance under TANF (as in effect on or after the welfare reform effective date); (10) women in the breast and cervical cancer eligibility group; and (11) 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. ***Benchmark Equivalent Coverage*** ▪ 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% 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. ***Substantial Actuarial Value for Additional Services Included in the Benchmark Package***

[19] Includes 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).

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		▪ Permits states to provide coverage with an actuarial value equal to 75 percent of the actuarial value of the coverage for: (1) prescription drugs; (2) mental health services; (3) vision services; and (4) hearing services. ***Coverage of Rural Health Clinics and FQHCs*** ▪ Individuals must have access to services provided by rural health clinics and FQHCs. ***Limitation*** ▪ Provides that states may only exercise the options under this section for eligibility categories established before the date of enactment. ***Effective Date*** ▪ Effective March 31, 2006. *(Federal savings - $1.3 billion over five years/$6.1 billion over ten years)*
STATE FINANCING		
Medicaid Managed Care Organization Provider Tax Reform (Sec. 6051)	▪ Until 1991, when the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) was enacted, states were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to drawn down Federal Medicaid dollars were then returned to the provider, in effect, holding them harmless for the tax they originally paid. ▪ The 1991 law restricted the use of health care provider related taxes, After 1991, state taxes on health care providers were required to: (1) be imposed on a permissible class of health care services; (2) be broad based or apply to all providers within a class; (3) be uniform, such that all providers within a class must be taxed at the same rate; and (4) avoid hold harmless arrangements in which collected taxes are returned	▪ Expands the Medicaid managed care organization (MCO) provider class to include all MCOs. ▪ Amends current law to provide that managed care organizations (MCOs) are treated the same as other classes of health care providers with respect to provider tax uniformity requirements. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. ▪ 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.[20]

20 The following states enacted a provider tax on Medicaid managed care organizations (MCOs) prior to December 8, 2005: California, Georgia, Michigan, Missouri, Ohio, Oregon and Pennsylvania.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	to the taxpayers directly or indirectly. ▪ The law permits the HHS Secretary to approve broad based (and uniformity) waiver applications if the net impact of the tax is generally redistributive and that the amount of the tax is not directly correlated to Medicaid payments. The hold harmless requirements cannot be waived. ▪ Current law, defines Medicaid managed care organizations as a separate class of health care services, which permits states, to impose taxes solely on Medicaid.	*(Federal savings - $435 over five years/$2.9 billion over ten years)*
Targeted Case Management (Sec. 6052)	▪ Targeted 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. ▪ Under current Medicaid law, targeted case management (TCM) is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. ▪ 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	▪ Defines the Medicaid TCM benefit, and codifies 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

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[21] 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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. ▪ 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. [21]	activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs. ▪ Provides that the TCM benefit would *not* include the direct delivery of an underlying medical, educational, social or other service to which an eligible individual has been referred. ▪ Provides that 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. ▪ Specifies 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. ▪ Effective January 1, 2006. *(Federal savings - $760 over five years/$2.1 billion over ten years. Actual Medicaid savings are $1.1 billion over five years, but the Congressional Budget Office (CBO) estimate assumes $350 million in costs shifting to foster care, making the net savings $760 million over five years)*
Federal Matching Payments	▪ P.L. 106-554 (Consolidated Appropriations Act of 2001),	▪ Provides that for FY 2006 and FY 2007, if the Alaska FMAP

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
Adjustment for Alaska (Sec. 6053 (a))	provided that for fiscal years 2001 through 2005, the FMAP for Alaska would be calculated using the Alaska per capita personal income divided by 1.05, instead of the Alaska per capita personal income. Dividing the per capita personal income by 1.05 lowers the per capita personal income and serves to increase the FMAP.	calculated under the formula is less than the FY 2005 Alaska FMAP (57.58), then the Alaska FMAP for that fiscal year would be 57.58 (the fiscal year 2005 Alaska FMAP). *(Federal costs - $125 million over five years/$125 million over ten years)*
Holdharmless for Katrina Impact (Sec. 6053 (b))	▪ 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% and maximum of 83%.	▪ Authorizes the HHS Secretary to **for purposes of computing Medicaid and SCHIP federal matching rates (FMAPs)** for any year after 2006 for a state that the Secretary 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, **to disregard the evacuees and their incomes**.
DSH Allotment for the District of Columbia (Sec. 6054)	▪ Each state's DSH allotments for FY 1998 – FY 2002 are set in statute.	▪ Raises the allotments for the District of Columbia for FY 2000, FY 2001, and FY 2002 from $32 million to $49 million. ▪ 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. ▪ Effective upon enactment and is retroactive to allotments beginning in FY 2000. *(Federal costs - $100 million over five years/$209 million over ten years)*
Increase in Medicaid Payments to Certain Insular Areas (Sec. 6055)	▪ 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.	▪ For each of fiscal years 2006 and 2007, increases the total annual cap on federal funding for the Medicaid programs in Puerto Rico ($12 million in each of FY 2006 and FY 2007); the U.S. Virgin Islands ($2.5 million in FY 2006; $5 million

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	▪ 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).[22] ▪ The federal Medicaid matching rate, which determines the share of Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent for the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories **up to the spending caps**.	in FY 2007), Guam ($2.5 million in FY 2006 and $5 million in FY 2007), the Northern Marianas ($1 million in FY 2006; $2 million in FY 2007) , and American Samoa ($$2 million in FY 2006; $4 million in FY 2007). ▪ For fiscal year 2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in each of the jurisdictions will be calculated by increasing the FY 2007 ceiling, as modified by this provision, by the percentage change in the medical care component of the Consumer Price Index for all Urban Consumers (CPI-U). *(Federal costs - $140 million over five years/$323 million over ten years)*
Medicaid Transformation Grants (Sec. 6081)	▪ No provision.	▪ Authorizes the HHS Secretary to provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance. ▪ Permissible uses of funds 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, (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

22 The Consumer Price Index (CPI) is a measure of the change in prices paid over time for a fixed market basket of goods and services. The Consumer Price Index for All Urban Consumers (CPI-U) measures the percentage change in prices faced by urban consumers and covers approximately 87 percent of the population.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		use of generics; and (6) methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital clinic systems ▪ Payment to a state would be conditioned on the state submitting to the Secretary an annual report on the programs supported by the grant. 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 $75 million in each of FY 2007 and FY 2008. The Secretary would specify a method for allocating the funds among states, that would provide preference for states that design programs that target health providers treating significant numbers of Medicaid beneficiaries. The method would also allocate at least 25% of the funds among states whose populations as of July 1, 2004 were more than 105% of their populations as of April 1, 2000. *(Federal costs - $150 million over five years/$150 million over ten years)*
Medicaid Health Opportunity Accounts (Sec. 6082)	▪ No provision.	***General Provisions*** ▪ Incorporates key components of health savings accounts (HSAs), authorized in the Medicare Modernization Act (MMA), into a new Medicaid demonstration pilot. Under the pilot, states could allow participating beneficiaries to self-direct a pre-funded account for medical care, roll over unspent balances, and retain a portion of account funds after leaving Medicaid to spend on medical care, health insurance, job training and tuition expenses. ▪ Effective January 1, 2007, authorizes the HHS Secretary to approve up to 10 state demonstration programs covering one or more geographic areas specified by the state. The programs would be approved for a 5-year period. ▪ After the initial 5-year period, unless the Secretary finds,

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		taking into account cost-effectiveness, quality of care, and other criteria established by the Secretary, that a state demonstration programs has been unsuccessful, the program may be extended or made permanent in the state. In addition, unless the Secretary finds that a state demonstration program was unsuccessful, other states may implement the program. ***Health Opportunity Accounts (HOAs)*** ▪ 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. ▪ 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. ▪ 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%, but no more than 110%, 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. ▪ 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		the coverage deductible did not apply, or from any other provider or managed care organization at payment rates not exceeding 125% of the Medicaid provider payment rates. ▪ 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. ***Health Opportunity Accounts (HOAs) - Eligibility*** ▪ 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%. ▪ 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. ▪ Establishes a one-year moratorium for reenrollment, whereby eligible individuals disenrolled from the state demonstration programs are not permitted to reenroll for a full year from the individual's disenrollment date. ***Studies*** ▪ Requires the Comptroller General of the Unites States to submit an evaluation of the demonstration programs to Congress, no later than 3 months prior to the end of the initial 5-year test period. *(Federal costs - $56 million over five years/$261 million over ten years)*

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
State Option to Establish Non-Emergency Medical Transportation Broker Program (Sec. 6083)	▪ 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 varies by state and ranges from 50% to 83%. 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. These costs are reimbursed by the federal government at 50%, and fewer federal requirements must be met.	▪ Allows 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 is not required to be statewide. ▪ 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. ▪ Requires the HHS Office of the Inspector General (OIG) of to submit a report to Congress examining the non-emergency medical transportation brokerage program implemented under this provision no later than January 1, 2007. Requires the report to include findings regarding conflicts of interest and improper utilization of transportation services under this program, as well as recommendations for improvements. ▪ Effective upon enactment. *(Federal savings - $55 million over five years/$235 million over ten years)*
Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program (Sec. 6084)	***Transitional Medical Assistance (TMA)*** ▪ 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	▪ Extends TMA through December 31, 2006. ▪ Extends the $50 million annual appropriation for the abstinence education block grant program through fiscal year

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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. 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). The authorization for TMA has been extended a number of times, because it is part of long-pending welfare reform legislation, most recently through December 31, 2005. ***Abstinence Education*** ▪ 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.	2006 and provides an additional $12.5 million for the program for the first quarter of fiscal year 2007. *(Federal costs - $761 million over five years/$762 million over ten years)*
Emergency Services Furnished by	▪ Medicaid law provides certain protections for beneficiaries	▪ A Medicaid provider that does not have a contract with a

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
Non-Contract Providers for Medicaid Managed Care Enrollees (Sec. 6085)	enrolled in managed care, including assuring coverage of emergency services under each managed care contract awarded by the state.	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 fee-for-service rate is the maximum payment rate. ▪ Provides that 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. ▪ Effective January 1, 2007. *(Federal savings - $50 million over five years/$130 million over ten years)*
FAMILY OPPORTUNITY ACT PROVISIONS		
State Option to Allow Families of Disabled Children to Purchase Medicaid Coverage (Sec. 6062)	▪ For disabled children, there are several potentially applicable Medicaid eligibility groups, some mandatory but most optional. Some of these children could qualify for Medicaid through more than one pathway in any given state. There are four primary coverage groups for which disability status or medical need is directly related to eligibility. ▪ Subject to one important exception, states are required to cover all children receiving Supplemental Security Income (SSI). Because SSI is a federal program, income and	▪ Establishes a new optional eligibility group for certain children with disabilities. In general, the new group would include children up to 18 who meet the disability definition for children under the SSI program, and whose family income is above the financial standards for SSI but not more than 300% of the federal poverty level (FPL). ▪ States would be permitted to exceed 300% FPL, but federal financial participation would not be available above that level. Medicaid coverage would be phased in depending on a

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23 The "209(b)" states are: Connecticut; Hawaii; Illinois; Indiana; Minnesota; Missouri; New Hampshire; North Dakota; Ohio, Oklahoma; and Virginia.

24 For example, states are required to provide Medicaid coverage to children under age 6 (and pregnant women) in families with incomes below 133 % of the federal poverty level (FPL), and in FY 2002, for children between ages 6 and 18 in families with income below 100 % of FPL. States may cover infants under age one (and pregnant women) in families with income between 133% and 185 % of FPL. Similarly, under the State Children's Health Insurance Program (SCHIP), states may extend Medicaid (or provide other health insurance) to certain children under age 19 who are not otherwise eligible for Medicaid in families with income that is above the applicable Medicaid standard but less than 200 % of FPL, or in states that already exceed the 200 % of FPL level for Medicaid children, within 50 %age points over that existing level.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	resource standards do not vary by state. In determining financial eligibility, parents' income is deemed available to non-institutionalized children (but the need of household members is taken into account). If family income is higher than the SSI threshold, the child will not qualify for SSI or Medicaid. ▪ The major exception to the required coverage under Medicaid of SSI recipients occurs in so called "209(b)" states.[23] These states can apply more restrictive income and resources standards and/or methodologies in determining Medicaid eligibility than the standards applicable under SSI. States that offer State Supplemental Payments (SSP) may also offer Medicaid coverage to SSP recipients who would be eligible for SSI, except that their income is too high. ▪ States may offer medically needy coverage under Medicaid. The medically needy are persons who fall into one of the other categories of eligibility (e.g., is a dependent child) but whose income exceeds applicable financial standards. Income standards for the medically needy can be no higher than 133 percent of the state's former Aid to Families with Dependent Children (AFDC) payment standard in effect on July 16, 1996. Individuals can meet these financial criteria by having income that falls below the medically needy standard, or by incurring medical expenses that when subtracted from income, result in an amount that is lower than the medically needy income standard. Resource standards correspond to those applicable under SSI. Older children or those with very large medical expenses may qualify for medically needy coverage. ▪ States may extend Medicaid to certain disabled children under 18 who are living at home and who would be eligible for Medicaid via the SSI pathway if they were in a hospital, nursing facility, or intermediate care facility for the mentally retarded, as long as the cost of care at home is no more than	child's age, beginning with qualifying children with disabilities up to age 6 beginning January 1, 2008; up to age 12 in FY 2009, and up to age 18 in FY 2010 thereafter. ▪ Applies to medical assistance for items and services furnished on or after January 1, 2008. *(Federal costs - $1.4 billion over five years/$6.4 billion over ten years, inclusive of all of Sec. 6062)*

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	institutional care. (This group is also called the **Katie Beckett** category.) The law allows states to consider only the child's income and resources when determining eligibility for this group. That is, states may ignore parents' income. ▪ States have an option to cover persons needing home and community based services, if these persons would otherwise require institutional care covered by Medicaid. These services are provided under Medicaid waiver programs. Unlike the Katie Beckett option, which requires all disabled children within a state to be covered, these programs may be limited to specific geographic areas, and/or may target specific disabled groups and/or specific individuals within a group. States may apply institutional deeming rules which allow them to ignore parents' income in determining a child's eligibility for waiver services. ▪ Disabled children can also qualify for Medicaid via other eligibility pathways for which disability status and medical need are irrelevant.[24]	
Interaction with Employer-Sponsored Family Coverage (Sec. 6062)	▪ States may require Medicaid eligibles to apply for coverage in certain employer-sponsored group health plans[25] (in which such persons are eligible) when it is cost-effective[26] 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. However,	▪ When certain conditions, described below, are met, states must require parents of children eligible for the newly defined coverage group to enroll in employer-sponsored family coverage. ▪ Requires states to require participation in employer sponsored family coverage, as a condition of continuing Medicaid eligibility for the child, when the employer of a parent offers family coverage under a group health plan, the parent is eligible for the coverage, and the employer contributes at least 50% of the annual premium costs.

25 "Group health plan" means a plan of (or contributed to by) an employer or employee organization to provide health care (directly or otherwise) for employees and their families.

26 "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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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.	▪ If 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 may pay any portion of a required premium for family coverage under an employer-sponsored plan; for families with income that does not exceed 300% FPL, the federal government would share in the cost of these payments. These employer-sponsored plans, not Medicaid, must pay for all covered services under the plan, as is the case with all other third party liability situations. ▪ This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.
State Option to Impose Income-Related Premiums (Sec. 6062)	▪ Generally, for certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. Further, states are specifically prohibited from requiring payment of deductions, cost-sharing or similar charges for services furnished to persons under 18 years of age (up to age 21, or any reasonable subcategory of such persons between 18 and 21 years of age, at state option). ▪ In certain circumstances, states may impose monthly premiums for enrollment in Medicaid. For example, states may require certain working individuals with disabilities (who but for earnings would be eligible for SSI) to pay premiums and other cost-sharing charges set on a sliding scale based on income. For one of these eligibility groups, states may require persons with income between 250% to 450% FPL to pay the full premium. However, the sum of such payments may not exceed 7.5% 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 can also waive premiums when such payments would	▪ Amends current law to permit states to require families with children with disabilities who would be eligible for Medicaid under the new optional eligibility group to pay monthly premiums for enrollment in Medicaid on a sliding scale, based on family income. ▪ This premium requirement could *only* be applied 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 may not exceed 5% of income for families with income up to 200% FPL, and may not exceed 7.5% for families with income between 200% and 300% FPL. (*Note: under Title XXI of the Social Security Act states have the option to impose certain cost sharing provisions, but these provisions may not exceed 5% of a family's yearly income.*) ▪ Prohibits states from requiring prepayment of premiums and from terminating eligibility of an enrolled child for failure to pay premiums, unless lack of payment continues for a minimum of 60 days beyond the payment due date. States may waive payment of premiums when payment would cause

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	cause undue hardship.	undue hardship. ▪ The provision would not change current law with respect to other cost-sharing by beneficiaries (e.g., deductibles, co-insurance, co-payments) which is not permitted for children under 18 years of age. ▪ This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.
Conforming Amendments (Sec. 6062)	▪ n/a	▪ This provision permits the income level for the new optional coverage group (set at 300% FPL) to exceed the otherwise applicable AFDC-related income standard for children under Medicaid. ▪ It 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 SCHIP E-FMAP would apply for determining the federal share of Medicaid expenditures for the new optional coverage group. ▪ In additional, federal payments would be drawn from the open-ended Medicaid account and not the capped SCHIP account. ▪ This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.
Demonstration Projects Regarding Home and Community-Based Alternative to Psychiatric Residential Treatment Facilities for Children (Sec. 6063)	▪ Medicaid home and community-based service (HCBS) waivers give states the flexibility 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-MRs).	▪ Authorizes the Secretary, during the period from FY 2007 - FY2011, to conduct demonstration projects in up to 10 states 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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. [27]	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 FY 2007-FY2011 for the state demonstration projects and the federal

[27] 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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. *(Federal costs - $36 million over five years/$110 million over ten years)*
Family-to-Family Health Information Centers (Sec. 6064)	▪ 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	▪ Increases funding under the Maternal and Child (MCH) Health Block Grant for the development and support of new family-to-family health information centers. ▪ Authorizes additional appropriations of $3 million for FY 2007, $4 million for FY 2008, and $5 million for each of FY 2009, FY 2010 and FY 2011 for this new 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	centers awarding up to $2.4 million to six projects for a four-year period starting in FY2006.	▪ 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. ▪ Requires the Secretary to develop family-to-family health information centers in at least 25 states in FY 2007, 40 states in FY 2008, and all states in FY 2009. *(Federal costs - $11 million over five years/$11 million over ten years)*
Restoration of Medicaid Eligibility for Certain SSI Children (Sec. 6065)	▪ States are required to provide Medicaid benefits to elderly individuals and certain persons with disabilities who receive Supplemental Security Income (SSI). (Under the 209(b) provision, states may apply more restrictive income and resources standards and/or methodologies for determining Medicaid eligibility than the standards under SSI.) ▪ For disability purposes, two groups of disabled children exist: those under the age of 18 and those age 18 through 21 (if a full time student). ▪ Eligibility for SSI is effective on the later of: (1) the first day of the month following the date the application was filed, or (2) the first day of the month following the date that the individual was determined eligible.	▪ Confers 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. ▪ Applies to medical assistance for items and services furnished on or after the date that is one year after the date of enactment. *(Federal costs - $105 million over five years/$315 million over ten years)*
Money Follows the Person Rebalancing Demonstration (Sec. 6071)	▪ 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)).	***General Provisions*** ▪ Authorizes 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% 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. ▪ Authorizes the Secretary to waive certain sections of Medicaid law to achieve the purpose of the demonstration. ▪ In a given fiscal year, funding would be capped at the amount

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	▪ 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 ICFMR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.	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. ***Eligibility*** ▪ Individuals will be eligible to participate in the demonstration if they meet the following criteria: (1) 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); and (2) 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. [28] ***State Requirements*** ▪ 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 77 the project, which must be for at least two consecutive fiscal years in a five-year period starting 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

[28] 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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; and (10) assurance that the state will continue services for participants after the demonstration ends, as long as the state offers the services and the individual remains eligible. ▪ The duration of the project must be for at least two consecutive fiscal years in a five-year period starting in FY 2007. ▪ 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. ▪ 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

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		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. ***Enhanced Matching Rate*** ▪ 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% of the difference between 100% and the normal FMAP rate. However, in no case can the FMAP rate exceed 90% 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. ***Technical Assistance*** ▪ Requires the Secretary to provide technical assistance and oversight to state grantees and permits the Secretary 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 through September 30, 2011. ***Evaluation*** ▪ Requires the Secretary to conduct a national evaluation and report its findings to the President and Congress no later than September 30, 2011 and permits the Secretary to use up to $1.1 million each year from FY 2008 through FY 2011 to carry out these activities. ***Appropriations, Funding and Carryover Funding*** ▪ Appropriates $250 million for the portion of FY 2007 which begins on January 1, 2007, and ends on September 30, 2007;

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		$300 million in FY 2008; $350 million in FY 2009; $400 million in FY 2010; and $450 million in FY 2011 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2011. ▪ 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. ▪ 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. *(Federal costs - $340 million over five years/$2 billion over ten years)*
STATE CHILDREN'S HEALTH INSURANCE		
Additional Allotments to Eliminate FY 2006 Funding Shortfalls (Sec. 6101 (a))	▪ 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),	▪ Authorizes and appropriates $283 million for the purpose of providing additional SCHIP allotments to shortfall states in FY 2006 (see footnote for detail).[29] ▪ From the additional SCHIP appropriation, each FY 2006 shortfall state will receive an allotment to cover its projected shortfall or, if the appropriated funds are inadequate to cover the FY 2006 projected shortfalls, the Secretary must distribute the available funds on a pro rata basis based on each such state's estimated shortfall.

[29] Shortfall states are defined 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. According to Federal Funds Information for States (FFIS) in *Issue Brief 06-03: Possible SCHIP Shortfalls; Territorial Medicaid Ceilings*, January 9, 2006, the following jurisdictions are likely to have 2006 shortfalls: Illinois, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, North Dakota, Rhode Island, South Dakota, Puerto Rico, the U.S. Virgin Islands and the other territories.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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 Balanced Budget Act of 1997 (BBA '97). Under current law, unspent original allotments from FY 2003 forward are to be redistributed according to the original BBA '97 methodology. That is, redistributed funds will go only to those states that spend all of their original allotments by the applicable three-year deadline, with the redistributed amounts determined by the Secretary of HHS and made available for one year only.	▪ The additional SCHIP allotments are available for one year only must be made on behalf of targeted low-income children. ▪ On October 1, 2006, any remaining unspent additional allotments will not be subject to redistribution, but will instead revert to the Treasury. ▪ Applies 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 Childless Adults (Sec. 6102)	▪ Section 1115 of the Social Security Act provides the Secretary of Health and Human Services (HHS) with broad authority to conduct research and demonstration projects under six programs, including Medicaid and SCHIP. Under Section 1115 authority, the Secretary may waive certain statutory requirements for conducting these projects. ▪ 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. ▪ Under the Bush Administration, a new Health Insurance Flexibility and Accountability (HIFA) Initiative was implemented using 1115 waiver authority for both Medicaid and SCHIP. The goals of this initiative are to encourage new approaches that will increase the number of individuals with health insurance coverage within current program resources, with a particular emphasis on broad statewide strategies that	▪ Limits the authority of the HHS Secretary to approve Section 1115 waivers that allow federal SCHIP funds to be used to provide assistance to childless adults (provides an exception for pregnant women). ▪ The provision would allow the Secretary to continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible, and to pregnant adults. ▪ Provides 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. ▪ Effective upon the enactment.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	maximize private health insurance coverage options and target individuals with income below 200% of the federal poverty level.	
Continued Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures (Sec. 6103)	▪ For specific Medicaid expenditures occurring after August 15, 2003, current law permits certain states to receive the federal SCHIP matching rate for the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). ▪ 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% 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 state receives for these children. The maximum amount that qualifying states may claim under this allowance is the lesser of the following two amounts: (1) 20% of the state's available FY 1998 through FY 2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY 2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% spending. ▪ Qualifying states include those that on or after April 15, 1997, had an income eligibility standard for children (other than infants) of at least 184% of the FPL. (Other qualifications apply to states with statewide waivers under Section 1115 of the Social Security Act.) ▪ Under current law, no 20% spending will be permitted in FY 2006 or any fiscal year thereafter.	▪ The provision would continue the authority for qualifying states[30] to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the provision would allow qualifying states to use any available FY 2004 and FY 2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds, as the case may be) for Medicaid services made on or after October 1, 2005 under the 20% allowance. ▪ Effective on or after October 1, 2005.
HURRICANE KATRINA ASSISTANCE		
Holdharmless for Katrina Impact	▪ The federal medical assistance percentage (FMAP) is the rate	▪ Authorizes the HHS Secretary to **for purposes of computing**

30 Qualifying states are: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
(Sec. 6053 (b))	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% and maximum of 83%.	**Medicaid and SCHIP federal matching rates (FMAPs)** for any year after 2006 for a state that the Secretary 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, **to disregard the evacuees and their incomes**.
Targeted Medicaid Relief for States Affected by Hurricane Katrina Subtitle C (Sec. 6201)	▪ 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 multi-state 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	▪ 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: (1) 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; (2) reasonable administrative costs related to such projects; (3) the non-federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP state plans; and (4) other purposes, if approved by the Secretary, to restore access to health care in impacted communities. ▪ The non-federal share paid to eligible states will 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.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
	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.	
STATE HIGH RISK POOLS		
Funding for State High Risk Pools (Sec. 6202)	▪ 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.	▪ Appropriates, for FY 2006, $75 million for the losses incurred by a state in connection with the operation of their qualified high risk pool. ▪ Appropriates $15 million in FY 2006 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.
LOW INCOME HOME ENERGY ASSISTANCE (LIHEAP)		
Supplemental Funding for the Low Income Home Energy Assistance Program (Sec. 9001)	▪ LIHEAP is a federally-funded program to help eligible low income households meet their home **heating** and/or **cooling** needs.	▪ Appropriates to the HHS Secretary of Health and Human Services a onetime only expenditure of $1 billion for FY 2007. The provision will sunset after September 30, 2007.
SUPPLEMENTAL SECURITY INCOME		

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
Social Security Administration Initial State Disability Review (Sec. 7501)	▪ Under current law, the Administrator of the Social Security Administration (SSA) is required to review 65 percent of favorable disability determinations for the Social Security Disability Insurance (SSDI) program. ▪ These "pre-effectuation reviews" apply to favorable decisions on initial claims, reconsiderations, and continuing disability investigations.	▪ Extends the SSDI requirement to the SSI program. ▪ Requires the SSA Commissioner to review 20 percent of the specified favorable decisions in FY 2006; 40 percent in FY 2007 and 50 percent in FY 2008 and thereafter. ▪ Directs the SSA Commissioner to review determinations that are likely to be incorrect, to the extent possible. *(Federal savings for SSI - $93 million over five years/$425 million over ten years; federal savings for Medicaid - $194 million over five years/$1 billion over ten years)*
Pay SSI Lump Sum Payments in Installments (Sec. 7502)	▪ When a beneficiary is due a past due payment and the amount of the payment, less any reimbursement to a state for interim assistance and attorney fees is greater than the product of 12 times the maximum monthly benefit payable to an individual, or if applicable, an individual and spouse, the payment must be made in not more than three installments made at six month intervals.[31]	▪ Requires the lump sum payments to be paid over three monthly installments. *(Federal saving for SSI - $425 million over five years/$540 million over ten years)*
MEDICAL CHILD SUPPORT ENFORCEMENT		
Mandatory Three-Year Update of Child Support Orders (Sec. 7302)	▪ Most states perform a full review of child support orders, and the remainder apply a COLA. No state currently makes automated adjustments. ▪	▪ Requires states to adjust child support orders of families on TANF every three years. States could use one of three methods to adjust orders: full review and adjustment, cost-of-living adjustment (COLA), or automated adjustment. Under current law, nearly half of the states perform periodic adjustments. ▪ The provision would take effect on October 1, 2007, and CBO estimates that it would reduce direct spending by $20 million over the 2008-2010 period and by $105 million over the 2008-2015 period. ▪ Although it would require additional spending for administrative costs, this provision would produce more

[31] This provision does not apply when a beneficiary is determined to have an impairment likely to result in death within 12 months, or in cases in which a person is not currently eligible for benefits and is not likely to become eligible for benefits in the next 12 months.

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
		income from child support collections and reduce spending for the Food Stamp and Medicaid programs. CBO estimates that there are 700,000 TANF recipients with child support orders in states that do not periodically adjust orders and that one-third of those orders would be adjusted each year. We assume that half of the states not already adjusting orders would choose to perform full reviews and half would apply a COLA. When a state performs a full review of a child support order, it obtains current financial information from the custodial and noncustodial parents and determines whether any adjustment in the amount of ordered child support is indicated. The state also may revise an order to require the noncustodial parent to provide health insurance. Children who receive TANF benefits are generally eligible for Medicaid, so any new health insurance requirements would reduce spending for that program. When a state makes a cost-of-living adjustment, it applies a percentage increase reflecting the rise in the cost of living to every order, regardless of how the financial circumstances of the individuals may have changed. When there are COLA adjustments, no additional health insurance coverage is required. CBO expects any increased collections for a family would continue for up to three years. While a family remains on TANF, the state would keep all the increased collections to reimburse itself and the federal government for welfare payments. The states would pay any increased collections stemming from reviews of child support orders to families once they leave assistance. That additional child support income for former recipients would result in savings in the Food Stamp program. Overall, CBO expects the federal share of administrative costs for child support to rise by $42 million and federal collections to increase by $39 million over the 2008-2010 period. Food Stamp and Medicaid savings would total $5 million and $18 million, respectively, over that period. *(Federal savings -*
Requirement to Seek Medical Support from Either Parent (Sec.	▪ Currently, about half the states explore both parents' ability to	▪ Requires all states to look to either parent or both parents to

ISSUE	CURRENT LAW	CONFERENCE AGREEMENT
7307)	provide health insurance when setting a child support order.	provide health insurance for their child. ▪ The policy would apply to child support orders that are issued or amended after enactment, so it would take effect gradually. (Federal Medicaid savings of $57 million over 10 years)[32]

32 Based on national survey data, CBO expects that the policy would result in additional private health insurance coverage for children and that, without that coverage, some of those children would receive Medicaid benefits. CBO estimates that private health coverage would be provided to nearly 200 children who would otherwise receive Medicaid benefits in 2006. That number would grow to more than 9,000 by 2015. Based on spending per child in the Medicaid program, CBO estimates that implementing this provision would reduce costs in the Medicaid program by an insignificant amount in 2006 and by $57 million over the 2006-2015 period.

MEDICARE SUBTITLE A – PROVISIONS RELATED TO MEDICARE PART A		
Hospital Quality Improvement (Sec. 5001)	▪ Operating payments to hospitals are increased each year based on the projected annual change in the hospital market basket (MB). ▪ Through FY 2007, the inpatient prospective payment system (IPPS) operating update under current law is the full MB rate for hospitals that submit specific quality information and is the MB rate minus 0.4 percentage points for hospitals that do not provide the information. ▪ The required data are the ten quality indicators established by the Secretary as of November 1, 2003. ▪ Beginning in FY 2008, the IPPS update will be the full hospital MB rate. ▪ A MB reduction in a year does not carry forward when computing the applicable percentage increase in subsequent years. 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. Certain secondary diagnoses are considered to be complications or comorbidities (CC) that increase the DRG weight and the resulting payment when present. Currently, no distinction is made concerning whether the secondary diagnosis was present at the time of admission or developed subsequently.	▪ Provides that hospitals that do not submit the required data in FY 2007 and each subsequent year will have the applicable MB percentage increase reduced by two percentage points. Any reduction applies only to the fiscal year in question and does not affect subsequent fiscal years. ▪ Requires the Secretary to expand the number of quality indicators required to be reported by acute care hospitals. ▪ Provides that beginning October 1, 2006 the Secretary must 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 (MMA). ▪ Directs the Secretary, beginning October 1, 2007, to 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. ▪ Permits the Secretary to vary and replace any measures in appropriate cases. ▪ Requires the Secretary 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. ▪ Requires the Secretary to report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to inpatient services on the CMS website. ▪ Requires the Secretary to develop a plan to implement a value-based purchasing program for IPPS payments to acute care hospitals beginning with FY 2009. The Secretary is required to consult with relevant affected parties and consider

		experience with applicable demonstration programs. ▪ Requires hospitals, starting for discharges on October 1, 2007, to report any secondary diagnosis codes applicable to patients at the time of admission. By October 1, 2007, the Secretary is required to identify diagnosis codes associated with at least 2 high cost or high volume conditions (or both high cost and high volume). Selected diagnosis codes are ones for which the DRG assignment has a higher payment weight when the diagnosis is present as a secondary diagnosis. These diagnosis codes also are to be ones that represent conditions, including certain hospital acquired infections, which reasonably could have been prevented through the application of evidence-based guidelines. ▪ Starting with discharges on or after October 1, 2008, the DRG assigned to a discharge with one of the identified diagnosis codes will be the DRG that does not result in higher payments based on the presence of these secondary diagnosis codes unless the diagnosis code was present at the time of the patient's admission. Changes in aggregate payments that occur because of this provision are not budget neutral and such changes also are not considered in adjusting the relative DRG weights. ▪ 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. ▪ Requires the Secretary to consult with the Centers for Disease Control and Prevention (CDC) and other appropriate entities when selecting and revising the identified diagnosis codes. The list of diagnosis codes and DRGs is not subject to judicial review. *(Federal savings - $300 million over five years; $800 million over ten years)*
Clarification of Determination of Medicaid Patient Days for DSH Computation (Sec. 5002)	▪ Hospitals that serve a high percentage of low income Medicare and Medicaid beneficiaries receive a disproportionate share hospital (DSH) adjustment that	▪ 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.

	increases their Medicare IPPS payments. The adjustment is based on a hospital's low-income patient percentage, which is defined in statute as the proportion of the hospital's total inpatient 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.) ▪ 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 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 revised for discharges 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.	These days will be counted as if they were provided to patients who were eligible for medical assistance under an approved Medicaid state plan. The existing regulations and their effective date are ratified. ▪ No hospital cost reports that are closed as of the enactment date will be reopened to implement this provision. *(Federal savings - $1.2 billion over five years/$3 billion over ten years)*
Improvements to Medicare-Dependent Hospital (MDH) Program (Sec. 5003)	▪ Certain rural hospitals with 100 beds or less that have at least 60% of its inpatient days or discharges during FY 1987 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 the national standardized rate or, if higher, 50% 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	▪ Extends the Medicare Dependent Hospital (MDH) program, which was created to provide financial protections to certain rural hospitals with less than 100 beds that have a greater than 60 percent share of Medicare patients, through October 1, 2011. ▪ Allows hospitals the option to use 2002 base year costs, in addition to base year costs from 1982 or 1987. ▪ Improves the blended payment rate by raising it from 50 percent to 75 percent of the difference between prospective payment system (PPS) payments and cost-based payments. ▪ Removes the 12 percent disproportionate share hospital

	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.	(DSH) payment cap for qualifying hospitals. *(Federal costs - $0 -$100 million over five years/$0 -$100 million over ten years)*
Reduction in Payments to Skilled Nursing Facilities (Sec. 5004)	▪ Medicare pays for the costs of certain items outside of the Prospective Payment System on a reasonable costs basis. Under current law, 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% of this bad debt. ▪ Skilled Nursing Facilities (SNFs) are among the Medicare entities that are currently being reimbursed for 100% of beneficiary's bad debt. ▪ Effective beginning with cost reports starting in FY2001, Medicare began reimbursing hospitals for 70% of the reasonable costs associated with beneficiaries' bad debt. [33]	▪ Amends current law to reduce the payment for the allowable bad debt attributable to Medicare deductibles and coinsurance amounts from 100% to 70% for services furnished in SNFs on or after October 1, 2005. ▪ Retains bad debt payments at 100% for dual eligibles, individuals eligible for both Medicare and Medicaid. *(Federal savings - $100 million over five years/$300 million over ten years)*
Extended Phase-In of the Inpatient Rehabilitation Facility Classification Criteria (Sec. 5005)	▪ 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.	▪ Sets implementation of the "75% rule," which is a criteria used to determine whether a hospital or unit qualifies as an inpatient rehabilitation facility (IRF). Changes the transition period for the compliance threshold (as established in the 2004 rule) as follows: at 60% from July 1, 2006 and before July 1, 2007; at 65% from July 1, 2007 and before July 1,

[33] 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%. 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.

	▪ The Medicare statute gives the Secretary of Health and Human Services (the Secretary) discretion to establish the criteria that facilities must meet in order to be considered an IRF. ▪ Recently issued regulations (May 7, 2004) by the Centers for Medicare and Medicaid Services (CMS) require that a facility treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. CMS adopted a transition period for the compliance threshold as follows: at 50% from July 1, 2004 and before July 1, 2005; at 60% from July 1, 2005 and before July 1, 2006; at 65 % from July 1, 2006 and before July 1, 2007; and at 75% from July 1, 2007 and thereafter.[34]	2008; at 75 % on July 1, 2008 and thereafter. *(Federal costs -$100 million over five years/$100 million over ten years)*
Development of a Strategic Plan Regarding Investment in Specialty Hospitals (Sec. 5006)	▪ 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 Medicare Modernization Act (MMA) established that the exception for self-referral and physician investment in the whole hospital would not extend to specialty hospitals[35] for a period of months from enactment (or until June 8, 2005).	▪ Directs the Secretary to develop a strategic and implementing plan to address issues regarding physician investment in specialty hospitals. ▪ Requires the Secretary to submit an interim report to the appropriate congressional committee, no later than three months after enactment, regarding the status of the development of the strategic and implementing plan. ▪ Requires the Secretary to make a final report to Congress no later than six months after enactment. The final report is to be accompanied by legislation and administrative initiatives the Secretary deems appropriate. ▪ Permits the Secretary to waive provisions of the Administrative Procedure Act the Secretary deems necessary to develop the plan and the required report.

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34 The rule, Medicare Program; Final Rule; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility, was published in the *Federal Register* on May 7, 2004 (*69 Fed.Reg. 25752)*.

35 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 and which meets certain specified requirements, such as requiring the same number of physician investors, the same categories of services, and a limitation in the growth of beds as of November 18, 2003.

		▪ Appropriates $2 million in FY 2006 for the Secretary to carry out the provisions of this section. ***Continuation of Suspension on Enrollment*** ▪ Extends the suspension on enrollment of new specialty hospitals to the earlier of: (a) the date the Secretary submits the final report; or (b) six months after the date of enactment. ***Extension of Suspension*** ▪ If the Secretary fails to submit the final report by the date specified in this Act, the Secretary must: (a) extend the suspension on enrollment for two additional months; and (b) provide a certification to the appropriate congressional committee regarding the failure to submit the required report. *(Federal costs - $0 -$100 million over five years/$0 -$100 million over ten years)*
Medicare Demonstration Projects to Permit Gain Sharing Arrangements (Sec. 5007)	▪ The Medicare inpatient prospective payment system (IPPS) for acute care inpatient hospital services generally pays hospitals a flat amount for each discharge, which creates strong incentives for facilities to contain costs in order to live within that amount. On the other hand, Medicare generally pays physicians a separate fee for each service, which creates no incentives for cost containment. ▪ Since the inception of PPS, hospitals have sought ways to realign these incentives. One approach is something called "gain sharing."[36] ▪ Until recently legal barriers made it very difficult to pursue such a strategy	▪ Directs the Secretary to establish a gain sharing demonstration program 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 quality and efficiency of care provided to Medicare beneficiaries." ▪ In addition, the demonstration projects are designed to improve financial and operational performance by sharing some of the hospital cost savings with the physicians. ▪ Directs the Secretary to solicit applications 90 days after enactment and to approve six gain sharing demonstration projects by November 1, 2006, two of which will be located in rural areas. (A project may be an individual hospital.) ▪ The projects will meet certain requirements to maintain or improve quality while achieving cost savings. The requirements include arrangements that allow hospitals to

[36] Gain sharing is an arrangement under which a hospital shares with physicians any cost savings achieved through their participation in a program designed to contain hospital costs.

		distribute a share of program savings to physicians, a written plan agreement outlining the project, 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. The projects are to be operational by January 1, 2007. ***Reports*** ▪ Requires the Secretary to report to Congress on the number of demonstration projects by December 1, 2006. ▪ Requires the Secretary to provide a project update to Congress including improvements toward quality and efficiency no later than December 1, 2007. ▪ Directs the Secretary to report to Congress on quality improvement and savings from the program by December 1, 2008. ▪ Directs the Secretary to submit a final report to Congress by May 1, 2010. *(Federal costs/savings - $0 -$100 million over five years/$0 -$100 million over ten years) -*
Post-Acute Care Payment Reform Demonstration Program (Sec. 5008)	▪ No provision.	▪ Directs the Secretary to establish a demonstration program to better understand costs and outcomes across different post-acute care sites by January 1, 2008. ▪ Under the program, for certain diagnoses specified by the Secretary, an individual receiving treatment for those diagnoses will receive a comprehensive assessment on the date of discharge from a hospital providing acute care inpatient hospital services and paid under the prospective payment system. The assessment will include clinical characteristics and patient needs to determine appropriate placement of the patient in a post-acute care site. ▪ Directs the Secretary to 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 will provide information on the fixed and variable cost for each individual and an additional comprehensive assessment will 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. ▪ Directs the Secretary to transfer $6 million from the Hospital Insurance Trust Fund to carry out the demonstration. ▪ Requires the Secretary to submit a report to Congress on results and recommendations no later than 6 months after the end of the program. *(Federal costs -*
SUBTITLE B – PROVISIONS RELATING TO MEDICARE PART B		
Transfer of Title of Certain DME to Patient After 13-Month Rental (Sec. 5101)	▪ Medicare Part B pays for certain items of durable medical equipment such as hospital beds, and non-customized wheelchairs under the capped rental category. Under this category, most items 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 the equipment effective thirteen months after the start of the rental period. If they choose the purchase option, Medicare continues to make rental payments for three additional rental months and then title to the equipment is transferred to beneficiaries after thirteen months of use. ▪ If the purchase option is not chosen, ownership of the equipment is retained by the supplier. Beneficiaries can continue to use the equipment, Medicare rental payments to the supplier will continue for up to five additional rental	▪ For durable medical equipment in the capped rental category, after a 13 month rental period, the supplier would transfer the title for the item to the beneficiary. ▪ Sets payments for capped rental items at 10 percent of the purchase price for each of the first three months and at 7.5 percent for the remaining months. ▪ Payments to suppliers for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) would be made if the Secretary determines they are reasonable and necessary. The Secretary would also determine the amount of payments for maintenance and servicing. ▪ This amendment would apply to items for which the first rental month occurs on or after January 1, 2006. ***Purchase Agreement Option for Power-Driven Wheelchairs***

	months, and cease after that. ▪ Rental cap payments are subject to beneficiary 20% coinsurance. ▪ 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 depending on whether the beneficiary has purchased the equipment or whether it continues to be owned by the supplier. ▪ In the case of purchased equipment, payment for necessary servicing and maintenance 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 the equipment was actually serviced by the supplier.	▪ Requires the supplier to offer the individual the option to purchase the wheelchair at the time the supplier furnishes it. Provides that the payment be made in a lump sum if the individual exercises the purchase option. ▪ Payments to suppliers for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) would be made if the Secretary determines they are reasonable and necessary. The Secretary would also determine the amount of payments for maintenance and servicing. ***Rental of Oxygen Equipment*** ▪ Limits Medicare payments for the rental of oxygen equipment to 36 months. Requires the supplier to transfer title to the equipment after the 36th month. Limits Medicare payments for maintenance and servicing to reasonable and necessary services. ▪ Effective January 1, 2006. For beneficiaries who are currently renting equipment, applies 36 months after January 1, 2006. *(Federal savings - $700 million over five years/$1.9 billion over ten years)*
Adjustments in Payment for Imaging Services (Sec. 5102)	▪ Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns higher values when a service is provided in the physician's office than when the same service is provided in a hospital or other facility (to account for the fact that the physician's own equipment and staff are involved in providing the service in the office setting). The relative values are then converted into a dollar conversion payment amount by a conversion factor. The conversion factor for 2005 is $37.8975. ▪ In a final rule published November 21, 2005 (70 FR 701116), CMS adopted a policy providing reduced payments for certain multiple imaging services, imaging services performed on contiguous body parts. This was done on a budget neutral basis; in other words, projected savings were offset by upward adjustments in practice expense values for	▪ For Medicare physician fee schedules beginning with 2007, projected savings from the multiple imaging payment reduction will be exempt from the budget-neutrality calculation; the savings will be retained by the Medicare program. ▪ Effective January 1, 2007, 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, will be subject to new payment caps. Payment for the technical component of these services (including the technical component of global fees) will be limited to the amount that would be paid for them under Medicare's outpatient hospital prospective

	physicians' services other than the imaging services subject to the multiple imaging payment reduction policy. ▪ Medicare has a separate prospective payment system for hospital outpatient services, under which services are categorized into ambulatory patient classification (APC) groups, with each APC assigned a set of relative values, which are in turn based on hospital claims and cost report data. These relative values are adjusted for geographic differences in hospital wages using the inpatient hospital wage index, and a conversion factor is applied to determine payment. For 2005, this conversion factor is $56.983. Numerous exceptions, adjustments, and other special policies also govern the payment of certain services provided in the hospital outpatient setting.	payment system. *(Federal savings - $2.8 billion over five years/$8.1 billion over ten years)*
Limitation on Payments for Procedures in Ambulatory Surgical Centers (Sec. 5103)	▪ Medicare has separate payment systems for ambulatory surgical centers (ASCs) and hospital outpatient departments. These payment systems were developed using different data and there are many differences in the two systems.	▪ Effective January 1, 2007, Medicare payment for ASC services will be capped at the amount that would be paid for these services under Medicare's hospital outpatient prospective payment system. *(Federal savings - $300 million over five years/$800 million over ten years)*
Minimum Update for Physician Services for 2006 (Sec. 5104)	▪ Physician services update is scheduled to be reduced by 4.4 percent effective January 1, 2006.[37]	▪ Increases payments to 2005 level effective upon enactment. *(Federal cost - $7.3 billion over five years; Federal savings - $400 million over ten years)*
Three-Year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals (Sec. 5105)	▪ 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 Medicare Prescription Drug Improvement, and Modernization Act of	▪ Extends the hold harmless provisions governing OPD reimbursement for small rural hospitals and rural sole community hospitals (SCH) to January 1, 2007. *(Federal costs - $100 million over five years/$100 million over ten years)*

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37 Physician payment updates are determined using the Sustainable Growth Rate (SGR) formula, which is based on four factors: (1) Medicare Economic Index (MEI); (2) Number of beneficiaries in Fee-For-Service Medicare; (3) Expenditures due to changes in law or regulations; and (4) Growth in real GDP per capita. Actual spending has been higher than spending projected by the SGR formula, which will result in negative updates for the next six years. Eliminating the SGR formula and adjusting payments for inflation would cost $154.5 billion over 10 years.

	2003 (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.	
Update the Composite Rate Component of the Basic Care-Mix Adjusted PPS for Dialysis Services (Sec. 5106)	▪ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. ▪ The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports. ▪ The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.	▪ Increases the composite rate component of the basic case-mix adjusted system by 1.6% for services beginning January 1, 2006. *(Federal costs - $500 million over five years; $1.3 billion over ten years. The Congressional Budget Office (CBO) assumes Medicare will make payment adjustments retroactively for services furnished prior to enactment)*
One-Year Extension of Moratorium on Therapy Caps (Sec. 5107)	▪ In 1997, the BBA created a financial cap on the amount of money Medicare could spend per beneficiary for outpatient therapy services. ▪ Two caps were set at $1,500 indexed to the Medicare Economic Index (MEI); one for physical therapy and speech language therapy, the other for occupational therapy. ▪ Since 1999, Congress has twice enacted a moratorium on implementation of the therapy caps. The moratorium is set to expire in 2006.	▪ Extends the moratorium for an additional year, through 2006. ▪ Directs CMS to improve coding to reduce inappropriate payments for therapy services. *(Federal costs - $500 million over five years/$500 million over ten years)*
Accelerated Implementation of Income-Related Reduction in Part B Premium Subsidy (Sec. 5111)	▪ Under provisions of the MMA, Medicare beneficiaries with incomes over $80,000 for an individual or $160,000 for a married couple will be subject to higher monthly Part B	▪ The higher Part B premiums for higher income beneficiaries will be phased in more rapidly, over a 3-year period (2007-

	premiums beginning in 2007. Income thresholds will be adjusted for inflation annually after 2007. The higher premiums are phased in over a 5-year period. By 2011, depending on their income, higher income beneficiaries will pay premiums ranging from 35 to 80 percent of Part B costs (rather than the 25 percent paid by others).	2009). *(Federal savings - $1.6 billion over five years/$1.6 billion over ten years)*
Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms; National Educational and Information Campaign (Sec. 5112)	▪ No provision.	▪ Provides for Medicare coverage of ultrasound screening for abdominal aortic aneurysms. Eliminates the requirement to meet the annual Part B deductible. ▪ Establishes a national educational and information campaign. ▪ Effective for services furnished on or after January 1, 2007. *(Federal costs - $200 million over five years/$1.3 billion over ten years)*
Improving Patient Access to and Utilization of Colorectal Cancer Screening Under Medicare (Sec. 5113)	▪ Current law covers: (1) Fecal Occult Blood Test - Once every 12 months; (2) Flexible Sigmoidoscopy - Once every 48 months; and (3) Screening Colonoscopy - Once every 24 months (if individual is "high risk") or once every 10 years, but not within 48 months of a screening sigmoidoscopy (if individual is not at high risk). Also provides that a physician can decide to use a barium enema instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if the individual is at high risk for colorectal cancer and every 48 months if the individuals is not at high risk. ▪ The beneficiary pays nothing for the fecal occult blood test. For all other tests, the beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible. If the flexible sigmoidoscopy or colonoscopy is done in a hospital outpatient department, the individual pays 25% of the Medicare-approved amount after the yearly Part B deductible.	▪ Provides for an enhanced Part B payment for colorectal cancer screening and diagnostic tests. Effective for services furnished on or after January 1, 2007. ▪ Provides for coverage of an outpatient office visit or consultation for the beneficiary education, prior to a colorectal cancer screening test. Eliminates the requirement to meet the annual Part B deductible. Effective for services furnished on or after January 1, 2007. *(Federal costs - $0 -$100 million over five years/$0 -$100 million over ten years)*
Delivery of Services at Federally Qualified Health Centers (FQHC) (Sec. 5114)	▪ 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). ▪ According to statute, a FQHC is required to provide certain	▪ Allows FQHCs to provide diabetes outpatient self-management training services and medical nutrition therapy services provided by a registered dietician or nutrition professional. ▪ Modifies the definition of FQHC services so that only the

	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. ▪ 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's 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.	primary preventative services required under provision of the Public Health Service Act pertaining to Health Centers, would be retained. ▪ The services would include those furnished to an outpatient of a FQHC that are provided by the center by a health care professional under contract with the center. ▪ Services furnished by a health care professional who is under contract with a FQHC would also be excluded from SNF consolidated billing. Payment for these services would be made directly to the FQHC. ▪ Allows FQHCs to be eligible for Health Care for the Homeless grants. *(Federal costs - $0 -$100 million over five years/$100 million over ten years)*
Waiver of Part B Late Enrollment Penalty for Certain International Volunteers (Sec. 5115)	▪ Medicare Part B is a voluntary program. People generally enroll in Part B when they turn 65. Persons 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% 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 permitted when an individual 65 or over has group health insurance coverage based on the individual's or spouse's current employment (with an employer with 20 or more employees). Delayed enrollment is also permitted for certain disabled persons. These are persons who have group health insurance coverage based on their own or a family member's current employment with a large group health plan. ▪ A large group health plan is one which covers 100 or more	▪ Permits individuals who volunteered outside of the United States through a 12-month or longer program sponsored by tax-exempt organization to delay enrollment in Part B without delayed enrollment penalty. ▪ They would have a special Part B enrollment period which would be the 6 month period beginning on the first day of the month the individual returned to the United States. Coverage would begin the month after the individual enrolled. ▪ This section would take effect 180 days after enactment. *(Federal costs - $0 -$100 million over five years/$100 million over ten years)*

	employees. 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.	
SUBTITLE C – PROVISIONS RELATING TO PARTS A AND B		
Home Health Payments (Sec. 5201)	▪ Payment rates under the home health prospective payment system are updated annually based on the projected change in the home health market basket (HHMB), with statutorily specified reductions applicable in some years. ▪ For the last three quarters of 2004 and all of 2005-2006, the home health update is the HHMB minus 0.8 percentage points. In 2007 and subsequent years, the payment update is the full HHMB. ▪ The MMA provided for a one-year additional payment of 5% for home health services furnished in rural areas. The additional payment was applicable for the period April 1, 2004 through March 31, 2005 and is excluded from the base used to determine future years' payments. It also was not budget neutral. ▪	▪ Update for 2006 is eliminated, freezing payments at the 2005 level for one year. ▪ The 5% add-on for home health services provided in a rural area is reinstated for one year, CY 2006. In 2007 and subsequent years, a home health agency that does not submit quality data specified by the Secretary would receive an update of HHMB minus two percentage points. Reductions apply only in one year and are not cumulative. ▪ Directs the Secretary to develop procedures for sharing quality data with the public. ▪ Directs MedPAC is to report to Congress by June 1, 2007 on a value-based purchasing program for home health services. *(Federal savings - $2 billion over five years/$5.7 billion over ten years. The Congressional Budget Office (CBO) assumes the payment reduction will not be imposed retroactively))*
Revision of Period for Providing Payment for Claims that are not Submitted Electronically (Sec. 5202)	▪ Since July 1, 2005, most providers have been required to submit claims electronically to Medicare. ▪ Exceptions include: (1) small providers with fewer than 25 full-time equivalent employees (FTEs) and physicians, practitioners or suppliers with fewer than 10 FTEs; (2) dentists; and (3) other providers specified by CMS. Medicare contractors must pay 95% of all "clean" paper claims within 27-30 days of receipt.	▪ In an effort to encourage electronic transmissions, directs Medicare contractors to delay the payment of claims that are not submitted electronically. ▪ Requires contractors to pay 95% of all "clean" paper claims within 29- 30 days of receipt. *(Federal savings - $100 million over five years/$100 million over ten years)*
Timeframe for Part A and B Payments (Sec. 5203)	▪ Medicare contractors accept, process, and pay claims submitted by providers for Medicare-covered services.	▪ Delays Medicare Part A and B payments by nine days. Claims that would otherwise be paid on September 22, 2006,

	Medicare contractors must pay interest on claims that are not paid promptly. ▪ The contractors must pay 95% 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 funds".	thru September 30, 2005, would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individual for any delay in a payment during the period.
Medicare Integrity Program (MIP) Funding (Sec. 5204)	▪ Under current law, certain amounts are to be appropriated from the Hospital Insurance Trust Fund for anti-fraud activities under the Medicare Integrity Program (MIP). ▪ For FY 2002 and subsequent years, the amount is established to be not less than $710 million and not more than $720 million.	▪ Increases MIP funding for FY 2006 by $100 million. *(Federal costs - $100 million over five years/$100 million over ten years)*
SUBTITLE D – PROVISIONS RELATING TO PART C		
Phase-Out of Risk Adjustment Budget Neutrality in Determining Payments to Medicare Advantage Organizations (Sec. 5301)	▪ Medicare Advantage payment rates are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. In 2006, twenty-five percent of the rate will be adjusted by demographic factors and 75 percent will be adjusted for health status indicators. ▪ In 2007, 100 percent of the rates will be adjusted for 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 data that show a difference in the reported health status of Medicare Advantage enrollees compared to the reported health status of	▪ Beginning in 2007, this section (1) changes the way MA area-specific non-drug monthly benchmarks (or MA benchmarks) are calculated, and (2) specifies 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% of per capita fee-for-service costs, the MA benchmarks will be equal to the 2006 rates as announced by the Secretary on April 4, 2005, with three adjustments that – (1) exclude any national adjustments for coding intensity, (2) exclude any risk adjustment budget neutrality factor, and (3) increase the benchmark based on the national per capita MA growth percentage calculated without adjusting for errors in the estimation of the growth percentage for a year before 2004. ▪ If the Secretary does rebase the rates in 2007, the MA benchmark will be set at the greater of either the rate

	beneficiaries in traditional Medicare. ▪ Specifically, these data show that Medicare Advantage plans are enrolling less healthy beneficiaries. ▪ The Administration has stated that as plans enroll less healthy beneficiaries, the need for a budget neutrality adjustment will decline.	calculated above, or 100% of per capita fee-for-service spending in the area. ▪ After 2007, if the Secretary does not rebase rates, the MA benchmarks will 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 will be equal to the greater of either the rate calculated above, or 100% of per capita fee-for-service spending. The Secretary can then adjust the benchmarks by an amount calculated by dividing the difference between payments had they been adjusted for demographic factors and payments specified in the above paragraph by payments specified in the above paragraph. This amount is then multiplied by an applicable percentage, which is equal to 55% in 2007, 40% in 2008, 25% in 2009, and 5% in 2010. ▪ When calculating the amount, the Secretary will (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, (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, (d) as necessary, adjust risk scores for lagged cohorts, and (e) adjust risk scores for changes in enrollment in Medicare Advantage plans during the year. ▪ Directs the Secretary to conduct an analysis of differences in coding patterns for the purposes of making such adjustments. ▪ Permits the Secretary to take into account estimated health risk of enrollees in preferred provider organizations (including MA regional plans) for the year. ▪ Prohibits the Secretary from making any adjustments to MA benchmarks, other than those specified above. The Secretary's authority to risk adjust MA benchmarks based on

		100% of per capita fee-for-service spending is not limited by these changes. *(Federal savings - $6.5 billion over five years/$4.1 billion over ten years)*
Rural PACE Provider Grant Program (Sec. 5302)	▪ No provision.	▪ Creates site development grants and provides technical assistance to establish PACE providers in rural[38] areas. ▪ Creates a fund for rural PACE providers to provide partial reimbursement for incurred expenditures above a certain level. ▪ Requires the Secretary to establish a process and criteria for awarding up to $7.5 million in site development grants[39] in up to 15 qualified PACE providers, (as defined under current law), that have been approved to serve a geographic service area that is in whole or in part in a rural area. ▪ Each grant award to a PACE provider must not exceed $750,000. *(Federal costs - $0 -$100 million over five years/$100 million over ten years)*

Sources:

Congressional Research Service (CRSS) Memorandum, *Side-by-Side Comparison of Medicaid, State Child Health Insurance Program (SCHIP), and Medicare Provisions in S. 1932 and H.R. 4241*, November 21, 2005.

Text and Conference Report to S. 1932

Federal Funds Information for States, *Issue Brief 06-03—Possible SCHIP Shortfalls; Territorial Medicaid Ceilings*, January 9, 2006.

House Ways and Means Committee, *Medicare Provisions in the Deficit Reduction Act*.

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38 A rural area would be considered any area outside of a Metropolitan Statistical Area or a similar area as defined by the HHS Secretary through regulation.

39 Site development grants could be used for expenses incurred to establish or deliver PACE program services in a rural area including: (1) feasibility analysis and planning, interdisciplinary team development; (2) development of a provider network, including contract development; (3) development or adaptation of claims processing systems; (4) preparation of special education and outreach efforts required for the PACE program; (5) development of expense reporting required for calculation of outlier payments or reconciliation processes; (6) development of any special quality of care or patient satisfaction data collection efforts; (7) establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size; (8) startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS; and (9) any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

Health Policy Alternatives, Inc., *S. 1932, Deficit Reduction Act of 2005---Summary of Conference Agreement: Medicare, Medicaid, and other Health-Related Provisions*, December 23, 2005.

Text of other Public Laws cited in this document.