EXECUTIVE COMMITTEE MEETING TO ACHIEVE THE COMMITTEE'S BUDGET RECONCILIATION INSTRUCTIONS TO REDUCE THE GROWTH OF OUTLAYS AS CONTAINED IN H. CON. RES. 95

TUESDAY, OCTOBER 25, 2005

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 9:33 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Hatch, Lott, Snowe, Kyl, Thomas, Santorum, Frist, Smith, Bunning, Crapo, Baucus, Rockefeller, Conrad, Jeffords, Bingaman, Kerry, Lincoln, Wyden, and Schumer.

Also present: Douglas Holtz-Eakin, Director of the Congressional Budget Office; Linda Fishman, Director, Office of Legislation, Centers for Medicare and Medicaid Services; Mark Hayes, Director, Health Policy, Senate Finance Committee; Roderick Whitlock, Colette Desmarais, and Becky Shipp, Health Policy Advisors, Senate Finance Committee.

Also present: Kolan Davis, Republican Staff Director; Ted Totman, Republican Deputy Staff Director; Dean Zerbe, Tax Counsel and Senior Counsel to the

Chairman; Russ Sullivan, Democratic Staff Director; Pat Bousliman, Democrat Acting Chief of Health Welfare Team; Carl Martin, Chief Clerk; and Amber Williams, Assistant Clerk.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. Normally I do not start until we have everybody here, particularly representatives on the other side of the aisle, but we are just going to spend the first part of the meeting with people giving statements. So, I am going to start with my statement.

Today we meet to consider the Senate Finance Committee's title of the Deficit Reduction Omnibus Reconciliation Act of 2005. This mark captures billions of dollars in savings and additional revenue for the States through reformed pharmacy policies and improved drug rebate practices.

These savings do not affect any beneficiary or service under Medicaid. In fact, the Chairman's mark increases and preserves coverage under Medicare and Medicaid. It would provide improved access to health care for over 500,000 disabled children, and it would save States from having to cut back or eliminate coverage for over 297,000 low-income beneficiaries currently enrolled in the SCHIP program.

An illustration of the dramatic savings we achieve. If States use their savings under this mark to provide for both State cost and Federal match, they could cover a

total of 610,000 additional children for the next five years, under Medicaid.

I had hoped to be joined by my friend and partner on this committee, Senator Baucus. I believe that the Finance Committee functions best with Democrats and Republicans working together to craft policy based on compromise and mutual agreement.

I began this process in anticipation of a bipartisan agreement that would both improve and strengthen the Medicaid program. There are extenuating circumstances that I fully understand, and sometimes that I am involved with, that prevented a bipartisan agreement.

I understand that a number of members are very concerned that the Congress has not acted on legislation vital to help the thousands of families who have had their lives devastated by Hurricane Katrina.

Now, I want everybody to know, and I think my speeches on the floor of the Senate show, I share their strong desire to move Hurricane Katrina relief legislation as soon as possible, and I have been working very hard to clear the way for Senate consideration of such a Katrina relief package.

So, I would draw my colleagues' attention to the Hurricane Katrina Medicaid provisions in the Chairman's mark, which obviously are a lot less than what I had in a

bipartisan piece of legislation last month.

I want to emphasize that this is, from my point of view, just a down payment on the help that we should provide the States of Mississippi, Louisiana, and Alabama, and the other States affected by this terrible natural disaster.

So I intend to continue working so that we can enact legislation that would direct additional relief to these States, and I would hope that the Congress would enact the bipartisan Emergency Health Care Relief package separately from this reconciliation process.

That would even be very beneficial to people on my side of the aisle. If that occurs, then provisions related to Hurricane Katrina relief that are included in the Chairman's mark would no longer be needed.

Again, I regret that the Senate's inaction on Hurricane Katrina relief is a principal reason why Senator Baucus is unable to support moving forward with a budget reconciliation package at this time.

As I explained, I fully understand that situation. I would add that I do not find fault with that process, because people on my side of the aisle have stood in the way of the Hurricane Katrina package, not people on his side of the aisle.

However, I do want to note that a number of

provisions in this legislation are bipartisan proposals that Senator Baucus and I agree on today, and we agreed on, quite frankly, a couple of months ago as we were talking.

In particular, he and I worked together on developing the Medicaid Value Purchasing Act, and that is included here. We worked together to address the moratorium on specialty hospitals, which is in this mark.

Regardless of the fact that Senator Baucus is not able to support the mark before committees today, I appreciate his ongoing comity and good will, and I sincerely appreciate the fact that when we disagree, Senator Baucus supports the efforts to keep the process going.

The mark before the committee represents nearly a year's worth of work on the part of myself, members of the committee, and our staffs. It is a carefully crafted compromise, because it is a compromise. Not every member on the committee got everything he or she wanted.

Now I have to point out that the Chairman's mark makes a number of improvements over current legislation. It achieves significant budget savings and makes real progress in getting a handle on the Federal deficit which threatens our economic security, it reduces wasteful and unnecessary spending, and directs these savings where

they are needed the most.

Because we are able to achieve gross savings above the net needed to meet our reconciliation instructions, we were able to direct funding to improve access to health care to vulnerable populations.

I think it bears repeating that this mark would ensure the continuity of health coverage for over 697,000 low-income children by providing funding to States that face shortfalls from the SCHIP program. Additionally, the mark includes several provisions that would expand outreach and enrollment to get eligible children into programs like Medicaid SCHIP.

The mark would expand Medicaid benefits to approximately 500,000 children through the Family Opportunity Act so that parents with severely disabled children can earn above poverty-level wages and still maintain vital services for family.

I would note that the Family Opportunity Act has broad bipartisan support and is co-sponsored by 13 members of this committee. This has been a priority of mine for several years and I am very optimistic that we will see enactment before year's end.

Additionally, we include funding that the President has been very interested in. Money follows the person. It is a rebalancing demonstration program which would

allow individuals currently in institutions to transfer to home and community.

The Chairman's mark also provides new options for private coverage of long-term care through the long-term care partnerships, as well as providing improved access to health care for seniors and individuals with disabilities in Medicare.

It helps protect rural beneficiaries of Medicare and preserve access to community hospital care by ending unfair competition from physician-owned limited service hospitals.

These important program improvements are possible because of savings that are achieved through other important provisions in the package because the mark includes provisions that would help State Medicaid programs obtain millions in payments owed by third party payors, it makes a number of significant reforms to the pharmacy payment system, closes drug rebate loopholes, and cracks down on Medicare fraud and abuse. This is responsible policy, long overdue.

Finally, I would thank the members of the committee and their staffs for their hard work. We have a great deal of expertise here and I want to thank everybody for their participation over several months.

We may disagree on specific provisions. However, I

am convinced that, no matter the differences in our approach, we share a common goal. That is, to improve the lives and well-being of our constituents, and our Nation as a whole.

I look forward to a lively debate on these issues as we continue this debate here, and on the Senate floor.

I now ask Senator Baucus to speak. Then, before other members speak, I would like to see what sort of efforts we can make to expedite everything that we have to do.

So, you take whatever time you need.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator Baucus. Thank you, Mr. Chairman.

The winds and waters of Hurricane Katrina did not take Emanuel Wilson's life, but Hurricane Katrina did take his job. As a result, Hurricane Katrina washed away his health coverage.

Emanuel Wilson has intestinal cancer, but he is not qualified for Medicaid. Emanuel Wilson survived one of America's worst natural disasters, but he does not fit into the right pigeon-hole to get America's health care.

Mr. Wilson put it this way: "I went to Medicaid and the lady I talked to let me know that Medicaid is mostly if you are disabled or pregnant. I do not want to become disabled, and I do not think I can become pregnant, so that leaves me out in the cold."

Mr. Chairman, I commend you for working with me to write a bill, S. 1716, that would cover Mr. Wilson temporarily under Medicaid. Our bill would get him back on his feet, would give him the health coverage that he needs.

But unfortunately we are not marking up that bill today. Instead, we are marking up a package to respond to a budget instruction written months before Katrina.

We are marking up a bill that would cut $10 billion out of the resources that this Nation devotes to health care.

I know that you have worked hard, Mr. Chairman, on this budget reconciliation bill. You have threaded a very difficult needle. I commend you for your diligence and for including important proposals that you and I have worked on, namely, advancing payment for quality in Medicare and extending the moratorium on specialty hospitals.

These provisions should improve health care quality and lower Medicare costs in the years to come. This mark also curbs managed care over-payments, it covers disabled kids, and prevents a physician payment cut that would impair access to care.

But the dire health care needs caused by Hurricane Katrina go mostly unaddressed. The bill before us does contain a provision that would give some help to States caring for Katrina victims, but the bill before us would not cover Mr. Wilson.

The bill does not provide coverage for tens of thousands of evacuees who are ineligible for Medicaid, although Congress did provide such coverage for New Yorkers in the aftermath of 9/11.

It does not help the health care providers who have given charity care in the aftermath of the hurricane,

charity care desperately needed by those providers in the Gulf area.

It does not relieve the financial plight that the Gulf Coast States, especially Louisiana, face. I am disappointed by these omissions.

Moreover, I am concerned about the fate of the bill we debate today. Although many of its policies are sound, I am not confident that most will survive a conference with the House.

As you know, the House leadership and Republican leadership have been pushing for deeper spending cuts in health programs, deeper, deeper than those provided for in the budget reconciliation.

Those same leaders plan to disregard the investments and improvements this mark makes in Medicaid and Medicare, while advancing several troubling policies, policies such as increased cost sharing that would hurt Medicaid beneficiaries, cuts to child care, child support, and child welfare, and increased work requirements for welfare recipients.

I do not believe these policies move our Nation toward a stronger safety net for the poor in this time of need. So, faced with a $10 billion savings target for budget reconciliation and this prospect that this target may grow, I must decline. Rather than cutting $10

billion from Medicaid and Medicare, we should be investing $9 billion to fund our Katrina health bill.

Mr. Chairman, you have performed a thankless job, and you have done it admirably. You have produced a balance mark, although I would not call it balance. It is one that I think is lopsided, because it does not take care of Katrina. Otherwise, it is balance. But it achieves several important ends.

Eight weeks ago yesterday, Katrina made landfall. Eight weeks ago today, the levies broke. Eight weeks later, I cannot, in good conscience, join in cutting a health care bill when Congress has left the health care needs of Katrina victims unaddressed.

The Chairman. All right. Thank you, Senator Baucus.

Before I go to members, there are a couple of things I would like to announce.

On October 21, 2005, the Senate approved S. Res. 284, which authorizes filming in the Senate chamber and the Senate office buildings for use at the Capitol Visitor's Center, so all members should be aware that a production company will spend a few minutes in our hearing room this morning to obtain footage for an educational video to be shown at that center.

Also, I would ask if members would limit their

opening statements to three minutes, because there is so much work we have to do in this committee. We do have a vote at 10:30. It would be my intention to keep the committee operating during that vote, so that we would take turns to go vote.

We always use the timing light, but in this particular instance, if you forget to see the timing light, we have a buzzer that will sound. I hope that a Senator will finish a thought very quickly at the moment the buzzer sounds. I appreciate everyone's cooperation, and thank you very much.

Although generally we do this by seniority at a mark-up by this, let us go by the way the list has been given to me by first-come. So, Senator Hatch would be next, even though he is next in seniority.

Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator Hatch. Well, thank you, Mr. Chairman. This is very serious business. I have to say that the committee was charged with almost an impossible task, under the circumstances. You and your capable staff face pressures from all directions. It is only because of your leadership as Chairman of the Finance Committee that we are here today considering the Budget Reconciliation mark.

That being said, this package, of course, is not perfect. In fact, while there is much in this package with which I agree, I still have several concerns.

While the mark achieves our goal of finding $10 billion in savings, it also spends a significant amount of money when our national focus needs to be on saving money.

I am also troubled by how we are paying for this spending. Close to $5 billion comes from eliminating the Medicare Advantage Regional Plan Stabilization Fund, something that I have strongly supported, and the provision of which I strongly oppose.

I do not understand why on earth we would be getting rid of this fund, especially before the Medicare drug

plan is even operational. It just does not make good policy sense, and that is why I oppose it.

It is also disappointing that we have ended up with limited Medicaid fraud and abuse provisions in this bill. As the Senate Finance Committee, we have the responsibility to addresses these issues facing the Medicaid program, and if we do not we fail the American people miserably.

Likewise, I am extremely disappointed that more extensive restrictions on asset transfers and inter-governmental transfers were not included in this package. Both policies would have severely curtailed activities where individuals and some State governments have intentionally defrauded our Medicaid program.

Now, I have heard the arguments about why we should not have included them in the proposal. Mr. Chairman, I, frankly, do not buy those arguments. More aggressive legislating in these areas would preclude some of the other reductions necessitated in this bill, such as those for the Stabilization Fund.

The provisions on payment for prescription drugs under the Medicaid program are another deep concern of mine, and you know my specific criticisms of these policies. I appreciate your willingness to work with me.

Let me say that, while I agree that changes are

necessary, and in fact needed, I am very worried about the current approach included in your proposal.

I am not sure that the new definitions created for average manufacturer's price, weighted average manufacturer's price, and the new formula which you created for the Federal Upper Payment Limit, will address the criticisms of the current policy.

In fact, these new definitions may make the situation worse. Therefore, I urge you to continue discussions with the various stakeholders who have a vested interest in making this policy work, in particular, the pharmacists and the pharmaceutical companies.

I was going to offer amendments to address my concerns with these matters, but since I have your commitment that you will work with me, I will withdraw them.

Mr. Chairman, I commend you for bringing this proposal forward and I will support you on moving this package through the Senate Finance Committee, however, I want you and other committee members to understand my concerns. I will stop at that, with one second to go.

The Chairman. Thank you very much.

Senator Thomas?

OPENING STATEMENT OF HON. CRAIG THOMAS, A U.S. SENATOR FROM WYOMING

Senator Thomas. Thank you, sir. Thank you, also, for your help. I suppose I will say some of the same things. But in any event, we are here because the Congress faces financial challenge. We continue to speak about record-breaking spending, and so on, so we have to start to make some choices that reduce the deficit. That is what this is for.

I remind my friend from Montana, this is a reconciliation bill. We also have $60 billion set aside for the Gulf Coast, and there will be more. But in any event, we passed a budget in order to do this, and that is what we are here for, is the reconciliation, which requires the Finance Committee to save $10 billion for the Medicaid program.

After making that commitment, then the debate shifted towards finding savings in the Medicare program. This is not a time, in my opinion, to open the Medicare bill, 21 days before seniors are beginning to role in the new prescription drug benefits. Some of the changes proposed here will make an impact, particularly on rural States, with regard to that new coverage that we are all so proud of having out there.

So, many experts, including GAO and CBO, agree that the Federal Government can save billions by reforming the Medicaid program--not by reducing the benefits, but reforming the way it is put in there. I support that idea, it does not mean cutting benefits. Frankly, I think that is one of the things we really should do.

In order to be ahead of Mr. Conrad, I wanted to show a chart here. [Laughter]. This has to do with some of the savings that might happen and shows what could be done, according to the *New York Times*, which is not always my basis for information. [Laughter]. But, nevertheless, there is an awful lot of fraud there, and that is really where we ought to be pointing, is in that area.

So this bill does not contain many of those fraudulent activity-stopping efforts, so I believe they could. In any event, I am concerned that there are too many changes in Medicare as we move into a new Medicare program that we have just designed to be out in the country, and so on.

So, I believe this reconciliation process should not be a vehicle to spend money on new programs, because we need to restrain spending, and we are looking for ways to reduce it, not expand it, and so on. So, Mr. Chairman, I am going to work with you.

I have some amendments, also. As the Senator from Utah said, since you have agreed to work with me in the future, I will try and resist putting those in today. But some of them have to do with senior mental health, some of them have to do with making sure that as this new program comes in, there are assurances that rural areas will be able to be served.

So, thank you very much, Mr. Chairman.

The Chairman. Senator Kyl, then Senator Conrad, then Senator Bingaman.

OPENING STATEMENT OF HON. JON KYL, A U.S. SENATOR FROM ARIZONA

Senator Kyl. Thank you, Mr. Chairman.

In reviewing this mark-up, there are things with which I agree and things with which I disagree, and it is the usual situation of supporting something because there is much good in it. But I do want to bring colleagues' attention to a couple of matters that I think we may want to revisit.

First of all, we were supposed to use this process to reform Medicaid. As my colleague from Wyoming has just pointed out, we have missed a good opportunity there, in my view.

This Medicaid program is now costing our States significantly, and we had an opportunity to really have some good reform that would not only save money at the Federal Government level, but also to help our States as well, and I think that we have foregone that opportunity.

Second, we are now deeply involved in Medicare. Here, too, I do not think that what we are doing here is reform. We simply found a couple of politically correct pay-fors in order to generate funds with which we can do other things. I do not think that is a good thing, either.

I am troubled by the fact that, in the Medicaid area, we are really turning to the pharmaceutical industry to pay for most of what we are doing here. About 60 percent of the so-called savings is coming from the pharmaceutical industry.

And I know that is politically correct, but I think we will regret the day that we started down the path that could get us to a European style drug pricing regime, and we will talk more about that in the future.

With regard to Medicare, I am concerned with some of the things that have been pointed out here by others, namely that we are going to be dealing with the Stabilization Fund in a way that is very troubling, that we are not sure that we are going to be able to stimulate the kind of regional PPOs without that Drug Stabilization Fund over the years. That is a matter of concern to us.

I am also concerned that, in the future, though this mark-up has an adequate reimbursement for physicians, that we are going to have to sustain that with our House colleagues. This is apparently the only vehicle by which we are going to achieve that.

In years past, we have managed to provide a modest increase for physicians, although not near enough to keep up with the rate of inflation. The same thing is done in this package with a 1 percent increase. But not

including it here, there may not be any other place to prevent a 4.4 percent cut in physician fees.

The point of this is, you cannot very well provide services to Medicaid and Medicare patients if you do not adequately pay the people who are supposed to provide those services, in this case, the physicians. So, those are some areas of concern, Mr. Chairman.

The Chairman. Now, Senator Conrad.

Senator Conrad. Thank you, Mr. Chairman. We have a new system here, do we not?

Senator Bingaman. Mr. Chairman, we were going to suggest that, in addition to the lights and the buzzer, maybe you could wire the chairs and give us a shot of electricity when our time is up. [Laughter].

The Chairman. Well, we thought about that. [Laughter]. But we are trying one step at a time. [Laughter].

Senator Conrad?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator Conrad. Thank you, Mr. Chairman.

First of all, I want to recognize the work that the Chairman and his staff have done. In a challenging situation, you have done very professional work. I want to acknowledge that.

I think the situation that we face here makes no earthly sense, however. Last year, the debt of the country rose $551 billion. If you look at the combined reconciliation package, it does not reduce the deficit, it increases the deficit.

So when I hear colleagues say that this is a step toward fiscal responsibility, it is almost like, words have lost their meaning. This total reconciliation package does not reduce the deficit, it increases the deficit. How is that?

Well, there are $35 billion of spending cuts, that is true. But the second part of the reconciliation package cuts taxes by $70 billion. The combined effect of the reconciliation package, therefore, is not to reduce the deficit, it increases the deficit. At a time when we have runaway deficits and runaway debt, what earthly sense does this make?

Let us go to the next chart. What I find most alarming, is if we look at the next five years, the debt of the country is on track to increase by $3.4 trillion. In this package before us today, we are talking about $35 billion of spending cuts.

Again, later, that will be combined with the $70 billion of tax cuts to have an overall reconciliation package that increases the deficit in light of a debt that is exploding. We are going absolutely the wrong way. Instead of reducing deficit, reducing debt, we are increasing.

Let us go to the next chart. This is the outlook as we go forward in terms of the debt of the country. We were at $7.9 trillion at the end of last year, and every year we see the debt going up, under the budget that has been passed, by $600 billion and more each and every year.

The debt is exploding at the worst possible time, right before the baby boomers retire. Here we are, instead of paying down debt, which is what the President promised when we started down this course, remember, he said his plan would provide for maximum pay-down of the debt.

Well, there is no pay-down of debt occurring here. The debt is exploding. As a result, foreign holdings of

our debt have increased by more than 100 percent in four years.

I thank the Chairman. I really like this new buzzer system. [Laughter]. I want to be recorded against the new buzzer system. [Laughter].

The Chairman. Senator Bingaman?

OPENING STATEMENT OF HON. JEFF BINGAMAN, A U.S. SENATOR FROM NEW MEXICO

Senator Bingaman. Thank you very much, Mr. Chairman. I join others who have spoken in complimenting you and the Ranking Member for doing your very best to put together a bipartisan package.

I do think it is unfortunate that, rather than pursuing serious deficit reduction, we are choosing to cut away at some of the health care programs that many in our country depend greatly upon.

I want to applaud you, though, for managing to include in your mark some very good things, the Family Opportunity Act, physicians payment fix, CHIP equity, continued lifting of the therapy caps, and extension of the rural hospital outpatient department reimbursement system.

I think it is unfortunate that, rather than just cutting Medicaid and health services to the poor, we are not instead trying to look at the broader challenge of, how do we reform this health care delivery system that leaves 46 million of our citizens without health insurance in this country.

The President's budget did propose, as I understand it, $120 billion for that purpose. There is very little

in this mark that is dedicated to that effort.

With those concerns in mind, I will offer some amendments because I think this is probably our only opportunity in this session of the Congress to do so, to try to address some of the access problems for people with disabilities, to try to address some of the problems of providing adequate health coverage for Native Americans and Indian Health providers, trying to shore up the safety net hospitals and community health centers, and ensure that our States are not being cut in Federal support for Medicaid at a time when the States are facing unprecedented challenges and trying to meet their own existing obligations to pay through that program.

So, I do have some amendments when the opportunity arises, Mr. Chairman, and I look forward to that opportunity.

The Chairman. Thank you, Senator Bingaman.

Senator Santorum?

OPENING STATEMENT OF HON. RICK SANTORUM, A U.S. SENATOR FROM PENNSYLVANIA

Senator Santorum. Thank you, Mr. Chairman. I appreciate the work that you have done here.

I would just say to my colleague from New Mexico, he listed a whole variety of increases--let me underscore that: increases--to health care and health services to the poor. He did not mention any cuts in health care services to the poor, and that is because, as far as I can see in this bill, there are not any.

The reductions in this bill are basically out of pharmacies and pharmaceutical companies--by and large, those are the two biggest areas--and insurance companies, Medicare in particular, with these funds that Senator Hatch and Senator Kyl talked about.

So the idea that we are cutting health care services, I challenge you to find a net cut in health care services in this bill. It does not exist. So, let us just talk about what the reality is here.

The reality is that we are squeezing providers, as we love to do around here, of health care services, whether they are pharmaceutical companies, pharmacies, and the like, to try to save some money, and in this case, provide a little extra services like programs for the

disabled, which I know the Senator from New Mexico is a big fan of, and allowing States to cover, in a couple of cases, disabled children.

We have hardly been Ebenezer Scrooges up here, looking for ways to affect the poor in the area of health care, whether it is Medicaid or Medicare. So let us just set the record straight. We are not cutting health care services to the beneficiary.

We are squeezing some--unfortunately not enough, in my opinion--fraud and abuse out of this system. We have squeezed some out. I would have personally liked to have done more. We could not get the votes to do that over here.

But we have squeezed some fraud out, we have squeezed providers, and we have taken some of that money and plowed it back into the system to provide additional health care services to the poor and to seniors--that is what this package does--and at the same time, reduce the deficit.

Now, I do not understand why people may vote against this, because it does save some money. But from the standpoint of what this does to the poor, what this does to seniors, and what this does to the deficit, it is a win-win-win. Thank you, Mr. Chairman. My buzzer did not go off. [Laughter]. I would be happy to yield to the

Senator from Arkansas.

The Chairman. Senator Bunning?

OPENING STATEMENT OF HON. JIM BUNNING, A U.S. SENATOR FROM KENTUCKY

Senator Bunning. Thank you, Mr. Chairman.

At the beginning of the year, we had a real opportunity to make some much-needed changes to the Medicaid program. The issues seemed obvious to me.

For example, some States are using financing schemes to pull down more Federal dollars than they are entitled. Some seniors are finding ways to shelter large amounts of assets so they qualify for Medicaid long-term care benefits earlier.

When people and States game the system, the American taxpayers lose. There is no free money to be given out. Instead, hardworking Americans have to send more of their money to Washington to make up for these bad actors.

As elected officials, we have a duty to ensure that the Federal money we provide to Medicaid, and all other government programs, is properly used. Unfortunately, with Medicaid, this seems, often, to not be the case. We let much of the opportunities we had to make real reforms to Medicaid slip by with this bill.

There are certainly some things in the bill that I support, and probably will support at the end. However, by and large, I feel we could have done a better job.

For example, I will be offering an amendment dealing with inter-governmental transfers. It is a shame we could not have come together to stop States from raiding Medicare dollars.

We also include Medicare in this bill, and even made some changes to the Medicare Advantage plan. I have strong concerns about eliminating the Stabilization Fund and the effect that it will have on Medicare PPO plans in all our States.

I hope we can improve this bill as it moves through Congress, and make something that we can be proud of before we are finished. Thank you.

The Chairman. Senator Lincoln?

OPENING STATEMENT OF HON. BLANCHE LINCOLN, A U.S. SENATOR FROM ARKANSAS

Senator Lincoln. Thank you, Mr. Chairman. I would like to certainly add my praises to others that have been here today. I hope the Chairman knows the tremendous respect I have for him. He has done an incredible job in what he has been given to do here.

I want to commend you on producing a mark that really does look, I think--or tries to look--fairly at spreading the entitlement cuts that you have been charged to find between both Medicare and the Medicaid programs, and I thank you for being so thoughtful in the way that you have gone about this, Mr. Chairman.

Like many other members of the committee, I do not think it is fair, or necessary, to gut the Medicaid program, which is our Nation's health care safety net, in an effort to cut government spending.

I do believe that there is certainly wasteful government spending in both of these programs that we can look to and find in a very thoughtful way, and my hope is that we will continue to do that.

But, Mr. Chairman, one in particular in the mark phases out the budget-neutral policy on the risk adjustment for the Medicare Advantage plans. Even when

budget neutrality is gone, the Medicare Advantage plans or payment rates set by Congress will still be higher in every county in the Nation than the average cost of the traditional Medicare program.

This means that taxpayers will spend far more to care for seniors in private plans than they do caring for seniors who are in traditional Medicare. I think that was a wise step, and one that could be made.

But, nonetheless, Mr. Chairman, I cannot forget the faces of the evacuees that I saw in the many, many evacuee camps that I visited in Arkansas, some of which do not fit the criteria that has been put into this package for the victims of the unbelievable natural disasters that happened in the Gulf Coast. I think it is our responsibility to set those priorities, to look at those Americans who need our help the most.

Mr. Chairman, I am reminded of a very dear friend of mine who was killed several weeks ago in an automobile accident. She was born in 1929. She had seven children, a wonderful husband. She was a military nurse who spent her entire life caring for people.

She did it in the military, she did it when she got out. She did it with her children, she did it with her community. She was a pioneer in providing health care for the uninsured, in dealing with hospice, and making

sure that programs were there for people who needed them.

At her funeral, which I was not able to attend because we had votes, there was an incredible quote in the program. It was a quote from Eleanor Roosevelt.

It goes: "I have always seen life personally. My interests, or sympathy, or indignation is not aroused by an abstract cause, but by the plight of a single person. Out of my response to an individual develops an awareness of a problem to the community, and then to the country, and then to the world."

My friend, Flo, lived that phrase. I think it is important for us as Americans here in the U.S. Senate to begin to reflect on the individuals who need our help as individual Americans.

I will offer some amendments, Mr. Chairman, but I promise not to be too bad.

The Chairman. Senator Lott?

Senator Lott. Thank you very much, Mr. Chairman. I appreciate your leadership in putting together this package. Like every member of the committee, I have concerns and have disappointments, and have amendments that I would like to offer.

I feel, frankly, that not enough savings or improvements have been made in Medicaid. I think probably more savings could be found in Medicare also. I

just think, overall, there is an inadequate amount of savings here, even though we have met our reconciliation instruction of just barely over $10 billion.

On the other hand, I do think some areas where we increased spending are unnecessary, and basically we cannot, I do not think, afford right now. I do appreciate the fact that there are some funds included for Katrina victims. It is an amount, I believe, that is sufficient for now.

I am sure we could extend it much more than that, as was suggested early on by the Chairman and the Ranking Member. But I am finding that it is very, very difficult to get what we really need to help the people, because it is expensive. But we do have funds in here for Katrina victims. It is offset, and not in ways I would necessarily like, but it is included.

But it is one of those things where I believe it is important for members of the Senate to look at the bigger picture. What happens if we do not do this? What happens if we start mixing everything up more or less here, more spending there, or vice versa?

I do not think we did nearly enough to take into account the bipartisan Medicare reform proposal by the National Governors Association that was presented to the committee here.

I am still very much concerned that people are basically defrauding the system, moving assets around so they can become eligible for Medicaid when they really should not be. I am very much concerned that governors need more flexibility, not less, and they do not really get it in this package. I could go right down the list.

We need to move this process forward. I am not just focused on process, but I learned a long time ago in the Senate, if you do not figure out a way to get something done, substance is irrelevant.

So you have to do the best you can on substance, find a way for this committee to act so we can join this with other committees, get it to the floor of the Senate.

It will be amended on the floor, some improvements will be made, hopefully, and it goes to conference and we go through the process. The net result will be, we will come up with some deficit reductions that should be positive.

With regard to the tax proposals that have been referred to, just keep in mind, if we do not act in the tax area, a lot of important areas will wind up having tax increases. What are we going to do about AMT? What are we going to do about expensing? What are we going to do about families with children?

So, our colleagues had better think about that. I

still believe that if you do taxes in the right way, it gives an incentive for growth and not a drag on the deficit.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. Thank you, Mr. Chairman.

I guess my comments would be in the following vein. I guess my point is, I think we have had some very good cooperation. We have worked very well together on the generic drug bill, and that has been included, and I appreciate your fairness and your openness to that.

Our staffs are working on long-term care amendments at this point. I think that we are getting closer and closer to the point where maybe we can do a colloquy on the floor, even if it cannot get done in here. I specifically thank you for that.

I do have, as the Senator from Arkansas indicated, major concerns, particularly about dual eligibles, and will have a couple of amendments on that.

Dual eligibles. There are 6.4 million people. Most people do not know what they are, outside of this room. They are the Medicare people who are so poor, they have to be on Medicaid.

We give them a very, very hard time, in a way which we could fix that would not cost money. So I think there is some merit into this bill. I think there are some real problems, some of them Senator Conrad pointed

out.

On the 1 percent physician fee update for 2006, which is less than actually we have done in past years, the fact that it is least 1 percent, I think, is good, the update, but it does nothing to shield beneficiaries from having to shoulder the burden of that increase in the form of higher Medicare premiums. So there are some good things, some rather not so good things in this mark, and we shall see how the process goes.

I thank the Chairman.

The Chairman. Senator Crapo?

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator Crapo. Thank you very much, Mr. Chairman. I have a prepared statement, but I am going to submit that for the record, if the Chair will allow, because I would like to make another correction to the record that I think is necessary because of some of the debate that has gone on here.

The Chairman. Your statement will be included.

[The prepared statement of Senator Crapo appears in the appendix.]

Senator Crapo. The part of the record that I think needs to be set straight, is that, again, today, Mr. Chairman, we have heard the worn-out rhetoric that we are trying to push for a tax cut as a part of the reconciliation process.

The reality is, if we do not act, there will be a tax increase. If we do not take the steps that are proposed in the reconciliation process that this committee is working on, we are going to see a $70 billion tax increase, not a $70 billion tax cut. I think it is important for America to recognize that.

What the committee is working on, is we are going to try to stop the Alternative Minimum Tax from encroaching

further upon the middle class of this country. We are going to try to protect the teachers of this country who now have a deduction for their out-of-pocket expenses for teaching, instead of letting that deduction be lost to our teachers in America.

We are going to try to extend the qualified tuition deduction for students across this country so that those middle income families, who are fighting so hard to find a way to pay for college education, can make some progress.

We are going to try to let our small businesses continue to be able to get their Section 179 deductions to strengthen the small businesses in this country, and to extend the lower tax rates we have on capital gains and dividends.

I have looked at what this means just in Idaho, Mr. Chairman. My time will not allow me to say all of this. But what will this mean in Idaho? This is similar across the country.

If we do not do this, what we have talked about for tax reconciliation, in Idaho this year, 25,000 Idaho seniors and middle income families will be unfairly subjected to the Alternative Minimum Tax.

If we do not do this, our teachers in Idaho, 13,781 of them, will lose their deduction for out-of-pocket

expenses. If we do not do this, 18,516 Idaho students and families will no longer be able to benefit from the tuition and fees tax deduction.

If we do not do this reconciliation, 18.5 percent of the tax returns filed in Idaho that report capital gains will see a tax increase. That is 107,000 Idahoans who will see a tax increase on their capital gains.

If we do not do this, 20.7 percent of the tax returns filed in Idaho will see an increase on their dividends. That is 119,000 Idahoans who will see a tax increase there.

So, Mr. Chairman, the point that I want to make is, as we see this rhetoric thrown about, accusing us of trying to pass a tax cut at a time when our country needs help, the reality is, we are trying to maintain the tax relief that we have already put into place that falls squarely on the backs of the middle class in this country.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Crapo.

Now, Senator Snowe?

OPENING STATEMENT OF HON. OLYMPIA SNOWE, A U.S. SENATOR FROM MAINE

Senator Snowe. Thank you, Mr. Chairman.

I would like to ask unanimous consent to include my entire statement in the record, and I would just like to make a few points here this morning.

I think that, without question, the Chairman had a very difficult and arduous task in blending the broad philosophical and policy differences on this committee to achieve the targeted instructions of budget reconciliation of more than $10 billion.

I think that we have to keep the alternative in mind. If we did not adhere to the parameters of the budget resolution, we would have been in a situation where the Budget Committee ultimately would have determined how we would achieve and accomplish those savings in $10 billion.

So the choice was either reconciling those differences among the members of the committee here in the Finance Committee, or relegating it to the jurisdiction of the Budget Committee.

I want to compliment the Chairman, because it obviously was a difficult task, to say the least. I want to compliment him from the standpoint of achieving a

comprehensive savings in this difficult fiscal climate, but understanding that we have to exercise restraint, and also achieving a balance on both sides of the ledger with respect to both spending and revenues, and achieving a balance between Medicaid and Medicare that are the bedrock health care programs for the uninsured, for low-income Americans, as well as our senior citizens.

I think that in order to do that we had to establish priorities, and setting those priorities did occur within this package, both in terms of the numbers and also, most importantly, in terms of the policy.

We did not affect beneficiaries. I think that is important to underscore and reinforce here today, because I keep hearing "cuts to beneficiaries." That is not the case. Beneficiaries' services are not reduced. The fact is, we did everything to eliminate anything that would even intimate that that would occur, because we understand that we cannot accomplish these savings at the expense of those who are the least advantaged Americans in the most vulnerable of populations. So, we did not include anything that would reduce benefits.

What we did include, was reforms for both Medicaid and Medicare programs that are going to be instrumental in strengthening and bolstering the program. Actually, there are also some spending initiatives that are going

to be very advantageous, I think, both to Medicaid and Medicare beneficiaries in the final analysis.

We understand the value of the Medicaid program. The value of the Medicaid program is that it is not only helping low-income Americans, it is helping the uninsured. It is filling a vacuum when it comes to the uninsured in America.

And, yes, Medicaid growth is occurring at a great extent, but at the same time, put it in the context of the explosive growth in the private health insurance industry. In fact, there was an article in my State newspaper talking about soaring premiums. The point is, this is a program that we cannot reduce or minimize at this point in time.

The Chairman. Thank you, Senator Snowe.

[The prepared statement of Senator Snowe appears in the appendix.]

The Chairman. Senator Smith? And so far, then, Senator Smith would be the last person to speak, then we will go to consideration. Oh. Senator Wyden, you are here now. We would be glad to take care of you.

Senator Smith?

OPENING STATEMENT OF HON. GORDON SMITH, A U.S. SENATOR FROM OREGON

Senator Smith. Thank you, Mr. Chairman. I want to join all of my colleagues in complimenting you and Leader Frist for producing a budget. To the point that Senator Crapo made, we have tried to balance many competing interests.

One of those competing interests, is that we not suffer a tax increase on the middle class through the expiration of some of these taxes that are so important to continuing economic prosperity, especially with high energy prices that small businesses, in particular, are suffering right now.

On the issue of Medicaid, I believe, if my colleagues and friends on the other side will look at what is in this package, they would want to vote for it because this does not hurt people.

This strikes a very delicate balance, in Medicaid in particular, in making sure that the changes do not fall to the people who depend upon this as their backstop, from heading to emergency rooms, or in the case of mental health, sometimes, going to county jails, or in the case of uncompensated care, simply cost shifting to the private sector that can ill afford to see us do that

right now.

So, Mr. Chairman, as I have promised you, while there are many amendments that my colleagues may offer that I would normally want to support, I will not support them because I understand the need to preserve this package, because, in the end, it advances the interests of the poor, the disabled, the elderly, the middle class, small business, and it is a balance that we have to preserve in this process.

But I also want to point out to them that there are many innovative ideas in there, such as, money follows the person, Mr. Chairman, that you have championed, that I believe will show some very real improvements in Medicaid, and I hope to see it succeed in a way that ultimately can be expanded to the whole country.

So, Mr. Chairman, thank you for your efforts. If I may, I would like to include my full statement in the record.

The Chairman. Your full statement will be included in the record.

[The prepared statement of Senator Smith appears in the appendix.]

The Chairman. Now we go to Senator Wyden.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator Wyden. Thank you very much, Mr. Chairman.

I would thank my colleague from Oregon, Senator Smith, for his efforts on Medicaid. You have done yeoman work, and I commend you for it.

I do fear that this budget exercise has been hot-wired by our colleagues in the House of Representatives to, in effect, put together a Robin Hood in reverse, where folks who are vulnerable and low-income will get hurt, the tax cuts will be preserved. But I just hope that what you and Senator Smith have been able to achieve here, that we will fight valiantly as we go into that process with the House.

The second point I would make, is I still believe that there are savings that can be made without hurting the vulnerable. For example, Senator Sununu and I have introduced legislation, an amendment, along those lines that I will offer today to make sure that Medicaid does not provide a second subsidy for pharmaceutical advertising on television and in the media.

This is the kind of bipartisan effort that ought to be low-hanging fruit. Yes, it means taking on a powerful special interest. But two U.S. Senators, Senator Sununu

and I, have spent a lot of time on it, and I hope we can continue that work.

I also hope, on the floor, that we will remove what is one of the most offensive provisions, in my view, in the history of public policy and health care, and that is the restriction on bargaining power in Medicare with respect to pharmaceuticals.

I mean, this is an outlandish piece of special interest legislation. In effect, the Federal Government, when the pharmaceutical begins in January, will be like somebody going to Cosco and buying toilet paper one roll at a time. Nobody would shop that way.

Senator Snowe and I got 49 votes in the U.S. Senate for that this last time, and we are not done prosecuting that cause. There are ways, colleagues, to make savings in these vital programs without hurting the vulnerable.

Mr. Chairman, I yield back.

The Chairman. Thank you very much. We are supposed to have a vote at 10:30, so I hope that members who want to offer amendments would go to the floor and vote.

Senator Baucus. Mr. Chairman, might I just suggest, I would imagine there are questions Senators may have of the mark, and also a walk-through. I might suggest that we continue with that phase, and then whoever wants to go vote, vote, and we just keep the process going.

The Chairman. All right.

Senator Baucus. Then you and I can just change back and forth.

Senator Lott. I understand we may have a vote at 10:30.

Senator Baucus. 10:30. Yes.

The Chairman. Yes. So I would follow on Senator Baucus' suggestion. Assuming there is no objection, I would do this. Normally we would have a walk-through on the mark that I laid down. I would like to dispense with that walk-through.

Then I would put down my modification, and we would do what Senator Baucus says, as a way of explanation of the modification right away while the vote would be going on so that people, if you go over and come back, would still be able to ask questions you had about the modification. That is the proposal I would put before the committee.

If that is all right, then I would introduce at the table Mark Hayes, who is the Director of Health Policy for the Finance Committee, Majority; Dr. Whitlock, who is Health Policy Advisor for the Majority staff; and we have Douglas Holtz-Eakin, Director of the Congressional Budget Office, who will be here to help answer questions about cost and budget impact. I thank all of you for your

presentation.

Assuming the consensus then, I would place the modification before the committee and ask for the description of the modification.

Mr. Hayes. Thank you, Mr. Chairman. There are a number of modifications. I will just walk through those quickly. There are a number of modifications added to the Chairman's mark which results in the modification that is before the committee this morning. They are as follows:

A provision related to the managed care provider taxes applied by States as part of their funding for the Medicaid program is included. It grandfathers five States.

There is also an increase in the rebate for multi-source drugs to 17 percent. There is a provision related to rural PACE programs, which is Hatch Amendment #8. There is a provision that waives late enrollment penalties for certain international volunteers. There is also a provision that adds coverage under the Medicaid program for services provided by podiatrists.

There is also a provision referred to as the Patch Act, which is Snowe Amendment #2. In addition, "money follows the person" provisions have been added to the Chairman's mark, with an effective date of January 1,

2009.

There is also a provision that provides for $25 million in funding for SCHIP, State Children's Health Insurance Program, outreach and enrollment efforts. There is also a Medicaid Institute of Medical Disease demonstration program, which is Snowe Amendment #1.

There is a technical correction related to the DSHP program in the District of Columbia, which is Hatch Amendment #9.

There is also a provision added to the section on the Stabilization Fund pertaining to a shift in payments, and there are a number of just small, technical corrections that have also been made to the Chairman's mark.

The Chairman. I thank you very much.

Are there any questions of the modification just described? [No response]. All right. Then if there are not any questions, then without objection, the Chairman's mark is modified.

We had 131 amendments filed. So in advance of our discussion, I would like to thank members on both sides who withheld amendments or consolidated the issues that they raised. I would also like to thank members who worked with us to incorporate amendments together.

Before we proceed to amendments, I would like to say something about the issue we have then with offsets. Our

instruction from the Budget Committee is to achieve $10 billion in savings from programs that are within the jurisdiction of this committee.

CBO has determined that my mark, with the modifications that Mr. Hayes just described, will save slightly more than $10 billion, in fact, $10.6 billion. Therefore, all amendments that will generate additional spending would be completely offset.

Furthermore, amendments must be completely offset in fiscal year 2006 over the five years covered by the budget resolution. I should say both. They have to be offset for fiscal year 2006, and then they obviously have to fit into the instructions for the full five years of the budget.

That means that, ideally, we would have reliable final CBO scores for both the amendment, and the offset designed to pay for it, before we vote today.

What we will do today, is ask, through the Director, for CBO to tell us whether an amendment, with its offset, has a net reduction, those would be in order. Amendments that CBO finds have a net increase in spending would not be in order.

The mark then, with this approach, is open for amendment. I would ask for members to tell us the number of their amendment in the process.

Did I offend members by assuming that we did not have any questions? Presumably, there were no questions on the modification, but there might be some questions on the underlying bill before modification.

Senator Bingaman?

Senator Bingaman. Thank you, Mr. Chairman.

Let me just ask some of the folks here at the table, I am trying to understand all of these different parts. One of the items in your spread sheet here, under Chapter 4, "tighten definition of TCA services." As I understand it, over the 10 years you are expecting to save something over $2 billion by tightening those definitions.

When I tried to read the Chairman's mark to understand what that was, it says here, "The proposal would specify that Federal Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including reimbursement under medical, social, educational, or other programs."

I guess what concerns me on this, is these are the targeted care management issue. The people in my State who run these programs are persuaded that what these provisions do, this tightening of definitions, as we call it, has the effect of just shifting the cost of these to Indian Health programs, which at least in my view are

under-funded right now, to AIDS drug assistance programs, which in my view are under-funded at this point, to foster care programs, which again are under-funded in my opinion.

Is that right? Is that what is going on here, is that we are claiming a savings of over $2 billion by shifting these costs to these other under-funded programs?

Mr. Hayes. Senator, the Chairman's mark includes this provision on targeted case management. I am going to speak briefly to it, then Ms. Shipp, who is on the committee staff, will provide further detail.

But the provision that is included in the Chairman's mark is modeled after a letter issued by the CMS during the Clinton administration to respond to areas where States were using the ambiguity in the statute for targeted case management to get the Federal matching rate for medical care services, which is higher for areas which are covered under other Federal programs, under more properly administrative functions of other programs. But Becky can provide more detail.

Ms. Shipp. Senator, thank you. The Chairman's mark does codify a January, 2001 letter issued under the Clinton administration which differentiated between Medicaid services and services that should be billed

administratively to other programs. The Chairman is aware of several concerns, through the HIV community. We are very mindful of those.

As we draft language, we are going to be sure that any service that is an eligible Medicaid service, which would be assessment of an eligible individual's service needs, development of a specific care plan, referral and related activities to help an individual obtain needed services, monitoring and following up of activities, will be billed to Medicaid.

Senator Bingaman. I guess, am I right, though, that there are $2 billion worth of savings claimed as a result of this change in definition over the 10 years? Am I misreading that?

Mr. Hayes. No, that is correct. Over the five-year period, $760 million worth of savings are achieved, according to CBO's estimates, and $2.07 billion worth of savings over the 10-year period.

Senator Bingaman. Right. So that is an extra $2 billion that is going to have to be picked up somewhere, presumably. That would be in these other things that I mentioned, the AIDS drug assistance programs, Indian Health programs, foster care programs. Am I right that those are the programs we are talking about having to pick up these costs?

Mr. Hayes. Senator, to the extent that States are transferring costs that are more properly allowable under those programs to the Medicaid program, then this provision does correct that loophole that States have been using. I would like to also ask Mr. Holtz-Eakin if he would like to add anything further.

Mr. Holtz-Eakin. I just want to clarify on the numbers. This is the net effect. So if, for example, there is a shift in these services away from Medicaid reimbursement to foster care reimbursement, we will see lower Medicaid outlays, that is reflected in the table, but also higher foster care outlays, and that is also reflected in the table. So this is the net impact on the Federal outlays in this area.

Senator Bingaman. But there are only higher outlays in these other areas if they are entitlements. The programs that I mentioned are not, as I understand it. So unless the Congress comes along and appropriates more money for those programs, there is just going to be --

Mr. Hayes. Right. And there is clearly a net savings.

Senator Bingaman. Yes. Yes, there are some net savings.

That was all I had, Mr. Chairman.

The Chairman. There are a couple of more questions,

one from Senator Rockefeller, then from Senator Wyden.

Senator Baucus. Mr. Chairman?

The Chairman. I am not trying to limit anything.

Senator Baucus. I am just trying to help the conversation here, because it is on the same subject.

The Chairman. All right. Go ahead.

Senator Baucus. Basically, the goal here is to assure that, when there are third parties that are liable, that they are, in fact, liable, so the State does not have to pay the cost. Is that correct?

Mr. Hayes. That is correct.

Senator Baucus. There is a worry here among some--maybe it is language in the bill here--that those waters are muddied. That is, the State may have to pay pick-up costs, even in those situations where third parties might be liable. That does not seem appropriate here, but that is not the intent of the law.

Mr. Hayes. Under current law, there are a number of areas in which it is unclear whether States are able to pursue claims that are due to the Medicaid program by third party payors.

As a result, States have been unable to claim payment from a third party payor where Medicaid is properly the payor of last resort. These are dollars owed to State Medicaid programs that they have been unable to collect.

So the provision in the Chairman's mark closes those loopholes so that Medicaid can pursue those claims where they are owed.

Senator Baucus. So those loopholes are closed, so it is more clear now that States can pursue those third parties.

Mr. Hayes. Yes, sir. This provision builds on a provision that was included in OBRA 93 that started that process, but further loopholes over time, as often occurs, emerged. This now tightens up that statute.

Senator Baucus. Does the mark clarify that Medicaid will also pay when other payors can pay, but are not legally liable? They can pay.

Mr. Hayes. I am sorry. Could you clarify that?

Senator Baucus. Does the mark clarify that Medicaid will also pay when other payors can pay, but they are not legally liable? That is, those other programs provide services but are not technically, legally liable.

Mr. Hayes. When medical services are provided where a third party payor is not liable for the costs, then States cannot collect from a third party payor for those costs.

Senator Baucus. Under what circumstances would a third party offer services, even those who, as you say, in your words, may not be liable?

Mr. Hayes. Those might be services in which the plan itself, by its design, does not cover those services. For example, there may be services that are covered by the Medicaid program that the third party payor does not offer in its benefit design. In those cases, the Medicaid program wraps around the third party payor, and then the third party payor is not liable for those.

Senator Baucus. Is it true that this provision is not intended to apply third party liability restrictions to voluntary payors who have no legal liability for payment by public schools, that is, Ryan White clinics or community health centers?

Mr. Hayes. The Chairman's mark maintains current law pertaining to Medicaid being the payor of last resort, including the latest of those programs. It does not change that at all.

Senator Baucus. So you do not intend to apply third party liability restrictions to voluntary payors that have no legal liability for payment, like public schools.

Mr. Hayes. That is correct. The Chairman's mark continues current law.

Senator Baucus. All right. Thank you.

Thank you, Mr. Chairman.

The Chairman. Before Senator Rockefeller, the vote

has been moved to right about now. It has not started. But I want to remind everybody that, presumably, they are going to enforce the 15-minute time limit on voting. I will have to see it to believe it. But just in case you do not want to lose your vote, get over there in 15 minutes.

Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, my point is technical and small. I am a co-sponsor with Senator Bingaman on FMAP forgiveness, so to speak. I was going through the chart and it is my impression that States are held harmless up to 5 percent, but not beyond that, but that Alaska is somehow singled out uniquely to have no limit. If that is true, that is tremendously unfair. I might know the reason for it. But I would just like to know if it is true.

Mr. Hayes. Thank you, Senator Rockefeller. The provision in the Chairman's mark related to the Alaska FMAP continues current law that has been in place since 1996. That provision expired on October 1 of this year, and the Chairman's mark would extend that provision for two additional years.

Senator Rockefeller. And so the answer to my question?

Mr. Hayes. The answer to your question, is that it

does not set the Alaska FMAP at an unlimited amount, but instead continues it at the same amount.

Senator Rockefeller. So you are telling me that Alaska, in all respects, co-reacts, under this formula, with all of the other 28 States, whatever it is.

Mr. Hayes. What the Chairman's mark does, is it says that FMAP for Alaska would not decrease over the next two years, but could increase if conditions under the formula required that.

Senator Baucus. May I follow up here?

Senator Rockefeller. Yes.

Senator Baucus. This is, frankly, a little bothersome, I think, to any objective observer. As I understand it, the mark prevents FMAP reductions in the three affected Gulf States. Is that correct?

Mr. Hayes. It does provide for a temporary FMAP relief for three States affected by Hurricane Katrina.

Senator Baucus. And how temporary is that? How long does that last?

Mr. Hayes. That lasts from the time of Hurricane Katrina through May 15 of next year.

Senator Baucus. And the mark also says, with respect to Alaska, that the scheduled reduction that would otherwise occur for 29 States, including Alaska, and for the State of Alaska, there would be no reduction

for, what, a year? Two years? How long?

Mr. Hayes. For two years, the Chairman's mark continues current law for the Alaska FMAP.

Senator Baucus. So is it true then, among all 29 States for which there is going to be an FMAP reduction if the law is not changed, that the mark provides that for those 29 States, three will see no reductions on a temporary basis--that is, the Gulf States--and one will see no reduction, i.e., Alaska, for two years?

Mr. Hayes. The FMAP provision for the three Gulf States provides for 100 percent FMAP only for the counties that were designated for individual relief by FEMA after Hurricane Katrina, so it does not provide 100 percent FMAP for the entire State of those --

Senator Baucus. Well, that makes the point even more starkly, because you are saying it applies not to those three States, but to the affected counties in those States. Is that correct?

Mr. Hayes. That is correct.

Senator Baucus. But for the State of Alaska, it is the entire State.

Mr. Hayes. For Alaska, it is the entire State.

Senator Baucus. And not only is it for the entire State, it is not temporary, in the sense that it is not several months, it is two years.

Mr. Hayes. It is for two years.

Senator Rockefeller. And why is that?

Mr. Hayes. The provision is included in the Chairman's mark on the grounds that the Medicaid formula does not take into complete consideration Alaska's higher health care costs, which result from higher transportation costs of a sparsely populated area over a large geographic area. I am told that Alaska has 9,000 miles of roads, which is lowest in the entire United States, including Rhode Island.

Senator Rockefeller. And one new bridge. [Laughter].

Mr. Hayes. I am sorry?

Senator Rockefeller. One new bridge. No. I am sorry, Mr. Chairman. But this strikes me as grossly unfair. I think it has something to do, probably, with picking up a few extra votes for the reconciliation package; I have no idea.

But I do not think any tsunami has hit Alaska. I do not think any earthquakes have hit Alaska. I just do not understand the reason for it, and I do not think we should proceed to do it until we know, clinically, the reason. I mean, there are lots of States. New Mexico, you go 100 miles without seeing anybody. In Alaska, you could go 500 miles without seeing anybody. I would just

like to know the reason.

Senator Baucus. I might say, the health care costs in my State, the rural health care costs, are stupendous. The same could be said with respect to many States.

Senator Lincoln. Mr. Chairman?

Senator Baucus. I just wonder. There has been no hearing on this. There should not be a hearing, I suppose. But we have not looked into this. We have not looked at the relative health care cost increases in various States. And just suddenly, willy-nilly by fiat, it is one State. And we know why. It is because the Alaska delegation is very powerful. But that does not make good policy.

I know it is dangerous to question provisions placed in by the powerful delegation from Alaska, but there comes a time when this body has to do what is right. I have a real problem, frankly, with that provision which singles out one State, and one State only, on such a lucrative basis, at the expense of every other State in the Nation. And more than that, poorer people in the Nation. On a policy basis, I have a question about this provision.

Senator Lincoln. Mr. Chairman?

The Chairman. On this point?

Senator Lincoln. Yes, sir.

The Chairman. Otherwise I was going to call Senator Wyden.

Senator Lincoln. Yes, sir.

The Chairman. On this point, go ahead, Senator Lincoln.

Senator Lincoln. Is there any estimate of the number of evacuees that are in Alaska?

Mr. Hayes. This provision is unrelated to Hurricane Katrina. There is an estimate of the number of evacuees in Alaska. I can get that for you, Senator Lincoln.

Senator Lincoln. That would be helpful. We have a lot, and we also suffered a decrease in our FMAP in Arkansas. Thank you.

Mr. Hayes. Senator Lincoln, the Chairman's mark would provide 100 percent FMAP for the evacuees that are in Arkansas, through May 15 of next year.

Senator Lincoln. As long as they have children and qualify under the narrow definition that is there. Correct?

Mr. Hayes. Under current law Medicaid eligibility rules. That is correct.

The Chairman. Senator Wyden?

Senator Wyden. Mr. Chairman, I have a couple of questions. What is your pleasure here? Do you want to go vote?

The Chairman. Can I interrupt you?

Senator Wyden. Shall we go vote and come back?

The Chairman. No. I think, ask your questions. I am going to go vote and come back.

Senator Baucus. I will say here.

Senator Wyden. I do not want to miss this vote. I might even want you here for my questions.

The Chairman. I will stay here. Go ahead.

Senator Wyden. I will do this real quickly.

How does the provider tax work, Mr. Hayes, and what States specifically are grandfathered on the provider tax? Senator Smith and I have an interest in this. Start with that. What States are grandfathered on the provider tax?

Mr. Hayes. Senator, the States that are grandfathered are Oregon, Pennsylvania, Michigan, Missouri, and California.

Senator Wyden. A second question. The Chairman, I, and Senator Smith all represent low-cost areas. We are in areas that Medicare has historically penalized for holding the costs down.

One of the reasons that I voted for the 2003 legislation, is Medicare Advantage plans, through the Stabilization Fund, would be able to get some of the additional money to attract regional plans to these kinds

of States. That is hard to do when the costs and the penalties under today's law are in place.

What does the mark do with respect to States that are low cost and have held their expenses down, like Iowa, like Oregon? This is particularly relevant, given the Stabilization Fund.

Mr. Hayes. The Chairman's mark would not affect current law related to Medicare Advantage payment rates that are designed to allow Medicare Advantage plans to participate in rural areas. Those Medicare Advantage payment rates enacted in the Medicare Modernization Act resulted in regional plans now bidding to offer coverage in 21 of the 26 CMS regions, beginning next year.

The Chairman's mark does not change the base rates for Medicare Advantage. The regional plans will also continue to have risk corridors that help plans that have to provide coverage over an entire geographic area of a State, including, in rural areas, to be able to take on that additional risk.

It also does not affect current law related to provisions related to network adequacy, which helps the regional plans to provide coverage in rural areas where the provider networks are going to be more sparse than in an urban area, and would not affect any of the other provisions related to regional plans that were provided

in the Medicare Modernization Act which are designed to make sure that those are viable.

Senator Wyden. We do not have a regional plan, number one.

The Chairman. Senator Wyden, I would suggest that we stop now so the four of us can go vote, and we can continue.

Senator Wyden. Good. Thanks.

The Chairman. And if Senator Hatch comes back, he is going to address his amendment. But we will go back to questions if they are not completed. There are only five minutes left to vote.

We will stand in recess.

[Whereupon, at 10:52 a.m. the meeting was recessed.]

AFTER RECESS

[11:07 a.m.]

Senator Hatch. Senator Thomas has some questions.

Senator Thomas. Thank you, Mr. Chairman. I actually was going to wait until the amendments, but I will ask now.

I guess I would like to know how we justify the eliminate of the Stabilization Fund when we just went through a whole process of setting up a delivery system in the States, private sector, a whole new idea, and this was designed to ensure that the PPOs were there, and the risk corridors, and so on, and now we eliminate that. Can you tell me how we justify that?

Mr. Hayes. Senator Thomas, the mark does not change current law related to the advantages provided to regional plans so that they will participate. The Stabilization Fund is designed to attract plans to regions, as well as to prevent plans from withdrawing from regions. There are 21 of 26 CMS regions that will have regional plans in them as a result of the base rates provided in the Medicare Modernization Act.

Senator Thomas. Let me interrupt.

Mr. Hayes. Yes, sir.

Senator Thomas. You said, to provide them and to keep them from being withdrawn. Now, how are you going

to ensure they are not going to be withdrawn?

Mr. Hayes. The mark does not change the base rates provided to those plans that were the basis for their bids for this next year.

Senator Thomas. I know. But the "withdrawn." What if the idea was they were initially there and they are withdrawn, and this was to stabilize it so they would not be? Now you have taken away that assurance.

Mr. Hayes. Congress provided the Stabilization Fund as a mechanism to bolster Medicare Advantage payments in years in which other payments are reduced in the fee-for-service program to prevent cost shifting to the Medicare Advantage program.

The Chairman's mark also does not reduce payments in that area, and in fact, increases payments to physicians, which will help mitigate the possibility of a cost shift to Medicare Advantage plans.

Senator Thomas. I will not take any further time. But why was it put in there in the first place, if you are implying that it not necessary, it was never necessary?

Mr. Hayes. I would not be in a position to speak to congressional intent during the MMA. Those who fought for that provision would be in a better position to speak to that. But I believe the understanding was that it was

there to ensure that plans could participate, that there would be the ability for regional plans to serve an entire region, and that those things, combined with the other advantages provided to regional plans, would make it possible for them to participate.

I believe the Chairman's mark includes this provision as a result of a recommendation by the MEDPAC, which advises Congress on Medicare payments, and also, in part, due to a statement by CMS on September 1 in which they said that the Medicare Advantage program itself had stabilized.

Senator Thomas. Again, I will not talk about it any more, but I just think we went through this program to put together a system. One of the concerns in that system was that the smaller States would not continue to encourage people to serve, and this was one of the provisions. In any event, I thank you, even though I disagree with it.

The Chairman. Yes. As we were leaving to go vote, I interrupted Senator Wyden, so we will go back to Senator Wyden's point.

Senator Wyden. Mr. Chairman, thank you. Thank you for the conversation that we had on the way to the floor.

Mr. Hayes, the long and short of it is, Iowa and Oregon, and other States, have historically been

penalized for holding the costs down in American health care. You would think, at a time of demographic revolution, those kinds of States would be rewarded.

So I am concerned about how the mark affects low-cost States, because the Chairman has indicated he would work, as this goes through the process, to try to get some modifications. If you could, tell me how the mark does affect low-cost States.

It is relevant, because the Stabilization Fund, which we voted for in 2003 as part of the Medicare reform legislation, would at least offer some dollars to States like Iowa and Oregon that have historically been penalized.

So take us through that, because I want to work with the Chairman to see if we can make some modifications for efficient, low-cost States who I think are laying out the policies that ought to be the future of Medicare.

Mr. Hayes. I am going to begin the answer to that question by speaking to some areas in which the Chairman's mark does provide for rural areas, and then Ms. Desmarais will speak to the areas around geographic differences in payment rates and how that is affected under the Medicare Advantage program currently.

The Chairman's mark includes a number of provisions that are designed to assist rural areas. They are in

current law. These are extensions of current law. One of those would extend the hold harmless for rural hospitals from the outpatient prospective payment system.

There is also a provision to extend the Medicare Dependent Hospital program, which is for small, rural hospitals that serve more than 60 percent Medicare patients as part of their patient care load in a hospital.

There are other things related to rural PACE programs which will assist rural areas. Generally speaking, the physician update will also protect access to physician services in rural areas.

Senator Wyden. See if your colleague can touch on the urban issue, because in Portland, for example, over half of the older people in Portland are in managed care plans. Historically, going back to the days when Kaiser got started and the like, we saw this as a win-win situation--good for the consumer, good for the government--because it held the costs down. Those are the kind of folks I am worried about.

I assume Washington State senators will be concerned about the same thing because they have practically the same kind of health care infrastructure in Seattle that we do in Portland.

Ms. Desmarais. Senator, you are absolutely right.

There is some disparity in payments around the country, not only in Medicare Advantage, but that reflects the underlying disparity in fee-for-service payments as well.

The Chairman's mark includes a bill that he introduced with Senator Baucus earlier this year, the Medicare Value Based Purchasing Act. That provision in the Chairman's mark establishes a pay-for-performance system in Medicare, so to speak, that not only applies to physician services and hospital services, but also to Medicare Advantage plans.

The way that would work, is it would create a pool from the funds that are paid to those plans, and then redistribute those funds to plans that perform well, that meet certain thresholds or demonstrate improvement in quality.

So, that is exactly attempting to get at your point that you are raising, that these places around the country--Portland, Seattle, places in Arizona and New Mexico, Minneapolis--that have a strong tradition of providing high-quality, efficient care, actually had their reimbursements lowered as a result. So, the mark includes that legislation and it would create that program for health plans, beginning in 2009.

Senator Wyden. Mr. Chairman, I will not belabor this. I think what both of our staff witnesses have said

is helpful. To some extent, I am asking about A, you are responding to what amounts to B. I happen to think B is pretty useful as well.

But, Mr. Chairman, I would like to work with you on the Stabilization Fund as well, because that is a significant amount of money and I think we want to make sure that we are not losing some of those dollars that are particularly going to help areas that I think are the future of American health care policy, low-cost areas that have been efficient, that have held down utilization, and have historically been penalized. I thank you for our conversation on the way to the floor.

The Chairman. Yes. I am glad to have you enter into that discussion when it involves the Stabilization Fund because, the extent to which I agree with you, I would welcome some bipartisan input on that. It is not quite as favorably received on your side of the aisle as it is on our side of the aisle.

Senator Lincoln. Mr. Chairman?

The Chairman. Yes, Senator Lincoln?

Senator Lincoln. I would just like to ask, I think it was in the Chairman's mark where the increase for the physicians payments is found. Or is that in the underlying bill?

Mr. Hayes. It is in the Chairman's mark, as

modified, that is before the committee.

Senator Lincoln. All right.

My question there is, will beneficiaries get the automatic increase in their share of the premium? Or I guess it is the co-pay. They are not held harmless here, are they?

Mr. Hayes. Under current law, any increases in spending in Part B result in increased premiums for the Part B program. The physician payment provision in the Chairman's mark does increase Part B spending.

There are also other provisions that decrease Part B spending, but the net effect is still an increase in Part B spending that will result in a small increase in the Part B premium.

Senator Lincoln. So Medicare beneficiaries will see an increase in their premium due to that, along with the actual increase in premium that they will get as of the first of the year, too. Is that right? So we have added to that increase with this?

Mr. Hayes. The premium increase would not affect it in 2006, because the premium for 2006 has already been set. It would impact in 2007. However, I would also mention that there are a number of other provisions in current law that are reducing out-of-pocket costs for beneficiaries, namely the new prescription drug coverage

that starts next year which will significantly lower out-of-pocket costs for beneficiaries.

Senator Lincoln. But not in their premiums. Not their Part B premiums. It is going to add an additional premium for whatever Medicare prescription drug piece that they choose to participate in.

Mr. Hayes. Their Part D premiums are going to be about 15 percent lower than expected in 2006, so their premium impact is lower than anticipated as a result of the bidding and competition in the Part D system that occurred this year.

Senator Lincoln. You are saying, their premium?

Mr. Hayes. Their Part D premium.

Senator Lincoln. Right. I know. I just did meetings on that.

Mr. Hayes. Their prescription drug will be lower than anticipated, about 15 percent lower than anticipated.

Senator Lincoln. That is an average that you are referring to, then. Right?

Mr. Hayes. That is on average.

Senator Lincoln. Right. It is not in our State.

Mr. Hayes. In some cases, it is actually far lower. But it is an average. In Iowa, for example, there is a stand-alone prescription drug plan at a monthly premium

of a $1.63 a month, which is a lot less than the anticipated $35 a month.

Senator Lincoln. That is just one.

Mr. Hayes. That is one plan. That is correct. On average, though, 15 percent lower. I think you would take all of these things in context, but there is an impact on the Part B premium as a result of --

Senator Lincoln. So they will see an increase in their premium in Part B due to this physician payment. Correct?

Mr. Hayes. That is correct.

Senator Lincoln. Great. Thank you.

Thanks, Mr. Chairman.

The Chairman. I think we are done with questioning. Before Senator Hatch, I would like to have Senator Baucus. He had an approach on his side with amendments. Would you like to state it at this time, the handling of amendments?

Senator Baucus. Yes.

The Chairman. Then I will call on Senator Hatch.

Senator Baucus. Yes. Mr. Chairman, you have been very, very good, fair, and balanced in the provisions you have in this mark, as well as how you have handled this proceeding.

I would suggest that, in the spirit of comity here,

that we move expeditiously, clearly, but also in return for a break for lunch, that we on our side will agree to keep our amendments, and our comments on our amendments, down to a minimum, and just bring up the most important.

I also say to my good friend that we on our side think it might be more helpful if we group amendments, like grouping the Katrina amendments together, the Medicaid amendments together, and the Medicare amendments together as much as possible so we get a sense of that.

The Chairman. I think that that is helpful. Then people will know when they need to be here to offer their respective amendments. So, we will do that.

I would also like to ask, if we had three minutes on opening statements, if we could have four minutes on offering amendments. That may seem like a short period of time, but if you got a chance to think ahead of time about how you could say the same thing with fewer words, it would help us move along. So, I would ask people to finish by the buzzer at four minutes.

There is always discussions of amendments and going back and forth, so I think every point of view is going to be brought out. We are going to break then for lunch, Senator Baucus and I worked out, from 12:45 to 2:15, Then we also feel that we can get done then by what we would call dinner time out here, and what Senator Baucus

and I just referred to as supper time, so we will be able to go home and get our beauty sleep, which we need.

Senator Hatch?

Senator Hatch. Well, thank you, Mr. Chairman. Let me just say before we begin that we all know Doug Badger. He was the top aide for Senator Don Nickles, a former member of this committee, and of course the chief White House negotiator for the Medicare Modernization Act. In fact, many of us who served on the conference worked with Doug on the operation of the Stabilization Fund that I am going to call on amendment in a second.

I just wanted to ask everybody to keep Doug and his family in their prayers because his wife and father-in-law got into a terrible accident last night. The father-in-law was killed, as I understand it, and the wife was seriously injured. So I just wanted to mention that for all of us. I know everybody in this committee respects Doug and will pray for him and his wife.

Mr. Chairman, I offer Amendment #1 on behalf of myself and Senators Kyl, Bunning, Thomas, and Frist. Our amendment would eliminate Section 6112 of the Chairman's mark and restore the Medicare Advantage Regional Plan Stabilization Fund.

Now, this fund was created through, and in, the Medicare Modernization Act of 2003. The drug plan has

not even been implemented yet and we are already eliminating this fund.

Now, during the Medicare Modernization Act discussion, many of the Senate negotiators who represented rural States, as I do, believe that their States would have difficulty attracting and retaining Medicare Advantage plans.

The purpose of the Stabilization Fund was to provide these plans additional financial incentives to continue providing coverage to these areas. The Stabilization Fund was the key component of the Medicare Modernization Act, and in my opinion it does not make sense to reverse this policy before we can even figure out whether or not the Stabilization Fund is needed.

If Utah's experience with the Medicare+Choice program is any indicator, this fund is necessary. The Stabilization Fund helps provide incentives to Medicare Advantage plans so they will continue providing services in certain regions of the country.

I do not understand why on this earth we would be getting rid of this fund, especially even before the Medicare Modernization Act plan program is even operational. I do not think it makes good policy sense. That is why I oppose Section 6112 of the Act.

Mr. Chairman, that is all I have to say about it.

Senator Bunning. Mr. Chairman?

The Chairman. Senator Bunning?

Senator Bunning. Thank you. I am a co-sponsor of Senator Hatch's amendment. I would just like to say a few words. In 2003, I worked closely with many of the other members of this committee to produce the Medicare prescription drug bill.

It certainly was not an easy process, but I believe that the bill we created was a good one and that will benefit many seniors, starting just in a few months.

One of the most important provisions of that bill was the creation of the Medicare Advantage plans, the Medicare HMOs, and PPOs. Those plans will offer many seniors a more comprehensive benefit than fee-for-service Medicare, and I hope that they will play an increasing role in the way Medicare beneficiaries receive care.

During debate on the Medicare bill, we created the Stabilization Fund to help PPOs enter and stay in the program. This was an important provision because we wanted Medicare PPOs to thrive and be able to reach all Americans.

I am afraid, with the elimination of the Stabilization Fund, this now jeopardizes what we worked so hard for only two years ago. It not only sends a bad message to the PPO plans that Congress cannot keep its

word, it also sends a bad message to Medicare beneficiaries who do not need Congress to be making changes to Medicare Advantage plans right before they start signing up for the drug benefits.

I hope that we can work with the Chairman on this issue and move this package forward.

I have got 10 seconds.

The Chairman. Well, I think that you should have gotten four minutes to start.

Senator Bunning. Thank you.

The Chairman. Oh, he did?

Senator Bunning. No, I did not. But that is all right.

The Chairman. Proceed.

Senator Bunning. This will be 15 seconds.

It would be a shame to start unraveling the Medicare drug bill piece by piece. Instead, we should take a step back and agree not to harm what we worked so hard to accomplish in 2003. Thank you, Mr. Chairman.

Senator Hatch. Mr. Chairman? Mr. Chairman, could I ask Mr. Holtz-Eakin, what would it cost to restore this provision?

Mr. Holtz-Eakin. The Stabilization Fund is $5.4 billion over 5 years, $10.2 billion over 10 years.

Senator Hatch. All right.

The Chairman. I would like to say that I oppose this amendment. When we designed the regional Medicare Advantage program, it obviously was new territory. And, yes, we did consider that plans would not be able to participate in programs because they might have difficulty forming networks, particularly in rural areas.

That is why we created not only the Stabilization Fund, but also several other steps to help make sure that regional PPOs are available. We fixed a severe flaw in the underlying base rate, and this mark does not reflect those underlying base rates.

The Medicare Modernization Act established a risk corridor system for regional plans so that if a plan's costs exceed a target, Medicare will make additional payments to the plans.

We also imposed a moratorium on local PPOs to give the regional PPOs a leg up on getting started. The Center for Medicare Services' regulations include network adequacy provisions that also will help promote regional PPOs. There is the essential hospital fund as well.

Finally, this mark includes a 1 percent update for physicians. When physician payments are low, they often look to the plans to make up those low payments. That 1 percent update then, of course, takes that pressure off.

MEDPAC recommended unanimously to repeal the fund.

In August, CMS noted that the Medicare Advantage has "stabilized and flourished." That certainly begs the question about the need for the fund.

When we worked on the Medicare Modernization Act, the idea was that if the fund was not needed, then the dollars were to return to the U.S. Treasury. It is clear that the fund is not needed because we do have strong participation, so I urge my colleagues to support the mark and oppose the amendment.

Senator Hatch?

Senator Hatch. I do not know if anybody else wants to speak.

The Chairman. Does anybody else want to speak?

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad?

Senator Conrad. Mr. Chairman, I represent a rural State. The Stabilization Fund has proven not necessary. We have 41 plans being offered in North Dakota. Forty-one different plans. Number one.

Number two, the original Medicare prescription drug bill, we were told, was going to cost $400 billion. Now we know it is going to cost well in excess of $500 billion.

Both the Chairman of the Budget Committee and I urged our colleagues to reopen the Medicare prescription drug

bill to find savings after we found out the cost was far in excess of what we had been told. I think any reasonable analysis would conclude that this is one place we could save money, and we should, because the underlying rationale has proven to be unnecessary.

The fact is, rural areas are getting duplicate plans, dozens of plans, so the Stabilization Fund is just a waste of money.

Senator Baucus. Mr. Chairman?

Senator Kyl. Mr. Chairman?

The Chairman. Senator Baucus, then Senator Kyl.

Senator Baucus. Mr. Chairman, as you, and as Senator Kyl--and we may have a different point of view--we were on the conference when this was debated. It was sort of set aside as an "in case it was needed" fund, suspect at the time, frankly, from my perspective.

We have found out now that it is not needed, as articulated by the Senator from North Dakota. It is just not needed. That is why you are correct, in my view, not to use those funds that were earlier set aside to help pay for provision of this bill.

At a later date, it may be needed. I do not know that. But certainly if it is needed at a later date, we will make some provisions in the law, and we will change the law in case it is needed.

But right now, we know it is not needed because so many plans have bid to participate in areas all across the country without any need for the Stabilization Fund. Some have called this a slush fund. I will not go that far, but I will say that it is just not needed.

I think, therefore, it is good to keep this provision in the mark and not delete it from the mark. If we, at a later date, need some incentives for these plans, the Congress shall plan for it accordingly.

The Chairman. Senator Kyl?

Senator Kyl. Mr. Chairman, I was not going to speak on this. I do support the mark, and I will, but I think that we should not revise history here. The reason for the Stabilization Fund was, in the event that in the future it should turn out that companies cannot make it without this support, that they would have that support available. I suspect that one reason there are so many plans that have started up, is that they appreciate the fact that they have a back-up, a fall-back, so to speak.

What I have heard, is if we eliminate that at the very beginning here, it is going to make plans very nervous, because at the point that they may need it in the future, it is not going to be there for them. I daresay it will be much more difficult to institute it at that time.

So, while I do support the mark, I want to make it clear that there was a good and sufficient reason why that was put in the conference report in 2003, and why we all supported it then.

I think we should be aware of that history as we go forward through our process on the reconciliation bill this year, making sure that we do not send the wrong signal by eliminating that fund. Nonetheless, I do support the mark, as the Chairman knows.

The Chairman. Senator Hatch, for closing remarks on the amendment.

Senator Hatch. Well, I appreciate the remarks of my colleagues who are for it, because how do we know that it will not be necessary? I think it will be. We worked very hard on that. The drug plan has not even been implemented.

This is a top priority of the administration, and the Stabilization Fund was a critical component to facilitating regional preferred provider organizations as the cornerstone of the Medicare Advantage program, thereby maximizing access to Medicare Advantage plans for beneficiaries throughout the country, particularly in rural areas. That is what our concern was. Of course, I was a member of the conference committee.

I am heartened by the comments of the distinguished

Ranking Member of the committee, who has made it clear that if it becomes necessary, we will then re-up it and make it.

So with that comment, and relying on the good faith of our colleagues that I know I can rely on, I will withdraw the amendment in the interest of getting this bill moving forward.

The Chairman. And I thank Senator Hatch for his cooperation.

I think we will go back and forth between Republican and Democrat. So could we call on a Democrat now to offer an amendment?

Senator Baucus. Yes. Mr. Chairman, as I said earlier, we attempted to group amendments, basically, Katrina, Medicaid, Medicare, and the other subjects.

I have two amendments, Katrina related. I do not know if I will need eight minutes. Four minutes might be sufficient to explain them both.

The Chairman. Understand, Senator Baucus is offering two amendments at the same time, so he has eight minutes.

Senator Baucus. Right. Right. Thank you, Mr. Chairman.

Essentially, I am trying to help enact provisions that you and I suggested, Mr. Chairman, in S. 1716. In

that bill, we wrote provisions to address the health care needs of people, especially in the coastal areas, who were adversely affected by the hurricane, primarily Katrina, and I suppose to some degree it will be Wilma now.

The point being, there are a lot of people who desperately need health care. They are either Medicaid eligible and they are getting that health care, or they are just above Medicaid eligibility provisions.

That is, they have lost their jobs, they do not have health insurance, they have severe--many people do--adverse health conditions, whether it is cancer related, whether it is diabetes, lots of near-emergency care situations, and we are turning our back on them. We are just turning our back on them.

As you know, in S. 1716, we provided temporary assistance for people in the Gulf region: it would just be a matter of five months; not permanent, but temporary, and we are going to raise the eligibility only a little bit for single people without children, and all people affected, and not get caught in this pigeon-hole situation they are finding themselves in with respect to Medicaid.

Our bill would also provide additional help to those States through FMAP, that is, make sure they do not get

reductions in their Medicaid FMAP payments, but rather a full 100 percent.

Perhaps we went a little far in our bill, Mr. Chairman. We provided for FMAP coverage for 29 States. That is, there are 29 States whose Federal contributions to the Medicaid program will be reduced. That is the law. So, we provided in our bill, S. 1716, that we are not going to allow those reductions to occur. That is, they are held harmless.

Now, it is true that some of those States are not Gulf State related--that is, they are States other than the Gulf States--but we felt it was good policy to allow those deductions to occur anyway.

Well, my first amendment, Mr. Chairman, is essentially S. 1716, but with two major modifications. The first, is that it is paid for out of FEMA. That is, the funds to pay for it are out of FEMA.

Therefore, it does not detract from the provisions in your bill, not using pay-fors in your bill to pay for most of S. 1716, rather, it is paid for out of FEMA. It is my understanding that there is about $29 billion left unspent in FEMA. This bill will cost roughly $8 billion, so it can easily be paid for out of FEMA.

The second major change, is we are not going to provide that FMAP coverage be maintained for all 29

States, rather, just the Gulf States and the affected States. I think we include Texas and the adjoining States, which is to say, this amendment is only Katrina related. We are not putting in provisions here that are not Katrina related.

It is important to remind ourselves, too, that the Medicaid provisions--that is, increasing eligibility--are the same provisions that this Congress enacted back when 9/11 occurred. Again, they were temporary. It was 100 percent of poverty, I think, for most people. For kids, I think it is 200 percent.

There is another category as well. That is what we are trying to do here, is enact the 9/11 provisions, make them only temporary, and make it solely Katrina related, that is, not apply to non-Gulf States, but paid for out of FEMA. That is the first amendment.

The second amendment essentially is the same as the first, except that the pay-fors are not out of FEMA, but rather there are additional offsets. These are offsets which basically just go a little bit further.

It includes some of the offsets that are in this bill, which is to say, first, they are both paid for. The first amendment is paid for out of FEMA, the second amendment is paid for out of provisions in this committee's jurisdiction.

FEMA payment raises questions of germaneness here because it is not in this committee's jurisdiction, that is true. My belief, though, Mr. Chairman, is very simple. This reconciliation bill was really conceived and developed prior to Katrina. But now we are post-Katrina and we are 20 U.S. Senators in this committee.

We have brilliant, creative staffs. It seems to me that we ought to adopt one of the two of these two amendments--I really do not care which one--and go to the floor. If we adopt the one that is technically not germane, we will figure out a way to make this work. There is always a way to skin a cat. Where there is a will, there is a way.

We should not let ourselves, as Senators, be hamstrung by budget reconciliation rules when we are facing a disaster. We should not let the technicalities of reconciliation prevent us from meeting the real needs of people in our country.

I know it is a bit extraordinary for us to take that course. We are kind of bound by rules here. But I think that there are sometimes, in rare cases, a need for an exception to a rule. I think this is that case.

This is a time for us to think big, to be creative, to do what is right, what is right for our country, what is right for the Senate, what is right for this

committee, and especially right for the people affected. Those are the two amendments, so we will have a choice.

On the first amendment, my understanding, Mr. Chairman, is that you will rule that amendment not germane because paying for this out of FEMA is not in this committee's jurisdiction. I understand that, and technically that is correct. It takes a two-thirds vote to overturn the Chair. The second amendment is germane, and there can be a straight vote on that.

My hope would be that if we want to do this, that is, pass one of these amendments, and if we want to pay for it with additional adjustments and modifications to some of the pay-fors already in this bill, but rather want to pay for it out of FEMA, that that should be our vote, that should be our result. It would take two-thirds of the members of this committee--that is 14 votes on this committee--to approve that.

But I think we should do it. More importantly, I think we should just pass that one unanimously, by UC, and just stand up, go to the floor, and figure out a way to make this work. That is our job. That is our job as Senators.

Those are the two amendments. We have a choice. I would hope that we pass one or the other. I would hope that we would stand up and meet the challenge that is

before us and meet our responsibilities and pass one of the two.

The Chairman. Senator Baucus, a couple of things before I respond to your amendments. What are the numbers of your two amendments?

Senator Baucus. That is a good question. Number 3 and Number 2.

The Chairman. In that order?

Senator Baucus. Correct.

The Chairman. All right.

And then, also, I would ask if you or your staff could give Director Holtz-Eakin a copy of your offsets so I could get him to respond. Just in case they involve the SGR, since Senator Kyl has been so active in that area, if they do affect it, I would ask Senator Kyl to respond to that part of the amendment.

Senator Baucus. I might say, Mr. Chairman, too, we have submitted the offsets to Mr. Holtz-Eakin. My understanding is, they are working on it now. I do not know if they have it all tabulated. I see him shaking his head. They do not have it yet.

The Chairman. I am not sure that you have to give us exact figures. I am just asking you to respond, the extent to which he changes the underlying mark, as modified. But before you do that, I would like to speak

to the first amendment that Senator Baucus has offered.

He has brought up the issue of this amendment possibly not being in order, and I do agree with that, so I would rule it out of order. But I would, in the process, thank my friend, Senator Baucus, for his continued effort to respond to the effects of Hurricane Katrina.

Since he and I worked together on S. 1716, and that is the substance of Amendment #3, I obviously do not disagree with him on the substance of it.

The mark before us that I have laid down makes a down payment to respond now to the health care needs of low-income families affected by the hurricane. This is a place holder for spending on Hurricane Katrina, because I believe it is extremely important that we address the needs of those who have been harmed.

But I am looking for other ways to move spending on Hurricane Katrina as well. You know that it is very much a priority for me to assist those affected by Hurricane Katrina. I think we came up with a very good package, and I am committed to its passage.

The mark before us does provide something less than ideal for the terrible disaster we have had, but it does provide $1.8 billion to protect Medicaid benefits in Alabama, Louisiana, and Mississippi. As I said before,

this is a down payment so that we can respond to the needs of those affected.

The mark provides targeted temporary relief to parishes and counties affected by Katrina. The mark reimburses States fully at 100 percent of FMAP for any claims paid on behalf of in-State and out-of-State evacuees. The increase is temporary, beginning on August 18, 2005, ending May 15, 2006.

So let me make it clear. I would prefer that this be done on the Senate floor or outside of the reconciliation process. I even have a lot of people on my side of the aisle who support the process, or support your approach, that would like to see it outside the reconciliation process. But I must rule the amendment out of order.

I do understand that there is sentiment among Senators to use unobligated FEMA funds to pay for Katrina relief, but FEMA programs, as Senator Baucus has said, and he knows, is not within the jurisdiction of this committee. So I would rule it out of order, but I would defer vote on it until a later time.

Any further debate?

Senator Lincoln. Mr. Chairman?

The Chairman. Maybe before you would speak, I would ask if the Director could identify the offsets and maybe comment on how they affect the underlying mark, without

necessarily expecting specific dollars from him.

Mr. Holtz-Eakin. As we understand the bill, and certainly we would stand corrected if there are some details we do not know, there were several offsets, four, primarily: one, accelerate implementation of the risk adjustment in Medicare Advantage; second, reduce payments for indirect medical education; third, eliminate the geographic adjustor and bring regional PPOs to the same payment rates as local plans. The combination of those is worth about $3.8 billion. The overall costs in the proposal are about $7 billion over the window.

In addition, the proposal is to more quickly claw back the increase in physicians' reimbursements to Medicare and use that mechanism to bring the remainder of the costs into line to balance it. That would require examining the exact details to see if it works.

Even with those, it would be necessary to worry about what happens in 2006, where there would be costs, but no offsets, I think, at the moment.

The Chairman. Yes. I would call on the Senator from Arkansas. But for everybody that wants to speak on this, if you could speak to both amendments at the same time, it would be helpful.

Senator Lincoln. Thank you, Mr. Chairman. And I apologize that we take the time to talk about it, but,

quite frankly, this is the only venue we have.

As you well know, I was willing to withdraw my amendment on the floor, with the idea that we would be able to work something out. The Chairman was enormously gracious and worked very hard to do that, along with Senator Baucus. Yet, we have met road blocks at every turn, albeit a road block of maybe two, three, or four individuals, but nonetheless, road blocks.

It is beyond me how we can tell these people, these Americans, our fellow Americans who have suffered such incredible devastation, that they are not important enough for us from other States to recognize the need that exists or to recognize their providers in terms of those who have provided for these evacuees without asking questions.

So, I just want to applaud my colleague from Montana, who, like Alaska, may not have a whole lot of evacuees in his State. I do not know what the numbers are in other States, but I do know what the numbers are in my State, Mr. Chairman.

I also know a 62-year-old man who comes to Arkansas as an evacuee who does not qualify for Medicaid coverage under the Louisiana law, or the 64-year-old couple whose children are over the age of 21, they too do not qualify. They do not have Medicare, they do not have Medicaid, and

they have lost everything in their lives.

They have lost their home, they have lost their pets, they may have lost family members. They have lost their jobs. They have lost their community, those providers that have been taking care of them, perhaps in the down times and in the up times as well.

Here, we have an opportunity, Mr. Chairman, an opportunity to show not just one another, but the rest of the world, what American values really are all about. It is about helping our fellow man and our fellow American when they are in the most devastating of times, when they have lost everything and they do not fall into the category that the need to, in this narrow category, to be able to get the kind of services they need, with dignity. I think that is the key here.

Mr. Chairman, they can go and beg. They can show up at a hospital emergency room. They can appeal to a community and to others in that community who, so far, have exhibited the spirit of American values. They have provided care, uncompensated care, not knowing how they are going to be reimbursed.

We have an opportunity, with Senator Baucus' amendment, to say, out of the $60 billion that we have already allocated to FEMA, we can make sure that the people who have provided these services can be made

whole. I just do not think that is too much to ask. We know that these disasters are going to continue to happen.

We have all watched them as they have crossed the television screen, and we have seen hurricane after hurricane continue to come about. Are we going to continue to turn a blind eye to those who are still suffering from the events of eight weeks ago? It is unbelievable to me that, in this body and in the compassion that we talk about, particularly for our fellow man, that we cannot find the time to act on their behalf.

So, I just want to applaud the Senator from Montana for reaching out and reaching beyond, to thinking of others and realizing how important it is to keep the communities that are continuing to serve these individuals, these fellow Americans from affected States, to make sure that we provide them the same basic plan that we did after 9/11 to ensure that they can not only serve the evacuees, the fellow Americans that have been devastated and lost everything, but they can keep those facilities whole for the constituents they serve day in and day out.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Lincoln.

I obviously want to give Senator Baucus an opportunity to have closing remarks. Did you want to speak, Senator Kyl?

Senator Kyl. Yes, Mr. Chairman.

The Chairman. Go ahead.

Senator Kyl. I would gather that we could, on the Senate floor, to the extent that we wanted to adopt any of the ideas in Senator Baucus' amendment, take the action from FEMA, if we wanted to do that. We just cannot do it in this committee. Is that correct?

Senator Baucus. Correct.

Senator Kyl. Yes. So there is an opportunity for us to do that on the floor, if that should be the will of the body.

Senator Baucus. I am sorry.

Senator Kyl. To the extent that the Senate wanted to take action on your amendment, we could do so on the floor of the Senate without a germaneness problem. We cannot do that here in the committee, in taking it from FEMA funds that are already allocated.

Senator Baucus. I do not know if that is true. I think on the floor, the same problem would lie. It is mixing --

The Chairman. As we have talked in private conversations with the Republican Senators that oppose

1716, they said that they would agree to taking it out of FEMA, not to offset 1716, but an alternative that they offered us.

They were willing to do that, but I think both sides felt that it would be necessary to have the assent of the Chairman and Ranking Member of the Appropriations Committee to get that job done, at least to overcome, if there was some sort of rule of order objection.

Senator Baucus. If I might respond, maybe I can help here. I do not know. But my understanding is, it would run into the same problems on the floor, because this would be in the jurisdiction of the Appropriations Committee.

My thought is that we should pass it here and help force a resolution of this on the floor.

The Chairman. Go ahead.

Senator Kyl. I am simply asking the question.

The Chairman. Well, let us have some dialogue back and forth between you two. Go ahead.

Senator Kyl. Yes. Yes. It seems to me, the Senate can do whatever we want to do. We passed an appropriation for FEMA. We could come along later and say we are going to amend that to allow some of that money to be used for X, Y and Z, perhaps some of the items in your amendment.

The Government Affairs Committee would otherwise have to sign off on it, but since it is the entire Senate, it seemed to me that we could do that.

Now, if none of us know the answer to that here today, then that is simply a discussion we will have to have later. But I was simply offering that as suggestion, because it seemed to me that we would have the authority to do it.

Senator Baucus. I appreciate that. My sense is, we would have some of the same technical infirmities on the floor that we have here. I am just trying to force the issue here, which makes it more likely that we would address the issue.

Senator Kyl. Mr. Chairman, might I speak to the second amendment for just a moment?

The Chairman. Yes. Then I will call on the Senator from New Mexico.

Senator Kyl. As Mr. Holtz-Eakin indicated, there were a couple of items in the offsets that relate to physician reimbursement: the medical education component and the physician reimbursement component. Both of those seem to me to be troublesome.

We have to remember that we are trying to provide quality medical care to people who are disabled and seniors. That requires very skilled personnel,

physicians, and other skilled personnel. They need to be paid. We cannot get this good-quality care for free. If you do not pay them, then they are not going to sign up for Medicare.

There are people today, physicians, who are not taking Medicare patients any more, or who are taking very few Medicare patients because we have, over the years, reduced the reimbursements to the point that it is not possible for them, with the other expenses of liability insurance and all the other things that we have imposed on them, to stay with their practice. We do not want that situation to exist if we are going to provide care to people.

Might I continue on the second point?

The Chairman. For a few seconds. Go ahead.

Senator Kyl. As a result, we decided, once we were going to open Medicare up for some of the costs to be saved, that we should also deal with the Medicare problem that we knew we were going to have to deal with by the end of the year, and that is to ensure that physicians did not take a 4.4 percent cut because of problems with the SGR formula, not problems of their making, actually, problems of our making. So we knew we would have to do that, and this was, therefore, the appropriate place to do it.

To now go back and claw back some of that reimbursement, which is, after all, simply paying doctors for the care that they are providing to people would not only be unfair to them and to their patients, but it obviously begins the process of dismantling the entire system of Medicare, because if you are not going to have providers who can provide the quality of care, then our promise to seniors is an ephemeral promise. It is simply one that is not kept.

Senator Baucus. Mr. Chairman, if I might?

The Chairman. If it is on this point, you can proceed.

Senator Baucus. It is on that point. Really, two points. The Senator is concerned about two offsets. One, is the SGR, and so forth. I fully support the increase that is in this bill. We just delay it for a number of months out in the future to find money to pay for Katrina, knowing full well that when the drop-dead date arrives, again, as it does this year, we will again put it back in again, and probably at a higher percentage, too.

This is just a technical scoring matter, as far as I am concerned. It is not a policy matter whatsoever, because the policy is going to still be there. Namely, the doctors are going to get their full update, as far as

I am concerned, when it expires, just as they are getting their full update as it is now expiring this year. So, this is just an accounting matter. It is still not addressing the policy. We want the doctors to still get their full update.

On the other, you are basically addressing a concern where teaching hospitals get a double payment. Senator Schumer talked about this provision and we have modified it to address some of the concerns of the New York teaching hospitals.

If there needs to be further modification--we all know that there are times on the floor, before you get to the floor, this is really a huge problem, as on the surface it may appear to be--we can make changes. But in the interim, I have made the major adjustment that, as I said, there are lots of teaching hospitals in the State that we are most concerned about, to accommodate potential concern.

Senator Kyl. Mr. Chairman, might I just pose one question to Senator Baucus?

The Chairman. Yes.

Senator Kyl. With regard to the first point you made, that this is simply delaying a payment that is going to be made anyway --

Senator Baucus. Correct.

Senator Kyl. [Continuing]. Then it is not really an offset for the expense, is it?

Senator Baucus. It is scored as an offset.

The Chairman. Senator Bingaman?

Senator Bingaman. Mr. Chairman, I was just trying to get clear in my mind what the alternative plan is if we do not adopt one of these two amendments that Senator Baucus is offering here, if we do not provide the assistance here. Is it possible for him to offer those as an amendment to reconciliation when it comes to the floor next week? Is that the expectation?

If so, would that require 60 votes or some different, super majority to pass? Is it the expectation that the Majority Leader would bring a separate bill to the Senate floor that would allow the assistance to be provided?

The Chairman. This is not much of an answer for you, except to know that we are trying to find an answer to this. There are some Republicans that want us to find an answer as well, so we do not have to have Katrina in reconciliation. But I do not have an answer for you. It is all of the above.

Senator Bingaman. Well, let me just conclude by saying that my information is that we are going to do this Labor/HHS appropriation this week, we are going to do reconciliation next week and the week after, and then

at some point we are going to vote on Harriet Miers' nomination.

I do not see how assistance to the survivors of Katrina fits into any of those very well. So it seems to me, if we do not act here, I would hate to see us agreeing to adjourn this session of the Congress and go home to enjoy the holidays with our families without dealing with this issue.

Senator Thomas. Mr. Chairman?

The Chairman. Senator Thomas?

Senator Thomas. I am not very knowledgeable about this, but we are implying there that you have to designate all these FEMA dollars for these particular purposes. We have got $20 billion out there now. When there are needs down there, regardless of what they are, that money is available to be allocated to these funds. It does not have to be put in the context of Medicaid, I do not believe.

So I think the implication that we are saying here, that we are not paying attention to the needs, is not a matter of fact, when that money is down there to help whatever people need under this problem.

Senator Bingaman. Well, let me ask for clarification, maybe from some of the folks at the staff table. Is it clear that the authority now exists under

current law for the allocation of funds to take care of these needs, even if we do not legislate?

The Chairman. We have talked about that with our staffs, so I assume, Mark, you have got an answer for that. I have been led to believe that there needs to be some legislation passed, even for the uncompensated care, if we are going to take care of the needs.

Mr. Hayes. Mr. Chairman, you may want to direct that question to CMS. There are individuals from CMS who are here today. My understanding is that additional legislation is required to do some of the things we have called for in S. 1716.

Senator Bingaman. It is required if it is going to be delivered under Medicaid.

The Chairman. Senator Bingaman needs an answer to his question, so if there are people here from CMS that can answer it, would you please answer it? You look familiar. There is life after the Finance Committee. Would you introduce yourself?

Ms. Fishman. Yes. I am Linda Fishman. I am Director of the Office of Legislation at CMS. Mark Hayes is correct, we are willing to work with the Congress on certain aspects of the financing of Katrina survivors.

As many of you know, we have a number of States that have applied for waivers under the Medicaid program. We

have granted waivers to 12 States, so far. We have some waiting in the wings to be approved.

We also, as part of those waivers, in many of the States, have granted the States uncompensated care pools to deal with some of the individuals that Senator Baucus and Senator Lincoln have referred to today. That uncompensated care pool operates in, I believe it is, seven States at the current time.

The way the uncompensated care pool works, is that it builds on the States'--and I am going to refer to those States as "host States" because they are hosting survivors of Katrina--existing Medicaid system, including its payment systems, to take care of those individuals who receive medically necessary services and supplies through the Uncompensated Care Fund.

Now, the process is such that individuals who are in host States are then, in effect, using the host State's Medicaid programs. Under current law, what happens is, the home States--and those are referred to as Louisiana, Mississippi, and Alabama--incur costs, if you will, for their continued share, State match, of those individuals who are now in other States. We would like to work with the Congress to take care of that problem, which would, in fact, need legislative change.

Senator Lincoln. Can I just ask a question on that?

The Chairman. Yes.

Senator Lincoln. So then those that are hosted, the host State would then file the Medicaid under the Louisiana plan or their Louisiana Medicaid qualifications. Is that correct? Then Louisiana would be held responsible for their Federal match.

Ms. Fishman. Their share.

Senator Lincoln. So we know, because the governor testified here not too long ago, that they were already in the hole because they were not prepared for the FMAP decrease they were going to get on October 1. I mean, where do we assume that money is going to come from?

It is a little humiliating to go to your neighbor who has been devastated, and say, you are going to have to cough it up. If they do not, then we are still made whole and they are not. I am assuming that is how it is going to be handled. I just wonder, where is the uncompensated pool going to come from? How are you going to pay for that?

Ms. Fishman. The uncompensated care pool is supported by funds through a program called the NDMS. It stands for the National Disaster Medical System. It was a program created under the Public Health Service Act.

At one time, the Secretary of the Department of Health and Human Services was responsible for

establishing criteria under which those monies would be paid out, but when the Department of Homeland Security was created, those responsibilities were transferred over to the Department of Homeland Security.

Senator Lincoln. Does that fund have money?

Ms. Fishman. Yes, it does. We expect that we have $100 million to fund the uncompensated care pool.

Senator Lincoln. Thank you.

The Chairman. Senator Bingaman?

Senator Bingaman. Let me just ask, to clarify. The uncompensated care pool is available to fund the Federal portion of the Medicare cost that is incurred. If I am a survivor and I am over in Texas, instead of being in Louisiana where I used to live, then when I get Medicaid services in Texas, the uncompensated care pool will pay for the Federal portion of the Louisiana-based Medicaid services, as I am understanding it, and then Louisiana has to pay the rest.

Ms. Fishman. There is a difference between whether or not that individual is eligible for Medicaid under simplified criteria that we put out in our application waiver process or whether that individual is one who is not Medicaid-eligible.

For example, in the case that Senator Baucus, I believe, spoke about, a Mr. Wilson, who is a childless

adult and is not Medicaid eligible, that individual would get his health care costs paid for from the uncompensated care pool, which pays the full share.

Senator Bingaman. So, Mr. Chairman, let me just ask this one final question. If I am right, then Congress does have to pass legislation in order that the States that were hit by these hurricanes are not loaded down with this cost of people getting Medicaid care, Medicaid-based care, while they are resident somewhere else.

Ms. Fishman. That is correct.

Senator Lincoln. Can I ask just one more quick question?

The Chairman. Yes. Go ahead

Senator Lincoln. So my understanding is that there is a deadline of October 31 for those States who are housing, or the host States, for these evacuees. By October 31, our States have to go all the way back to Labor Day and they have to define or qualify all of those that have been served under the qualifications of the Louisiana Medicaid qualifications to be able to submit to you then what their request is, and then CMS will then review what is submitted to them on October 31?

Ms. Fishman. Yes. There are a number of things going on, Senator Lincoln. With respect to those individuals in Arkansas, the State of Arkansas needs to

adjust its claims paying system to account for those individuals, for example, to put codes on the billing systems to identify those people as survivors of Katrina, and then they would qualify for special treatment relative to others in the Arkansas program.

My understanding is that, by October 31, States have to submit a plan to CMS to describe what they are going to do in terms of helping individuals. It is not that it is cut out. In fact, the uncompensated care pool is going to run until January 31 of next year.

Senator Lincoln. But in other words, these States now, in their already over-taxed Medicaid programs, are going to have to reinvent a new system or program by denoting these evacuees, in a system that they then submit to you, and may or may not get authorization from CMS in terms of those that they have been servicing or providing care for since Labor Day.

Ms. Fishman. That is not exactly the way it is going to work. Actually, one of the things the administration is quite pleased about, is that we have been able to direct our efforts and attention toward building upon existing State Medicaid programs, as opposed to creating, as we believe, S. 1716 does, entirely new systems, which in fact would require a substantial amount of effort on the part of CMS to create

a new way to pay for those individuals.

I think the beauty of what we have done, is that it requires a very minimal amount of change on the part of host States in terms of using their systems. It is just a matter of places like Arkansas and Texas coding properly so that we can then get the money to the right place.

Senator Lincoln. Well, 1716 was really based on what we did in 9/11. It appeared to me, after 9/11, what we were able to do was to be able to provide services for those individuals and make sure that the providers were whole.

In these instances, we are having to backtrack all the way to Labor Day to people who did not ask questions and who provided those services, and who are now going to have to go back and meet all of that criteria in terms of the specifics, whether these people were childless, whether they were 62, 64, 55, or whatever. So, I do not know. It just seems like we are asking for an awful lot more than what we have in the past in terms of servicing these individuals. So, thank you.

The Chairman. Linda, I know you worked for the Finance Committee, so you have got a lot of common sense. I know you are also tied down by what the administration does, because you are working for them.

But I think that we see here something that is pretty obvious, and that is that we are two months away from Katrina, we are a month and a half away from the introduction of our bill, and we do not have this issue solved.

Our bill was only five months along anyway, so there would only be three more months of it to operate, and we would have all these problems taken care of. I think you ought to go back down to the White House and tell them to move ahead on this legislation.

We even have scaled it back considerably, and probably could scale it back some more, to work things out, and pay for it from the offsets that even Republicans agree we ought to be using. We do not have to have all these questions.

This is a complicated answer that you have given to three or four Senators here. I mean, you gave a correct answer. You gave the answer that is the right answer. But it emphasizes that we ought to get some version of 1716 passed yesterday, or this afternoon, by unanimous consent, or something, and move this thing along.

Senator Baucus?

Senator Baucus. Well, Mr. Chairman, I really appreciate that. You and I worked very hard on that bill. Our staffs worked very hard on that bill. It is

unanimously agreed to on our committee, that bill.

We worked with the affected Senators, the Gulf State Senators, and they all agree, I might add, on both sides of the political aisle. The governors of the affected States, they all agreed, they wanted it. It is kind of a strange surrealistic situation we are in where we are not passing something that is definitely needed.

I share your concern. But, Mr. Chairman, you have, a couple of times, characterized this as a down payment. As the Senator from New Mexico pointed out, there is not a lot of time left, or opportunities left, between now and Christmas. I worry, frankly. This is not a down payment. It is a last payment.

If this body, the Senate and the House, will not, absent what we do here in this committee, pass any significant health-related Katrina legislation, I am afraid it is not going to happen. I see the White House undermining you in your diligent efforts.

I see a couple of Senators on the floor, standing up and preventing what we have tried to get passed. We have gone to those Senators a couple of times with suggestions, trying to meet their concerns. Two major concerns that they presented to me, and to you as well, is, number one, let us have FEMA pay for it. So that is one of my amendments, to have FEMA pay for it.

The other big objection I heard is, well, gosh, you have 29 States that have FMAP relief, and some of those States are not related to Katrina. So my amendment--in fact, both of them--has taken that out. We are just providing FMAP assistance to the affected Gulf States.

But even with that, we are having a tough time here. I would like to hope that there are the opportunities on the floor to address people's needs, but I am a realist, too. I am trying to call them as I see them, to be honest and objective about this.

I am afraid that I do not see any other times, just in terms of schedule, and also lack of will on the part of the White House or Senators on your side of the aisle. I do not blame you at all.

In fact, I wish other Senators on your side of the aisle would listen to you a little more, because you are doing the right thing. You do not put politics ahead of policy, you put policy ahead of politics. You are doing the right thing, and I very much appreciate that.

I must say, too, I am interested in some of the administration's efforts, but I understand the administration, as I hear today, as $100 million set aside for uncompensated care.

As you know, Mr. Chairman, in our bill we set aside $800 million for uncompensated care. That is not going

to begin to be enough. We do not want to pay for all the uncompensated care, but we do want to provide for some of the uncompensated care down there.

I have here an estimate by the State of Louisiana as to their uncompensated care needs. Now, I grant you, this is the State of Louisiana, so maybe it is up a little more.

But these are their estimates, the State of Louisiana, of their Katrina-related critical needs. Uncompensated care. What is their estimate for uncompensated care needs? $425 million. Not $100 million, $425 million. That is one State.

Now, let us cut that in half. Let us say it is not quite that much. That is $200 million. That is just one State. We had $800 million in our bill, which still is not going to be enough. We know that.

I might add, too, that these waivers the administration talks about do not do the job. As the Senator from New Mexico pointed out with his questions, the administration does not have legal authority to do what needs to be done.

One, is to expand eligibility for people who really need health care, even if on a temporary basis. The administration cannot address that with their waivers. It is illegal for them to do so. It is illegal for them

to do some of the things that we provide for in our bill, again, on a temporary basis. So, I would hope very much we could find some way to address the people's needs through one of these two amendments that I am suggesting.

The Chairman. Now I would like to set aside the two Baucus amendments and go on to other amendments that would be debated. I was going to go back and forth to Republicans. Did Senator Kyl have an amendment?

Senator Kyl. Yes.

The Chairman. We will go to Senator Lincoln then.

Senator Lincoln. Thank you, Mr. Chairman.

I would like to offer my first amendment, which is the health care relief for our Katrina survivors, our neighbors in the Gulf State, our fellow Americans. This amendment incorporates the language from the Emergency Health Care Relief Act of 2005, which was S. 1716.

It would provide coverage for all Katrina survivors, up to 100 percent of the Federal poverty level, and up to 200 percent of the Federal poverty level for pregnant women and children, or up to 300 percent of the SSI benefit for disabled individuals. It is also a provision, as I said, from S. 716.

I do want to commend the Chairman, because his mark does provide relief for some of the Hurricane Katrina survivors, and I thank him for that, but I do believe

that the scope is too narrow.

If I just look around this committee room and look at the number of individuals who would not be covered, if you should find yourself as an individual or a couple under the age of 65 whose children were over the age of 18, all of a sudden losing everything that you had in life, you had no job, you had no income, you had no home, and maybe your children had suffered the same devastation, they were not there to care for you, this committee itself disproportionately would not be covered under this legislation, the base legislation.

So I really ask my colleagues to look at making sure that we are providing the kind of temporary care that these individuals need. A hurricane survivor could be eligible based on income, but just because they do not have a child means they cannot receive health care coverage. It is so unfair. It is so un-American. It is just unacceptable, Mr. Chairman.

I shared the heartbreaking story in the Finance Committee hearing recently that really illustrates why having categorical restrictions on eligibility is so problematic, and I think it is only appropriate just to revisit that story today.

There was an article that was entitled "Swamped" in *The Economist*. After sleeping on top of her refrigerator

for three days to avoid the flood, Maude Jordan was eventually rescued from New Orleans and she was taken to a relief center in Baton Rouge, where, penniless and diabetic, she was a little bit hurt or disgruntled to have been served donuts for breakfast every day.

But on the plus side, she assumed that she would qualify for some free medical treatment under Medicaid, the health program for the poor.

Her application was rejected, however. She received a letter which said she was unable to establish categorical eligibility because they could not establish categorical eligibility for a single woman under 65 with no children.

That may make sense to a Medicaid bureaucrat, but to Ms. Jordan, it was about as clear to her as the lake of the diluted sewage that had swamped her home. I just think we have to think outside the box here. We cannot be the bureaucrats that people know us to be. We have got to look at the human suffering that has occurred and recognize that, on a temporary basis, we can respond.

We can respond as a Congress, and certainly as fellow Americans. Why in the world should Maude Jordan be excluded from receiving temporary medical assistance? It is just beyond all reasoning.

For those of us who have grown up in communities

where we know how important it is to be a good neighbor, to care for your neighbors, and certainly as Americans to know that if we were in that situation, we would want our Nation to be able to respond.

My amendment would ensure that Maude Jordan was covered, so I encourage my colleagues to support it. Mr. Chairman, it is offset. I thank you for the opportunity to speak on this, because it has been limited on the floor.

Again, I apologize to continually be bringing this up here, but we have had no other opportunities and no other venues, and I do feel like it is an important issue. Thank you, Mr. Chairman.

I have two amendments. I did not know if you wanted me to go ahead and offer them all at one time.

The Chairman. Yes. Proceed.

Senator Lincoln. Oh, you do?

The Chairman. Yes. Please do.

Senator Lincoln. All right.

Mr. Chairman, my second amendment is Lincoln Amendment 2. This is the disaster relief our providers need. Again, Mr. Chairman, it incorporates the language from the Emergency Health Care Relief Act of 2005, S. 1716, which again you were so instrumental in helping to negotiate. We all were willing to make compromises in

order to move forward.

I did not get to ask Ms. Fishman, but it is my assumption--and I do not know if it is true--but I do not think any of our providers that have provided care to survivors have actually gotten payment for that care that they have provided, because after eight weeks we are still thrashing around, trying to figure out what we are going to do and how we are going to do it, and then it is going to be further delayed after our States have to file these plans with CMS. But that can certainly be a question answered at another time.

The amendment creates an $800 million disaster relief fund to provide payment to those Medicaid providers who experienced a significant increase or decrease in their patient volume due to Hurricane Katrina.

As I said in my opening statement, Mr. Chairman, or tried to, health care providers all over the country came to the aid of hurricane survivors. They were not asked to. No one had to force them to do this.

When their fellow Americans arrived on their doorstep, when they were hurt, when they were in need of health care, when their family members were in need of health care, they did not have to be asked.

Hospitals airlifted people to area hospitals. Children's hospitals went into immediate response in

providing the kind of unbelievable care that those children needed. Doctors and nurses took care of the injuries.

Pharmacists provided people with their prescriptions so that they could continue their cancer treatment, get the insulin they needed, or provided also the mental health pharmaceuticals they needed to at least keep peace in the evacuee camps that we had. These people did not have to be asked. They responded as Americans, and they expected us to respond as Americans, too.

Health care providers should not be left empty-handed for doing the right thing. It is so important, at a time when we as a Nation need to truly exhibit the values that all of us talk about day in and day out, about what it means to be an American, to be able to depend on your Nation and the values that your Nation stands for.

My hometown of Helena, Mr. Chairman, welcomed hurricane survivors from New Orleans, Slidell, Gulf Port, Mississippi, and many other of the affected areas. They dipped into their emergency medicine fund from their local health care foundation.

Now, Mr. Chairman, my hometown is in one of the 25 highest poverty counties in the Nation. It has unbelievable needs on its own, not to mention what happens when it sees its neighbors to the south or to the

east in dire situations.

The reason they have a health care foundation, is because their local hospital had almost closed its doors three times in the last several years. Doing all that they could possibly do, they scraped together to build a foundation to try and reinforce the foundation of the health care needs in that community, to make sure that the infrastructure itself could hang on long enough to be able to meet the needs of the local residents.

They had to dip into that emergency fund, a much-needed foundation that the community established to help support their community and the health care needs of that community.

They provided insulin, syringes, Glucometer strips. They almost had 200 prescriptions to hurricane survivors. This is coming from a community that did not have it to give, Mr. Chairman. It is not a rich community. It is not a wealthy community.

It is a rich community in the values that it espouses and its ability to reach out to its fellow man and to recognize someone in need. They have worked for years to establish this foundation, and yet they did not hesitate to dip into those funds when their neighbors needed it. They would do it again in a heartbeat.

The health foundation is not alone, Mr. Chairman.

Hospitals, doctors, churches, and organizations all across this country have provided similar services in the days and weeks following the devastation in the Gulf Coast, and should be compensated for their good deeds and the services that they provided.

I really encourage my colleagues to join me in supporting this amendment in terms of reinforcing the values that were set and established in this country, but exhibited by the providers in the host States where these survivors found themselves. So, I encourage my colleagues to support it, and it is offset, Mr. Chairman.

The Chairman. I will not take eight minutes in opposition to your amendments, because much of what I would say I have already said in regard to the Baucus amendment. So, I will not repeat that at this point in regard to the substance of your amendments.

But let me make a point on your offsets, because I am concerned about the proposed offsets. It would accelerate the phase-out of the budget-neutral modification of the Medicare Advantage risk adjustor.

The mark calls for a phase-out schedule, announced September 1 by the administration. The new CMS schedule is slightly faster than the phase-out schedule included in the President's budget, and unanimously endorsed by the Medicare Payment Advisory Commission just in April.

A faster phase-out would be harmful to the Medicare Advantage program because it would cause steep reductions in payments. I want to avoid that sort of outcome, and probably that is more true of rural America than it is urban America, but it still gives us some equity in rural America.

Senator Lincoln. Mr. Chairman? Just in respect for your concerns there, I did modify my amendment.

The Chairman. Is my staff available on the modification? So, we do not find fault with her modification and I have got to start over again? [Laughter].

Ms. Desmarais. I think the amendment, as modified now, the accelerated risk adjustor is no longer part of the offset. Correct?

Senator Lincoln. Right.

Ms. Desmarais. All right. Sorry. It would offset the amendment by delaying paying for fiscal year 2006 Medicare Part A and Part B claims, and moving back the number of days for which claims would be delayed by the number necessary to cover the spending in fiscal year 2006.

Senator Lincoln. That is correct, Mr. Chairman. What we can try to come up with from what CBO scored of your package before -- and I still do not understand why

CBO cannot give us a score for our amendments when these are directly out of the previous bill that I co-sponsored with you. Maybe Mr. Holtz-Eakin can help us, as to why we cannot get a score for those.

But looking at the score and the estimates that we can make for what was in the bill, 1716, it appears as if that would only be one day. Thank you, Mr. Chairman.

The Chairman. You have the right to modify your amendment, but it makes it difficult for my responding to it if we do not know about the modification. So, regardless of modification, based upon the statements that I made about Senator Baucus' amendment, not dealing with the offset but dealing with the substance of the underlying amendment, I would oppose your amendment.

Now we would set aside your two amendments and go to Senator Rockefeller.

Senator Rockefeller. Thank you, Mr. Chairman.

I would like to call up my amendment to provide a six-month period for dual eligibles, individuals, therefore, who are eligible for both Medicare and for Medicaid because of the drastic nature of their family circumstance.

Senator Bingaman and Senator Lincoln, I am happy to say, are co-sponsors of this. It would protect millions of senior and disabled Americans. What we are basically

doing, is people who are not dual eligibles under this transition to a new plan, they get six months to do it.

But there are 6.4 million folks who just happen to be poor, women, minorities, most of whom who are in nursing homes, have diseases substantially worse on a net basis than the rest of the Medicare community. The 6.4 million dual eligibles only get six weeks of transition. If they do not make it, I guess that is their tough luck.

So, on a philosophical basis, I do not understand why one does not provide the same transition time to figure out what these new plans are. We are ready about them already in the newspaper. People are getting confused. I know that is happening in West Virginia.

Everybody ought to have the same amount of time. What we are saying is, people who are more likely to be a little bit less sick and maybe have better financial circumstances will get six months, but 6.4 million Americans will not. They will only get six weeks.

I do not think that is fair. The prescription drug plan goes into effect January 1, 2006. MEDPAC went out and surveyed two very large industries, 75,000 and 25,000 employees each, just two, and said that those companies were going to have a terrific problem meeting six months' time.

So, our amendment would allow States to continue to

provide the Medicaid wrap-around for dual eligibles beyond January 1, 2006, when they would hit the bottom. States would be able to continue receiving Federal Medicaid matching funds for dual eligible prescription drug coverage until July 1, 2006, i.e., both of them have a six-month transition period.

If there was ever a question of fairness, this strikes me as a matter of fairness. My offset is exactly the same as the first one that the Senator from Arkansas offered which you said that you would oppose.

I mean, to be quite honest, when you are doing things like this, here is a massively unfair situation, dual eligibles, six weeks. A lot of them do not have phones. They are in nursing homes. They do not know what is going on. Alzheimer's rates are very high there. The rest of the community, six months.

One approach? No, there are two approaches here. They are not going to make it in six weeks. They will be lost. I think stretching it to six months is fair. I have to go somewhere to get an offset. There are not many places to go.

I go to the same risk adjustment matter that Senator Lincoln proposed that you said you would be opposed to. I think that sort of means that most of the amendments that are going to be suggested, at least from this side,

are going to be turned down.

I would earnestly ask the Chairman, one, to say this is a massive problem, terribly unfair, very unlike America, ought to be fixed, and yet the offset mechanism which both the President's budget and MEDPAC both recommend was a phase-out of the budget-neutral policy.

So, it does not strike me as either radical or wrong, unless the Chairman says it is. Then, of course, I am in a spot, and 6.4 million people pay the price.

The Chairman. Director Holtz-Eakin, could you tell me about the offset and whether or not it works?

Mr. Holtz-Eakin. The offset is certainly large enough over the five-year budget window to cover the cost of this proposal. The only residual question that I do not know the answer to, is whether the costs in 2006 would be covered or not. They are small. I do not know for sure. We can take a closer look.

The Chairman. All right.

I would like to speak to why I oppose the amendment, because I do not think that there is a need to delay the transition to dual eligibles. Now, oddly, when this bill first went through the Senate two years ago, our bill had treated dual eligibles, or left dual eligibles alone because they had coverage, and we wanted to help those that did not have coverage.

So if we were talking two years ago, Senator Rockefeller, you and I would have been on the same side of the fence. But that is water over the dam now, because of compromise with the House on where we are. We only have one program now, so you do not have dual eligibles.

Over six months ago, CMS issued a 44-page strategy for transitioning dual eligibles from Medicaid to Medicare prescription drug coverage. That strategy lays out in great detail the steps that CMS will take to ensure continuity of coverage for the beneficiaries.

CMS established safeguards with which all prescription plans have to comply. First and foremost, CMS carefully reviewed all of the plan's formularies to ensure that beneficiaries would have good access to the drugs they need.

Many plans around the country cover nearly all of the top 100 drugs used by seniors. CMS required plans to cover all, and substantially all, drugs in six drug classes, including anti-psychotic, anti-depressant, anti-cancer, anti-convulsant, immunosuppressants, and HIV-AIDS.

They were also required for transition plans, and when we were considering the MMA we made the determination to transition the duals into the Medicare

prescription drug benefit. All States wanted this. There were members on both sides of the aisle that wanted it, even though it was not in the Senate bill.

In my opinion, giving what many States have been forced to do, I find it difficult to understand why folks feel that dual eligibles are better off under Medicaid. Many States have strict limits on the number of drugs that beneficiaries can get filled each month, and if the beneficiary needs that sixth prescription in a State that only covers five, then that beneficiary is out of luck. That is not the case with the Medicare drug benefit. There is no limit per month.

I agree that every step needs to be taken to ensure that there is no disruption in coverage and those steps are being taken. Delaying their transition then is bad policy and, importantly, bad for these vulnerable beneficiaries who deserve to have the same choices in prescription drug coverage as other beneficiaries.

Senator Rockefeller. Mr. Chairman?

The Chairman. Go ahead.

Senator Rockefeller. I understand what you are saying. The President, in fact, on June 13, spoke to the Illinois Medical Society and said that he wanted to see dual eligibles taken care of just like everybody else. Now, two years ago was two years ago. This conversation

took place within the last eight months.

We are not talking about cost here, really. We are talking about time. It is transition. It is a one-time thing. It is a transition. Here I am, and you are going to say, oh, there goes Rockefeller again in Appalachia.

I have so many people I can think of in my mind's eye right now who live alone on the top of some hill in Braxton County, or Calhoun County, or someplace. You have tons of them. Blanche, you have tons of these folks, too. They may not have a phone. Incidentally, Medicaid has better coverage than does Medicare.

But this would only be for transition so they could get into a proper plan. They cannot do it in six weeks. That is what your bill calls for. That is not enough time. They cannot do it. They are poorer. They are sicker. They just will not work the system and they will fall out. I do not think the Chairman wants that. I know the Chairman does not want that.

The Chairman. I obviously have not convinced you. Could I ask staff if they could do a better job?

Senator Baucus. Before you do that, Mr. Chairman, might I just point out something here?

The Chairman. Go ahead, Senator Baucus.

Senator Baucus. This is a problem. Six weeks before the end of this year tends to be a time when

people are distracted, they have other things to do. It is just kind of hard to focus on one's business, or one's needs, or a plan.

Generally, people, I think, kind of put things off a little bit the end of the last six weeks and start thinking, all right, the first of the year, that is when we really need to start getting grounded again. That is when we are going to restart and rebalance, and so forth, and get moving again.

Now, I mention that because I think there are, on average, about 20 plans per State. Seniors are going to have a very difficult time choosing among plans. I think there are too many plans. I think there are way too many plans.

It is confusing enough as it is, but when seniors now have to decide among roughly 20 different plans for their drug benefits, I mean, it is going to be, just, Katy bar the door in terms of complexity.

My sense is that, maybe the first year, but maybe even the first six months, that we are going to need--to use that awful word--experience under these plans to have an idea which plans are working better than some others, which have better benefits than some others, so people counseling people in this category, that is, dual eligibles, will have better information in helping people

know which plans tend to make the most sense.

I just think that is the least we can do here. With the proliferation of plans, the complexity, we need a little test drive here as to which plans are better than some others. It could well be that someone is going to sign up for a plan and that plan is going to go belly-up and be gone. There is going to be a big shake-out period among all these plans.

Now, maybe not in the first six months, maybe in the first year. But I just think it makes sense to kind of give the most vulnerable people in America an extra little break so we are not disadvantaging them.

Otherwise, I think, as Senator Rockefeller said, there are going to be people out in the country somewhere, no telephone, and lo and behold, they did not meet the six-week sign-up and they are going to be in tough shape. I am sorry if I interrupted you.

The Chairman. I do not question the sincerity of my colleagues, but, Mark, either you or Linda, maybe, can satisfy them that what we have in place here is going to take care of people's needs and get them enrolled.

Mr. Hayes. I would be glad to speak to that. I think it would be appropriate for CMS to respond also.

The Chairman. Well, then let us just have one of you speak to it. Linda, will you speak to it?

Mr. Hayes. Under current law, while Linda is coming to the table, I would just want to make clear that dual eligibles can choose a plan until May 15 during the entire open enrollment period, just like any other beneficiary. They are automatically enrolled as of January 1, 2006 so that they will have no gap in coverage.

Senator Rockefeller. Mr. Hayes, they may be automatically enrolled. I apologize for interrupting you. They may be automatically enrolled, but half of them are not even going to know it. They have no way of knowing it. They have no way of going down and calling your friendly 1-800 number at CMS.

They are just not going to know that. I mean, what you are saying makes sense, and you say it in good faith. But the practicality of living in rural areas, or for that matter in real urban areas, is people just throw stuff out.

They are presented with 20 plans for this and they cannot handle it. They are automatically enrolled and they do not know it, so they do not go to their pharmacist. Then we should make the whole thing six weeks for everybody under this program.

The Chairman. Ms. Fishman?

Senator Rockefeller. I am serious about that.

Mr. Hayes. Senator Rockefeller, it is true that the dual eligible population will be one of the hardest populations to reach, as a general matter. That is why the auto enrollment is so key, to make sure that they are enrolled in a plan so they have no gap in coverage.

If a beneficiary arrives at a pharmacy at the first of the year, the pharmacy will be able to look up what plan they have been auto-enrolled in and know where to place their claim so that they will be able to get their coverage with no difficulty. CMS has built a special system just for that purpose.

Senator Rockefeller. Do you know that CMS has never maintained a list of dual eligibles? Did you know that, Mr. Hayes?

Mr. Hayes. I believe, for this system, however, they have developed a list of the dual eligibles with the States so that the auto enrollment process can take place. I believe Ms. Fishman can detail that for you.

Senator Rockefeller. Do you know that States have never been required to keep a specific list of dual eligibles?

Mr. Hayes. Here again, Senator, I do believe that that has been an issue in the past that had to be overcome here in order to make sure that the duals transitioned into the universal benefit could be

accomplished.

Senator Rockefeller. My heavens, Mr. Chairman. I do not want to go on. I mean, my next amendment is going to be for three months, and then the next one, if that fails, to have a report from the CMS Director or from Mike Leavitt as to how he thinks this transition is going to be taking place. It is only a transition. This is not a permanent program, it is a transition.

These people do not vote. It has nothing to do with any of that stuff. It is that they are being discriminated against because they cannot do it. They may be auto-enrolled, but I will guarantee you, you will not find people who know that, and therefore they will not go to their pharmacy.

The Chairman. Linda, would you speak for CMS? Can you get this job done or can you not?

Ms. Fishman. Yes, we believe we can. I just say to say, very clearly, that I participate in many meetings at CMS, and this is an area in which our Administrator, Dr. McClellan, is personally involved. We meet several times a week on this issue and we are very concerned about making sure this population has access to the drug benefit on January 1.

We are days away from mailing letters to all the dual eligible individuals, telling them to which drug plan

they are assigned beginning January of 2006. That letter should go out, as I said, in a few days.

With respect to the database you talk about, we get names of individuals from the States every month. There is a data tape that gets updated, I believe. Our data are getting better and better all the time in terms of identifying these individuals.

If an individual does not recognize the plan to which he or she has been assigned through the letter, throws the letter out, or whatever, if that individual goes to a pharmacy on January 1 seeking prescription drugs, the pharmacist will be able to submit an electronic query to CMS that will enable the pharmacist to tell that individual what plan he or she is in.

They will also have a determination then of whether the pharmacy is in or out of network. If it is in network, the pharmacist will be able to fill a prescription for that individual. If not, the pharmacist will be able to direct the individual toward the 1-800 Medicare number, or hopefully the name of the plan that individual is in.

Senator Lincoln. Mr. Chairman?

The Chairman. I promised Senator Wyden, first.

Senator Lincoln. All right.

The Chairman. And then Senator Lincoln, then

Senator Schumer.

Senator Wyden. Mr. Chairman, obviously the risk adjustor is the magnet for a whole host of amendments now. What Senator Rockefeller is talking about is a heartfelt need. We have a lot of those people. We also have people, particularly in Portland, a low-cost area, an extremely efficient area, more than 50 percent of older people in managed care, who could get hurt by this.

So what I need to know, and I suspect New York and other States have some questions about as well, is where is the administration in terms of calculating this risk adjustor? Because my understanding is that the data is not available at this point and I think that is why it is hard for some of us to really assess how we might fund some of these incredibly deserving causes that Senator Rockefeller has talked about.

I happen to think we ought to be financing some of these needs in terms of low-income people on the tax side. That is not on the table, so that is where we are. We are on the risk adjustor today.

Ms. Fishman, can you tell us where the administration is in terms of calculating this?

Ms. Fishman. Do you mean the budget neutrality adjustment and the proposal to accelerate it?

Senator Wyden. Yes. I mean, I gather the data is

not even available now.

Ms. Fishman. I believe the data are available. I believe it is September 1 or late August, as I recall. I do not have the materials in front of me. We made an announcement that we were going to phase the risk adjustor/budget neutrality adjustment out of the system, as the President's budget stated, in early 2005 for the 2006 budget.

We have a schedule. We modified it somewhat to account for an error in the data that we found, but we will be taking on that schedule, which I can get for you.

Senator Wyden. How much money is being saved?

Ms. Fishman. In the risk adjustor?

Senator Wyden. Yes.

Ms. Fishman. I have a chart, Senator Wyden.

Senator Wyden. But that is the question. That is the question Oregon wants to know, New York wants to know. I mean, we have got these very difficult calls to make because taxes are off the table. So, I really need to know how much is being saved.

Ms. Fishman. Well, up to $6 billion, which is what the score was for the Chairman's mark.

Ms. Desmarais. The Chairman's mark phase-out schedule is the same that was called for by the administration in its September 1 notice. That would

save $6.46 over five years.

Senator Wyden. Six billion dollars more out of the system. Folks, the numbers do not add up. People are going to get hurt, and these are vulnerable people. These are seniors walking on an economic tightrope. They are walking on an economic tightrope in New York and elsewhere.

Senator Rockefeller has talked about an incredibly important set of needs, and I want to support him. If we are pulling $6 billion out of the system, I do not see where you are going to meet these needs.

The Chairman. Senator Wyden, I think you raise a question and you want answers to it. But can we go on to Senator Lincoln?

Senator Lincoln. Thank you.

Senator Wyden. We can, Mr. Chairman. Just to finish up, the point is, the risk adjustor is the magnet for all of these amendments. That is why I thought it was important that we figure out what kind of money we are talking about.

The Chairman. All right.

Senator Lincoln?

Senator Lincoln. Mr. Chairman, thank you.

To Senator Rockefeller's amendment, during the last couple of break times that we have had I have gone home

to Arkansas, because I worked diligently with you in the Medicare reform bill and was pleased to vote for it. It was not a perfect bill, but I thought it was really much needed, and time for us to move forward in modernizing Medicare with a prescription drug component.

I held about eight meetings across our State and we had no less than 250 at all of those meetings; some we had many, many more. I think the concern about the dual eligibles stems from the fact that there are, particularly in our State, a high number of dual eligibles. As of January 1, they will automatically be put into a Part D plan, one of the 40 possible plans that are offered in Arkansas.

I think the real question becomes, does CMS have the database that indicates to them more of who these people are and what their needs are, so on January 1 when they go to that drugstore and hand that Medicaid card over and the pharmacist says this is no longer any good, if the pharmacist is great, which most of ours really are--they are tremendous people and they have already been helping seniors and disabled look at what these plans are--they are going to say, let me go online and figure out what you've been signed up to.

But that pharmacist may have to come back after that and say, well, you have been signed up to Plan ABC, and

it does not cover these three prescriptions that you take, it only covers these other two prescriptions that you take.

The concern that we have, is we are talking about an element of beneficiaries who do not have a lot of access to information. They may not have the assistance they need in evaluating 40 very complicated plans.

Now, we got down in the weeds of these meetings and, again, people were not angry, but they were anxious. They were concerned about the amount of information they were going to have to wade through. You have got a great tool. I am not sure if it is up and running yet. We had to tell them that it was not up and running on time yet.

But your tool on CMS's website is very helpful, and that is encouraging. But I think the concerns that we have are that this is an element that is going to need a little extra time if, in fact, CMS does not have the ability to choose for these individuals the plan that is going to be best for them, and certainly best for the taxpayer, in putting them into plans that are economical and that are going to be able to provide the prescription drugs that those individuals need.

So maybe you can answer that, Ms. Fishman, as to what criteria CMS will use in putting those individuals into a plan if they do not choose one. Now, you said that there

is a letter going out, but technically they are not supposed to be able to sign up for a plan until November 15. Is that correct?

Ms. Fishman. Yes.

Senator Lincoln. So the letter is not going to tell them what plan they are.

Ms. Fishman. Yes, it is.

Senator Lincoln. Oh. So you can sign up the dual eligibles prior to November 15?

Ms. Fishman. Yes. We have been working on this for quite some time.

Senator Lincoln. Good.

Ms. Fishman. The letter will contain the name of the plan that that person has been assigned to. The statute directed us to assign these individuals, on a random basis, to plans --

Senator Lincoln. On a random basis. All right.

Ms. Fishman. [Continuing]. That had premiums at or below the low-income subsidy benchmark, which differs from State to State.

Senator Lincoln. Right.

Ms. Fishman. So the choices are, perhaps, not as many as 40, but there is certainly a robust number of them.

Now, a dual eligible person can elect to choose

another plan, if he or she is not happy with that plan, at any time.

The Chairman. Senator Schumer?

Senator Schumer. Thank you, Mr. Chairman.

I just want to echo and augment the comments made by my colleague from Oregon. I think what the Rockefeller amendment shows, is how we are all between a rock and a hard place.

The only way you can get money for something good, is to take money away from something good. There is not much in this bill that there is a consensus, or even a glimmer of consensus. It is wasteful and we ought to get rid of it. So, that is the dilemma. We are sort of robbing Peter to pay Paul.

I totally agree with Jay on dual eligibles. We need to do it. It is important to do it, giving them the extra time. There is no argument against it, as best I can tell.

On the other hand, where we are taking the money is devastating to my State. We have 518,000 seniors enrolled in the Medicare Advantage program, and they depend on it. That is all they have. These are not rich people. These are people who are, just by their fingernails, hanging on to the middle class.

Because of the ups and downs of this program, HMOs

have come in and then pulled out, leaving them high and dry. Their premiums went as high as $170 a month. Now, figure that out for someone whose income is $15,000, $16,000, or $17,000 and owns a home. And they are in a well-to-do area or a higher income area, so the costs are different than Oregon's.

Our costs are very, very high. We just cannot tolerate taking more money out of this program. Their premiums are going up as it is. I think in some of the plans it is going up $41 a month more than last year.

So, I just cannot abide by having seniors having to pay something like $2,000 a year more when they cannot afford it, the HMOs come in, go out, come in, go out. It is confusing, it is confounding, it is frustrating.

I do not think there is an issue in, say, Suffolk County, sort of a middle class county in a wealthy metropolitan area, that is greater than this one. Because the formula is so wacky, seniors in New York City do not pay anything and these folks paid as much as $170 a month, even though they are in the same SMSA where costs are pretty much very similar.

So I, regretfully, cannot support my friend's amendment, even though I very much support the cause. Again, as Senator Wyden said, if we are going to keep taking taxes off the table and keep cutting taxes, this

rob Peter to pay Paul situation is going to be constantly with us. And I know the Chairman has tried, on Medicaid and others, to find a way out of that, and I very much appreciate it. But it ought to make us think about this real, real hard.

The Chairman. Senator Rockefeller wants to be recognized. Before you speak, Senator Rockefeller, because we will recess when you are done, we do have a vote at 2:15 which we did not anticipate, so I would suggest 2:30.

Senator Baucus. Fine.

The Chairman. We will come back at 2:30. At that point, I would ask Director Holtz-Eakin about the offsets for the second Baucus amendment, both of Lincoln's amendments, and Senator Rockefeller's amendment before we vote.

I would also suggest that I would give each one of the sponsors, on each one of their amendments, a minute to explain their amendment when everybody is here before we vote so we will have an opportunity to hear again the purpose of it.

I need to know from Director Holtz-Eakin, to make sure that the offsets completely make the amendment in order. I would also ask you, at that point, to fully describe the amendment. So, you will have an hour and a

half or so to work on that.

Senator Rockefeller?

Senator Rockefeller. Thank you, Mr. Chairman.

Senator Wyden has complicated this by saying it is going to cost $6 billion, and everybody has said, oh, gee. No, it is not. He is including all the private plans that lavish in a State like Oregon, which run from a State like West Virginia.

I am not aware that we have any private plans in existence right now. In fact, that was one of the questions the President asked me, what about private plans. I said, we do not have any. We do not have any.

So, a lot of that $6 billion that you referred to is in that fact and a lot of other States do not have the degree of private plans. So, I think that is a big difference there.

Second, I have got a three-stage approach, and I might as well just tell you up front. If the six-month thing fails, thus making them unequal to the rest of the Medicare population, then I am going to have a three-month extension, Mr. Chairman.

If that fails, then I a going to have an amendment asking Mike Leavitt to have a plan to handle this transition, in that you talked about, we will just send them out a letter, but failed to take into account that

you do not know who they are and you do not have their addresses, so you are not going to be able to send them any letter with a plan. You do not know who they are.

Ms. Fishman. We get data tapes from the States identifying who those individuals are.

Senator Rockefeller. Yes. And I just have said that the States do not have that data. This is why it is so complicated. So I am just saying that I am going to have the three-tiered amendment, Mr. Chairman. The last one, obviously, is not going to cost any money because it will be asking Mike Leavitt to come up with a plan to figure out what to do with these large numbers of people, and just for the period of transition.

The Chairman. All right.

Senator Lincoln. Mr. Chairman? May I just qualify on the risk adjustment? It was my mistake. I think I had taken the risk adjustment out of my pay-fors in both of my provisions. But it does include both the risk adjustment, as well as the modification or the delay on the 2006 Medicare Part B and A claims. Thank you.

The Chairman. We stand in recess until 2:30.

[Whereupon, at 1:05 p.m. the meeting was recessed.]

AFTER RECESS

[2:40 p.m.]

The Chairman. If any of the members who are present have an amendment that they wanted to offer, I would recognize that person at this point, for the reason that the five votes we have coming up, none of the three are present right at this minute so I cannot proceed on what I had hoped to proceed on.

So does anybody have an amendment that they would like to offer and debate at this point? Senator Conrad? The number of your amendment, as well.

Senator Conrad. It would be my Amendment #1, Mr. Chairman, that deals with critical access pharmacies. Could I just go ahead and make my presentation, very quickly?

The Chairman. Yes, please. Yes.

Senator Conrad. I would ask Senator Baucus, is it all right if I proceed?

Senator Baucus. Go ahead.

The Chairman. Then when you are done with that one, we will set yours aside and go to Senator Baucus's amendment. Go ahead.

Senator Conrad. Small, independent pharmacies, Mr. Chairman and members of the committee, are significantly disadvantaged by implementation of an AMP system for

Medicaid drug reimbursement.

The AMP is based on a weighted average that includes discounts afforded to large chains, long-term facilities, and others, but small, independent pharmacies do not have access to these discounts and are often forced to pay might higher prices as a result.

Under this provision, independent pharmacies could be left with no other decision than to stop accepting Medicaid payments. That would force residents in many rural areas to drive great distances to the nearest pharmacy.

This reimbursement policy is not restricted to the Medicaid program. If the insufficient AMP reimbursement led a small, rural pharmacy to close, people would have to travel even greater distances to get their prescriptions filled. Frail, elderly patients will be driving extended distances, and in my State sometimes, in very adverse weather. North Dakota is certainly not alone.

My amendment would give independent pharmacies an enhanced reimbursement to help them remain open. For isolated pharmacies not within a 20-mile radius of another pharmacy, my amendment would give them the option of receiving AMP plus 8 percent for brand-name drugs, and AMP plus 50 percent for generics, or a reasonable

acquisition cost.

This will allow pharmacies to cover the cost of doing business and maintain access. It will also reestablish the incentive to dispense lower-cost generic drugs, which will actually result in savings to the Medicaid program.

My amendment also requires States to consider the costs associated with operating an independent pharmacy when setting the dispensing fee. These pharmacies have unique costs that large, urban pharmacies simply do not. My amendment would ask States to consider these costs when determining the appropriate dispensing fee.

Mr. Chairman and members of the committee, my amendment is fully offset by increasing the cap on the Medicaid drug rebate sufficient to cover the cost of the amendment. Now, CBO has scored this amendment as less than $200 million. Not billion. Less than $200 million.

The National Governors Association has supported an increase in the cap to 20 percent. The underlying mark only raises it to 17 percent. This would very marginally increase the cap on the Medicaid drug rebate.

Now, Mr. Chairman, this is really a question of survival of rural pharmacies and I hope my colleagues would support the amendment.

The Chairman. Thank you very much. I want to speak on your amendment and say why I think it is not needed.

First of all, you do reflect very definitely a concern that has been raised by pharmacists, and particularly small, rural independent pharmacists. But our mark does several things that we feel would protect the independent pharmacists.

First, in the way we reimburse for multiple-source drugs, the reimbursement is reflective of the costs of higher-priced brands, so that the average price for the generic should always be higher than the acquisition costs. Then we add 15 percent on top of that.

Second, we require States to take into account geographic factors in setting dispensing fees so that we can expect that the States will provide the rural independent pharmacists with additional assistance.

My colleague's amendment appears to reimburse both brands and generics at AMP. The effect of that is to create a disincentive for generic drugs. More accurately, it creates an incentive for pharmacists to dispense the most expensive drug. I thought the point of changing the reimbursement policy was to get away from that kind of gaming of the system.

I am also concerned about the offset used for this amendment. The mark that we are considering today increases the rebate paid by drug manufacturers to States through the Medicaid program to 17 percent. The mark

also closes a pair of loopholes that have the impact of increasing the rebate.

First, we require the best price of an authorized generic to be considered in brand-name drugs' best price calculation. That will have the effect of increasing the rebate.

Second, we require physicians to notify the State Medicaid program on what drugs the physician administers in the office. Currently, nothing in statute requires physicians to disclose that information and States miss out on appropriate rebates.

When all these policies are taken into consideration, we have increased the rebate paid by drug manufacturers by $1.7 billion. Now, of course, my colleague probably feels that that is still not enough to protect independent pharmacists, but I would encourage you to look at the CBO report put out this past June, examining the price of name-brand drugs. That report shows that the effective rebate being paid by drug manufacturers is actually 31.4 percent, not 15 percent.

We have looked at this area and come up with responsible policies that addressed those loopholes. I do not think we need to just casually increase the rebate just because we can. Therefore, I would encourage my colleagues to oppose the amendment and the offsets that

fund it.

Senator Conrad. Mr. Chairman?

The Chairman. Yes, go ahead.

Senator Conrad. Mr. Chairman, first of all, you know I have great respect for you. I think you have done things that are in the mark that attempt to, in some way, offset the larger effects of the mark.

But I would remind my colleagues, in the Medicaid savings of the mark, 60 percent of the savings are in pharmacy, and it is 2 percent of the cost. Sixty percent of the savings when they are 2 percent of Medicaid costs.

The result is--and I know it is unintended--and my pharmacies across my State tell me, that rural pharmacies, if this is enacted, are going to be under further pressure to close.

I believe we ought to take this additional step, which is relatively modest, that increases the rebate from 17 percent to 17.3 percent. That is relatively modest.

On the question of generics versus name brands, I could not disagree with the analysis more. This enhances the incentive to go with generics, which will save Medicaid money because my amendment clearly calls for a differential treatment. It provides for name brands, AMP plus 8 percent. For generics, it is AMP plus 50 percent,

or reasonable acquisition cost.

I would just say to my colleagues, I hope that you are hearing from your pharmacists. Now, many of you represent States far more urban than mine, but each and every one of you has rural areas. These rural pharmacists are sent a very clear and powerful message: if they do not get some additional assistance, they are going to be under increasing pressure to close. In my State--I cannot speak for other members' States--enormous pressure on rural pharmacies.

We are already losing pharmacies in my State. We have lost a lot of them in the last decade. We are, in many rural communities, down to one pharmacy. For example, in Bowman, North Dakota, it is 40 miles away from the nearest pharmacy, and there is only one pharmacy in that town.

Mr. Chairman, I hope we think very carefully about the effect on rural pharmacies in the mark.

The Chairman. We have, now, six amendments, with Senator Conrad's amendment. We have Baucus #3, Baucus #2, as modified, Lincoln #1, as modified, Lincoln #2, as modified, Rockefeller #1, and Conrad, #1.

Senator Conrad. Mr. Chairman, might I just conclude by saying I think the staff supports my amendment. [Laughter]. My staff. [Laughter].

The Chairman. All right.

Not right now, but before we vote, I am going to give each sponsor a minute to describe their amendment. But before we begin voting, I announced beforehand that I would ask our Director of CBO to give us his report on the offset used in the amendment and the assessment of CBO of each amendment's impact on spending in 2006, as one very important point, and over the five-year budget window as the second important point.

If the amendment results in an increase in spending in either 2006 or over the five-year window, then the amendment will be ruled out of order..

In addition, if the amendment, on spending, is unknown, then the amendment will also be ruled out of order. I feel that this is necessary because the amendment could result in the Finance Committee title for reconciliation not meeting its savings target.

It is clear that not knowing the impact of the amendment on spending, it obviously cannot be acceptable for the purposes of this reconciliation mark-up, maybe as opposed to mark-ups, generally, because we cannot be in violation of the Budget rule.

So with that said, would you, Director Holtz-Eakin, give us the information we need at this point, and identify which amendment you are talking about?

Mr. Holtz-Eakin. All right. Of the six, let us start with Baucus Amendments #2. Number 1 is offset by FEMA. Amendment #2 offsets the $5.4 billion in costs with two mechanisms. The first, is the geographic adjustment, the ISAR provision. The second, is the indirect medical education. They total $1.9 billion over the budget window.

There is also a faster claw-back, as I mentioned earlier, of the increase in physicians' reimbursements. Depending on how that was done, it could raise as much as $7 billion. So, that could be done in a way that allowed the full cost of $5.4 billion to be offset over the five-year budget window.

There are 2006 costs in the amendment. These are offset by an extension of the payment holiday that is in the Chairman's mark from 6 to 10 days, so that the net cost in both 2006 and over the entire window would be offset.

Lincoln Amendment #1 would cost $1.8 billion over the five years. Here, the acceleration of the risk adjustment elimination would offset the $1.8 billion, and any 2006 costs would be covered, again, by an extension of the payment holiday.

Lincoln Amendment #2 would cost $800 million. This same set of offsets would easily cover both the $800

million over the five-year window and any 2006 costs through a shift in the payment holiday.

Rockefeller Amendment #1 is a small saver, a bit under $100 million, no offset necessary either in 2006 or over the five-year budget window.

Conrad #1 has no costs in 2006. As the Senator mentioned, it costs about $100 million over the first five years, $200 million over the 10 years, and the increase in the cap on the Medicare drug rebates would be sufficient to offset those costs.

So in each case, over the five-year budget window, costs are fully offset by the specified offsets, and in most cases any residual problems in 2006 are addressed through the payment holiday.

The Chairman. Now I would call on Senator Baucus to describe the purpose and what his Amendment #3 does.

Senator Baucus. Mr. Chairman, I will be very brief. There are two amendments. The first basically enacts the bulk of the provisions for Katrina health assistance that was contained in S. 1716, the bill you and I sponsored, and unanimously agreed to on this committee.

It is to cut back slightly, with the effect that FMAP held harmless will not apply to 29 States as was originally contained in 1716, but rather apply only to the affected Gulf States. That is paid for out of money

from unspent FEMA obligations. FEMA has, I am told, $37 million not spent. The total cost of this bill is about $6 billion. So, there is certainly room for six.

The other amendment --

The Chairman. Let us take one at a time.

Senator Baucus. All right. And I might say, just to add, Mr. Chairman, you are going to rule this amendment out of order. I understand that. But it is my hope that, on appealing the ruling of the Chair, we would have a very gentlemanly vote on overturning the Chair.

The Chairman. All right.

First of all, before I rule, I said this earlier when he offered his amendment. I obviously do not disagree on the substance of his amendment, because this was worked out in a bipartisan way on an independent bill.

I have already said to people that worked for the administration what I feel the administration ought to do, and I think I have said that several times in the last couple of weeks. But I have the responsibility, as Chairman of this committee, to try to report according to budget reconciliation.

A package as large as what you are proposing for this bill would divide the people that are going to support me in getting this budget reconciliation instructions filled. So, I would rule that the amendment is out of

order, and I would turn to the Senator.

Senator Baucus. Mr. Chairman, I move that your ruling be appealed.

The Chairman. All right.

Those that agree that the Chair should be overturned, vote aye. Those that agree that the Chair should not be overturned, vote no.

The Clerk will call the roll.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

Senator Baucus. I might note, Mr. Chairman, the Clerk did not call the names of some Senators who are not here.

The Chairman. My staff advises me that we cannot vote proxies for this issue.

Senator Baucus. That is correct. I would just note that, had they been here, how they would have voted. But under the rules, their votes are not counted. Just so people are wondering about the status of their votes.

The Chairman. All right.

The Clerk. Mr. Chairman, the tally is 6 ayes, 9 nays.

The Chairman. The vote to overturn requires a two-thirds vote. Not receiving the two-thirds vote, the motion made by the Senator from Montana is defeated.

I would now call on Senator Baucus for one minute for his explanation of Amendment #2.

Senator Baucus. Mr. Chairman, this is basically the same amendment, but paid for within this committee's jurisdiction, so it is not out of order. There is no ruling that this amendment is not germane.

I might, again, urge my colleagues to consider that this is probably the last chance we have to deal with Katrina in a meaningful way. It is said that this is a down payment. It is less than 25 percent of what we originally contemplated or are trying to get passed on the floor.

I might add, the Senator from Arkansas had a Katrina amendment--I am talking about health-related matters--which is more generous than this. I think it is our duty as Americans, as Senators, to do something to help these poor people, and I urge Senators to dig down deep in their conscience and do what is right and support this amendment.

The Chairman. Yes. So far, the Senator has been right. Every time he has said that this may be the last chance, it tends to be accurate. But I want him to know

that I still will try to work with him in some other venue beyond the relief that we have in our bill to help accomplish that.

Would the Clerk call the roll?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

Senator Conrad. Mr. Chairman?

The Chairman. Yes?

Senator Conrad. Might I inquire, on this proxy voting, I noticed your side was voting proxies, our side was precluded from voting proxies. How does that work?

The Chairman. No, no. Senator Baucus voted

proxies.

Senator Conrad. But they do not count?

Senator Baucus. No, no. If I might.

The Chairman. Just on that first vote for appealing the ruling of a chair, a procedural vote.

Senator Conrad. I see.

The Chairman. It did not count.

Senator Conrad. I am glad to know that.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. All right. By a vote of 9 to 11, the Baucus Amendment #2 is defeated.

I now call on Senator Lincoln for modified Amendment #1.

Senator Lincoln. Well, thank you, Mr. Chairman. Again, this is just simply an attempt, I think, to reach out and express the values that we feel as Americans, not only in terms of trying to help our fellow man and our fellow Americans when they have been devastated by things they have absolutely no control over, but also to make sure that we do not discriminate.

Those that were devastated by the natural disasters in the Gulf Coast, the waters of the hurricane, the force of the hurricanes, could not discriminate against rich or poor, all of them were hit alike.

All we are simply saying here in this amendment is to incorporate the language from the Emergency Health Care Relief Act that would provide coverage for all Katrina survivors, up to 100 percent of Federal poverty level, and up to 200 percent of Federal poverty level for pregnant women and children, or up to 300 percent of the SSI benefit for disabled individuals, or the State income eligibility levels, whichever is higher.

Again, Mr. Chairman, if you looked at the group in this committee, less than half would be able to access, under the criteria that is in the underlying bill.

I would like to think that we would not discriminate against men or women who do not have children, who happen to maybe be older and their children are older but have not reached Medicare age.

But the simple fact is, we are not covering all of these survivors as we should, and I would like to think that my colleagues would do what we would think would reflect our American values.

The Chairman. I will not repeat what I said when the amendment was first offered. It was the same as what I said about Senator Baucus's amendment, particularly #3. So, I would ask people to vote against this amendment.

Would you call the roll?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. So the results of the vote mean that the Lincoln Amendment #1, as modified, is defeated.

I would now call on Senator Lincoln to describe, in one minute, Amendment #2, as modified.

Senator Lincoln. Thank you, Mr. Chairman.

It saddens me to think that we miss yet one more opportunity to be able to help our neighbors, our fellow Americans in the Gulf Coast, and yet, that is what we are doing today.

These are just small pieces of the overall package that you and Senator Baucus worked so hard to craft in a bipartisan way. I would like to believe that there is something we could do later on, something we could do on the floor, that people would really take seriously the devastating that our fellow Americans have felt, but it looks as if we are going to miss one more opportunity to exhibit our American values.

This amendment simply incorporates a part, only a part, of the bill, language from that Emergency Health Care Relief Act. It creates an $800 million disaster relief fund to provide payments to those Medicaid providers who experienced a significant increase in the patient volume due to Hurricane Katrina.

Once again, for those of us who border those States, our providers have been heroic. Starting on Labor Day when they worked 24/7, when these survivors came into our communities needing health care and attention, no one asked the question, who was going to help them.

No one asked, was the Federal Government going to exhibit the American values that we all believe in so strongly. They made those services available. They care for their fellow man.

Yet, we still cannot tell them where, if, or when they are going to get that reimbursement to make them

whole to continue to care for and provide services to their regular constituency, as well as the survivors that still are there in their communities.

So, I would certainly encourage my colleagues, if you do not want to help the coverage for the individual, maybe you will at least look at the providers and recognize that, in your communities, you have providers, doctors, nurses, pharmacists, and hospitals, who may be in the same way that we are, and that is, that you are already working in a dangerous situation and this has just created a worse scenario for them. I would like to ask for my colleagues' support.

The Chairman. All right.

Mrs. Martin, would you call the roll, please?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. As reported, the amendment is defeated, Lincoln #2, as modified.

Now we go to Rockefeller #1. Would Senator Rockefeller take a minute to describe his amendment?

Senator Rockefeller. Mr. Chairman, this has to do with dual eligibles. Most of the members on the other side of the aisle were not here during the discussion this morning, so I am constrained by one minute.

But there are 6.4 million people in America who are both on Medicaid and on Medicare, the most distressed of all of our people. They tend to have worse health problems. Many of them are living alone. Many of them are in nursing homes. They have very little access to sort of keeping in touch with things.

Now, we passed a Medicare prescription drug bill. In that, the dual eligibles will only have six weeks, the poorest of the poor, to make up their mind about what they want to do. I just posit to you that they are going to have absolutely no idea, with all these plans coming

in, what they possibly could do. All the rest of Medicare beneficiaries who are not dual eligibles will have six months to make up what they are going to do.

I would hope I would get just a second for my different financing thing.

The Chairman. Please go ahead. Is one more minute all right?

Senator Rockefeller. One more minute is fine.

It is just a matter of equity and justice. I mean, 6.4 million people do not have the chance to transition, do not have the information. CMS said does not have their mailing addresses. States do not. You saw that in the SCHIP program, how unwieldy that was when it started off. So I know my time is limited.

I just heard Mr. Holtz-Eakin say that the funding of this is not the problem, I think was your words, because it is less than $100 million. So in order to accommodate the concerns of my colleagues from Oregon and New York, I would consider modifying my amendment and offset its modest costs by seeking to remove the FMAP relief for Alaska, which is the only State --

Mr. Holtz-Eakin. Can I clarify? No offset is necessary. It is a saver of $100 million.

Senator Rockefeller. Case closed. [Laughter]. I did not know. I thought "no problem" meant "no cost."

Mr. Chairman, I would just appeal to the members on the basis of equity. I do not want to have partisan votes here all afternoon. This is a real chance for us to help people who will not get the help otherwise: six weeks versus six months, all Americans.

The Chairman. All right. I will not repeat what I said about the amendment earlier, but I do want to impress upon people that I think Senator Rockefeller is very sincere in what he is saying, and he obviously has not accepted the description of how the administration feels that they have this under control and will make sure that everybody gets registered appropriately that is dual eligible.

I would think, within the next few days, somebody in the administration ought to make a serious effort to try to convince Senator Rockefeller that we have got this thing under control. Otherwise, we have got problems.

Senator Santorum. Mr. Chairman?

The Chairman. Now, maybe I should not have said anything, because I do not want a long debate. I just limited these people to one minute over here. But if you have got something you can say quickly.

Senator Santorum. I just have a question of Mr. Holtz-Eakin.

The Chairman. All right. That is legitimate.

Senator Santorum. Explain to me again why this saves money.

Mr. Holtz-Eakin. For every day that the beneficiary is on Medicaid where the Federal Government does not pay the full cost, instead of Medicare, where they do, the net cost to the Federal Government is actually smaller.

Senator Santorum. But they are automatically enrolled. But the Senator's amendment would delay automatic enrollment.

Mr. Holtz-Eakin. And enlarge the period in which people could potentially be on the Medicaid program instead of the --

Senator Rockefeller. But in defense, to me, because they do not have the list of who these folks are. The States do not have the list, CMS does not have the list. They said they are going to send letters out telling them what plans they are going to get. They have to make up their minds in six weeks. All the rest of the Medicare world, in prescription drugs, which is mammoth, gets six months. I really do not understand that.

Senator Santorum. Mr. Chairman?

The Chairman. Who is calling for me?

Senator Santorum. Just a further question. You said they get six months. But if they do not make their decision in six weeks, they do not get coverage right

away, as opposed to these people on Medicaid that are being covered right away, will continue coverage.

Senator Rockefeller. If anybody knows who they are.

Senator Wyden. Mr. Chairman?

The Chairman. Senator Wyden? Then I think I am going to ask Mark to comment on it. This is a serious issue. I did not want to take this amount of time, but I think it is worth it.

I do still emphasize, regardless of what happens here at this meeting, Senator Rockefeller should be convinced that what the administration says, that he is wrong in his assumptions, that he is wrong, otherwise he obviously feels he is right.

Go ahead, Senator Wyden. Then I will call on Mark.

Senator Wyden. Just very briefly. First, I want to thank Senator Rockefeller for working with Senator Schumer and I. I am going to support this.

I think, to me, the idea of helping some of the most vulnerable people in our society, the dual eligibles, in a modest way, if ever there was compassionate conservatism, this is what Senator Rockefeller is doing. So, I hope we will take it.

The Chairman. Senator Kyl? But I do want Mark to speak, too.

Senator Kyl. I understand. I have a question for

staff, if I could.

The Chairman. Yes.

Senator Kyl. Is it correct that these folks are automatically enrolled, but that they also have the same amount of time anybody else does to change their mind if they want to and enroll in a different program?

The Chairman. The answer is yes.

Mr. Hayes. Yes, sir. That is correct.

Senator Kyl. So that is compassionate conservatism.

Senator Baucus. Well, I am sorry. The problem is, if somebody is automatically enrolled --

Senator Rockefeller. He has to know it.

Senator Baucus. [Continuing]. First of all, he or she does not know it. Second, it is a random plan. Third, people do not know what the random plan contains.

Senator Kyl. Fourth, they have six months to change their mind if they want to.

Senator Baucus. But they do not know. They do not know. So when that person tries to figure out what to do, it just takes a longer time.

Senator Kyl. So your six months is more than the six months they already have.

Senator Rockefeller. No, they do not have six months. They have six weeks.

Senator Baucus. They do not have six months now.

Let me add one other point here, too. For whatever it is worth, I am strongly supporting this, basically because my experience with Uncle Sam, frankly, with a lot of different agencies and programs like this, lately, has not been good.

Just one small example. I know this is a different agency, but USDA, over a year ago, was supposed to mail out disaster assistance payments to livestock producers. That was over a year ago. Over a year ago. It still has not been done. I talked to USDA. Well, their computers do not work. They are having a hard time getting the computers up to speed. It is one thing after another. It just does not work.

Look at what happened to FEMA. FEMA is not known for its efficiency. To be honest, this administration, in many areas, there are certain questions of competence. Inefficiencies are being related in lots of different areas.

So if you ask me whether this is going to be done on time and done properly, particularly for poor folk, my guess is, probably not. I am saying, let us give the CMS a little extra chance here to get this done and get it done right.

The Chairman. Senator Bingaman?

Senator Bingaman. Could I just ask staff to

clarify? My understanding is, the six weeks that we are talking about that is in current law runs from November 15 until the end of the year, right after Christmas. Is that accurate?

Mr. Hayes. That is correct.

Senator Bingaman. Thank you.

The Chairman. All right.

Mark, would you explain?

Mr. Hayes. Well, I think it is very important for members to know whether CMS has the ability to reach the dual eligibles in the time period we are discussing here, and I would like to ask Ms. Fishman to respond to that.

Ms. Fishman. Thank you. I had the opportunity over the lunch hour to get some more detailed information about how we are enrolling the duals, what kinds of data we have, and the processes we are going through to make sure we reach out to them.

I received some information, first of all, that States send monthly dual enrollment files, which are matched to our Medicare databases. The validation of these data show the match rates of over 99 percent for all States.

CMS has developed a new data feed to identify full-benefit dual eligibles for the purpose of low-income subsidy deeming, auto enrollment, and phased-in State

contributions. We spent three months validating these files on a test basis from March to May, 2005.

We contracted with Mathematica Policy Research in order to validate the quality of the State MMA data, and all States have met the threshold for data quality. All States are submitting data to us on a monthly basis.

As I said earlier, we are days away from sending out the letters to the dual eligible individuals, notifying them of the plan that they will be assigned to. CMS will use the address data we have in our systems, and we are partnering on this with the Social Security Administration. So, we are exchanging data in that respect.

I would like to correct I misspoke about earlier. States do not send data to CMS directly, but we are working through the Social Security Administration on that.

Our auto enrollment letters are going to go out First Class postage, so if they are marked "undeliverable" we will get all of them back. We have a process in place so that we can follow up on each undeliverable notice to research the address and then re-send the auto enrollment letter.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I just want to

say, philosophically, that this one, to me, is so clear. It looks like we are going to have a series of Democratic/Republican votes all afternoon and we will lose everything that we want to fight for. This is not the nature of the Chairman.

But with respect to what you have said, Ms. Fishman, I am glad that you got so enlightened over lunch because this morning you did not know any of this stuff. I do not mean that disrespectfully. It did sound disrespectful, and I apologize for that. But CMS did send out, at random--I do not know how many of them were dual eligibles--what they thought were letters to dual eligibles already and they turned out to be empty envelopes, and there has never been an explanation of how that happened.

Now, why do I bring that up? To make CMS look bad? No. But to re-emphasize my point, it just seems to me, when you are not talking about something permanent, when you are only talking about transition over a six-month period, and it saves money, that there ought to be somebody on the Republican side who can be helpful so we can pass this.

The Chairman. Well, I would recommend that Republicans vote against it, because if it saves money we will have a big fight on our side where to spend it.

[Laughter].

Senator Rockefeller. Mr. Chairman, that is not an argument that helps the 6.4 million people.

The Chairman. All right. Yes.

Would Mrs. Martin call the roll, please?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No. And I would suggest to you, how has Senator Lott voted?

Senator Lott. Yes, Mr. Chairman. I would like to be recorded as "no."

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. All right. The Rockefeller amendment is defeated.

Senator Rockefeller. I have three that go right in a row.

The Chairman. We want to vote on the Conrad amendment first.

Senator Rockefeller. All right. But this is like a Bach fugue, it is so perfect, Mr. Chairman. You will love it.

The Chairman. If it is all right with Senator Conrad, we will go to Senator Rockefeller.

Senator Rockefeller. We can do this by vote count or just a voice vote. Then to reduce that from six months to three months for the dual eligibles.

The Chairman. All right.

Those in favor, say aye.

[A chorus of ayes].

The Chairman. Those opposed, say no.

[A chorus of nays].

The Chairman. The nays appear to have it. The nays do have it. The amendment is defeated.

Senator Rockefeller. And, Mr. Chairman, my third effort to try and help these folks requires nothing more than the following, and that is for the Secretary of the Department of Health and Human Services to, by November -

-

The Chairman. Could I ask you to defer on your amendment? I want to have my staff talk to your staff about it and learn more about it.

Senator Rockefeller. All right.

The Chairman. Just put it off just for a while.

Senator Rockefeller. All right. Well, I am not on a roll, so I had better say yes. [Laughter].

The Chairman. We will vote for it.

Senator Conrad, one minute on your amendment.

Senator Conrad. Thank you, Mr. Chairman.

This is an amendment to help preserve rural druggists that are a long distance from other rural drugstores.

Small, independent pharmacies are significantly disadvantaged by moving to the average manufacturer's price for Medicaid drug reimbursement. That is because the average manufacturer's price is based on a weighted average that includes discounts afforded to large chains and long-term facilities.

Small, independent pharmacies do not have access to those discounts. They could be left with no alternative but to close, at least to close to providing medicines to Medicaid beneficiaries. My amendment would give independent pharmacies an additional reimbursement to help them remain open. For pharmacies outside a 20-mile

radius of another pharmacy --

The Chairman. Proceed for a little while.

Senator Conrad. [Continuing]. My amendment would give them the option of receiving AMP plus 8 percent for brand-name drugs, and AMP plus 50 percent for generics, or reasonable acquisition costs fully paid for by increasing the Medicaid drug rebate from 17 percent in the underlying mark to 17.3 percent.

The Chairman. I gave my reasons for opposing this amendment, so I will not repeat them, since everybody was here.

So Mrs. Martin, would you call the roll, please?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.
The Clerk. Mr. Smith?
Senator Smith. No.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Crapo?
Senator Crapo. No.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Jeffords?
Senator Baucus. Aye by proxy.
The Clerk. Mr. Bingaman?
Senator Bingaman. Aye.
The Clerk. Mr. Kerry?
Senator Baucus. Aye by proxy.
The Clerk. Mrs. Lincoln?
Senator Lincoln. Aye.
The Clerk. Mr. Wyden?
Senator Wyden. Aye.
The Clerk. Mr. Schumer?
Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

Senator Conrad. Mr. Chairman, could I have two additional votes?

The Chairman. Two additional minutes?

Senator Lott. You mean, votes on that side or votes on this side? [Laughter].

Senator Conrad. I do not care where they come from, but something to put me over the top here.

The Chairman. Well, the answer right now is no. [Laughter]. I do not want to defer on that question.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. All right. Accordingly, Conrad Amendment #1 is defeated.

Now, I was going to go back and forth. I hope Republicans do not have amendments, but if there is a Republican that has an amendment, I should offer them that opportunity before we go back to the other side.

[No response].

Senator Baucus. Senator Bingaman is next then.

The Chairman. Senator Bingaman has the next amendment.

Senator Bingaman. Thank you, Mr. Chairman.

The Chairman. And the number of your amendment?

Senator Bingaman. It is Bingaman Amendment #1.

The Chairman. All right.

Senator Bingaman. I am going to get four minutes instead of just one, right?

The Chairman. Yes.

Senator Bingaman. All right. Because they started counting me down to zero here already.

Mr. Chairman, as I think everyone here knows, under current law, starting the first of this current month, many of our States started seeing a reduction in the matching funds that the Federal Government was providing to the State for Medicaid. That began on October 1 of this year, and will continue for the rest of the year.

What my amendment does, is to say that the amount of that reduction in the Federal matching rate will not be more than 0.5 percentage points for any State that is covered, with the exception of Alaska, which I am leaving alone.

As has been mentioned a couple of times, Alaska was provided a full hold harmless of the estimated $135 million that it would otherwise would expect to lose over the next two years in the Chairman's mark. I am not suggesting that we hold our own States harmless. I am suggesting that we limit the amount of loss that they suffer.

There are 15 members of this committee representing States that will experience a loss, and I could go through that. But I have got a chart that we have distributed that will tell each of you how much additional funding would be made available to your State if this amendment is adopted.

This is, I think, very much needed in order to assist the States in maintaining Medicaid payments. In addition to these expenses, of course, or this loss of revenue, they also have these claw-back payments that are coming into effect in 2006, so there is a substantial new burden on the States.

The total cost of this amendment would be $515 million. I have an offset that is this indirect graduate medical education component. It removes that component of the fee-for-service payment rates, in effect, for Medicare Advantage plans, beginning in 2007. The Congressional Budget Office has come out very strongly in favor of eliminating that, and I will be glad to inquire from Mr. Holtz-Eakin if they still stand by that.

But their earlier statement was that "payments for indirect GME are included in the estimate of per capita fee-for-service spending, even though the Medicare program makes the indirect GME payments directly to the teaching hospitals for inpatient stays and Medicare

Advantage enrollees.

As a result, the Medicare program is paying twice for indirect GME in counties in which Medicare Advantage or HMO rates is equal to per capita fee-for-service spending." They go on to say that "this is unnecessary Medicare expenditures. It gives private health plans an unfair advantage over the fee-for-service sector." So, this is an adequate offset.

In addition, we would suggest that any costs incurred in 2006 would be offset by moving that back by a certain number of days for Medicare Parts A and B claims. I think that is the offset that has earlier been recognized as adequate to cover that.

This is a very good provision. This is the only opportunity we are going to have to fix this problem. It means a great deal to each of our States, and I hope we will adopt this, Mr. Chairman.

Senator Lincoln. Mr. Chairman?

Senator Lott. Mr. Chairman?

The Chairman. I would recognize Senator Lincoln first.

Senator Lincoln. Thank you, Mr. Chairman.

I just want to applaud my colleague. Again, as one of those neighboring States that not only has a disproportionately high share of Medicare and Medicaid in

our population, but now, as a neighbor to the Gulf Coast region and already having suffered, as of October 1, a decrease in our FMAP, I think it is an important thing that we can do.

He is not asking us to be held harmless, he is just asking that that burden that we are trying to carry be lessened. I think it is a tremendous effort and I am grateful to him for doing it, and recognizing that there is a problem that exists there for 29 States.

He has not asked Alaska to give up what they have in this bill. He is just simply asking all of us to recognize that there are a lot of States going through a lot of hardship right now, and we have an opportunity to help them, particularly many States, like mine and others', who are already serving many of these that have been devastated by the Gulf Coast natural disasters and are still going to see a cut, or are already seeing a cut, in our Federal matching rate. Thank you.

The Chairman. Senator Lott?

Senator Lott. Thank you, Mr. Chairman. I just wanted to, again, emphasize that we do have funds in this deficit reduction package to be of assistance to the Hurricane Katrina victims, approximately $1.8 billion. I want to make sure everybody understands that, because I have the impression maybe there have been some

indications that there was not assistance in this legislation.

So this is in there, and I think it is a good start. I think as we go forward we may need to add something to it, and I may be inclined to support amendments of some kind as the process goes forward.

But the most important thing right now, is for us to move this deficit reduction package, get it to the floor of the Senate, get it through the Senate, and get it into conference. As we go along, we will have an opportunity to perhaps address some of the additional shortfalls, if we find it is necessary.

I must say that I am worried about the impact that Katrina has had on other sections of my State and other States, and as many as 29 other States. But I would like for us to at least, at first, help the people that are in the region that need this help that are suffering right now.

So, I want to just make those points and explain that we do have funds in there that we need desperately to help people, and second, we will have opportunities to consider others, if they are necessary. Thank you.

The Chairman. Director Holtz-Eakin, would you comment on the offset, according to our instructions, if it is adequate, and what it does?

Mr. Holtz-Eakin. Certainly. The total costs over 5 years are $625 million. As the Senator mentioned, the indirect medical education savings could be upped to $1.8 billion, so, appropriately written, it would cover that.

Senator Bingaman. Mr. Chairman, I believe the cost is $515 million over five years, after you subtract out Alaska. I am not affecting the current mark with regard to Alaska, and I was told that that drops it to $515 million.

Mr. Holtz-Eakin. I will clarify that. But certainly the funds are there to offset that. There are costs in 2006, and those would have to be addressed using the payment holiday, extending the current holiday in the Chairman's mark.

The Chairman. All right. I appreciate Senator Bingaman's thoughtful amendment. I will just say in a minute how I have some thoughts in that direction, as I have been working with Senator Baucus over the summer on a piece of legislation, because I think we can agree that the fluctuation of the FMAP calculation creates problems for States.

At the beginning of the current fiscal year, many States saw their FMAP go down. Their FMAP went down because it is supposed to go down, under the formula, and that determines the outcome. In some years, a majority

of States has had their FMAPs increase. When the formula has determined that sort of outcome, I cannot recall anyone lobbying me to lower the FMAPs.

I do think there are some good ideas in your amendment, Senator Bingaman, and a similar amendment submitted by Senator Baucus, and I would be willing to work with you in the future to bring greater predictability.

I would be willing to introduce the FMAP corridor proposal that Senator Baucus and I worked on over the summer and have you join us as a co-sponsor. It would certainly bring some stability to FMAP.

However, for today's amendment, and on this mark, this amendment is not consistent with the agreement that we have reached, so I must ask my colleagues to oppose the amendment.

I will give you final comment.

Senator Bingaman. Mr. Chairman, I was just wanting to clarify. Do you think it is possible that the provision that you and Senator Baucus worked on, that we could work on that between now and the time we get to the floor and see if some variation of that would be an appropriate thing to add to this reconciliation bill on the floor?

The Chairman. I am always open to discussion. I

hate to give encouragement, not because your request is not legitimate, and I think something might be worked out, but you do not realize how hard I had a chance of getting Republicans together on what we have before us. So, that is always in the background of my mind, any agreement I make with you that screws up what I have worked out over here. [Laughter].

So, I would be glad to talk to you about it and see what we could work out, but that is a very major problem for me. Like I have often said, it seems like, in this committee, it is easier to get a bipartisan agreement than it is to get a partisan agreement.

Senator Snowe. Mr. Chairman?

Senator Bingaman. Mr. Chairman, I appreciate those comments. I know Senator Snowe has been the prime co-sponsor with me on this bill which we introduced. With her help, maybe we can find something that is acceptable.

The Chairman. All right.

Senator Snowe. Mr. Chairman?

The Chairman. Go ahead.

Senator Snowe. I agree. I hope that at some point in the near future, and perhaps even on this vehicle after it leaves the committee, we could address this concern because we need a more accurate measurement and reflection for a formula for the States and its

distribution of the Federal assistance.

Currently, with a look-back formula--the last three years in my State, for example--we lost considerable money and it was not an accurate portrayal of economic conditions at that time, and where it is today.

So I would hope that we could re-examine the formula and the calculation upon which the distribution of funds is based, because it really has represented a disproportionate loss to the Medicaid program in Maine, and I know that is true in 28 other States as well, as Senator Bingaman indicated. So I hope we can work on this particular question at some point in the near future, and hopefully on this vehicle in some way.

Thank you, Mr. Chairman.

Senator Thomas. Mr. Chairman?

The Chairman. Senator Thomas?

Senator Thomas. I want to join in urging this, too. I notice that we have left Alaska out, but Wyoming is the next highest State here. So, I will not insist on the vote now, but I would urge that we talk about it.

The Chairman. All right.

Senator Rockefeller. Mr. Chairman, might I just say to the Senator from Wyoming that I would be very happy to work with you, because the carve-out for Alaska is absolutely shameless. It is outrageous. That would also

provide the money.

Senator Thomas. We could have one similar. [Laughter].

Senator Rockefeller. You can have whatever you want, just as long as it gives me the money for the amendment which I just introduced, which it would. It would.

Senator Thomas. Well, I understand. Thank you.

Senator Rockefeller. And it is interesting that we are not really taking this Alaska matter seriously as a committee.

Senator Baucus. We are.

Senator Rockefeller. I know you are. I know you are. But we are not taking it seriously as a committee. One State is allowed to have no reduction for a period of two years, and all the rest of us are getting clobbered, every single one of the other 28, 29 States. I really question whether we are living up to our responsibilities as a Finance Committee to allow that to happen.

The Chairman. All right.

The Clerk will call the roll.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

The Chairman. Mr. Bunning, no by proxy.

The Clerk. Mr. Crapo?

The Chairman. Mr. Crapo, no by proxy.

The Clerk. Mr. Baucus?

Senator Baucus. I will vote aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. As reported, the amendment is defeated.

Senator Smith, my staff told me you wanted to offer and amendment and withdraw it.

Senator Smith. Mr. Chairman, I will be very brief. I will offer it, and I now withdraw it, but let me just describe it. It is an amendment that allows States to create demonstration projects in Medicaid to provide health care services to low-income individuals living with HIV.

The point is that this has been tried on a number of areas of health care, specifically breast cancer, and

others, and it was shown to be very helpful in reducing later costs that are much more expensive, and specifically with HIV, from it becoming a full-blown case of AIDS, which is inordinately more expensive. So in the interest of time, I have offered it. I have now withdrawn it. Thank you for the time.

The Chairman. Since we have had more Democrat amendments, Senator Thomas has an amendment. I will go to Senator Thomas.

Senator Baucus. Senator Wyden.

The Chairman. Senator Wyden?

Senator Baucus. Senator Wyden is next on our side.

Senator Wyden. I would be happy to go after Senator Thomas.

Senator Thomas. Thank you. I will be very brief.

I would like to introduce an amendment, along with Senator Lincoln, that has to do with permitting mental health counselors and marriage and family therapists to bill Medicare for their services.

This would result, of course, in increased choices for senior citizens, who many times have to travel long distances in rural States like ours. Seniors have a proportionately higher rate of depression and suicide than other populations.

Seventy-five percent of the 518 nationally designated

areas are in rural areas. One-fifth of all these rural counties have no mental health care. I believe it is very important that we consider this.

I know that we have considered it here, and I will withdraw the amendment. But I do want to mention how important I think it is, and that we hopefully can find a way to work with this issue because it does continue to exist. Thank you for the time, sir.

The Chairman. Thank you.

Senator Wyden? Or did you want to speak on this amendment?

Senator Lincoln. I just want to compliment my colleague, simply because having been out there and realized the number of individuals in terms of mental health needs is so critical, and I applaud my colleague for offering and looking to this amendment, as well as recognizing that that is one of the biggest and most serious volumes of issues that we have dealt with, particularly with the evacuees, since we have talked an awful lot about these displaced persons and their needs specifically in terms of mental health. So, I applaud the gentleman. It is great to work with him. Thank you.

Senator Thomas. Thank you.

The Chairman. Senator Wyden?

Senator Wyden. Thank you, Mr. Chairman.

There has been a lot of discussion about spending money. Senator Sununu and I would like to save some money, and that is what this proposal is based on, our legislation, S. 1128, the Pharmaceutical Advertising and Prudent Purchaser Act.

Here is how it works today, colleagues, with pharmaceutical advertising in America. When a pharmaceutical company advertises on TV and all those pills dance across the television set, the companies get a tax break for doing it.

That is their First Amendment right. Senator Sununu and I are not talking about taking away that right, or the tax break that comes for exercising that right. If any other business advertises, if the pizza parlor advertises, they get the same kind of tax break.

But what Senator Sununu and I think is wrong, is for taxpayers, through Medicaid, to pay for a second subsidy. Medicaid buys the drugs, the most popular drugs that are advertised on TV--Prevacid, Lipitor, Plavix, all these popular drugs--and the advertising costs are included in the purchase price.

So what this amendment says, is that Medicaid, the program for the most vulnerable, should not have to pay for advertising costs. The amendment would increase the rebate, if a drug has been advertised to the consumer, by

2 percent.

So what it comes down to, for myself and Senator Sununu, as we have prosecuted this cause, is Medicaid is one buyer that does not need pharmaceutical advertising on television. That is what this is all about. If you vote against this, you think there should be a double subsidy for advertising on TV. There already is one. Nobody is going to take it away. It is a First Amendment right. All the other businesses get it.

But we are spending more than $4 billion on advertising in America and it seems to me that Medicaid is a program that ought to use the money to help the vulnerable rather than to have advertisements that we know at least some professionals in the field believe drives up utilization and increases the costs in the program. This is an amendment that saves money. It does not spend it on anything else, it purely saves money. I hope my colleagues will support it.

Senator Santorum. Mr. Chairman?

The Chairman. Senator Santorum?

Senator Santorum. I have a question of the staff.

The Chairman. Go ahead.

Senator Santorum. Is there a part of the Medicaid reimbursement for drugs that is specifically allocated for advertising in drug purchasing?

Mr. Hayes. No, Senator, there is not. It is not specifically allocated for advertising.

Senator Santorum. So the Senator from Oregon's amendment is simply taking a figure that has come up with. Does the staff happen to know where he has come up with that number of 2 percent advertising costs?

Mr. Hayes. I have not been provided with any type of formula.

Senator Santorum. But there certainly is nothing in which the Federal Government specifically pays for advertising costs for drugs on Medicaid.

Mr. Hayes. That is correct.

Senator Santorum. Thank you, Mr. Chairman.

Senator Wyden. Mr. Chairman, if I could respond, I do not want to get him in trouble, but I started talking to the Chairman's staff about this in August, myself, personally, and the suggestion for the 2 percent rebate came from the staff of the Majority. I am open to another figure.

But the gentleman makes the key point: no, there is not a specific line item in Medicaid purchasing for advertising, but make no mistake about it, advertising is included in the overall sum Medicaid pays.

When you go home tonight, on television, when you watch those ads, Medicaid is buying the pharmaceuticals

advertised on TV, and those costs are included in what Medicaid pays for it. There is no disallowance. What we want to do, Senator Sununu and I, is to disallow that expense. We do not think Medicaid is a buyer that needs pharmaceutical advertising.

If my colleague from Pennsylvania believes that it would be better in the State of Pennsylvania for low-income people to have money go for advertising on TV, vote against the amendment. If he would rather see the money that Senator Sununu and I want to target go to low-income people in Pennsylvania and all around the country, he will support Senator Sununu and I.

Senator Santorum. Mr. Chairman?

The Chairman. Yes?

Senator Santorum. May I ask another question of the staff?

The Chairman. Yes.

Senator Santorum. Might I ask, are there any other services that Medicaid provides for that we discount for advertising? For example, if a dialysis center advertises on television, do we take an advertising amount out of their payment?

Mr. Hayes. No, sir, we do not.

Senator Santorum. Is there any other service that Medicaid provides for, or Medicare provides for, that we

specifically take out money for advertising?

Mr. Hayes. Not that I am aware of.

Senator Santorum. So this would be unique, that we are now going to pick the pharmaceutical industry and just suggest that, because they happen to be one of many providers of services to the health care system in this country, that they are unique in the sense that they are going to have an arbitrary figure taken out of their reimbursement because they advertise on television. Is that correct?

Mr. Hayes. That would appear to be the case.

Senator Santorum. My other question is, do we not in this bill increase the amount of money that we take from the pharmaceutical industry as a rebate or kick-back to the Medicaid program by, what is it, 2 percent?

Mr. Hayes. The Chairman's mark increases the rebate for single-source drugs from 15.1 to 17 percent.

Senator Santorum. So, already in this bill we are taking almost 2 percent more out of pharmaceutical companies who sell to Medicaid. So what the Senator from Oregon wants to do, is take an additional 2 percent. Why do we not just claim that the 2 percent we took out this time is for advertising, and then the Senator will have accomplished what he wants to do?

Senator Wyden. Mr. Chairman, I think I have a few

seconds remaining.

The Senator from Pennsylvania is right, there is a rebate in there. But the fact of the matter is, Medicaid is going to continue to keep paying for these ads unless this proposal that Senator Sununu and I have advanced becomes law.

Now, the gentleman is right, there probably are other areas that are advertised. There is no health care are that is going up as fast in costs, I would say to the Senator from Pennsylvania, as pharmaceuticals. There is also evidence most recently in *The Journal of American Medicine* that this increases utilization, which increases expenses to Medicaid.

But at the end of the day, to the Senator from Pennsylvania and others, if he would rather have the pharmaceuticals get this advertising money, he can vote against my amendment.

If he would rather have low-income folks get it, I would image there is a fair amount of them vulnerable in Pennsylvania, then he would support putting the money in the programs so it can go to people rather than the pharmaceutical companies.

Senator Santorum. Mr. Chairman?

The Chairman. Go ahead.

Senator Santorum. I just want to make it clear that

this money is not for advertising. There is no evidence that the Senator from Oregon has presented that there is an advertising component in the Medicaid pricing any more than I could suggest that the 2 percent that we are taking out under this bill is for advertising.

This is a "whack the pharmaceutical industry," which I know is a very popular thing and plays well back home. This is a, "whack the pharmaceutical," single them out from every other provider of Medicare, every other person who advertises who provides Medicaid and Medicare services, and for this particular group we are going to say that we are just going to take more money because you advertise. That, to me, should get a negative vote.

The Chairman. I had several points that I was going to make in opposition to this amendment, but I think the Senator from Pennsylvania has made the same points that I have made, more strongly than probably I could, so I will not do that.

I would ask the Clerk to call the roll.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

The Chairman. No by proxy.

The Clerk. Mr. Crapo?

The Chairman. No by proxy.

The Clerk. Mr. Baucus?

Senator Baucus. No.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. No.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 6 ayes, 14 nays.

The Chairman. All right. According to the announcement of the roll call, the amendment has been defeated.

Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I am going to, with your permission, discuss two amendments which I will withdraw, so they will not require much lifting.

The first one is Medicaid waiver transparency. There are a lot of folks going around, governors amongst them, saying, you know what? I am going to be able to get universal health care coverage. They are going around saying, we can get everybody covered in X State if we get a Medicaid waiver.

Now, the deep, dark secret, of course, is that

everybody knows that Medicaid is made up of a mandatory part and also an optional part. We in here know that the optional part is two-thirds of the total amount of Medicaid, which is the largest budget that we have, and only one-third is mandatory.

So what governors then have the chance to do, is to cut benefits. They do a whole series of things that are available to them and they can cut benefits or take away some of the benefits people had, but then still stand up in front of a television camera and say, everybody in my State is covered. But they may only be covered by 25 to 35 percent of their need.

I went to the National Governors, along with Gordon Smith, to work very hard against this whole concept. So what I was going to suggest, is we have no transparency. It is a secret process that takes place between the governor, or his or her designee, and CMS. Nothing gets out to the public.

There are several phases: the concept phase, proposal phase, pre-implementation phase, operational, et cetera. Until the pre-implementation phase, the public does not know one single thing that is happening. There is a lot of damage that can be done on this. Not everybody may agree on it, but it sets up some criteria which are just bonanzas for governors, but not good for Medicaid people,

in my judgment.

So I was going to suggest that CMI be caused to post public notification on their website within five business days, whenever a State submits a waiver concept paper, for feedback from the public, et cetera, or a formal waiver of proposal for discussion and review.

In other words, that the public be allowed to understand what is going on and the advocacy groups also so that this would be understood. I am advised that it is wise not to pursue this and, regrettably, therefore, I am not going to ask for a vote on it.

The second one, is the Medicaid estate tax. I have got a lot of experience with this. Max Baucus and I were on the Pepper Commission together many, many years ago and we passed, 11 to 4, a long-term care policy. Mr. Chairman, we passed both an acute care policy and a long-term care policy; a two-year work product, this was. It was good. It was under the Reagan administration, with his appointees dominating it, and everything was passed.

But in that, in 2006 to 2008, wealthy Americans will be allowed to protect $2 million in assets, $4 million for couples, while low-income Americans continue to have no protection against impoverishment from the high cost of long-term care in nursing homes, which is $85,000 to $115,000, or $130,000 in California, so they have no

assets left.

This would make Medicaid State recovery optional and it would create a floor of protection against impoverishment for people with long nursing home stays, to wit, $20,000 in assets, $40,000 for couples.

As I say, we did this in the Pepper Commission at a higher amount. I think people ought to know about that. It is not fair. People talk about the death tax, I talk about the estate tax.

But it is badgering to death, so to speak, people who are in nursing homes and have lost everything and have nothing, except their houses, that they can continue to keep, if they are allowed to continue to keep their houses to which they will never return. I have made that amendment, and I now withdraw that amendment.

My final one is so simple, Mr. Chairman. It simply says that end-of-life care planning is important for seniors; should I go to hospice, what is going to happen? Seniors and chronically ill patients cope with complicated and very emotional medical decisions all the time.

It is obvious that patients and families would be better served if they had had some advice, knowledgeable advice. Death is a difficult subject for people. Dying is a difficult subject. People deserve to have a chance

to do their own planning about what they want when they can no longer make decisions themselves.

Now, a lawyer, of course, can do this. My amendment would simply require the inclusion of physician consultation and advice regarding advance directives during the initial "welcome to Medicare" visit.

It costs nothing. It would ensure that a physician has the time to spend with patients to explain the importance of advance directives and the options they have, including hospice benefits.

Jack Danforth and I started on this in 1989, and the 2004 *JAMA, Journal of the American Medical Association,* reported that patients who died in institutions had unmet physical, psychological, and spiritual needs: Family members of patients who died at home with hospice services reported a much better experience.

I would move for the adoption of this amendment.

The Chairman. I thank the Senator. I will not comment, but I did listen very much to what you had to say. Thank you for your withdrawal.

Senator Rockefeller. No. I was not withdrawing. I withdrew two, but not the last one.

The Chairman. You did? All right.

Senator Rockefeller. The end is just compassion, end-of-care. It is just being able to consult with a

doctor when you have your "welcome to Medicare" thing, which includes a visit with a doctor. It is pretty benign, but it is tremendously important.

The Chairman. Senator Conrad?

Senator Conrad. Mr. Chairman, could I offer my Amendment 3 at this point?

Senator Baucus. We have to dispose of this one.

Senator Conrad. We are not stacking?

The Chairman. I promised Senator Schumer after Senator Rockefeller here.

Senator Conrad. Are we stacking amendments?

The Chairman. We are not stacking amendments. But I have got a problem right now. I would like to defer the Rockefeller amendment and go to the Schumer amendment for a minute.

Senator Schumer. I can wait.

The Chairman. Senator Schumer?

Senator Schumer. Mr. Chairman, we have a difficulty with the CBO score, so I am willing to wait a minute and then come back.

Senator Conrad. Mr. Chairman?

Senator Schumer. Mr. Chairman, there is a difficulty, evidently, with the CBO score.

The Chairman. Now I know what the problem was. We did not even have your amendment on the list that we

thought we were going to work on. So, let us get some information on it.

Senator Schumer, go ahead. Are you talking about Schumer's amendment or Rockefeller's amendment?

Senator Schumer. Mine.

The Chairman. All right.

Senator Conrad. Mr. Chairman?

The Chairman. Go ahead.

Senator Conrad. He wants to defer for the moment.

The Chairman. Senator Conrad?

Senator Conrad. I will be brief.

Mr. Chairman, this is my Amendment #3. Ambulance personnel are critical health care providers, but they have been left out of this mark. My amendment would ensure that critical access hospitals receive cost-based reimbursement for ambulance services.

Currently, there is a 35-mile limit between ambulance services for critical access hospitals to receive cost-based reimbursement. That is an arbitrary test for ambulance payment. No similar test exists anywhere else for critical access services. My amendment would eliminate that isolation test.

This amendment has been approved previously by this committee, approved by the Senate. I was eliminated in the conference committee on the Medicare Modernization

Act.

Ambulance providers are simply too important, especially in the rural parts of our country, to continue short-changing them when they provide services to critical access hospitals. These hospitals serve a vital role in ensuring that rural Americans have access to health care.

My amendment is fully offset by dealing with the Medicare Advantage risk adjustor. I thank the Chair. I hope my colleagues can support the amendment.

Senator Baucus. Might I ask, Mr. Chairman?

The Chairman. Proceed.

Senator Baucus. Does this include ground as well as air ambulance service?

Senator Conrad. No.

Senator Baucus. This is just ground ambulance service.

Senator Conrad. Just ground.

Senator Baucus. And what is the cost, basically?

Senator Conrad. We have not gotten a CBO score. Perhaps the Director could tell us if they have now had a chance to score it. It is my Amendment #3, Director Holtz-Eakin.

Senator Baucus. Well, while we are waiting for that, I might say, Mr. Chairman, I run into this problem

a lot in Montana. In fact, I have talked to hospital administrators who are worried about opening themselves up to a lawsuit because they, on a business basis, could not pay for the ambulance to get to certain critical access facilities or certain parts of the State.

Now, maybe my State is a little different because it is so large, certainly eastern Montana, but it seems to me we had better find some way to get this passed.

The Chairman. All right. I want to ask Director Holtz-Eakin the score of the amendment and to comment on the offset.

Mr. Holtz-Eakin. The offset is the focused medical review of the services? I just want to make sure I had the correct offset.

Senator Conrad. For my Amendment #3, the offset is adjusting the Medicare Advantage risk adjustor.

Mr. Holtz-Eakin. Certainly. The five-year score is $250 million. The available total offset in the Medicare risk adjustor is $1.8 billion over the window, so certainly that would more than offset. There is a $30 million 2006 score, which would have to be offset in some way.

The Chairman. All right. So I would rule that amendment out of order.

Senator Conrad. Mr. Chairman, I would ask to modify

the amendment to have it only take effect after fiscal year 2006 so we avoid the 2006 problem. It is then fully offset. This is a modest amount of money.

I can just tell you, for those of us who have rural parts of our States, I think virtually everybody around this table is in this fix. These critical access hospitals are not getting their basic costs on running their ambulance service.

Now, they have told me in my State that, unless we get this fixed, rural ambulance service for these critical access hospitals is endangered. It is $200 million. We have paid for it. I would hope my colleagues could support this amendment. It is a modest amendment.

If we do not figure out a way to deal with this rural ambulance problem and these critical access hospitals, we are just saying that part of the country just does not get ambulance service.

The Chairman. I would thank Senator Conrad for introducing his amendment. In fact, I would have to confess that, on at least two or three occasions, yet a year ago in my 2004 town meetings, I heard the same thing.

But it does not take into consideration the fact that these hospitals, critical access hospitals, are

reimbursed at the rate of 101 percent of the cost of their ambulance services instead of by a fee schedule. Suppliers of ambulance services would much rather make agreements with critical access hospitals because they are paid more.

This provides, of course, an unfair playing field for other hospitals that make arrangements with entities to provide ambulance service. As you know, I support the idea that critical access hospitals have access to ambulance services.

However, I believe that critical access hospitals have adequate access to ambulance services without the need to eliminate these additional requirements, based upon what we did to get 101 percent cost reimbursement in the MMA three years ago.

Therefore, I would ask my colleagues to oppose the amendment, and I know some of my colleagues would have problems with the offset that is being offered.

Would you call the roll, please?

Senator Conrad. Mr. Chairman, just before we proceed to that.

The Chairman. Yes.

Senator Conrad. I would just say with great respect, the 101 percent of cost is not a 101 percent cost, because we all know that does not include the

capital cost. That is number one.

Number two, the Chairman and the Ranking Member helped get this provision in the Medicare Modernization Act. Mr. Chairman, you were supportive of it. I appreciated it then. I wish you would reconsider it at this moment because I know you are in this situation where you just want to defeat all amendments.

But I would just hope, on something like this where it is paid for, it is a very small amount of money, and there is a real need -- nine organizations have endorsed this amendment. Virtually every rural health organization has endorsed this amendment, saying if we do not do it we are going to lose rural ambulance service.

The Chairman. The Clerk will call the roll.

Senator Wyden. Mr. Chairman? Mr. Chairman, before we call the roll.

The Chairman. Go ahead.

Senator Wyden. We have been working with Senator Conrad's staff because he makes a very good point. Senator Schumer and I have had concerns. Can we be clear with respect to how Oregon and New York would be handled? I know I have got rural facilities and urban facilities, and I am sympathetic to what the Senator from North Dakota is trying to do.

The Chairman. Can we have the Director respond to

your question?

Senator Wyden. We can. But I think Senator Conrad is looking at possibly something that may affect what the Senator from New York and I think, so we need to do both. We need to hear how Senator Conrad has actually written the amendment, and we need to hear from the Director.

Senator Schumer. In terms of offsets.

Senator Wyden. Right.

Senator Conrad. Would that be all right, Mr. Chairman, if I respond to that?

The Chairman. My staff missed the point that you modified your amendment.

Senator Conrad. Yes, sir.

The Chairman. Yes.

Senator Conrad. To address the concerns of the Senator from New York and the Senator from Oregon.

Mr. Holtz-Eakin. And I wanted to clarify the record. We reviewed the language and there is no 2006 spending, so there is no need to modify the amendment for that.

Senator Conrad. Oh, even better.

Now, my colleagues, I renew my urgent appeal for all of those who have critical access hospitals in rural areas that have ambulance service. This is one we ought to find a way to agree on.

If not here, Mr. Chairman, if we could just work on this before we get to the floor, I really would hope that we would find a way to deal with this issue.

The Chairman. If your offer is to withdraw it and work on it before we get to the floor, I said previously, and I think you were here then, to Senator Bingaman or somebody else, that sometimes that creates a lot of problems on our side.

Obviously, I have some sympathy for what you are trying to do, because what I have said about people in my State contacting me on this, but we have got a careful balance on our side. So if you want to take a chance on that, then I would be glad to work with you.

Senator Conrad. I guess we should vote.

The Chairman. All right.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Ms. Snowe?

The Chairman. No by proxy.

The Clerk. Mr. Kyl?

The Chairman. No by proxy.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

I would ask Senator Snowe to cast her own vote, now that she is here.

Senator Snowe. No.

The Chairman. All right. Then did I say no for Senator Bunning and no for Senator Crapo? I am sorry.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

The Chairman. No by proxy.

The Clerk. Mr. Crapo?

The Chairman. No by proxy.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Schumer. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. All right. According to the report of the tally, the amendment is defeated.

Now I go to Senator Schumer.

Senator Baucus. Mr. Chairman, before we do that, might I say, I just urge my colleagues to come up with their modifications early and submit their modifications early to save time here. Second, I told the Chairman we would try to finish by supper time, so I urge everyone here to try to help us all out. Thank you.

The Chairman. In the case of Senator Schumer, that is dinner time for you.

Senator Schumer. Every meal is dinner for me, Mr. Chairman. I want to eat all of those Iowa farm products.

The Chairman. Especially during fundraising season. Go ahead, Senator Schumer.

Senator Schumer. Thank you, Mr. Chairman.

Mr. Chairman, first, before I get to this amendment, I have two statements. One is on an amendment that I had on hospital reimbursement. And while there are some cuts, I know you have labored mightily to make them as fair as possible, and I thank you for that and I am not going to offer the amendment.

But I would ask unanimous consent that my statement about that amendment that I was going to offer be put in the record.

The Chairman. Without objection.

[The prepared statement of Senator Schumer appears in the appendix.]

Senator Schumer. Second, another statement, so again we can afford the committee and save time. A couple of my amendments deal with specific hospitals in New York. One of the problems we face, and others, is that the metropolitan area has greatly expanded, raising the costs. Hospitals 30 miles away get reimbursed for New York City's costs, but these hospitals do not.

They cannot get any nurses because the hospitals that are part of the New York SMSA get huge amounts of money--I know we have this problem in other States--and the ones

that are not, do not. So, these were amendments to provide relief.

I know that the committee was not going to look favorably on them so I will not ask for an amendment, but I ask that my statements be submitted in the record with them as well.

The Chairman. Without objection.

[The prepared statement of Senator Schumer appears in the appendix.]

Senator Schumer. All right.

Now, to the amendment at hand, which is really sort of a combination of Schumer-Rockefeller 1 and 2. The reason that we have changed them and put them together, is that the print changed this morning in relationship to generic drugs.

We all know generic drugs are a boon. Many of us on this committee on both sides of the aisle, particularly my friend from Utah, have been a leader on this issue. It is a great way to control costs in the health care system.

Medicaid spent $23 billion on prescription drug in 2002. Generic drugs account for half the drug prescriptions that Medicaid patients use, but 16 percent of the costs, so it is a great opportunity for savings.

But there is a new amendment here that was just put

in this morning that would virtually prohibit Medicaid from using generic drugs, and it is really troubling and I hope my colleagues will pay attention to it.

When drug companies sell drugs to Medicaid, they have to provide a rebate back to the government. That is for the cost of selling it, and all that. This rebate is 15 percent for brand-name drugs and 11 percent for generic drugs.

The mark that was released on Thursday reflected the increase in the rebate for brand drugs from 15 percent to 17 percent. I guess that will provide some kind of savings because the rebate is greater, but it made sense. That is because brand drugs are becoming more and more expensive and more and more profitable, and everyone supported that.

But this morning, for the first time, something extra was put in the bill. In addition to asking brand-name manufacturers to refund 17 percent, the Chairman's mark tells the generic drug companies to do the same thing. That is going to increase the rebate by 6 percent compared to the brand rebate of 2 percent.

It puts generic drugs at a decided disadvantage. Generic drugs are so much cheaper that they do not have this extra margin to pay back a rebate. In both Missouri and New Jersey, when the rebate was increased, generic

drugs dropped out of the market. They could not afford it. Then we ended up paying a whole lot more money.

So this is sort of a penny wise, pound foolish proposal that was just put in the bill this morning. What is going to happen is, we are not going to have generic drugs being sold in Medicaid.

Then they are going to go to the brand-name prescription drug, which is much, much more expensive. The loss by going to that is far going to exceed the gain by raising the generic rate not 2 percent, which we are doing for brand-name drugs, but 6 percent. So, I think that that is a bad, bad idea. The idea of raising the rate a little bit, that is fine.

Just to give you a contrast, pharmacists who dispense brand-name drugs get a 5 percent dispensing fee; the pharmacists dispensing generic drugs receive 15 percent. There is always a difference because we realize it is harder to sell generic drugs. That is the other side of it.

This is not the rebate that has to be repaid, but what they give to the pharmacists. The generic drug is so much cheaper, if you just give the same amount or the same percentage, you are never going to get them to sell the generic drug.

So, I am going to cut short my remarks here. But I

would urge, Mr. Chairman, I do not understand why we did this. I guess we have a CBO score that shows some savings, although I do not understand it. We are going to save on the rebate, but when the use of generic drugs dramatically declines, it is going to cost us more overall. I would ask CBO, maybe, if they took that into account. I would ask the Director. It just does not make any sense.

I would ask that we go back to the old system, that the generic drug rebate that the generic drug companies had to repay to Medicaid was less than the prescription drug rebate, as their profitability is much less and their cost is much less.

The Chairman. Before the Director comments, I would ask the question along the same lines, but phrase it a little differently. I put a mark down that is $10.6 billion savings, so I meet the mark. His amendment is an amendment to strike, as I understand it. So if it strikes, will we still be within the $10 billion instruction that I have?

Senator Schumer. Well, Mr. Chairman, I neglected to mention, because we have just put it together, we do have an offset so it would not cost. It is the same offset that we have been using all along, so it would not cost anything. But I would like to hear the question without

the offset, if it pleases you, Mr. Chairman.

The Chairman. All right. He can answer your question, but in the final analysis, then, I want to know the effect of the offset and the effect of the amendment.

Mr. Holtz-Eakin. In rough terms, the inclusion of the generics, as the Senator mentioned, does affect the score by a bit over $300 million, $330 million. I can get a precise estimate in a second. It would need to be offset as a result to meet the five-year reconciliation target. We would have to check on the 2006 impact. There is certainly enough in the offset proposed in total.

The Chairman. You have to check before we vote on it, because I announced that the assumption is, if it is unknown, then I am going to rule it out of order, because I cannot take a chance on reporting a bill that is under $10 billion.

Senator Schumer. Mr. Chairman, could I just get the answer to the first question? Did CBO take into account that there will be many fewer generic drugs used by Medicaid, and rather that prescription drugs will be used?

Mr. Holtz-Eakin. It is certainly the case that, in putting together the estimates, we take account of the substitution between brand names, authorized generics,

and generics, and those who will use more and less, in total. So in principle, yes. I would be happy to work with you on whether we got the numbers right.

Senator Schumer. It is hard to imagine, given the experience of States that did this. CBO just admits that the number of generic drugs used, or the percentage, will go down if this amendment passes.

Mr. Holtz-Eakin. It is an issue of magnitudes. If you change the incentives in the system, we always assume people will respond.

Senator Schumer. And so it will go down. Right?

Mr. Holtz-Eakin. Yes.

Senator Schumer. Well, it seems to me it is just perfectly logical. Given that the generic drug, on average, costs a half or a quarter of what the prescription drug does, that changing the percentage of the rebate from 2 to 6 percent, which is what we do, is not going to equal, except in a rare drug, the substitution.

Now, you may say there will be a very low substitution, but that is not what experience says. Is that what CBO is assuming, that very few generic drugs will drop out of the system with this rebate?

Mr. Holtz-Eakin. It would depend, obviously, on the particular therapeutic class. You would have to go

through piece by piece. I would be happy to work on that. I do not actually have that.

Senator Schumer. Mr. Chairman?

The Chairman. Let me break in, though, because I think since it is my mark, you ought to consider how we feel this will work. The way our bill reimburses the multiple-source drugs creates, as we see it, a tremendous incentive for the use of generic drugs, obviously, contrary to what you believe, Senator Schumer.

But when a brand drug and a generic drug are in the same multiple source class, the price is weighted average of the entire class. That creates a tremendous incentive to dispense lower-cost generics over higher-cost brands.

Also, we require that States provide higher dispensing fees for generics over brand drugs. So, I see my mark as having significant incentives for generic utilization.

Senator Schumer. But, Mr. Chairman, if, as the experience in these two States which did this, the generic company drops out and will not sell the drug, then the argument you made goes by the way side because they are not part of this grouping, this big package. That is what I think will happen. That is what has happened in the past.

The Chairman. Can I ask the pharmacist on my staff

to state how he feels it is going to work?

Mr. Hayes. Mr. Chairman, the Chairman's mark, in applying an increased rebate on the generic drugs, does not affect the reimbursement to pharmacies, which still remains unchanged and provides and incentive to generic substitution.

It does not affect any State laws that require generic substitution and it will not affect the out-of-pocket costs or the co-pay paid by a beneficiary for a generic drug. So, all of the incentives for generic substitution and for utilizing generic drugs rather than a brand-name drug when they are available still exists.

The rebate is paid after the fact, after the drug is prescribed by the physician, dispensed by a pharmacist, and used by a beneficiary, so it would not affect generic utilization, prescribing habits, or generic substitution.

Senator Schumer. Mr. Chairman, could I ask this gentleman a question?

The Chairman. Yes.

Senator Schumer. But is it not true that, even so, five percent of the brand-name drug is going to be a lot more in actual dollars than 15 percent of the generic, in most cases?

Mr. Hayes. Well, the rebate increase from 15.1 to 17 percent raised about $1.1 billion.

Senator Schumer. That is not what I am asking.

Mr. Hayes. Compared to $330 million for this.

Senator Schumer. No. But that is not what I am asking. Or maybe I am missing your answer, or maybe I am not stating my question clearly.

In terms of the incentive to use a generic, which is what this whole system is sort of jiggered to do, correctly -- this is the other side of it. The five percent of the brand drug, since the brand is so much more expensive, is going to be a lot more money to the company than the 15 percent of the generic, which is not enough to pay the freight.

Mr. Hayes. The rebates do not go to the pharmacies so they do not affect generic substitution.

Senator Schumer. No. There are two parts to this, the amount that goes to the pharmacy to encourage the pharmacist and the amount that goes to the drug company to encourage the company to be part of this and make some kind of reasonable profit. That is where it falls down.

Mr. Hayes. The issue would be then that the rebate paid by a generic company, if they factored that into their price, would affect the average manufacturer price or the weighted average manufacturer here paid to pharmacies for the purchase of that drug.

The generic companies would have to recoup that in

the price they charged to pharmacies, but it does not mean that it affects the generic utilization rate itself.

Senator Schumer. So, CBO is assuming that generic drug companies will stay in the system and participate to the same extent that they do now. Right? Is that true?

Mr. Holtz-Eakin. There are two pieces. One piece is the constellation of incentives in co-pays and pharmacy reimbursements to have a mix of generics versus brand names, and that set of incentives favors generics over brand names.

Senator Schumer. Right.

Mr. Holtz-Eakin. There is a second set of issues on the rebate side, which largely affect whether a particular drug company participates in the Medicaid market at all.

Senator Schumer. Correct.

Mr. Holtz-Eakin. And if they cannot pass along a cost, be it a rebate or any other cost, in the form of prices and cover their costs, then it will reduce their incentive to participate.

Senator Schumer. All right. Right. I agree.

Mr. Holtz-Eakin. So there are two margins, participation or not, and then once you are in, how it is set up.

Senator Schumer. Well, this amendment which Senator

Rockefeller and I have sponsored, we believe, will make sure that the generic drug companies stay in the game. CBO has assumed, even with this change--you tell me if I am wrong--that generic drugs will stay in the game to the same extent. History shows that not to be true. Where is that statement wrong?

Mr. Holtz-Eakin. We would be happy to go through that evidence with you. I think at this point it is a disagreement about the empirical magnitudes for introducing this into the system as a whole. I would be happy to work with you.

Senator Schumer. And you have only had since this morning to look at it. Is that right, or have you looked at it earlier, before it was introduced?

Mr. Holtz-Eakin. I saw this for the first time about three minutes ago.

The Chairman. The question for me, in ruling, is his amendment paid for?

Senator Schumer. Yes.

Mr. Holtz-Eakin. His amendment is paid for in 2006, and between 2006 and 2010.

The Chairman. All right. Then we will vote on the amendment.

Would you call the roll?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

Senator Lott. No.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. I vote "aye" three times. [Laughter].

The Clerk. Mr. Conrad?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Jeffords?

Senator Baucus. No by proxy.

The Clerk. Mr. Bingaman?

Senator Bingaman. Aye.

The Clerk. Mr. Kerry?

Senator Kerry. Aye.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Schumer. Aye.

Senator Baucus. Mr. Chairman?

The Chairman. Go ahead.

Senator Baucus. Senator Jeffords votes aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. The Chairman votes no.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. All right. According to the roll call then, the amendment by Senator Schumer is defeated.

Senator Bingaman?

Senator Bingaman. Mr. Chairman, as you know, this

list of amendments that you passed here, the order of likely amendments, there are four remaining amendments there with my name on them. I would call up and describe one of those right now and ask for a vote on it, and then the other three I would like to talk about just a minute, but not call for a vote on them.

The Chairman. I will recognize you after the vote.

Senator Bingaman. All right.

The one I would like to call up for a vote is Bingaman Amendment #8 related to Indian Medicaid Health Improvement amendments. I think we are all aware that the Indian Health Service operates at substantially less of a budget than they actually need.

The U.S. Commission on Civil Rights has estimated that they operate with 52 percent of the budget needed. The estimate that we have is that most Americans' spending on health care is over $4,000 per person; IHS spends $1,900 per person for Native Americans. The average spending on Navajo patients, many of whom live in my State, is $1,187 compared to the $4,000 figure for most Americans.

Consequently, we have severe health disparities for Native Americans in this country compared to the rest of the population. We are all familiar with the tuberculosis rates, the diabetes rates, all of the other

problems that afflict the Native American community.

The GAO has issued a report entitled "Indian Health Service Health Care Services Are Not Always Available to Native Americans" in August of this year, pointing out that there are shortages. These funding shortages have caused waiting periods, lack of services, personnel shortages, and a variety of other things.

My amendment goes through and picks out five of the particular problems that result in these disparities and tries to fix them. I can go through those in as much detail as members would like.

The first one, is that it calls for 100 percent FMAP for services that American Indian Medicaid patients receive at urban Indian Health programs. Under current law, there is 100 percent Federal matching funds for services received at an IHS facility, but if it is an urban Indian Health program supported by the IHS, it is not and the State has to pick up a portion of that. So, we are trying to change that so that that is fixed.

There is a provision in law which says Medicaid is required, once an older American dies after the age of 55, Medicaid is required to go after the estate of that individual to get reimbursement for long-term care services.

Again, this is totally inappropriate, in my view,

when you are talking about Indian citizens who live on Indian land. We should not have States trying to go after Indian-owned land or property after a person dies. So, we are trying to fix that in this amendment.

As I say, there are three other specific provisions that I am glad to go through in whatever detail you would like. We have an offset for this amendment. Under current law, Medicaid health plans are prevented from acquiring drugs under the Medicaid prescription drug rebate program.

Under this amendment, this offset, we would allow health plans to acquire drugs through the drug rebate for their Medicaid beneficiaries, while maintaining their prescription drug utilization management tools.

This is a provision that has been endorsed by the National Governors Association. It is strongly supported by everyone who has looked at it. Secretary Leavitt's Medicaid Commission voted unanimously in favor of this offset being adopted on a freestanding basis, so I believe it more than pays for the cost of this amendment. This cost has been estimated at $300 million over five years.

The Chairman. I want to wait for Director Holtz-Eakin.

Senator Kyl. Mr. Chairman, while you are waiting

for that, might I just say a word?

The Chairman. Yes, please do.

Senator Kyl. I just want to note that, while I am not sure about all of the aspects of the Bingaman amendment, at least some of them are problems that, in Arizona and New Mexico, we have worked on for many years, and not with complete success.

His amendment would go a long way toward ameliorating some of the concerns that have affected primarily the Navajo, but also some other Indian tribes as well, and represent a good solution to those problems.

I do not know about the offset, and I think that may be what you are prepared to ask Mr. Holtz-Eakin about. But I do want to say that the effort that Senator Bingaman is talking about here, whether in this particular context in this reconciliation bill or not, is something that we should address and it is a good approach.

The Chairman. Before I address the amendment, I would like to ask the Director to comment on the offset itself, the impact of the offset, and then whether or not if offsets fully.

Mr. Holtz-Eakin. There are two offsets. The offset that covers the cost of the proposal over the budget window is allowing access of managed care organizations

to the Medicaid drug rebates, and then there are still use of the payment holiday in 2006 to offset any net costs in 2006.

The Chairman. All right. So it is fully offset.

Mr. Holtz-Eakin. Yes.

The Chairman. Yes. Then I would speak procedurally, and not to the substance of your amendment, because we have been a little bit involved in the goals that you seek through this committee. I would only point out that the Indian Affairs Committee has been developing the Indian Health Care Improvement Act under Senator McCain's leadership.

The staff of this committee has been in, from what I understand from talking to my staff, very productive conversations on that bill, and doing that in an effort to move it through the Senate.

So, I want to say that I appreciate your concerns, but I hope that you would consider letting the regular order of process continue and not try to attach it to this reconciliation bill.

Senator Thomas. Mr. Chairman?

The Chairman. So he asked for a vote, and we will give a vote. But I would like to ask him to know that we are interested in this as well.

Senator Thomas?

Senator Thomas. Mr. Chairman, I just wanted to endorse what you have said. This has gone on all day, of course, and I agree entirely that there is a need to do that. I am on the Indian Affairs Committee.

But we cannot fix all of these things here. We have to remember why we are here, and that is to get a reconciliation bill to get some reductions in spending. It is not the platform for doing everything we would like to do.

So I guess my point is, I agree entirely. I think it is a problem we need to deal with. I just do not think this is the place to do it.

The Chairman. All right. Would you like to have a closing comment?

Senator Bingaman. Yes, Mr. Chairman. I appreciate your comments.

I would make two points. Number one, the Indian Health Care Improvement Act has been stalled in committee for over six years, so this is the only stage out of Dodge. If people want to make these changes, this is the time to do it. We have got a way to pay for it.

I mean, I am not trying to usurp the jurisdiction of any other committee. I think that the members of that other committee, Senator Thomas and others, when they review the details of this, will be very pleased to see

this enacted. So, that is one point.

The other point is, as I understand it, there are provisions in the House version of reconciliation which make these provisions that affect Native Americans even more onerous.

If we do not do something like I am proposing in this amendment, the disparities in funding for the Indian Health programs as compared to other Americans will grow rather than stay the same.

The Chairman. All right.

The Clerk will call the roll.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

The Chairman. No by proxy.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?
The Chairman. No by proxy.
The Clerk. Mr. Bunning?
Senator Bunning. No.
The Clerk. Mr. Crapo?
Senator Crapo. No.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Conrad?
Senator Baucus. Aye by proxy.
The Clerk. Mr. Jeffords?
Senator Baucus. Aye by proxy.
The Clerk. Mr. Bingaman?
Senator Bingaman. Aye.
The Clerk. Mr. Kerry?
Senator Kerry. Aye.
The Clerk. Mrs. Lincoln?
Senator Lincoln. Aye.
The Clerk. Mr. Wyden?
Senator Baucus. Aye by proxy.
The Clerk. Mr. Schumer?
Senator Baucus. Aye by proxy.
The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. The announced roll call means that the amendment by Senator Bingaman is defeated.

Senator Bingaman?

Senator Bingaman. Mr. Chairman, can you give me a minute to get my papers here so I can properly explain these next couple of amendments?

The Chairman. While you are doing that, Senator Bingaman --

Senator Bingaman. I am ready to go whenever you are ready, Mr. Chairman.

Senator Baucus. We will just do a little bit of housekeeping here and then we will do yours.

The Chairman. Yes. We have several nominations and we have a quorum right now. So as long as everyone is here, Senator Baucus and I would like to take care of this. The agreement is that the following nominees ought to be favorably reported to the full Senate. I would like to approve them en bloc. The nominees in question are: the Honorable James Halpern, reappointed to the position as Judge of the U.S. Tax Court; the Honorable Karan Bhatia, to be Deputy U.S. Trade Representative; the Honorable Susan Schwab, to be Deputy U.S. Trade

Representative; the Honorable Franklin Lavin, to be Under Secretary of International Trade, U.S. Department of Commerce; and Mr. Clay Lowery, to be Deputy Under Secretary for International Affairs of the U.S. Department of the Treasury.

Those in favor of voting these out en bloc, say aye.

[A chorus of ayes].

The Chairman. Those opposed, say no.

[No response].

The Chairman. It appears that it is unanimously reported.

I thank everybody for their consideration, and move now to Senator Bingaman.

Senator Bingaman. Mr. Chairman, I wanted to briefly discuss Amendment #2 that I have offered. I will not call for a vote on this. This amendment would make permanent the Qualifying Individual program, the QI program, that expired on September 30 of this year.

As I understand the Chairman's mark, we are extending it for a two-year period. My concern is that we have just gone through a period of several weeks here during which it has lapsed and the States have been very confused about what to do.

Some of them have refused to enroll additional people. Others have sent out notices telling people they

were no longer covered. There is a variety of courses that States have followed.

The absurd thing is that we have had to pass legislation extending this QI-1 program nine times over the last three years. This is not fair to the people who are covered by the program. It is no something that I want to see us do in the future. I think making this permanent would be a very major step forward.

As I say, I will not call for a vote on it at this time. I understand that it would be defeated. But I think it is something that we need to have high on our list of priorities.

I would also like to briefly describe and discuss this Amendment #5 that I have offered. This is an amendment which would end the Medicare disability waiting period. There is legislation that Senator DeWine and I have introduced in June of this year that tries to deal with this problem.

As I am sure members know, when Medicare was expanded in 1972 to include people who had significant disabilities, Congress, in its great wisdom, created what was called the Medicare waiting period, which essentially says, for two years after you become eligible for SSDI, you cannot receive Medicare.

The result of this, of course, is that we are taking

people when they are at their most vulnerable and denying them this coverage. Now, under current law, a person with disabilities faces three consecutive waiting periods before they can get health care coverage.

First, they have to get a determination by SSDI of their eligibility for SSDI from the Social Security Administration. That is the first waiting period. Next, they have a five-month waiting period to receive SSDI after the determination is made.

Third, there is another 24-month waiting period that we have written into the law which is highly unfair, and really has not justification in policy. It is strictly a way to save money for the Medicare program.

Again, I will not offer this today because I realize it would be defeated, but this is an amendment that should be adopted. The bill Senator DeWine and I have proposed phases out the waiting period over the next 10 years, and we are doing it in a fiscally responsible way, but this is a problem with the current law which I think clearly needs to be corrected.

The final issue that I would just raise, is I have an Amendment #10 which calls for establishing demonstration programs in the Medicaid program to deal with this problem of obesity, to allow States to do that. This is a very high priority for the country.

I think it is appropriate that we try to do something in Medicaid to begin to come to grips with this. We are very, very glad to pay people's costs for dialysis once they contract diabetes and require dialysis after that. We are even glad to pay the costs of treating their diabetes.

But we are unwilling to try to get out ahead of the problem and assist people with avoiding the problem of obesity, which leads to these conditions that we reimburse for at the current time.

So, again, I will not offer that amendment because I realize it would be defeated during this mark-up, but I hope that the committee can give attention to it as we move ahead, and hopefully there will be another opportunity in this Congress, probably in the second session of this Congress, to return to each of those three items. Thank you very much.

The Chairman. Thank you. I appreciate very much your consideration of the time constraints that we have.

If I could, now, go to Senator Rockefeller's amendment. What I would like to have you do, Senator Rockefeller, would you take a minute to summarize your amendment? I would like to speak on it, then I would like to have you finish or respond to me, and then we will vote. Is that all right?

Senator Rockefeller. All right. I will make a deal. Let us do that, if you will put my opening statement in the record in full.

The Chairman. I will put your opening statement in the record in full.

Senator Rockefeller. All right.

[The prepared statement of Senator Rockefeller appears in the appendix.]

Senator Rockefeller. I had explained this once before but the Chairman was busy with another matter.

We have a lot of chronically ill patients, older, who have sort of, in various ways, begun to lose their powers of judgment as to what ought to happen to them with respect to the next era of their care. It is a very big problem. I experienced that with my own mother.

Death is a very difficult subject for people to talk about, and I understand that. But people deserve time to make their own decisions based upon their own values, and most particularly if they have had a chance to talk with a physician.

A lawyer may be able to file the paperwork for an advance directive, but only a physician can really give good advice to an older person in a matter of this sort. So, my amendment would require the inclusion of physician consultant and advice. That is a natural thing.

We have something called "welcome to Medicare" visits that are with doctors, so it is just simply to increase their interest in trying to keep in touch with that patient about what might be happening to them.

It would just ensure that the physician has a time to be with patients in something which is very complicated and very hard to talk about, as I recalled just a while ago.

This is something that Jack Danforth and I started working on in 1989 and actually have not made that much progress. The private parts of our society have made progress, but the public parts have not. Medicaid is a very public part, and that is why I would advance this amendment and ask for its support, Mr. Chairman.

The Chairman. First of all, the necessity of making this decision that you ask each individual to make, I do not have any argument with. I have made some of those decisions, my wife and I have made some of those decisions. I only raise questions about the process, so my answer is not in any way condemning your goals that you seek.

While the goal of this amendment is clear, I have lots of questions. What are physicians currently doing in regard to advance directives, as part of standard medical practice? Are physicians comfortable in the

role?

Are they trained to provide this very personal type of consultation that gets to the heart of an individual's spiritual beliefs and values? Are there standard ways that hospice personnel and physicians are approaching the issue?

I also have to raise questions about whether the amendment is too proscriptive. I would want my doctor to address this issue at different points during my medical care as part of standard practice. I would want a physician to have the flexibility to respond to each individual's health care status and family situation.

I am not sure that directing a physician in such a proscriptive way is the best way of promoting the use of advance directives, and it seems to me that these are very personal decisions. Such decisions about end-of-life care may change over a period of time, and it seems to me it is well to involve family.

Prescribing that physicians do a one-shot, end-of-life, one-on-one orientation just does not seem like the right approach when so many factors are involved, meaning the factors that I have just raised.

Also, the MMA has a provision that promotes end-of-life care planning and covers consultation with a hospital physician for someone with terminal illness.

This was only implemented in January through the physicians' fee schedule.

Congress should see how this additional service works before we begin telling doctors how and when to advise their patients. So, I thank you very much for your concern, but I would ask my colleagues to oppose the amendment at this point.

Could I ask whether the amendment has a score, and is it paid for?

Mr. Holtz-Eakin. CBO's judgment on what little we have seen of this, is that it would have some small cost. We do not have a precise estimate yet. There are no offsets, to our knowledge.

Senator Rockefeller. It would be paid for in the same manner that we have previously done with respect to risk adjustment.

The Chairman. All right. Then it is obviously paid for. He has the right to modify his amendment.

I will give you opportunity to have closing remarks.

Senator Rockefeller. Yes. I just want to make an observation. That was a good statement you made. But what occurs to me, is we are not living in a world of absolutes. I suspect both of us have been through periods where family members--in some cases, wives--are under enormous pressures.

You and I are in a position--most of us that work in this complex--to have those decisions made, to give people advice as to what people ought to be doing, what they should be looking forward to, is it time to talk about advance directives.

You can always say there is another way to do it. You can always say there is a better way to do it. But we are not doing it. That is, for that Medicaid population out there, we are not doing it. We are not doing it for the Medicare population.

To be honest with you, I remember that Jack Danforth and I, in our second round of ideas, wanted to have information put on the chart at the end of the patient's bed stating the person's wishes. Let us say, if this person does not want to be kept alive artificially, that should go on the chart, or some other thing so the doctor is faced with that.

So the Chairman's points are good. But my question is, it is a little bit like, all of the amendments today have come from our side and they have all been defeated. With the exception of one, I think they have all been defeated by the same vote.

And the Chairman knows how much I respect him. I think you are an absolutely outstanding and fair Chairman, where you advise your colleagues to vote "no."

It seems to me that it is up to the individual Senator. But this is so crucial and people are so helpless in the face of these kinds of deeply human problems, that at some point it would be useful if we got started on it.

There is this thing called the "welcome to Medicare" visit. A doctor does not have to start giving advice at that point, but can say, this is something that you are going to be thinking about, perhaps using a number of the ways that you, yourself, have suggested. It just seems a shame to take this and toss it out.

The Chairman. Well, it is true that the amendments from the other side have been defeated today, but you do not know how many amendments, in rump caucuses, were defeated by members on my side, and a lot of people wanted things in this bill that they did not get or we could not afford, things of that nature.

I do not know whether I have got anybody on my side that is satisfied. In fact, I even had to compromise a lot of things that I have been fighting for for six years to get into this bill just to get past Senator Santorum, as an example. [Laughter].

Would the Clerk call the roll, please?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

Senator Smith. No.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Senator Rockefeller votes "aye" six times. [Laughter].

The Clerk. Mr. Conrad?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Jeffords?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Bingaman?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Kerry?

Senator Kerry. Aye.

The Clerk. Mrs. Lincoln?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Wyden?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. As reported, Senator Rockefeller's amendment is defeated.

Senator Baucus, do you want to be next?

Senator Baucus. Senator Kerry, I think, was next.

The Chairman. All right. Senator Kerry, you are next.

Senator Kerry. Thank you, Mr. Chairman. I apologize for not being here earlier. I was at a funeral for one of our soldiers. But I appreciate your indulgence in letting me go now.

Listening to the discussion by Senator Rockefeller, I mean, I know that the good ideas on our side have been faring brilliantly. So with that in mind, I still am going to offer this amendment. It is Amendment #1. I hope maybe we can persuade colleagues to think about it individually. It certainly is in the interest of citizens who live in their States.

Under the Medicare Part B premium structure, we, all of us on this side of the aisle, Mr. Chairman, understand completely your need and our need to get a payment adjustment in the provider reimbursement rates under the bill, and we certainly applaud that effort.

But all of us are also intimately familiar with the way the Medicare Part B premiums are calculated. We are very concerned that, as written, the change in payments to doctors is going to result in yet another increase in the out-of-pocket costs for seniors in all of our States.

Now, over the last three years, Medicare beneficiary premiums for seniors--obviously for seniors--have increased 50 percent, or roughly $30 a month. In 2005, the Part B premium increased roughly 17 percent, to $78.20, or it was $11.60 more a month in 2005.

This dollar increase for seniors is the largest increase in the program's history. Part B premiums for 2006 are now going to increase by another 13 percent, to

$88.50. That is a $10.30 increase, as announced by CMS.

Now, CBO estimates that the sustainable growth rate fix that is in the reconciliation mark is going to cost $10.8 billion over five years. When you calculate against that sustainable rate growth, what beneficiaries are going to get hit by, they are going to pay more than $1 billion more on top of all of the increases that I just listed in higher Part B premiums during that same period.

AARP strongly supports this amendment. Mr. Chairman, I would ask unanimous consent that a letter in support of it from AARP be put in the record.

The Chairman. The letter will be included.

Senator Kerry. Thank you, Mr. Chairman.

[The letter appears in the appendix.]

Senator Kerry. My point is, we should not be creating a worse problem as we try to fix a problem, which is in the rebate structure.

I know doctors deserve some relief, and I think we can give the doctors relief. But a lot of these folks who are on fixed incomes should not be hit again with another unexpected increase in the Medicare premiums. That is what is going to happen if we do not pass this amendment.

The new COLA adjustment for Social Security is 4.1

percent. That has already been deemed to be insufficient to help cover the cost of the projected increase in the Part B premium for this year, and that is without calculating the further impact of the increases if we do not take some step now to hold beneficiaries harmless under the reconciliation package.

So, Mr. Chairman, my amendment seeks to hold those beneficiaries harmless. It is offset by providing an accelerated phase-out of the budget neutral modification to the risk adjusted payment rates to the MA plans. So, you already have that neutrality in the mark, and all I am trying to do is speed it up.

If you speed it up, instead of the four-year phase which you have put in, we can have a complete hold harmless to seniors. That is what my amendment does. It has been scored at no cost for next year, $1.35 billion over five years.

I want to thank Senator Bingaman, Senator Lincoln, and Senator Rockefeller for also co-sponsoring this amendment.

The bottom line is, if you want to avoid seniors having an increased rate above the largest increase in history with no budget impact, complete neutrality, simply speed up the process, this is the way to do it.

The Chairman. All right.

Senator Lincoln. Mr. Chairman?

The Chairman. Mrs. Lincoln?

Senator Lincoln. Can I just add a few quick comments, if I may?

The Chairman. Yes, of course.

Senator Lincoln. I certainly support you. You have done a tremendous job in the provisions in your mark to ensure that physicians do not receive that 4.4 percent cut in their Medicare reimbursement rather than a 1 percent increase, but I am desperately concerned about the impact it will have on the beneficiaries when we do not hold them harmless in this increase, because they will receive an automatic increase.

I am sure Senator Kerry is much aware, but it will also will mean an increase to the States. For those in the QMB and the SLMB programs where the States provide assistance in paying for the Medicare premiums and deductibles for those lower income individuals, the States are going to see an increase.

So, I just think it is something that is really important for us at a time when these services are absolutely vital to these individuals and they are being hit, most of them, fixed income individuals, with enormous gasoline price increases. We are talking about light and heat right now, the unbelievable problems they

are going to see in their heating this winter; on top of that, an enormous increase this January.

So, I just would plead with my colleagues to please, if you cannot support it now, work at some point to realize what a critical component of the overall quality of life for seniors this could take a toll on.

Thank you, Mr. Chairman.

The Chairman. I have a letter in front of me that was sent to Josh Bolton on July 25, asking for an increase in reimbursement for doctors under the SGR. Eighty Senators signed this letter, of which Senator Kerry, Senator Lincoln, and other co-sponsors are also signers on it. So we have tried to respond to what a vast majority of the Senators have done, and we have done it. Now we are being criticized that it might lead to an increase in premium for some.

So, I would ask my colleagues who have supported this for a long period of time and asked for us to put this increase in here, and everybody that signed the letter surely had to understand that this would lead to some increase in the Part B monthly premiums, that they would stick with our mark and defeat this amendment.

Senator Kerry. Mr. Chairman, could I respond?

The Chairman. Yes.

Senator Kerry. I stand by my signature, providing

an increase to the doctors. I just said to you, we all want to provide some relief to doctors. There is nothing that negates that in my amendment. The money comes out, not from the doctors, it comes through the HMO component. So, this does not deny doctor relief.

We can all provide the relief to the doctors, and it is revenue neutral in terms of the rest of the effort. So, my hope would be that we could really not be rigid here in our approach, but rather vote sort of common sense about how we could do both at the same time.

Senator Kyl. Mr. Chairman?

The Chairman. Senator Kyl?

Senator Kyl. As another signatory to that letter and one who has sought to ensure adequate reimbursement for all providers, because without that we are not going to have anybody providing care to seniors or anybody else, we do have to realize that it is not free, that it has to be paid for by somebody.

I think it is important for us to know who pays for it. The taxpayers pay for three-fourths of it, so this will be an increase for taxpayers, three time as much as the beneficiaries.

Second, it is my understanding that for the year 2006, this will not be reflected in the premiums. For the year 2007, it will be less than $2.50. If I am wrong

on that, would somebody please correct me?

I think this year the physician component of the increase in premiums is less than $2 out of a $10 and something increase in premium. Again, if my figures are incorrect, please let me know.

But the bottom line here is, we get from physicians a tremendous amount of quality care in this country. I think all of us here are willing to pay for that because we know what would happen if we do not pay for it.

For people who are on Medicare who are asked to pay only one-fourth of the increase in those payments, this represents still a great opportunity to get high-quality health care at a significantly taxpayer-subsized price.

The Chairman. All right.

Senator Kerry?

Senator Kerry. Currently there is an over-payment that is made in the risk adjusted basis, so what would happen is, this would come out of that over-payment and it would not, in fact, result in an increase, either in the tax base itself, or come out of the doctors. So that is why, as I said before, it is a budget neutral policy. All it comes by, is by accelerating the phase-in of what the mark does anyway.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

Senator Thomas. No.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

Senator Frist. No.

The Clerk. Mr. Smith?

The Chairman. No by proxy.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Jeffords?

Senator Jeffords. Aye.

The Clerk. Mr. Bingaman?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Kerry?

Senator Kerry. Aye.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. Accordingly, Senator Kerry's amendment is defeated.

Senator Baucus, do you have something?

Senator Baucus. Yes.

The Chairman. I will yield to you. Senator Baucus?

Senator Baucus. Mr. Chairman, I have an amendment similar to the one offered by Senator Conrad with respect to retail pharmacists.

Essentially, my amendment is suggesting that when AMP

is calculated, that the prices paid to pharmacists who sell directly, and long-term care, be excluded so that the retail pharmacists get a little bit of a break with respect to the rest of the pharmacists in calculating AMP. That is all this is.

The bigger pharmacists, the chain pharmacists, will still be able to get a better price through wholesalers and manufacturers, because of their size, and get a discount. But it is the little guys, the retail guys, that just cannot. That is all this is.

So it is just saying, when you calculate the AMP, when the pharmacists are paid, it is AMP plus a certain percentage, that calculation excludes the prices for direct sale and long-term care because those tend to be lower.

So as a consequence, the result to AMP will be a little higher, which means that the retail guys will get more of a rebate, and the direct sale and long-term care, because they are larger, will still be able to get their discounts. This is just to help the little guys, frankly. I suggest it is an option.

The Chairman. Obviously, this amendment raises some very interesting issues, and probably these have not been entirely addressed by our understanding of the AMP. But your amendment raises the question of, what is a retail

pharmacy?

Should we really consider brick-and-mortar pharmacies and mail-order pharmacies as legitimate competitors? If you look at the nature of our economy, if you look at how people use the Internet today for mail-order delivery, it seems to me to be counterintuitive to make such a distinction. I am not convinced that brick-and-mortar pharmacies are not competing with mail-order pharmacies, generally.

Finally, the amendment creates a fundamental disconnect where the best price calculation is concerned. It is my sense that the purpose of the best price calculation is that it should reflect the discount the best purchaser gets over the average of the market.

By curtailing the definition of AMP, as the amendment does, the best price becomes the difference between the discount available to the best purchaser and a very limited subset of the market.

Do you have any comment on the score or anything?

Mr. Holtz-Eakin. The proposal costs $825 million over the budget window. It is fully offset by the proposed reduction in payments, and there is no 2006 net cost.

The Chairman. Yes.

Senator Baucus, do you have a closing comment?

Senator Baucus. We all know that retail pharmacists are getting squeezed. This just helps them so they do not get squeezed quite as much as the discount, larger pharmacies. Not everybody can go online, either.

I know a lot of people, seniors especially, that cannot use computers. They do not know what the Internet is. They need to go their retail pharmacist, if they can find one. I just think it is good policy. It is good for the country if we have retail pharmacists.

Otherwise we are going to move much more to the homogeneity of chains and discounts and Internet, and I do not think that is good for America. This is not a subsidy for retail pharmacies, it just gives them a little bit of help and prevents them from going out of business more quickly, frankly.

The Chairman. Do you want a roll call vote?

Senator Baucus. Yes, I do.

The Chairman. Would you call the roll, please?

The Clerk. Mr. Hatch?

Senator Hatch. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Ms. Snowe?

Senator Snowe. No.

The Clerk. Mr. Kyl?

Senator Kyl. No.

The Clerk. Mr. Thomas?

The Chairman. No by proxy.

The Clerk. Mr. Santorum?

Senator Santorum. No.

The Clerk. Mr. Frist?

The Chairman. No by proxy.

The Clerk. Mr. Smith?

The Chairman. No by proxy.

The Clerk. Mr. Bunning?

Senator Bunning. No.

The Clerk. Mr. Crapo?

Senator Crapo. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Conrad?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Jeffords?

Senator Jeffords. Aye.

The Clerk. Mr. Bingaman?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Kerry?

Senator Baucus. Aye by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. Aye.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

Senator Baucus. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. Mr. Chairman, the tally is 9 ayes, 11 nays.

The Chairman. According to the reported tally, the amendment by Senator Baucus is defeated.

Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I want to bring a little happiness to our little circle here, and particularly while Olympia Snowe is here, because she is very much a part of this, Senator Hatch also, and yourself, and most of us.

We passed, a number of years ago, the Children's Health Insurance Program. It was a fascinating process. It really began when everybody left the room and we just sat around a table here, people stood up and began talking about the importance of getting insurance to children. That has developed now.

John Chaffee and I both felt very strongly it ought

to take place under Medicaid because people clearly understood where that happened and they would have been able to get to people right away as a result. It took some States a lot of years to get it going, but that is history. It is now going.

Some--not all--States have spent all of their money because some of them were slow in starting, so we have this question of money remaining over, which is actually put to the SCHIP program, but it reverts to the Treasury.

I do not think any of us wanted to see the Treasury get the extra whatever amount of money and not see children get that. I talked with the Chairman. I was going to have an amendment on that and I talked with the Chairman, and I would just like to say that we agreed on a colloquy that we will make on the floor, if necessary, or we can make here, whatever, in which we each--and it is specified who says what exactly--state what the problem is.

Nobody gets 100 percent of what they want out of this, but it is something where Chairman Grassley and myself, involving Olympia Snowe and a lot of other people, seek accommodation to achieve a good purpose.

The Chairman. If it is all right with you, Senator Rockefeller, obviously we agree on this and we have worked it out. I appreciate the comments that are in the

suggested colloquy. I would suggest we just put it in the record and then we will repeat it on the floor as well. So, this colloquy will be made a part of the record at this point.

Senator Snowe. Mr. Chairman?

The Chairman. Senator Snowe?

Senator Snowe. I just want to join Senator Rockefeller, and I thank you, Mr. Chairman, for your willingness to work on this issue, because more than a billion dollars has reverted to the Treasury. That is unfortunate for the States that depend upon this money to help with children's health insurance. More than six million children have been enrolled in this program. It has been an extraordinary success.

Obviously, we need to do far more, so it is regrettable that we have not been able to address this problem. But we need to recapture that funding that was lost to the Treasury and to return it to those States who are experiencing shortfalls. So, I hope that we can work this through ultimately. It really needs to be done.

So, I thank you, Mr. Chairman. I thank you, Senator Rockefeller, for your leadership.

The Chairman. Before I call on Senator Lincoln, we are winding down now. I would expect to have a vote shortly, so we need at least one more member for the

necessary quorum, I think it is. Any other members that want to be here for this vote and meet the rules, we need to have them here.

Senator Lincoln?

Senator Lincoln. Thank you, Mr. Chairman. I will try not to take too much time, but I do feel like there are so few opportunities for us to really bring up these issues that mean so much to us.

One of my amendments -- and your staff, as well as you, Mr. Chairman, have been enormously gracious in discussing this issue with us. I guess what I really would like to ask, is that we could continue that discussion with you and your staff on the Amendment #4 that I offered, which was access to health care coverage for uninsured children.

Private insurance is often limited. It can leave families with difficult choices of either impoverishing themselves to pay for the health care services, or if they cannot afford to make up the slack, watching in heartache as their child goes without the services that they need.

We do not want to incentivize families to drop their private insurance so that their children can qualify, and that was never the intention of SCHIP. So what we would like to do, is see the wrap-around ability for Medicaid

in SCHIP through the private coverage.

It would allow children to continue to be enrolled in their family's private health policy, and at the same time obtain the full spectrum of health services that they so vitally need as children with special needs and special concerns.

So I hope, and would really like to ask the Chairman to continue being engaged with us in that discussion as we move forward, because I do think it is important and I think it is something we can do at a minimal cost.

I also want to compliment Senator Hatch and thank him very much for his work here in this bill, as well as the freestanding bill of the PACE program in rural areas. I think it is an important tool for elderly people in rural areas to be able to maintain the ability to continue living in their communities.

The amendment that is included here in the Chairman's mark, I think, does a tremendous job towards that and I want to thank the Chairman and Senator Hatch.

Just the last couple. We do, and have included in the Medicare reform, the ability to look at quality of care in the Medicare program. My hope is that we would extend that also, Mr. Chairman, to children's health.

The amendments that I had offered in both Amendments 7 and 8--I think that is right. I cannot keep up with

them--are to make sure that we could include both a demonstration in terms of the quality of care with health care for children, but also making sure that we provide the quality measurement for children's hospital services also through a project.

I think there is great ability there for us to not only take a look at what we are doing in providing children's health care, just as we are doing through the Medicare program for the care of our elderly and our disabled, but also to make sure that we are providing the kind of quality of care with the efficiency and effectiveness that these types of demonstrations, as well as projects, can provide us.

It is critical information if what we want to do is to make sure that we are eliminating the fraud and abuse, but also maintaining the quality of care, particularly for our children.

These are amendments that are a part of the ABC piece of legislation that Senator DeWine and I have introduced. We felt like this was an appropriate place to put them if, in fact, this is the only train leaving the station, and that is why I brought them up today. I hope that you will consider those and continue to work with us and talk with us about those very important pieces that are out there.

And I guess the last thing, Mr. Chairman, is there were two pieces in terms of Medicare. If we are finishing this up, I just want to mention them briefly.

The demonstration project on direct access by beneficiaries to outpatient physical therapy services is something that could occur. There are already States out there that allow that direct access.

We wanted to make sure that we could do that in a demonstration project in those States where they already do, by State law, allow that to happen. I think it provides both efficiency and effectiveness for beneficiaries in reaching the goals that we want to.

The last, was a Kidney Disease Educational Benefit Act that Senator Santorum, as well as Senator Conrad, have in a bill that they have introduced. There are many members of this committee that are co-sponsors of that bill. It is an amendment that provides Medicare coverage for chronic kidney disease education, which services for Medicare-eligible patients.

It consists of no more than six sessions of kidney disease education services. But I think that the benefits that we would reap, as well as those beneficiaries would reap, could be monumental.

So, all of these amendments, Mr. Chairman, were very practical amendments. I think they were things that we

could really make improvement in the delivery of services to both children, as well as Medicare beneficiaries.

Again, I have no earthly idea, in the next several months and approaching the holiday season, when we will have another opportunity to discuss these, so I hope that we can continue to talk about them.

These are vitally important programs that I think could help us in the delivery of health care to the people of this country, and I hope that you can continue to stay engaged with us in those discussions.

So, thank you, Mr. Chairman. Those are, briefly, the amendments that I had hoped we could see make happen.

The Chairman. I will not speak to all of your amendments. First of all, you asked if I would consider working with you on these, or continuing to work with you on these, and of course we will.

But I did way to say, on your Amendment #4, that the wrap-around approach that you have is one that I have endorsed, and it is part of the Family Opportunity Act, which is part of this bill.

Senator Lincoln. Yes, sir.

The Chairman. So, it is something that obviously we can continue talking about because I accept that concept.

Senator Lincoln. Thank you, Mr. Chairman.

The Chairman. Senator Baucus?

Senator Baucus. Mr. Chairman, I have two amendments. I will not ask for a vote on either one, but I think they are both very important.

The Chairman. Did you want a voice vote?

Senator Baucus. No voice vote. I would lose, so there is no point.

The Chairman. So you withdraw them?

Senator Baucus. I withdraw both.

The Chairman. All right. Go ahead.

Senator Baucus. The first, is with respect to so-called 1115 waivers. I think we all agree that the administration has gone too far in granting these so-called Section 1115 Medicaid waivers. It is usurping the prerogatives of Congress. In fact, they are, in effect, making law. This Congress is abrogating its oversight responsibilities in making sure that, frankly, the law is adhered to.

These waivers are also agreed to between CMS, HHS, and the States, virtually secretly. Other States have no idea what is going on. People in States, even the States affected, do not know what is going on. It is not an exaggeration to say these are done in the dead of the night. It is just wrong. It is just wrong.

So, I am offering--but will withdraw--the amendment, S. 222, a bill which I and others have introduced to try

to correct and put some limitations on the waiver process.

Essentially, it would require notice, no block granting, and just add some more transparency to the waiver process so it is done fairly. Otherwise, I will tell you, some of these waivers are going to go way too far and they will be very embarrassing to an awful lot of people.

I am just trying to get some orderly process in the waiver process. The waiver process was set up, first, to give waivers to help States in special situations, not to enact broad policy. Now they are being used to enact broad policy.

A good example, is the recent waiver in Florida. I do not know if that is a good idea or not a good idea, but it is so sweeping in its effect, and the effect it will have on Floridians, Medicaid patients in Florida, and on national policy.

Maybe, Mr. Chairman, when we get to the floor we can figure out some way to do this, because if I offer this now I know it is going to get defeated. The fix is in. There is not a single amendment on this side that has been agreed to. They are all voted down, regardless of the merits, because that is just the way things are today. But I would just hope that we can address this

issue because it is so, so important and should not be dealt with lightly.

That is the amendment I was going to offer. I have offered it. Now I am going to withdraw it, so we do not have to vote on it.

The second amendment is much different, and it is with some trepidation that I raise the subject. That is the degree to which various States have their FMAP payments reduced or not reduced. We all know in the law that there are about 29 States whose FMAP payments--that is, Federal payments for Medicaid--are going to be reduced.

In your mark, Mr. Chairman, you say, all right, for certain States, Gulf States, those FMAP payments should not be reduced because, after all, those States are where there are a lot of Katrina victims that really need some help.

Unfortunately, in this mark, there is a provision that Alaska will have no reduction. The provision in the mark says that FMAP will be reduced only temporarily--that is, no FMAP reductions, only temporarily--for the States affected. I think there are three States, or portions of three States in the bill. That is it. It is only for, I think it is, five months. I have forgotten the exact number of months.

But the mark also says that, for Alaska, there are no reductions whatsoever for a couple of years, and Alaska is not a Katrina State.

So what does that mean for various States? It means, for about 29 States, but for the 3, so for 26 States, there will be significant reductions in Federal payments. Fifteen members of this committee represent States where there will be significant reductions in Federal payments under Medicaid. That is just the law. It is due to the formulas.

But the mark also contains the provision that there will be no reduction whatsoever for the State of Alaska, and that would be for two years. I just do not think that is fair. I think that all States should be treated in the same way.

That is, whatever the formula provides, that is what the results should be. Now, maybe there should be some adjustments. Maybe the formula is not perfect in every situation, in every case, but let us deal with that on an orderly basis, not just make an exception for the State of Alaska.

I might say, too, that Alaska got a huge, big break for Medicare reimbursement to doctors in the Medicare Management Act. That is not widely known. But my doctors in my State came to me and said, holy mackerel,

Max, what happened? How in the world do Alaskan doctors get so much more?

I know Alaska is supposed to be more expensive and so forth, but in that bill there is a provision there where Alaskan doctors get so much more than do doctors in other States.

Now, I am not going to push the amendment, but I am raising the subject because I think the right policy would be to deal with this in a correct, orderly basis, not in a non-orderly policy basis.

I hope that by the time we get to the floor, we can work out some rationale here as to what the FMAP reductions are or are not, whether they should be reduced or not reduced, because otherwise, I would just remind my colleagues, every 15 States represented by Senators on this committee, plus about 12 others, are going to find significant reductions. But one State will not get any reduction based not on any formula, but just because that is just the way it is. I do not think that is the way it should be.

The Chairman. I now ask that the committee favorably report, so I would ask for the yeas and nays.

The Clerk. Mr. Hatch?

Senator Hatch. Aye.

The Clerk. Mr. Lott?

Senator Lott. Aye.

The Clerk. Ms. Snowe?

Senator Snowe. Aye.

The Clerk. Mr. Kyl?

Senator Kyl. Aye.

The Clerk. Mr. Thomas?

Senator Thomas. Aye.

The Clerk. Mr. Santorum?

Senator Santorum. Aye.

The Clerk. Mr. Frist?

Senator Frist. Aye.

The Clerk. Mr. Smith?

Senator Smith. Aye.

The Clerk. Mr. Bunning?

Senator Bunning. Aye.

The Clerk. Mr. Crapo?

Senator Crapo. Aye.

The Clerk. Mr. Baucus?

Senator Baucus. No.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Conrad?

Senator Baucus. No by proxy.

The Clerk. Mr. Jeffords?

Senator Jeffords. No.

The Clerk. Mr. Bingaman?

Senator Baucus. No by proxy.

The Clerk. Mr. Kerry?

Senator Baucus. No by proxy.

The Clerk. Mrs. Lincoln?

Senator Lincoln. No.

The Clerk. Mr. Wyden?

Senator Wyden. No.

The Clerk. Mr. Schumer?

Senator Baucus. No by proxy.

The Clerk. Mr. Chairman?

The Chairman. Yes.

Senator Baucus. Mr. Chairman, I might say, you have done a heck of a job on this bill. I just want to thank you very, very much, how you handled all of this.

The Chairman. Well, thank you.

Senator Baucus. I think anybody who knows anything about this process and what is in this bill would agree that you have done an admirable job, and we all thank you for it.

The Chairman. I thank you very much. More importantly, I thank you for your cooperation because a few days ago, you were concerned about the schedule I had set for it. I accommodated you. You said you would help us move the bill along, and you have delivered.

First of all, the bill is favorably reported based on the roll call. I would ask unanimous consent that the staff have authority to draft necessary technical and conforming changes to the Chairman's mark. Without objection, that is so ordered.

[No response].

The Chairman. The committee is adjourned.

[Whereupon, at 5:35 p.m. the meeting was concluded.]

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CHAIRMAN'S MARK

OF THE DEFICIT REDUCTION OMNIBUS RECONCILIATION ACT OF 2005

MODIFICATION

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Section 6000. Amendments to Social Security Act; Table of Contents of Title

Current Law

No provisions.

Explanation of Provision

The provision specifies the title of the Act and includes a table of contents.

Subtitle A - Medicaid

CHAPTER 1 - PAYMENT FOR PRESCRIPTION DRUGS UNDER MEDICAID

Section 6001. Pharmacy Reimbursement

(a) Definition of Average Manufacturer Price

Current Law

Medicaid is a health benefits program administered by the states under broad federal guidelines. Its costs are shared by the states and the federal government based on a formula that takes each state's average per capita personal income relative to the national average into account. Federal statute defines certain groups of individuals as mandatory for inclusion in states' programs and other groups that are optional for states. The same is true of benefits covered — federal law defines a number of health care items and services required to be provided under state Medicaid programs, others are optional. Coverage of prescription drugs under Medicaid is an optional service, although all states presently include such coverage.

States have a great deal of flexibility in setting the payment amounts for pharmacies that provide prescription drugs to Medicaid enrollees. The total cost of prescription drugs paid under the Medicaid program, however, is intended to be kept as low as possible through two policies laid out in federal Medicaid law. Total federal reimbursement for state prescription drug

spending is subject to a ceiling called the federal upper limit (FUL), and manufacturers that enter into agreements to have their drugs available to Medicaid beneficiaries must pay states rebates.

Pharmaceutical manufacturers that wish to have their products available to Medicaid beneficiaries enter into "rebate agreements" under which they agree to provide state Medicaid programs with the rebates. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs. In return for entering into agreements with the Secretary, state Medicaid programs are required to cover all of the drugs marketed by those manufacturers (with possible exceptions of 10 categories of drugs that states are allowed to exclude from coverage). Rebate requirements do not apply to drugs dispensed by Medicaid managed care organizations when the drugs are paid as part of the MCOs capitation rate, and to drugs provided in hospitals, and sometimes in physicians' or dentists' offices, or similar settings. Rebate requirements, on the other hand, do apply to prescription drugs provided on a fee-for-service basis as well as to nonprescription items, such as aspirin, when they are prescribed for a Medicaid beneficiary and covered under the state's Medicaid plan.

The rebates are calculated based on the average manufacturer's price (AMP) of each product, and for certain other products, the best price at which the manufacturers sells the drug. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation.

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. Nominal prices are defined by CMS to be those that are below 10% of the average manufacturer's price. Based on explanatory material of the Senate Finance committee for OBRA 1990, this exclusion appears to have been intended to allow manufacturers to sell drugs at deeply discounted prices to charitable organizations. The purpose of the nominal price exclusion, however, was never codified nor formalized in regulation.

Explanation of Provision

The provision would modify the definition of AMP to specify that sales exempted from inclusion in the determination of best price, nominal sales, and bona fide service fees would be exempted from the computation of the AMP. The provision further specifies that the computation of AMP would include cash and volume discounts; free goods and nominal price sales that are contingent on purchase requirements or agreements; chargebacks or rebates to a pharmacy (excluding pharmacy benefit managers), or any other direct or indirect discounts; and any other price concessions which may be based on recommendations of the Inspector General of HHS.

The provision would establish a new definition of the *weighted* AMP. The *weighted* AMP would be defined, with respect to the rebate period, as the average manufacturer price for the

form of the drug, weighted by the total number of units sold relative to the sum of all units for all forms of the drug that are therapeutically equivalent and bioequivalent.

For the purposes of computing the AMP, sales by a manufacturer of covered outpatient drugs that are single source, innovator multiple source drugs, or are authorized generics that are made available at nominal prices to the listed entities are to be excluded. Sales to a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area are eligible for sales at the nominal price. The nominal price limitations would not, on the other hand, apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule.

For the purpose of computing the AMP, bona fide user fees are defined as expenses for a service actually performed by an entity for a manufacturer that would have generally been paid for by the manufacturer at the same rate had these services been performed by another entity.

Manufacturers' drug price reporting requirements under Medicaid would be modified to include the total number of units sold for each covered drug for the rebate period, and information and data on any sales made during the reporting period at a nominal price. Such reports would include, for each nominal price sale, the purchaser, the name of the product, the amount or number of units of product sold at the nominal price, and the nominal price paid.

The amendments made by this subsection would become effective as if enacted on January 1, 2006 except for the provisions related to the exclusion of nominal prices from AMP. Those provisions would become effective on the later of the expiration date of a contract in effect on the date of enactment or October 1, 2006 and would apply to sales made and rebate periods beginning on or after that date.

(b) Upper Payment Limit for Ingredient Cost of Covered Outpatient Drugs

Current law

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 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.

Explanation of Provision

The provision would replace the current FUL requirement with a new FUL formula. The FUL for a single source drug would be equal to 105% of the AMP for the drug. The FUL for a multiple source drug would be equal to 115% of the *weighted* AMP.

For those drugs sold during an initial sales period in which data on sales for the drug are not sufficiently available from the manufacturer to compute the AMP or the *weighted* AMP, the provision would establish a transitional upper payment limit to apply only during such period. During the initial sales period, not to exceed 2 calendar quarters, the upper limit for single source drugs would be calculated to be equal to the wholesale acquisition cost (WAC) for the drug. For first innovator multiple source drugs, the upper limit during the transition period would be calculated to be equal to the AMP for the single source drug rated as therapeutically equivalent minus 10%. For subsequent non-innovator multiple source drugs, one of two rules would apply. First, if the Secretary has sufficient data to determine the weighted AMP for the drug, the upper limit must be the weighted AMP determined for the therapeutically equivalent and bioequivalent form of the drug. Second, if the Secretary does not have sufficient data to determine the weighted AMP for the drug, the upper limit must be the AMP for the single source drug that is rated as therapeutically equivalent and bioequivalent to the drug minus 10%.

The provisions would define wholesale acquisition cost (WAC) to be the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

In the case of an innovator multiple source drug that a prescribing health care provider determines is necessary for treatment of a condition and that a non-innovator multiple source drug would not be as effective for the individual or would have adverse effects for the individual or both, and for which the provider obtains prior authorization in accordance with the states' program, the upper payment limit for the innovator multiple source drug shall be equal to 105% of the AMP for such drug.

The Secretary would be required to update the upper payment limits on a quarterly basis, taking into account the most recent data collected for purposes of determining such limits and the Food and Drug Administration's (FDA) most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations." Beginning on January 1, 2006, the Secretary would be required to collect data with respect to the AMP and volume of sales of covered outpatient drugs or, in the case of covered outpatient drugs that are first marketed after that date, beginning with the first quarter during which the drugs are first marketed.

If there is a lag in the reporting of information on rebates and chargebacks so that adequate data are not available on a timely basis to update the *weighted* AMP for a multiple source drug, the manufacturer would estimate those amounts by applying a methodology based on a 12-month rolling average. For years after 2006, the Secretary would be required to establish a uniform methodology for this purpose. Beginning with the first quarter of FY 2006 for which data are available, and for each fiscal year quarter thereafter, the Secretary would be required to make available to States the most recently reported AMP for single source drugs and the *weighted* AMP for multiple source drugs.

The provision would provide the Secretary with the authority to enter into contracts with appropriate entities to determine AMP, volume and other data necessary to calculate the upper payment limit for a covered outpatient drug and to calculate such limit.

The provision would require the Secretary to devise and implement a means for electronic distribution of the most recently calculated *weighted* AMP and AMP for all covered outpatient drugs to each State Medicaid agency. States would be permitted to use such data in establishing payment rates for covered outpatient drugs under state Medicaid programs.

The provision would require states to pay a dispensing fee for each covered outpatient drug. The dispensing fees for a non-innovator multiple source drug (generally referred to as generics) must be greater than the dispensing fee for an innovator multiple source drug that is rated as therapeutically equivalent and bioequivalent to that drug. States would be required to take into consideration, in setting those fees, such requirements as the Secretary establishes. Those requirements would be required to include: (a) any reasonable costs associated with a pharmacist's time in checking for information about an individual's coverage or performing quality assuring activities, and (b) costs associated with: the measurement or mixing of a covered drug or filling the container, physically providing the prescription to the Medicaid beneficiary, delivery, special packaging, overhead relating to facility maintenance, equipment and staff salaries; and geographic factors that impact operational costs; patient counseling; and the dispensing of drugs requiring specialty pharmacy care management services.

Not later than 15 months after the date of enactment of this Act, the Secretary must establish a list of covered outpatient drugs that require specialty pharmacy care management services, and must update this list on a quarterly basis. This list would include only those drugs, as determined by the Secretary, for which access would be seriously impaired without the provision of specialty pharmacy care management services. The term "specialty pharmacy care management services" means services provided in connection with dispensing or administration of a covered outpatient drug that requires: (1) significant caregiver and provider contact and education regarding relevant disease state, prevention, treatment, drug indications, benefits, risks, complications, use, pharmacy counseling, and explanation of existing provider guidelines; (2) patient compliance services, including coordination of provider visits with drug delivery, compliance with a drug dosing regimen, mailing or telephone call reminders, compiling compliance data, and assisting providers in developing compliance programs; or (3) tracking services, including developing referral processes with providers, screening referrals, and tracking patient weight and dosing requirements.

Provisions in Subsection (b) would become effective on the later of January 1, 2007 or six months after the close of the first regular session of the State legislature that begins after the date of enactment.

(c) Interim Upper Payment Limit

During the period January 1, 2006 through the effective date as defined above, the Secretary would apply the FUL as under current law and regulations except that instead of limiting federal matching at 150% of AWP, it would be 125% of AWP. In the case of covered outpatient drugs that are marketed as of July 1, 2005, the Secretary would be required to use the AWPs, direct prices, and WACs in those determinations. For new drugs that are first marketed between July 1, 2005 and January 1, 2007, the federal matching would be limited to 125% of AWP.

Section 6002. Increase in Rebates for Covered Outpatient Drugs

Current Law

Since December 31, 1995, basic Medicaid rebates for single source and innovator multiple source drugs are equal to the greater of 15.1% of the AMP or the difference between the reported AMP and best price for each drug. Since December 31, 1993, the basic rebate for all other multiple source drugs is equal to 11% of the AMP.

Explanation of Provision

The provision would modify the formulas for prescription drug rebates under the Medicaid program. Beginning on January 1, 2006, rebates for single source and innovator multiple source drugs would be equal to the greater of 17% of the AMP or the difference between the reported AMP and the best price for each drug. Beginning on January 1, 2006, rebates for noninnovator multiple source drugs would be equal to 17%.

Changes to the rebate formula would begin on January 1, 2006.

Section 6003. Improved Regulation of Authorized Generic Drugs

Current Law

Under the Medicaid drug rebate program, rebate amounts are calculated separately for brand name drug products provided to Medicaid beneficiaries and for generics. The rebate for brand name drugs, referred to as single source and innovator multiple source drugs, is equal to the greater of 15.1% of the average manufacturer's price (AMP) or the AMP minus the best price

available from the manufacturer. The rebates for generics, referred to as multiple source drugs, is equal to 11% of the AMP.

Prescription drug manufacturers participating in the Medicaid program are required to report to the Secretary of HHS data on 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 brand name drugs since the best price is part of the rebate computation for only those drugs.

Drug price reporting is based on each drug product's unique "national drug code" (NDC). For each product for which pricing has been reported, HHS calculates the rebate amount. The NDC code numbers are assigned to each drug product by the Food and Drug Administration (FDA) together with the manufacturers.

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 usually distributed by a second manufacturer and are provided with a separate NDC code. The rebate is calculated for each manufacturer's product and, for brand name products, takes into account the best price reported for each drug. Such price often does not include the price of the product sold as the authorized generic both because it is considered a separate product (with its own unique NDC number) and is sold by a separate manufacturer.

Explanation of Provision

The provision would modify the current law definition of AMP to include, in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA to be inclusive of the average manufacturer price paid for such drugs.

The current law definition of best price would be changed to apply not only to each single source drug and innovator multiple source drug, but also to each authorized generic drug, or any other drug of a manufacturer that is sold under a new drug application (NDA) approved by (under Section 505c of FFDCA) FDA. In addition, the definition would be modified so that the best price, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA, is inclusive of the lowest price such authorized generic or other drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity except for those entities excluded under current law.

The provision would modify the current law definition of AMP to include, in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA to be inclusive of the average manufacturer price paid for such drugs.

Finally, the provision would add a definition of authorized generic drug to the definitions section of the outpatient prescription drug provisions of Medicaid law. An authorized generic drug would be defined as a drug listed (as the term is used in Section 505j of FFDCA) that has been approved by the FDA under Section 505(c) of such Act and is marketed, sold or distributed directly or indirectly to the retail class of trade under a different labeling, packaging (other than repackaging the listed drug for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.

The provision would become effective on October 1, 2005.

Section 6004. Collection of Rebates for Certain Physician-Administered Drugs

Current Law

Manufacturers are required to provide rebates to states for all outpatient prescription drugs with some exceptions. Outpatient prescription drugs provided through managed care organizations are explicitly exempted from the rebate requirement. In addition, outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs are exempt from the rebate requirement. Certain drugs administered by physicians in their offices or in another outpatient setting, such as chemotherapy, have often been excluded from the drug rebate program although there is no specific statutory exclusion. This is because providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectible prescription drugs, including cancer drugs. The HCPCS J-codes do not, however, provide States with the specific manufacturer information necessary to enable them to seek rebates. The NDC number is necessary for the state to bill manufacturers for rebates. CMS has requested that states identify Medicaid drugs, specifically those using HCPCS J-codes, by their NDC codes so that rebates can be collected for these drugs (Letter to State Medicaid Director, SMDL #03-002, dated March 14, 2003). CMS has concluded that because of this coding, many state Medicaid programs have not collected rebates on these drugs, resulting in millions of dollars in uncollected rebates.

Explanation of Provision

As a condition of receiving Medicaid payment, states would be required to submit to the Secretary of HHS, utilization data and coding information for physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required. The reporting would include J-codes and National Drug Code numbers. The purpose of the reporting would be to allow the Secretary to secure rebates for such drugs.

Effective upon enactment.

CHAPTER 2 - LONG-TERM CARE UNDER MEDICAID

Section 6011. Reform of Medicaid Asset Transfer Rules

(a) Requirement to Impose Partial Months of Ineligibility

Current Law

Current law requires states to impose penalties on individuals applying for Medicaid who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for individuals receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

The length of the delay is determined by dividing the total cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

When calculating the length of the penalty period when assets are transferred for less than fair market value, current law allows states to "round down," or not include in the ineligibility period the quotient amounts (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month. For example, in a state with an average private stay in a nursing home of $4,100, an ineligibility period for an improper transfer of $53,000 could be 12.92 months (i.e. $53,000/$4,100=12.92). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31 day month), other states may round down the quotient to an ineligibility period of 12 months only.

Explanation of the Provision

This provision would amend Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period.

(b) Authority for States to Accumulate Multiple Transfers into One Penalty Period

Current Law

Current law and additional CMS guidance provides that when a number of assets are transferred for less than fair market value on or after the look-back date during the *same* month, the penalty period is calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or individual's spouse) divided by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. When a number of assets are transferred during *different* months, then the rules vary based upon whether the penalty periods overlap. If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

Explanation of Provision

This provision would amend Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

(c) Inclusion of Transfer of Certain Notes and Loans Assets

Current Law

Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed $2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets.

Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Under Medicaid and SSI rules, non-countable assets include an

individual's primary place of residence, one automobile, household goods and personal effects,[1] property essential to income-producing activity, up to $1,500 in burial funds, life insurance policies whose total face value is not greater than $1,500, and miscellaneous other items.

Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

Explanation of Provision

This provision would amend Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

(d) Treatment of Annuities

(1) Inclusions of Transfers to Purchase Balloon Annuities

Current Law

Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary of DHHS defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal). If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place. The State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound.

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1 Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, no. 24, Feb. 7, 2005.

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).

Explanation of Provision

This provision would amend section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

(2) Requirement for State to be Names as a Remainder Beneficiary

Current Law

No provision.

Explanation of Provision

This provision would amend section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

(3) Inclusion of Certain Annuities in an Estate

Current Law

Medicaid Estate Recovery. Current law requires states to recover the private assets (e.g., countable and non-countable assets) of the estates of deceased beneficiaries who have received certain long-term care services. Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21 and no surviving child who is blind or has a disability. Estate recovery is limited to the amounts paid by Medicaid for services received by the individual and is limited to only certain

assets that remain in the estate of the beneficiary upon his or her death. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate.

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state *probate* law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. Thus assets such as living trusts, life insurance policies, certain annuities, which may pass to heirs outside of probate, would be subject to Medicaid recovery only if a state expanded its definition of "estate."

Explanation of Provision

This provision would amend Section 1917(b)(4) of the Social Security Act to include an annuity in the definition of estate that is subject to estate recovery unless the annuity was purchased from a financial institution or other business that sells annuities in the state as part of its regular business.

(e) Inclusion of Transfers to Purchase Life Estates

Current Law

Current law does not specify whether life estates should be treated as countable or non-countable assets for purposes of applying the Medicaid asset transfer rules. In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets. The guidance also explains that a transfer for less than fair market value occurs whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate. According to CMS, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

Explanation of Provision

This provision would amend Section 1917(c)(1) of the Social Security Act to add a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

(f) Protection Against Undue Hardship

Current Law

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

CMS guidance requires that state procedures, at a minimum, provide for and discuss (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Explanation of Provision

This provision would amend Section 1917(c) of the Social Security Act by adding a requirement that states establish undue hardship procedures (in accordance with standards specified by the Secretary) that would provide for: (1) a notice that an undue hardship exception exists before the imposition of a penalty period to an applicant for Medicaid who would be subject to such a penalty; (2) a timely process before the imposition of a penalty for determining whether an undue hardship waiver will be granted for the individual; (3) a process under which an adverse determination can be appealed; and (4) an application of criteria that specifies that undue hardship exists when application of the ineligibility period or counting of trusts would deprive the individual of medical care so that the individual's health or life would be endangered or when it would deprive the individual of food, clothing, shelter, or other necessities of life.

(g) Effective Dates

Current Law

No provision.

Explanation of Provision

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act's enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act. In the case of a state that has a two-year legislative session, each year of the session would be considered to be a separate regular session of the state legislature.

Section 6012. State long-term care partnerships

Current Law

Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.

In general, states allow individuals to retain no more than $2,000 in countable assets and exempt certain non-countable assets such as an individual's primary place of residence, one automobile, household goods and personal effects.

Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66) allows states with an approved state plan amendment as of May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. All of these states, except Iowa, have implemented programs, known as Long-Term Care Partnership programs. .

The four partnership states with active programs have different models for determining the amount of assets that an eligible participant may protect. Connecticut and California use a *dollar-for-dollar* model, in which the amount of the assets protected is equivalent to the value of the benefit package paid by the policy purchased (e.g., $100,000 of nursing home or assisted living coverage enables that individual to retain up to $100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a *total asset protection* model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policies, LTC insurance products are

largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners
(NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including the following:

Model Regulations:

- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Requirements to deliver shopper's guide.

Model Act:

- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary;
- Accelerated death benefits; and
- Incontestability period.

While many state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards. As a result, there is significant variation in regulatory practices across states.

Explanation of Provision

This provision would amend section 1917(b)(1)(C)(ii) of the Social Security Act to exempt two groups of persons with certain long-term care insurance plans from Medicaid estate recovery. They would include individuals who received Medicaid: (1) under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below and (2) under a current LTC insurance partnership program in one of the 5 states (in which the state received approval for state plan amendments as of May 14, 1993 allowing for the disregard of any assets or resources to the extent that payments are made under a *LTC insurance policy* or because an individual has received (or is entitled to receive) benefits under a *LTC insurance policy)* and the Medicaid state plan satisfies requirements B through G described below as long as the LTC insurance policy was sold on or after 2 years after enactment.

This provision would define *LTC insurance policies* as including, but not limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term "Qualified State LTC Insurance Partnership," would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another state's Qualified LTC Insurance Partnership" or a long-term care insurance policy in 2 above, the same as the state treats benefits paid under such a policy under the state's plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed $250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest $100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold;

(F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and

(G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective.

LTC insurance policies would be required to meet the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). The requirements include the following topics described below.

Model Regulations:

Guaranteed renewal or noncancellability with the exception of paragraph (5) and the requirements of section 6B of the Model Act relating to such section 6A

Prohibitions on limitations and exclusions with the exception of paragraph (7);
Extension of benefits;
Continuation or conversion of coverage;
Discontinuance and replacement of policies;
Unintentional lapse;
Disclosure with the exception of section 8F, 8G, 8II, and 8I
Required disclosure of rating practices to consumer;
Prohibitions against post-claims underwriting;
Minimum standards;
Application forms and replacement coverage;
Reporting requirements;
Filing requirements for marketing;
Standards for marketing, including inaccurate completion of medical histories with the exception of paragraphs (1), (6), and (9) of section 23C;
Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
Standard format outline of coverage; and
Deliver shopper's guide.

Model Act:

Preexisting conditions;
Prior hospitalization;
Contingent nonforfeiture benefits;
Right to return;
Outline of coverage;
Requirements for certificates under group plans;
Policy summary; and
Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act would be treated as including any other provision the Regulation or Act necessary to implement the provision. The determination of whether any requirement under the Model Act or Regulation have been met would be made by the Secretary.

These amendments would become effective on October 1, 2007 and apply to long-term care insurance policies sold on or after that date.

No later than one year after enactment, the Secretary, in consultation with the NAIC, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies would be required to develop uniform standards for:

Reciprocity. These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such LTC insurance partnerships;

Minimum reporting requirements. These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;

Suitability. These standards would be for determining whether a long-term care insurance policy is appropriate for the needs of an applicant (based on guidance of the NAIC regarding suitability).

The Secretary, in consultation with those listed above, would also be required to submit recommendations to Congress with respect to the following:

Incontestability. Recommendations regarding whether the requirements relating to incontestability for LTC insurance policies sold under a state LTC insurance partnership program should be modified based on guidance of the NAIC regarding incontestability;

Nonforfeiture. Recommendations regarding whether requirements relating to nonforfeiture for issuers of LTC insurance policies under a state LTC insurance partnership program should be modified to reflect changes in an insured's financial circumstances;

Independent certification for benefits assessment. Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be conducted by independent entities should be established for issuers of LTC insurance policies under such a state partnership program, and if so, what such standards should be;

Rating requirements. Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for LTC insurance policies sold under such a state partnership program should be established and if so, what such standards should be; and

Dispute Resolution. Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under LTC insurance policies sold under such a state partnership program and the delivery of the benefits promised under such policies.

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures.

CHAPTER 3 - ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID

Section 6021. Enhancing Third Party Recovery

Current Law

Third-party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. In general, federal law requires Medicaid to be the payor of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered medical support (including health insurance) from noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (with certain exceptions, such as the Indian Health Service).

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. To this end, they must: (1) collect health insurance information from individuals at the time of initial application for Medicaid and during any subsequent redeterminations of eligibility, (2) match data provided by Medicaid applicants and recipients to certain files maintained by government agencies (e.g., state wage and income, Social Security Administration wage and earnings, state workers' compensation, state motor vehicle accident reports), (3) identify claims with diagnosis codes that would indicate trauma-related injury for which a third party may be liable for payment, and (4) follow up on TPL leads identified through these information-gathering activities.

If the state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

As a condition of eligibility for Medicaid, individuals are required to assign to the state Medicaid agency their rights to medical support and payment for medical care from any third party. This assignment of rights facilitates TPL recovery by allowing the state to collect, on behalf of Medicaid enrollees, amounts owed by third parties for claims paid by Medicaid.

Explanation of Provision

(a) Clarification of Right of Recovery Against Any Third Party Legally Responsible for Payment of a Claim for a Health Care Item or Service

This subsection would amend the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include: (1) self-insured plans, (2) pharmacy benefit managers, and (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It would also amend that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual.

(b) Requirement for Third Parties to Provide the State with Coverage Eligibility and Claims Data

A state would be required 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.

(c) Effective Date

The provision would be 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).

Section 6022. Limitation on Use of Contingency Fee Arrangements

Current Law

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or human resources umbrella agency, will often contract with other public or private entities (e.g., other state agencies or departments, consulting firms) to perform various administrative functions. In some cases, contingency fee arrangements are used to pay contractors based on Medicaid dollars saved, recovered, or otherwise obtained for the state (e.g.,

a fee equal to 10% of third party liability collections). The federal reimbursement rate for most Medicaid administrative costs is 50%.

In determining the amount of administrative costs — including contingency fees — that may be eligible for federal reimbursement, states must comply with a number of federal statutes and regulations. In general, federal Medicaid law requires states to use methods of administration that are found by the Secretary of HHS to be necessary for the proper and efficient operation of their Medicaid programs. With regard to contingency fee contracts, guidance issued by the Centers for Medicare and Medicaid Services to its regional offices in 2002 notes that in order to be eligible for federal reimbursement, contingency fees must: (1) be based on Medicaid cost avoidance savings or recoveries in which the federal government shares, (2) be intended to produce Medicaid program savings, not additional expenditures reported for federal reimbursement, and (3) not be contingent upon recoveries from the federal government. CMS guidance also notes that states may not claim federal reimbursement for contingency fee payments made to another government unit for Medicaid administrative activities.

Additional federal guidance is contained in Office of Management Budget (OMB) Circular A-87, which establishes principles and standards for determining allowable costs for states (and other governmental units) under federal grant programs such as Medicaid. The circular specifies that the cost of professional and consultant services are allowable when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the federal government (meaning that the state may not claim federal reimbursement for payments made to a contractor whose fees are dependent on obtaining additional federal dollars for the state).

Explanation of Provision

(a) In General

States would not be eligible for federal reimbursement of amounts expended in connection with a contract or agreement (other than a Medicaid managed care contract) between the state Medicaid agency (or any state or local agency that administers a portion of the Medicaid program) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet standards established by the Inspector General of HHS.

(b) Contingency Fee Arrangement Standards

The Inspector General of HHS would issue standards for the terms of compensation of consultants and other individuals or entities contracting with state agencies (or their designees) administering state Medicaid programs. The standards would be designed to ensure prudent purchasing and program integrity with respect to federal funds. The Inspector General would annually review the standards and revise them as necessary to promptly address new compensation arrangements that may present a risk to Medicaid program integrity.

The standards would be issued no later than six months after enactment of this provision.

(c) Effective Date

The requirements in subsection (a) would be effective January 1, 2007 (except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance).

Section 6023. Encouraging the Enactment of State False Claims Acts

Current Law

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.

Explanation of Provision

(a) In General

If a state has in effect a law relating to false or fraudulent claims that meets certain requirements (described below), the federal medical assistance percentage, with respect to any amounts recovered under a state action brought under such a law, shall be decreased by 10 percentage points.

The state law relating to false and fraudulent claims must be determined by the Inspector General of HHS, in consultation with the Attorney General, to:(1) establish liability to the state for false or fraudulent claims described in the federal False Claims Act, with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal False Claims Act, (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act, (5) contain provisions that are designed to prevent a windfall recovery for a *qui tam* relator that files a federal and state action for the same false or fraudulent claim.

(b) Effective Date

The provision would be effective January 1, 2007.

Section 6024. Employee Education about False Claims Recovery

Current Law

No provision.

Explanation of Provision

(a) In General

A state would be required to provide that any entity that receives annual Medicaid payments of at least $1 million, as a condition of receiving such payments, must: (1) establish written policies, procedures, and protocols for training of all employees of the entity, and of any contractor or agent of the entity, that includes a detailed discussion of the federal False Claims Act, federal administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, (2) include in such written materials detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (4) require mandatory training for all employees of the entity and of any contractor or agent of the entity, at the time of hiring, with respect to such laws and the entity's policies and procedures for detecting fraud, waste, and abuse.

(b) Effective Date

The requirement would be effective January 1, 2007 (except in the case of a state whose legislative calendar does not allow for timely passage of state laws necessary for compliance).

Section 6025. Prohibition on Restocking and Double Billing of Prescription Drugs

Current Law

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. 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.

Explanation of Provision

Provision would prohibit federal matching payments for the cost of a covered outpatient drug claim if the claim has already been submitted and for which the pharmacy has already received payment.

Would become effective on the first day of the first fiscal quarter beginning after enactment.

Section 6026. Medicaid Integrity Program

Current Law

States and the federal government share in the responsibility for safeguarding Medicaid program integrity. States must comply with federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare and Medicaid Services 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.

Explanation of Provision

(a) Establishment of Medicaid Integrity Program; Medicaid CFO; Medicaid Program Integrity Oversight Board

A Medicaid Integrity Program would be established under title XIX. The Secretary of HHS would enter into contracts with eligible entities to carry out the program's activities, which would include: (1) review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, (2) audit of claims for payment for items or services furnished or for administrative services rendered, (3) identification and recovery of overpayments to individuals or entities receiving federal funds under Medicaid, (4) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

An entity would be eligible to enter into a contract to carry out Medicaid Integrity Program activities if it meets eligibility and contracting requirements similar to those under the Medicare Integrity Program. Beginning in FY2006 and every five years, the Secretary — in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of HHS, and state officials with

responsibility for controlling provider fraud and abuse under Medicaid — would establish a comprehensive plan for ensuring Medicaid program integrity by combating fraud, waste, and abuse. Appropriations for the Medicaid Integrity Program would total $50 million in FY2006, $50 million in FY2007, $50 million in FY2008 and $75 million in each fiscal year after FY2008. No later than 180 days after the end of each fiscal year (beginning with FY2006), the Secretary would submit a report to Congress that identifies the use and effectiveness of the use of funds appropriated for the program.

A Medicaid Chief Financial Officer (CFO) and Medicaid Program Integrity Oversight Board would also be established under title XIX. The Medicaid CFO would be appointed by and would report directly to the Administrator of the Centers for Medicare and Medicaid Services. The duties and authority of the Medicaid CFO would be comparable to those of other CFOs with respect to the management and expenditure of federal funds under federal health care programs. A Medicaid Program Integrity Oversight Board would also be established by the Secretary. The duties and authority of the board would be comparable to those of the Medicare Contractor Oversight Board, and would include responsibility for identifying vulnerabilities and developing strategies for minimizing integrity risks to state Medicaid programs.

(b) State Requirement to Cooperate with Integrity Program Efforts

States would be required to comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program, or the duties of the Medicaid CFO and the Medicaid Program Integrity Oversight Board.

(c) Increased Funding for Medicaid Fraud and Abuse Control Activities

In each of fiscal years 2006 through 2010, $25 million would be appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended).

(d) Increase in CMS Staffing Devoted to Ensuring Medicaid Program Integrity.

The Secretary would 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.

(e) 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.

CHAPTER 4 — STATE FINANCING

Section 6031. Reforms of Targeted Case Management

Current Law

Under current Medicaid law (Section 1915(g)(2) of the Social Security Act), targeted case management is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. 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.

Several states extend the Medicaid TCM benefit to individuals who may also be receiving case management services as a component of another state and/or federal program. For example, a state may provide TCM services for Medicaid beneficiaries in foster care – defined in the Medicaid state plan as "children in the state's custody and who are placed in foster homes." As part of the foster care program, children receive certain case management services regardless of whether or not they are a Medicaid beneficiary.

In addition, the existing federal guidance is conflicting with respect to the process states should follow to claim Medicaid reimbursement for TCM services when another program also covers case management services for the same beneficiary. The State Medicaid Manual (Section 4302.2) states that claims for targeted case management services must be fully documented for a specific Medicaid beneficiary in order to receive payment. In addition, documentation that includes time studies and cost allocation plans "are not acceptable as a basis for Federal participation in the costs of Medicaid services." Cost allocation plans are a narrative description of the procedures that a state agency uses in identifying, measuring, and allocating the state agency's administrative costs incurred for supervising or operating programs. Per federal regulations (45 CFR 95.505), the cost allocation plan does not include payments for services and goods provided directly to program recipients. However, a State Medicaid Director's (SMD) letter dated January 19, 2001, which discusses targeted case management services for children in foster care under the federal Title IV-E program, requires states to "properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program." Thus, this letter extended the application of cost allocation plans to claim reimbursement for case management services when a child is receiving these services under both the Title IV-E (foster care) and Medicaid programs.

Explanation of Provision

This proposal would further define the Medicaid TCM benefit under Section 1915(g)(2) of the Social Security Act, and would codify the ability of states to use an approved cost allocation plan (as outlined under OMB Circular A-87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.

Specifically, the proposal would clarify that the TCM benefit includes the following: 1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; 2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; 3) referral and related activities to help an individual obtain needed services; and 4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The proposal would also specify certain activities that are not reimbursable as TCM services. First, the TCM benefit would *not* include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. In addition, with respect to the direct delivery of foster care services, the TCM benefit would *not* cover: research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the *eligible* individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.

Finally, consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

This provision would be effective January 1, 2006.

Section 6032. Temporary Federal Matching Payments for Medical Assistance

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal reimbursement rate for Medicaid administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive enhanced (usually 75%) reimbursement.

SCHIP service expenditures are reimbursed at an enhanced FMAP that varies by state and may range from 65% to 85%, subject to the availability of funds from a state's federal SCHIP allotment. SCHIP administrative expenditures are reimbursed using the enhanced FMAP that applies to SCHIP services; however, federal reimbursement for SCHIP administrative expenditures is capped at 10% of the state's SCHIP allotment.

P.L. 106-554 (Consolidated Appropriations Act of 2001), 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.

Explanation of Provision

(a) Temporary Federal Matching Payments for Medical Assistance.

For items and services furnished during the period that begins on August 28, 2005, and ends on May 15, 2006, the FMAP would be 100% for providing medical assistance under a Medicaid state plan to any specified individual (described in subsection (b)). Costs directly attributable to all administrative activities that relate to the provision of such medical assistance would also be reimbursed at 100%. In addition, the federal reimbursement rate for providing child health assistance under an SCHIP state plan to any specified individual, as well as for costs directly attributable to all related administrative activities, would be 100% during the period.

(b) Specified Individual defined.

The provision would define a specified individual as any individual who had a primary residence in a parish or county during the week preceding August 28, 2005.

In Louisiana, the parishes of Acadia, Ascension, Assumption, Calcasieu, Cameron, East Baton Rouge, East Feliciana, Iberia, Iberville, Jefferson, Jefferson Davis, Lafayette, Lafourche, Livingston, Orleans, Pointe Coupee, Plaquemines, St. Bernard, St. Charles, St. Helena, St. James, St. John, St. Mary, St. Martin, St. Tammany, Tangipahoa, Terrebonne, Vermilion, Washington, West Baton Rouge, and West Feliciana.

In Mississippi, the counties of Adams, Amite, Attala, Claiborne, Choctaw, Clarke, Copiah, Covington, Forrest, Franklin, George, Greene, Hancock, Harrison, Hinds, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lamar, Lauderdale, Lawrence, Leake, Lincoln,

Lowndes, Madison, Marion, Neshoba, Newton, Noxubee, Oktibbeha, Pearl River, Perry, Pike, Rankin, Scott, Simpson, Smith, Stone, Walthall, Warren, Wayne, Wilkinson, Winston, and Yazoo.

In Alabama, the counties of Baldwin, Choctaw, Clarke, Marengo, Mobile, Pickens, Greene, Hale, Sumter, Tuscaloosa, and Washington.

(c) Temporary Provision Relating to Alaska.

Provides that for fiscal years 2006 and 2007, if the Alaska FMAP calculated under the formula is less than the fiscal year 2005 Alaska FMAP (57.58), then the Alaska FMAP for that fiscal year would be 57.58 (the fiscal year 2005 Alaska FMAP).

Section 6033. Managed Care Organization Provider Tax Reform

Current Law

The Medicaid program is administered by the states but its costs are shared by the states and the federal government based on a formula that takes each state's average per capita personal income relative to the national average into account. States generally pay for Medicaid program costs and then seek reimbursement for the federal share as determined by the formula.

Under federal law and regulations, a state's ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be "broad-based." A broad-based tax is a tax that is uniformly applied to all providers or services within the provider class. The federal statute identifies each of the classes of providers or services for the purpose of determining whether a tax is broad-based.

"Medicaid managed care organizations" (MCOs) are identified as a separate class of providers for the purposes of determining if a tax is broad-based. This class is unlike all of the other classes of providers or services because it is limited to only Medicaid providers. Other classes of providers or services identified in statute, such as inpatient hospital services, outpatient hospital services, physicians — are not restricted to Medicaid providers or Medicaid services.

Explanation of Provision

The proposal would expand the provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-

Medicaid MCOs. This would make the MCO provider class more consistent with the other provider classes for purposes of determining if a provider tax is broad-based.

The provision would become effective on January 1, 2006 except in States that have, as of December 31, 2005, a tax on the "Medicaid managed care organizations" class of health care items and services as defined under current law. In those states, the provision would not apply.

Section 6034. Inclusion of Podiatrists as Physicians.

Current Law

Under current Medicaid law, podiatrists may be covered under the optional benefit category, within the scope of practice as defined in state law. States choose which "other practitioners" they are going to cover under this optional benefit category. "Physician services" are a mandatory Medicaid benefit. Physician services must be furnished by or provided under the personal supervision of a licensed doctor of medicine or osteopathy, and must be within the scope of such practice as defined under state law.

Explanation of Provision

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

Section 6035. DSH Allotment for the District of Columbia

Current Law

Under Medicaid law, states (including the District of Columbia) are required to recognize, in establishing their payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. These payments are referred to as disproportionate share hospital (DSH) payments or DSH adjustments. The DSH adjustment was intended to offset the costs to hospitals of treating low-income and special needs patients who are often uninsured, and to protect access to care for vulnerable populations. Under broad federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment. In addition, federal statute includes hospital-specific ceilings as determined by a statutory formula.

Each states' DSH allotment was set in federal statute for fiscal years (FY) 1998 - 2002. In general, for fiscal years after 2002, state DSH allotments are required to be calculated based on the prior year's amount increased by the consumer price index for all urban consumers (CPI). Beginning in fiscal years 2001, however, special formulas were established that have increased DSH allotments over either the specified amounts for fiscal years up to and including 2002 or the amounts that would have been calculated using the general rule for fiscal years after 2002

Explanation of Provision

The proposal would raise the specified allotments for the District of Columbia for FY 2000, 2001, and 2002 from $ 32 million to $ 49 million. These higher allotments would impact both retroactive DSH payments and would raise allotments for fiscal years after 2002, since subsequent years' allotments are calculated based on earlier years' amounts.

The provision would be effective upon enactment and is retroactive to allotments beginning in FY2000.

Section 6036. Demonstration Project Regarding Medicaid Reimbursement for Stabilization of Emergency Medical Conditions by Non-Publicly Owned or Operated Institutions for Mental Diseases

Current Law

The 1950 amendments to the Social Security Act established the prohibition of federal assistance for IMD residents as well as for patients diagnosed with a psychosis found in other medical institutions. When the Medicaid program was established in 1965, it created the state option that, for the first time, allowed Medicaid funding for inpatient psychiatric care rendered in general hospitals as well as funding for specific services provided to residents age 65 years and older in institutions for mental diseases (IMD). Further amendments in 1972 allowed for optional coverage, under certain circumstances, for IMD residents under age 21 or, in some cases, under age 22. Thus, the IMD exclusion generally prohibits Medicaid reimbursement for services obtained in IMDs by Medicaid eligible adults age 22 to 64 years of age.

Explanation of Provision

This provision would require the Secretary to establish a demonstration project under which eligible states must provide reimbursement under the state Medicaid plan to IMDs that are not publicly owned or operated and that are subject to Medicare requirements for such institutions, for the provision of medical assistance to individuals who are between the ages of 21 and 64, are eligible for Medicaid, and require IMD services to stabilize an emergency medical condition.

Eligible states include Arizona, Arkansas, Louisiana, Maine, North Dakota, Wyoming, and four additional states selected by the Secretary to provide geographic diversity, upon approval of an application submitted by such states to conduct such a demonstration project. The demonstration projects must be conducted for a period of three consecutive years.

The provision also authorizes and appropriates a sum of $30 million for FY2006 for this demonstration project, out of any funds in the Treasury not otherwise appropriated. This appropriation must remain available for obligation through December 31, 2008. Payments made under this provision may not exceed $30 million under any circumstances, and such payments may not be made after December 31, 2008.

Funds for this demonstration project would be allocated to eligible states based on their applications and the availability of funds. State expenditures for IMD services provided under this demonstration would be matched at the usual federal medical assistance percentage (FMAP) applicable to each state, and these federal dollars would be drawn from each eligible states allocation.

The Secretary would be required to submit annual reports to Congress regarding the progress of the demonstration project. Not later than March 31, 2009, the Secretary would be required to submit to Congress a final report, which must include: (1) a determination of whether the demonstration project resulted in increased access to inpatient mental health services under Medicaid, (2) an analysis regarding whether the demonstration significantly reduced the use of higher cost emergency room visits for Medicaid beneficiaries, (3) an assessment of the impact of the demonstration on the costs of providing inpatient psychiatric care and services under Medicaid, and (4) a recommendation regarding whether the demonstration project should be continued after December 31, 2008, and expanded on a national basis.

For the purposes of the proposed demonstration project, the following definitions would apply. Emergency medical condition would have the same meaning applicable under Medicare, i.e., a medical condition with acute symptoms of sufficient severity such that the absence of immediate medical attention could result in (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any organ. (Additional conditions are specific to pregnant women and the unborn child). The term federal medical assistance percentage would mean the proportion of state Medicaid expenditures that the federal government will reimburse, based on the standard Medicaid formula that takes into account a state's average per capita personal income relative to the national average, which may range from 50 to 83% in a given fiscal year. As is currently defined in Medicaid, an IMD would mean a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. As is currently defined in Medicaid, the term medical assistance means payment of part or all of the costs of the care and services provided to eligible beneficiaries as identified in federal Medicaid statute. The term stabilize has the same meaning used under the Medicare program, i.e., to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. (Additional conditions are specific to pregnant women.) The term State includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

CHAPTER 5 - IMPROVING THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

Subchapter A - Family Opportunity Act

Section 6041. Short Title of Subchapter

Current Law

No provision.

Explanation of Provision

The provision specifies the subchapter of the Act.

Section 6042. Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children

(a)(1) State Option to Allow Families of Disabled Children to Purchase Medicaid Coverage for Such Children

Current Law

For children with disabilities, there are a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. Generally, when a child lives with a parent, that parent's income and resources are counted when determining a child's financial eligibility for Medicaid.

There are four main coverage groups for which disability status or medical need is directly related to eligibility. First, states are required to cover children receiving Supplemental Security Income (SSI) for which the income threshold is about 75% FPL nationwide. SSI is a federal cash assistance program for certain persons with disabilities. (Under the 209(b) provision, some states apply more restrictive financial standards and/or methodologies for determining Medicaid eligibility than the standards under SSI.) Second, states may offer medically needy coverage under Medicaid. The medically needy (MN) are persons who fall into one of the categories of eligibility (e.g., dependent children) and whose income is no higher than 133 and 1/3% of the state's former Aid to Families with Dependent Children (AFDC) payment standard in effect on July 16, 1996. These standards are typically lower than the current FPL. Individuals can meet these financial criteria by having income that falls below the MN standard, or by incurring medical expenses that when subtracted from income, result in an amount that is

lower than the MN standard. Third, states may extend Medicaid to certain children with disabilities 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 institutional care. (This group is also called the Katie Beckett or TEFRA category.) The law allows states to consider only the child's finances when determining eligibility for this group. Fourth, 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 waiver programs authorized under Section 1915(c) of Medicaid law. States may ignore parents' income in determining a child's eligibility for waiver services. Unlike the Katie Beckett option which requires that all qualified children with disabilities within a state be covered, waiver programs may be limited to specific geographic areas, and/or may target specific groups. States may also cap the number of people who can receive waiver services.

Children with disabilities can also qualify for Medicaid via other eligibility pathways for which disability status and medical need are irrelevant. For example, parents and children in families with income that meets AFDC financial standards (typically below the FPL) must be covered under Medicaid. Additional pathways cover children at higher income levels than those applicable to most of the disability-related eligibility categories. States are required to provide Medicaid coverage to children under age 6 (and pregnant women) in families with incomes below 133% FPL, and for children between ages 6 and 18 in families with income below 100% FPL. States may cover infants under age 1 (and pregnant women) in families with income between 133% and 185% FPL. Similarly, under the State Children's Health Insurance Program (SCHIP), states may extend Medicaid coverage to children under age 19 in families with income above the applicable Medicaid standard but less than 200% FPL, or in states that already exceed the 200% FPL level for Medicaid children, within 50 percentage points over that existing level.

Explanation of Provision

A new optional eligibility group for certain children with disabilities would be added to Medicaid statute. 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% 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 child's age, beginning with qualifying children with disabilities: up to age 6 beginning January 1, 2008; up to age 12 in FY2009, and up to age 18 in FY2010 forward. This provision would apply to medical assistance for items and services furnished on or after January 1, 2008.

(a)(2) Interaction with Employer-Sponsored Family Coverage

Current Law

States may require Medicaid eligibles to apply for coverage in certain employer-sponsored group health plans (in which such persons are eligible) when it is cost-effective to do

so (defined below). This requirement may be imposed as a condition of continuing Medicaid eligibility, except that failure of a parent to enroll a child must not affect the child's continuing eligibility for Medicaid. If all members of the family are not eligible for Medicaid, and the group health plan requires enrollment of the entire family, Medicaid will pay associated premiums for full family coverage if doing so is cost-effective. However, Medicaid will not pay deductibles, coinsurance or other cost-sharing for family members ineligible for Medicaid. Third party liability rules apply to coverage in a group health plan. That is, such plans, not Medicaid, must pay for all covered services under the plan.

"Cost-effectiveness" means that the reduction in Medicaid expenditures for Medicaid beneficiaries enrolled in a group health plan is likely to be greater than the additional costs for premiums and cost-sharing required under the group health plan.

"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.

Explanation of Provision

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. Specifically, when the employer of such a parent offers family coverage under a group health plan, the parent is eligible for such coverage, and the employer contributes at least 50% of the annual premium costs, states must require participation in such employer-sponsored family coverage plan as a condition of continuing Medicaid eligibility for the child. Also, if such coverage is obtained, states must reduce premiums by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability. States 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.

(b) State Option to Impose Income-Related Premiums

Current Law

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 such

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 cause undue hardship.

Explanation of Provision

The provision would add a new section to Medicaid law governing premiums applicable to the new optional eligibility group. It would allow 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.

Such a 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.*)

States must not require prepayment of premiums, nor are states allowed to terminate eligibility of an enrolled child for failure to pay premiums, unless lack of payment continues for a minimum of 60 days beyond the payment due date. States may waive payment of premiums when such payment would cause 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.

(c) Conforming amendments

Current Law

Unless otherwise specified for a given coverage group, Medicaid eligibility for children is limited to those in families with income up to 133 and 1/3% of the applicable AFDC payment standard in place as of July 16, 1996. In addition, targeted low-income children under SCHIP statute are defined as those who would not qualify for Medicaid under the state plan in effect on March 31, 1997.

Payments for services provided to children who receive Medicaid benefits through an expansion of eligibility under SCHIP authority are reimbursed by the federal government at the enhanced federal medical assistance percentage (E-FMAP) rate, and funds based on this rate are

drawn from annual SCHIP appropriations. The SCHIP E-FMAP builds on the Medicaid FMAP. The FMAP formula is designed to provide a higher federal matching rate for states with lower average per capita income levels, compared to the national average. As of FY2005, the Medicaid FMAP ranged from 50% (statutory floor) to 77.08% compared to the SCHIP E-FMAP ranging from 65% (statutory floor) to 83.96%. The Medicaid FMAP and the SCHIP E-FMAP are subject to ceilings of 83% and 85%, respectively.

Explanation of Provision

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.

Section 6043. Demonstration Projects Regarding Home and Community-based Alternative to Psychiatric Residential Treatment Facilities for Children

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act 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). Federal approval for these waivers is contingent on the state's documentation of the waiver's cost-neutrality. Cost-neutrality is met if, on average, the per person cost with the HCBS waiver is no higher than the cost if the person were residing in a hospital, nursing home, or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

For children with psychiatric disabilities, many states provide Medicaid funding for inpatient psychiatric residential treatment facilities. However, because the waiver cost-neutrality calculation does not allow a comparison of HCBS waiver expenditures to expenditures in these psychiatric residential treatment facilities, most states have had difficulty covering HCBS waiver services for children with psychiatric disabilities. Four states (Indiana, Kansas, New York and Vermont) have been able to offer HCBS waiver services for children with psychiatric disabilities by documenting the cost-neutrality of the waiver compared to the state's hospital expenditures. However given the cost-neutrality requirement, those states that have limited the use of hospitals for children with psychiatric disabilities may be unable to develop HCBS waivers for this population.

Explanation of Provision

The Secretary would be authorized during the period from FY2007 through 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 Medicaid. These demonstration projects will develop home and community-based services as an alternative to a psychiatric residential treatment facility. However, these projects must also follow the requirements of the HCBS waiver program. Specifically, demonstration participants would be required to meet the level of care of a psychiatric residential treatment facility, and the average, per-person project expenditures may not exceed the average, per-person cost of a psychiatric residential treatment facility.

The demonstration states would be selected through a competitive bidding process. At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project.

As part of the demonstration, the following conditions would apply: (1)projects must meet the same terms and conditions that apply to all HCBS waivers; (2) the Secretary must ensure that the projects are budget neutral; that is, total Medicaid expenditures under the demonstration projects will not be allowed to exceed the amount that the Secretary estimates would have been paid in the absence of the demonstration projects; and (3) applications for a demonstration project must include an assurance to conduct an interim and final evaluation by an independent third party and any reports that the Secretary may require.

This proposal would appropriate $218 million for FY2007 through FY2011 for the state demonstration projects and the federal evaluations and report. Total expenditures for state demonstration projects would not be allowed to exceed $21 million in FY2007, $37 million in FY2008, $49 million in FY2009, $53 million in FY2010, and $57 million in FY2011. Funds not expended in a given fiscal year would continue to be available in subsequent fiscal years. An additional $1 million would be available to the Secretary to complete a *required* interim and final evaluation of the project and report the conclusions of the evaluations to the President and Congress within 12 months of completing these evaluations.

Section 6044. Development and Support of Family-to-family Health Information Centers

Current Law

Family-to-family health centers provide information and assistance to help families of children with special health care needs navigate the system of care and make decisions about the needs and available supports for their child. No provision in current law specifically authorizes a dedicated amount of funds for these family-to-family health information centers. However, since 2002, the Department of Health and Human Services (HHS) has awarded approximately $6.9

million to develop these information centers in 36 states under various program authorities including: (1) Special Projects of Regional and National Significance Program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) operated by the Health Resources Services Administration (HRSA); (2) the Real Choice Systems Change grant program operated by the Centers for Medicare and Medicaid Services (CMS); and (3) a one-year direct Congressional appropriation to an organization in Iowa. Federal funding for these projects is time-limited. Except for the one-year direct appropriation, state projects have generally been funded for a three or four-year period. HRSA intends to fund additional family-to-family health information centers awarding up to $2.4 million to six projects for a four-year period starting in FY2006.

Explanation of Provision

This proposal would increase funding under the SPRANS program of Title V of the Social Security Act for the development and support of new family-to-family health information centers (described below). This proposal would appropriate an additional $3 million for FY2007, $4 million for FY2008, and $5 million for FY2009 for this new purpose. For each of fiscal years 2010 and 2011, the bill would authorize to be appropriated to the Secretary $5 million for this purpose. Funds would remain available until expended.

The family-to-family health information centers would: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health delivery models; (4) develop a model for collaboration between families of such children and health professionals; (5) provide training and guidance with regard to the care of such children; and (6) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals. The family-to-family health information center would be staffed by families who have expertise in public and private health care systems and by health professionals.

The Secretary would be required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.

Section 6045. Restoration of Medicaid Eligibility for Certain SSI Beneficiaries

Current Law

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.

Explanation of Provision

The provision would confer 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. It would apply to medical assistance for items and services furnished on or after the date that is one year after the date of enactment of this Act.

Subchapter B — State Children's Health Insurance Program

Section 6051. Rules for Availability, Redistribution, and Extended Availability of Allotments for Fiscal Years 2003, 2004, and 2005

(a). In General

Current Law

Funds for the State Children's Health Insurance Program (SCHIP) are authorized to be appropriated for FY1998 through FY2007. From each year's appropriation, each state is allotted an amount determined by a formula set in law. Federal funds not drawn from a state's original allotment by the end of each fiscal year continue to be available to that state for two additional fiscal years (for example, FY2005 allotments are available through FY2007).

At the end of the three-year period, the unspent funds from the original allotment are reallocated in ways that vary depending on the fiscal year. The original SCHIP law, the Balanced Budget Act of 1997 (BBA97, P.L. 105-33), 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); these redistributed funds would be available for one year only. However, later laws (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) and the State Children's Health Insurance Program Allotments Extension Act (P.L. 108-74)) overrode how the reallocation of unspent FY1998 to FY2001 original allotments would occur.

States that fully expended their FY1998 or FY1999 original allotment within the applicable three-year period (i.e., redistribution states) received a redistribution equal to their excess spending (i.e., the difference between the state's spending during the three years of availability and the amount of the applicable original allotment). The remaining unused funds (after a set-aside of 1.05% of the total unspent funds for the territories that fully exhausted their original allotments) were then divided among those states that did *not* spend their original allotments by the applicable three-year deadline (i.e., retention states) in proportion to their contribution to the total pool of unspent funds. Reallocated funds from the unspent FY1998 and FY1999 original allotments were available until the end of FY2004.

For the unspent FY2000 and FY2001 original allotments, a set-aside of 1.05% of the total unspent funds was made for territories that fully exhausted their original allotments. Retention states kept one-half of their unused funds. The remaining unspent funds were then distributed among redistribution states in proportion to their contribution to the total pool of excess spending. Reallocated funds from the unspent FY2000 and FY2001 original allotments are available until the end of FY2004 and FY2005, respectively.

The redistribution of unspent FY2002 SCHIP original allotments was determined by the Secretary of HHS in accordance with the default redistribution provision in BBA97 and published in the January 19, 2005, *Federal Register*. On September 29, 2005, the final notice was released announcing the revised amounts redistribution states would receive based on states' SCHIP spending estimates from August 2005 rather than from November 2004. States that were projected to exhaust their available federal SCHIP funds in FY2005, based on their estimated FY2005 expenditures, received access to FY2002 redistribution money equal to their estimated shortfall. The remaining balance of unspent FY2002 funds (after a set-aside of 1.05% of the total unspent funds for the territories that fully exhausted their original allotments) was then divided among the redistribution states, including the five shortfall states, in proportion to their contribution to the total pool of excess spending. Redistributed funds from the unspent FY2002 original allotments are available until the end of FY2005.

Under current law, unspent original allotments from FY2003 forward are also to be redistributed according to the original BBA97 methodology. That is, redistributed funds will go only to those states that spend all of their original allotments by the applicable three-year deadline, with the redistributed amounts determined by the Secretary of HHS and made available for one year only.

Explanation of Provision

The provision would reduce the period of availability of the FY2004 and FY2005 original allotments from three years to two, and would specify rules for the reallocation of unspent FY2003, FY2004, and FY2005 SCHIP original allotments. The reallocated FY2003 and FY2004 funds would be available in FY2006; the reallocated FY2005 funds would be available in FY2007.

In FY2006, the unspent FY2003 original allotments remaining at the end of FY2005 (after a set-aside of 1.05% of the total unspent FY2003 funds for the territories) would be redistributed to states with an initial projected FY2006 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures in FY2006 would exceed the amounts available from the state's FY2005 and FY2006 original allotments. Each state with an initial projected shortfall would receive a portion of the available unspent FY2003 original allotments in proportion to its contribution to the total pool of such shortfalls. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2003 original allotments for the territories.

Also in FY2006, the territories would receive a set-aside of 1.05% of the total unspent FY2004 original allotments available at the end of FY2005.

"Described states" would be permitted to extend the use of their unspent FY2004 original allotments in an amount equal to the shortfall still remaining after receiving redistributed FY2003 funds. Described states would be defined as states that (1) spent all FY2003 original allotments by the end of FY2005, (2) did *not* spend all of their FY2004 original allotment by the end of FY2005, and (3) reported an initial projected FY2006 shortfall. After the set-aside for the territories as well as the reduction of FY2004 extended funds for the described states, the remaining unspent FY2004 funds would be available to states with a *net* projected FY2006 shortfall, defined as each state's initial projected shortfall reduced by the redistributed FY2003 funds it received and by the extended FY2004 funds if it is a described state. Each state with a net projected shortfall would receive a redistribution of FY2004 funds to cover its net projected shortfall. Any remaining FY2004 unspent original allotments would then be extended proportionally to states that did not spend their FY2004 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2004 original allotments for the territories. The FY2004 reallocation pot for states and territories would be available until the end of FY2006.

In FY2007, the territories would receive a set-aside of 1.05% of the total unspent FY2005 original allotments available at the end of FY2006. Described states would be permitted to extend the use of their unspent FY2005 original allotments in an amount equal to their initial projected FY2007 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures for FY2007 exceeds the amount available from the state's FY2006 and FY2007 original allotments. Described states would be defined as states that (1) did *not* spend all of their FY2005 original allotment by the end of FY2006, and (2) reported an initial projected FY2007 shortfall. After the set-aside for the territories as well as the reduction of FY2005 extended funds for the described states, the remaining unspent FY2005 funds would be available to states with a *net* projected FY2007 shortfall, described as each state's initial projected shortfall reduced by the extended FY2005 funds for the described states. Each state with a net projected shortfall would receive a redistribution of FY2005 funds to cover its net projected shortfall or, if the remaining funds are inadequate to cover the FY2007 projected shortfalls, a portion of the available unspent FY2005 original allotments in proportion to the state's contribution to the total shortfall pool. If any FY2005 unspent original allotments remain, they would then be extended proportionally to states that did not spend their FY2005 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2005 original allotments for the territories. The FY2005 reallocation pot for states and territories would be available until the end of FY2007.

To calculate the amounts available for redistribution and retention in each formula described above, the Secretary would use expenditures reported by states not later than November 30, 2005, for the FY2003 and FY2004 redistributions, and November 30, 2006, for the FY2005 redistribution. To calculate states with projected shortfalls in each formula described above, the Secretary would use projected expenditures reported by the states not later than September 30, 2005, for the FY2003 and FY2004 redistributions, and not later than September 30, 2006, for the FY2005 redistribution.

This provision would be effective upon enactment of this Act.

(b). Use of Redistributed Funds for Child Health Assistance for Targeted Low-Income Children

Current Law

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. A state's share of program spending for Medicaid is equal to 100% minus the federal medical assistance percentage (FMAP). The enhanced SCHIP FMAP is equal to a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%. All SCHIP assistance for targeted low-income children, including coverage provided under Medicaid, is eligible for the enhanced FMAP. In addition, approved SCHIP Section 1115 waivers are deemed to be a part of a state's SCHIP state plan. Claims submitted to, and approved by CMS, for expenditures under the demonstration waiver are matched at the same enhanced matching rate as all other SCHIP claims. The Medicaid FMAP and the enhanced SCHIP FMAP are subject to a ceiling of 83% and 85%, respectively.

Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

Explanation of Provision

The provision would limit the types of payments that could be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the FY2003, FY2004, and FY2005 redistributed funds available to shortfall states. Specifically, the provision would require the federal government to make matching payments at the SCHIP enhanced matching rate for child health assistance payments made on behalf of targeted low-income children. However, expenditures drawn against the FY2003, FY2004, and FY2005 redistributed SCHIP funds would occur at the regular Medicaid FMAP rate for all other approved SCHIP expenditures, consisting of the following: (1) benefit expenditures for adults (other than pregnant women) approved under the Section 1115 waiver authority; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

This provision would be effective upon enactment of this Act.

Section 6052. Authority to Use Up to 10% of Fiscal Year 2006 and 2007 Allotments for Outreach

Current Law

In general, Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate can be made for the following four specific health care activities: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

For a given fiscal year, payments for these four specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP insurance benefits and other specific health care activities combined.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) created a special rule for the redistribution of unspent FY1998 and FY1999 original allotments. Under BIPA, states that did not use all of their original allotments for the year were permitted to use up to 10% of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap, described above.

Explanation of Provision

The provision would allow states to use up to 10% of their FY2006 and FY2007 original allotments for expenditures on outreach activities incurred during FY2006 and FY2007 respectively. This allowance would be over and above spending for such activities under the general administrative cap described above. Outreach activities would include: (1) activities to promote the coordination of the administration of SCHIP with other public and private health insurance programs; and (2) strategies to market the program to the target population and to simplify and expedite the eligibility determination and enrollment process.

This provision would be effective upon enactment of this Act.

Section 6053. Prohibition Against Covering Nonpregnant Childless Adults with SCHIP Funds

Current Law

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. Specifically, the Secretary may waive provisions in Section 1902 of Medicaid statute (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP.

With respect to SCHIP, the Clinton Administration issued a July 31, 2000, letter to state health officials regarding treatment of adults. While this Administration was supportive of using 1115 authority to expand the SCHIP program to parents of Medicaid or SCHIP-eligible children, as well as certain pregnant women, it opposed coverage of childless adults.

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 maximize private health insurance coverage options and target individuals with income below 200% of the federal poverty level.

Explanation of Provision

The provision would limit the Secretary of Health and Human Services's Section 1115 waiver authority by prohibiting the approval of waiver, experimental, pilot, or demonstration projects that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The provision would allow the Secretary to continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible children (as defined under Section 1931 of Medicaid statue), and to pregnant adults.

Finally, the provision would allow for the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to such projects) affecting federal SCHIP funds that had been approved under the Section 1115 waiver authority before the date of enactment of this Act. However, nothing in the provision would imply congressional approval of any waiver, experimental pilot, or demonstration project affecting SCHIP funds that has been approved prior to the date of enactment of this Act.

This provision would be effective upon the enactment of this Act.

Section 6054. Continued Authority for Qualifying States to Use Certain Funds for Medicaid Expenditures

Current Law

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 FY1998 through FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% 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 FY2006 or any fiscal year thereafter.

Explanation of Provision

The provision would continue the authority for qualifying states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the provision would allow qualifying states to use any available FY2004 and FY2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds, as the case may be) for such Medicaid services made on or after October 1, 2005 under the 20% allowance.

This provision would be effective on or after October 1, 2005.

Section 6055. Grants to Promote Innovative Outreach and Enrollment Under Medicaid and SCHIP.

(a) Grants for expanded outreach activities

Current Law

Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, that meets certain requirements. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

For a given fiscal year, payments for other specific health care activities (described above) cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

Explanation of Provision

The provision would establish a new grant program under Title XXI to: (1) finance innovative outreach and enrollment efforts designed to increase enrollment and participation of eligible children under both SCHIP and Medicaid, and (2) promote understanding of the importance of health insurance coverage for prenatal care and children.

In awarding grants to qualifying entities, the Secretary must give priority to (1) entities that propose to target geographic areas with high rates of eligible but unenrolled children (including those residing in rural areas), or racial and ethnic minorities and health disparity population (including those that address cultural and linguistic barriers to enrollment), and (2) entities targeting the same populations that are federal health safety net organizations (defined below) or faith-based organizations or consortia.

Five types of entities would be eligible to receive these grants. They include: (1) state or local governments, (2) federal health safety net organizations, (3) national, local or community-based public or nonprofit private organization, (4) faith-based organizations or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of Section 1955 of the Public Health Service Act (relating to grant awards to non-governmental entities), and (5) elementary or secondary schools.

Federal health safety net organizations include a number of different types of entities, including for example: (1) Indian tribes, tribal organizations, urban Indian organizations (UIOs) and Indian Health Service (IHS) providers, (2) federally qualified health centers, (3) hospitals that receive disproportionate share hospital (DSH) payments, (4) entities described in Section 340B(a)(4) of the Public Health Service Act (including, for example, certain family planning projects, certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (5) any other entity that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

Entities seeking a grant must submit an application to the Secretary containing information on the quality and outcome performance measures to be used to evaluate the effectiveness of grant activities to ensure that these activities are meeting their goals. In addition, the application must provide assurances that the entity will (1) conduct an assessment of the effectiveness using such performance measures, and (2) collect and report enrollment data and other information from these assessments to the Secretary in a form and manner as required by the Secretary. In turn, the Secretary must disseminate these data and submit an annual report to Congress on the outreach activities funded by the new grant program.

The provision would appropriate $25 million or fiscal year 2007 for the purpose of awarding grants under this new program. These funds would be in addition to existing SCHIP appropriations, and would not be subject to restrictions on expenditures for outreach activities under current law (described above).

Of the total annual appropriation, 10% is set-aside for the Secretary to award grants to IHS and UIO providers that receive funds under Title V of the Indian Health Care Improvement Act for outreach to and enrollment of Indian children.

Federal funds awarded under the new grant program must be used to supplement, not supplant, non-federal funds that are otherwise available for these grant activities.

The Secretary may set-aside a portion of the new appropriation for this grant program to award performance bonuses to eligible entities that meet enrollment goals or other criteria established by the Secretary.

Subchapter C — Money Follows the Person Rebalancing Demonstration

Section 6061. Money Follows the Person Rebalancing Demonstration.

Current law

Under Medicaid, states can offer a variety of home and community-based services to Medicaid beneficiaries who need long-term care. Some of these services may be offered statewide as part of the Medicaid state plan (e.g., home health services and personal care services). Other services may be offered through a home and community-based services (HCBS) waiver under Section 1915(c) of the Social Security Act. These waivers allow states to provide a broad range of home and community-based services to individuals who would otherwise require the level of care provided in certain types of institutions (i.e., a hospital, nursing facility or intermediate care facility for individuals with mental retardation (ICF-MR)). For example, HCBS waiver services could include respite, personal care, adult day care, or therapy. As part of the HCBS waiver, states have the ability to define the specific services that will be offered, to target a specific population (e.g., elderly individuals) and to limit the number of individuals who can participate in the waiver.

Approval for an HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if the average per person cost under the HCBS waiver is no higher than the average per person cost of receiving care in a hospital, nursing facility or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

Under current law, Medicaid beneficiaries who are residents of an institution (such as a nursing home) and who would like to leave that institution would be entitled to receive those Medicaid services covered by the Medicaid state plan. However, individuals may not be able to access the broader range of services under an HCBS waiver because many states have waiting lists for the waiver.

Medicaid expenditures for services (including the Medicaid state plan and HCBS waiver) are generally shared between the federal and state governments. In FY2003 (the latest expenditure data available), the federal government covered 59% of the cost of services; states covered the remaining 41% of expenditures. The specific federal share of a state is based on the state's federal medical assistance percentage (FMAP) rate which can range from 50% to 83%.

Explanation of Provision

The proposal would authorize the Secretary to conduct a demonstration project in states to (1) increase the use of home and community-based care instead of institutions; (2) to eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long term services in the settings of their choice and, (3) to increase the ability of the state Medicaid program to assure continued provision of home and community based long term care services to eligible individuals who choose to transition from an institution to a community setting.

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. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community-based long-term care program, as described below.

Individuals will be eligible to participate in the demonstration if they meet the following criteria: they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); they are receiving Medicaid benefits for the services in this facility; and they will continue to require the level of care of the facility but for the provision of HCBS services.

The state's application for a demonstration project will be required to include, at a minimum, the following information: (1) assurance that the project was developed and will be operated through a public input process; (2) assurance that the project will operate in conjunction with an existing Medicaid home and community-based program; (3) the duration of the project, which must be for at least two consecutive fiscal years in a five-year period starting in FY2007; (4) the service area, which may be statewide or less-than-statewide; (5) the target groups and the projected number to be enrolled and the estimated total expenditures for each fiscal year; (6) assurance that the project defers to individual choice and that the state will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible; (7) information on recent Medicaid expenditures for long-term care and home and community-based services and proposed methods to increase the state's investment in home and community-based services; (8) methods the state will use to eliminate barriers to paying for long-term care services for participants in the setting(s) of their choice; (9) assurance that the state will meet a maintenance of effort for Medicaid HCBS

expenditures and will continue to operate a HCBS waiver that meets the statutory requirements for cost-neutrality.

A state will also be required to describe a plan for quality assurance and improvement of HCBS services under Medicaid; any requested waivers of Medicaid law; if applicable, the process for participants to self-direct his or her own services (meeting standards outlined in this proposal); and compliance with reports and evaluation, as required by the Secretary.

In addition to evaluating the merits of a state's application, in selecting demonstration projects, the Secretary will be required to consider a national balance of target groups and geographic distribution and to give a preference to states that cover multiple groups or offer project participants the opportunity to self-direct their services. The Secretary will be authorized to waive certain sections of Medicaid law to achieve the purpose of the demonstration.

To qualify for grant awards after year one, states will be required to meet numerical benchmarks measuring the increased investment in services under this proposal and the number of individuals transitioned into the community. States will also be required to demonstrate that they are assuring the health and welfare of project participants. For states that do not meet these requirements, the Secretary will be required to rescind the grant award for future grant periods and will be allowed to re-award unused funding.

The proposal will require the Secretary to provide technical assistance and oversight to state grantees and may use up to $2.4 million for three quarters of FY 09, beginning January 1, 2009 and four quarters of FY 10 in each of the years FY2009 through FY2013 to fund these activities. The Secretary will also be required to conduct a national evaluation and report its findings to the President and Congress no later than September 30, 2013 and may use up to $1.1 million each year from FY20010 through FY2013 to carry out these activities.

This proposal would appropriate $250 million for the portion of FY2009 which begins on January 1, 2009, and ends on September 30, 2009; $300 million in FY2010; $350 million in FY2011; $400 million in FY2012; and $450 million in FY2013 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2013.

Payments for home and community-based long-term care services under the demonstration project shall be in lieu of payment with respect to expenditures that could otherwise be paid for by Medicaid. However, if a state exhausts its grant funding in a particular year, the state is not prevented from using Medicaid to pay for home and community-based long term care services. Finally, a state that does not use all of its funding in a given fiscal year will continue to have access to that funding for four subsequent fiscal years.

CHAPTER 6 — OPTION FOR HURRICANE KATRINA DISASTER STATES TO DELAY APPLICATION

Section 6071. Option for Hurricane Katrina Disaster States to Delay Application

Current Law

The Robert T. Stafford Disaster Relief and Emergency Assistance Act authorizes the President to issue a major disaster declaration to speed a wide range of federal aid to states determined to be overwhelmed by hurricanes or other catastrophes. Section 401 of the Stafford Act describes the procedure for declaring a major disaster or emergency. The Federal Emergency Management Agency (FEMA) makes the decision as to when a major disaster or emergency is "closed out" for administrative purposes.

Explanation of Provision

Notwithstanding any provision of or amendment made by this bill subtitle, the state of Louisiana, Mississippi, or Alabama may elect to not have the provisions of or amendments made by the subtitle apply with respect to the state during any period for which a major disaster declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act with respect to a parish (in the case of Louisiana) or a county (in the case of Mississippi or Alabama) as a result of Hurricane Katrina is in effect.

Subtitle B - Medicare

Section 6101. Improvements to the Medicare-Dependent Hospital (MDH) Program

Current Law

Certain rural hospitals with 100 beds or less that have at least 60% of its inpatient days or discharges during FY1987 or during two of the three most recently audited cost reporting periods (for which there is a settled cost report) are attributed to patients covered under Medicare qualify for special treatment under the inpatient prospective payment system as Medicare dependent hospitals (MDH). MDH hospitals are paid at 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 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%.

Explanation of Provision

The MDH status for qualifying rural hospitals would be extended through discharges occurring before October 1, 2011. Starting for discharges on October 1, 2006, a MDH would be able to elect payments based on their adjusted FY2002 hospital-specific costs if that would result in higher Medicare payments. MDH payments would be based on 75% of their adjusted hospital-specific costs starting for discharges on October 1, 2006. MDH's that qualify for a disproportionate share hospital (DSH) adjustment would not have the adjustment capped at 12%.

Section 6102. Reduction in Payments to Skilled Nursing Facilities for Bad Debt

Current Law

Medicare pays for the costs of certain items outside of the Prospective Payment System on a reasonable costs basis. Section 1861(v)(1)(A)(I) of the Social Security Act states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. Under this authority, the Secretary adopted a bad debt policy in 1966. Under this policy, Medicare reimburses certain providers for debt unpaid by beneficiaries for coinsurance and deductibles. Historically, CMS has reimbursed certain providers for 100% of this bad debt. 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. 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.

Explanation of Provision

The provision would amend Section 1861(v)(1) of the Social Security Act to reduce the payment for the allowable bad debts attributable to Medicare deductibles and coinsurance amounts by 30% for services furnished in SNFs on or after October 1, 2005.

Section 6103. Two-Year Extension of the 50 Percent Compliance Threshold Used to Determine Whether A Hospital or Unit of a Hospital is an Inpatient Rehabilitation Facility under the Medicare Program

Current Law

Inpatient rehabilitation facilities (IRFs) are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) used to pay short-term general hospitals. The Medicare statute gives the Secretary 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 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.

Explanation of Provision

The compliance threshold would be established at 50% from July 1, 2005 though June 30, 2007. The Secretary would not be permitted to change the designation of an IRF that is in compliance with that threshold. The Secretary would be required to restore the status of a facility as an IRF from July 1, 2005 through the effective date of this provision because of not meeting the 60% threshold required as of July 1, 2005. The Secretary would be required to make appropriate payments to those facilities.

The provision would deem those IRFs that failed to meet the 50% compliance threshold as meeting the threshold while directing the Secretary to examine an additional 6 months of claims data. If after review of the new data the IRF is still not in compliance with the 50% threshold, then the deemed status of the IRF will be revoked retroactively to the beginning of the 6 month period. The Secretary will collect any overpayments made to the IRF.

The Inspector General would conduct a study that analyzes the types of patients treated at IRFs that have a compliance rate between 50% and 60%, and report to Congress and the Secretary by January 1, 2007 with its findings. A rehabilitation advisory council would be established by the Secretary to provide advice and recommendations concerning the coverage of rehabilitation services under the Medicare program.

Section 6104. Prohibition on Physician Self-Referrals to Physician-Owned Limited Service Hospitals

Current Law

Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital).

Section 507 of MMA established that the exception for self-referral and physician investment in the whole hospital would not extend to physician-owned limited service hospitals for a period of 18-months from enactment (or until June 8, 2005). In this instance, a physician-owned limited service 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 physician-owned limited service 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.

Explanation of Provision

The prohibition on Medicare and Medicaid referrals to physician-owned limited service hospitals by physician investors would be effective on and after December 8, 2003. Existing physician-owned limited service hospitals could continue to operate under certain exceptions. The exception to the definition of physician-owned limited service hospital would be modified to include those: (1) where the percent investment by physician investors is no greater than the percentage on June 8, 2005; (2) where the percent investment by any physician investor is no greater than the percentage on June 8, 2005; and (3) where the number of operating rooms is not greater than the number on June 8, 2005; and (4) where the number of beds is not greater than the number on June 8, 2005. These amendments would be effective on June 8, 2005.

Section 6105. Minimum Update for Physicians' Services for 2006

Current Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule, in place since 1992, is intended to relate payments for a given service to the actual resources used in providing that service. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2005 is $37.8975.

The conversion factor is the same for all services. It is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for

physicians' services. Several factors enter into the calculation of the formula. These include (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians' services; and (3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The technical calculation of the update adjustment factor is equal to the sum of the prior year adjustment component and a cumulative adjustment component. In no case can the adjustment factor be less than minus seven percent or more than plus three percent.

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

The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to occur in 2003 and 2004; however, legislation prevented this from occurring through 2005. A negative update of 4.4 percent is slated to occur in 2006.

Explanation of Provision

The provision would specify that the update to the conversion factor in 2006 could not be less than one percent. The provision would further specify that these amendments would not be considered as a change in law for purposes of calculating the SGR.

Section 6106. One-Year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals Under the Prospective Payment System For Hospital Outpatient Department Service

Current Law

The prospective payment system for services provided by hospital outpatient departments (OPD) was implemented in August 2000 for most acute care hospitals. Under hold harmless provisions, as modified by the Medicare Prescription Drug Improvement, and Modernization Act of 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.

Explanation of Provision

The hold harmless provisions governing OPD reimbursement for small rural hospitals and rural SCH would be extended to January 1, 2007.

Section 6107. Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services

Current Law

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

The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.

Explanation of Provision

The provision would increase the composite rate component of the basic case-mix adjusted system by 1.6% for services beginning January 1, 2006.

Section 6108. One-Year Extension of Moratorium on Therapy Caps

Current Law

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

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

The Balanced Budget Refinement Act of 1999 (BBRA) suspended application of the limits for 2000 and 2001. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection

Act of 2000 (BIPA) extended the suspension through 2002. Implementation of the provision was delayed until September 2003. The caps were implemented from September 1, 2003 through December 7, 2003. MMA reinstated the moratorium from December 8, 2003 through December 31, 2005. The caps are slated to go into effect again beginning January 1, 2006. In the August 2005 proposed physician fee schedule regulation for 2006 (*Federal Register*, vol 70, no. 151, 45851), CMS estimated that the cap would be $1,750 in 2006.

Explanation of Provision

The provision would extend the moratorium for an additional year, through 2006.

Section 6109. Transfer of Title of Certain DME to Patient after 13-Month Rental

Current Law

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 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.

Explanation of Provision

The provision would implement the recommendation from a 2002 report by the Inspector General of the Department of Health and Human Services to "eliminate the semi-annual maintenance payment currently allowed for capped rental equipment and pay only for repairs when needed." 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. 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. The option for a supplier to retain ownership of the item after a 15 month rental period would be eliminated. The option for beneficiaries to purchase power wheelchairs at the time they are initially furnished would be moved to the tenth month as with other rental cap items. This amendment would apply to items for which the first rental month occurs on or after January 1, 2006.

Section 6110. Establishment of Medicare Value-Based Purchasing Programs

(a) In General

Current Law

No provision.

Explanation of Provision

The Medicare statute would be amended by redesignating the existing Section 1860E as Section 1860F and by adding a new Section 1860E which requires the Secretary to establish value-based purchasing systems for different providers.

Part E Value-Based Purchasing Programs

Quality Measurement Systems for Value-Based Purchasing Programs

1860E-1. (a) Establishment

Current Law

No provision.

Explanation of Provision

Specifically, Section 1860E-1 would require the Secretary to develop provider-specific quality measurement systems for making value-based payments to hospitals, physicians and practitioners, Medicare Advantage (MA) plans, end stage renal disease providers and facilities, and home health agencies. Measures for each quality system would be required to (1) be evidence-based; (2) be easy to collect and report; (3) address process, structures, outcomes, beneficiary experience, efficiency, and overuse and under use of health care; and (4) include at least one measure of health information technology infrastructure during the first year of implementation. Additional measures would be added in subsequent years. Measures would include those that assess the quality of care furnished to older, frail individuals and those with multiple complex chronic conditions. By 2008, hospital quality systems would be required to

include at least 5 measures that take into account the unique characteristics of small hospitals located in rural areas and frontier areas.

Before a measure would be used to determine whether a provider receives a value-based payment, data on the measure must have been collected for at least a twelve month period. Each set of quality measures selected for specific categories of providers would be able to vary in their application to an individual or entity depending of the type, size, scope and volume of services provided by the individual or entity.

The Secretary would be required to establish risk adjustment procedures and to control for differences in beneficiaries' health status and characteristics and to assign weights to measures used by each quality system. If appropriate, the Secretary may weigh some types of measures more heavily than others. The Secretary would be required to revise the quality measurement system, but not more often than every twelve months. The revision would permit a comparison of data from one year to the next. The Secretary would be required to use the most recent quality data for a provider type. However, if the Secretary determines that there is insufficient data because of the low service volume, the Secretary would be able to aggregate data across more than one fiscal or calendar year.

In developing and updating each quality measurement system, the Secretary would be required to consult with provider-based groups and clinical specialty societies. The Secretary would also take into account quality measures developed by nationally recognized entities, existing quality measurement systems, reports by the Medicare Payment Advisory Commission (MedPAC) required by this Act, results of relevant demonstrations, and the report on Health Care Performance Measures being developed by the Institute of Medicine under section 238 (b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In implementing each quality measurement system, the Secretary would be required to consult with entities that have joined together to assess the feasibility of collecting and reporting quality measurements as well as a wide range of stakeholders.

By July 1, 2006, the Secretary would be required to have in place an arrangement with an entity that will provide the Secretary with advice and recommendations about the development and updating of the quality measurement systems established by this Act. This arrangement, with a private nonprofit entity, would meet a specific set of requirements. For FY2006 and FY2007, $3,000,000 is authorized for this purpose, with the amount in subsequent years increased by the Consumer Price Index for urban consumers.

1860E-2 PPS Hospital Value-Based Purchasing Program

Current Law

No current law

Explanation of Provision

The Medicare statute would be amended by adding a new Section 1860E-2 which establishes the hospital value-based purchasing program for inpatient hospital services, starting FY2007. The program would make value-based payments to hospitals based on data reported under the quality measurement system established by the Secretary. Hospitals paid under Medicare's prospective payment system (PPS) that have substantially improved the quality of care over the prior year or exceeded an established quality threshold would receive a value-based payment as determined by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to hospitals that are receiving such payments for exceeding a quality threshold. Starting in FY2008, the percentage of fund for exceeding a threshold (rather than for quality improvement) in any fiscal year would be greater than the equivalent percentage paid in the previous year. Hospitals would be required to comply with all the quality data reporting requirements and attest to the accuracy of the data in order to be eligible for a value-based payment. The total amount of value-based payments in a fiscal year would equal the total amount of available funding for such payments for that year. The payments would be based on the methods determined by the Secretary and would be made to hospitals no later than the close of the following fiscal year. The Secretary would provide each hospital with a description of how its payments for a period determined appropriate by the Secretary would have been affected had the value-based payment program been in effect during that period.

Value-based payments in a fiscal year would be made from Medicare's Part A Trust fund and would equal specified reductions in those trust fund expenditures as established in Section 6110(b) of the bill.

1860E-3. Physician and practitioner value-based purchasing program

Current Law

No current law.

Explanation of Provision

This provision would direct the Secretary to establish a program under which value-based payments are provided each year to physicians and practitioners that demonstrate the provision of high quality health care to individuals enrolled under part B. In addition, MedPAC would be required to conduct five studies evaluating the new program.

The first study would examine how the Medicare value-based purchasing programs under this section will affect Medicare beneficiaries, Medicare providers, and Medicare financing, including the impact of these programs on the access of such beneficiaries to items and services, the volume and utilization of such items and services, and low-volume providers. The initial report would be due to Congress and the Secretary no later than March 1, 2008, and a final report due no later than June 1, 2012.

The second study would examine the advisability and feasibility of establishing a value-based purchasing program for critical access hospitals (CAHs). This report would be due to Congress and the Secretary no later than March 1, 2007.

The third study would address the advisability and feasibility of including pediatric renal dialysis facilities in the value-based purchasing program described in this section or establishing a separate value-based purchasing program for pediatric renal dialysis facilities under this title. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2007.

The fourth study would be a report on the feasibility of implementing an end-stage renal disease (ESRD) provider and facility value-based purchasing program for facilities paid under the bundled case-mix adjusted payment system established under Section 623(e) of MMA. This report would include issues for the Secretary to consider in operating the ESRD provider and facility value-based purchasing program under the bundled case-mix adjusted payment system as well as recommendations on such issues. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2008.

The fifth study, due to Congress and the Secretary by June 1, 2007, would report on the advisability and feasibility of establishing a value-based purchasing program for skilled nursing facilities (SNFs).

The value-based purchasing program would be established so that value-based payments will be made initially in 2009 and in each subsequent year. The definition of a physician would not be changed as a result of this section and would remain as given in current law (section 1861(r)). The term 'practitioner' would mean: (i) a practitioner defined under current law[2]; (ii) a physical therapist; (iii) an occupational therapist; and (iv) a qualified speech-language pathologist. The Secretary would be charged with establishing procedures for the identification of physicians and practitioners for payment purposes under this section, such as through physician or practitioner billing units, physician identifier number, unique physician identifier number, tax ID or national physician identifier.

The value-based payments would be based on either relative or absolute standards. The Secretary would be able to make a value-based payment to a physician or a practitioner if both the quality and efficiency of care to an individual enrolled under Part B has improved substantially or has exceeded an established threshold. In determining which physicians and practitioners would qualify for a value-based payment, the Secretary would be required to use both the quality measurement system developed for this section with respect to the quality of the care provided by the physician or practitioner and the comparative utilization system developed under this section with respect to the efficiency and appropriateness of such care.

In determining the amount of the award and the allocation of awards under the value-based purchasing program, the Secretary would determine the amount of a value-based payment provided to a physician or a practitioner with respect to physicians and practitioners that meet the quality threshold requirements described above.

The Secretary would ensure that a majority of the total amount available for value-based payments for any year is provided to physicians and practitioners who meet the threshold for receiving such payments. Additionally, the percentage of value-based payments would not be able to decrease. For every year beginning in 2010, the Secretary would be required to ensure that the percentage of the total amount available for value-based payments for any year that is used to make payments to physicians and practitioners is greater than the previous year's percentage.

In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner would be required to submit quality data with respect to that year, and provide the Secretary (under procedures established by the Secretary) with an attestation that the data submitted is complete and accurate.

The Secretary would be required to establish value-based payments such that the estimated total amount of the value-based payments is equal to the total amount of available funding for value-based payments for the year. The payment of value-based payments would be based on such a method as the Secretary determines appropriate, and the Secretary would ensure that

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2 Section1842(b)(18)(C) defines a practitioner as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or a registered dietitian or nutritional professional.

value-based payments with respect to a year are made by not later than December 31 of the subsequent year.

The Secretary, in consultation with relevant stakeholders, would develop a comparative utilization system for purposes of providing value-based payments. The resulting comparative utilization system would measure the efficiency and appropriateness of the care provided by a physician or practitioner. Under this comparative utilization system, the Secretary would select the measures of efficiency and appropriateness and review the most recent claims data with respect to services furnished or ordered by physicians and practitioners to determine utilization patterns. The Secretary would establish risk adjustment procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics.

Beginning in 2007, the Secretary would provide physicians and practitioners with annual reports on the utilization of items and services under this title based upon the review of claims data. The 2007 and 2008 reports would be confidential and not be made available to the public. The Secretary would provide each physician and practitioner with a description of how its payments for a period determined appropriate by the Secretary would have been affected had the value-based payment program been in effect during that period.

Payments to physicians and practitioners under the value-based payment program would be made from the Federal Supplementary Medical Insurance (Part B) Trust Fund. The total amount available for value-based payments with respect to a year would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the amendments made by Section 6110(c)(2) of the bill, as estimated by the Secretary.

1860E-4. Plan Value-Based Purchasing Program

Current Law

No provision in current law.

Explanation of Provision

The Secretary would establish a program to award value-based payments to Medicare Advantage (MA) organizations that provide high quality health care. The quality payment pool would be established in 2009, and continue each year thereafter. The program would apply to both MA regional and local plans. It also would apply to reasonable cost contract plans.

The Secretary would make payments for each plan offered by an MA organization if the plan substantially improved over the prior year, or exceeded a minimum threshold. The Secretary would use measures of quality developed for the plan value-based payments system (Section 1860E-1) and ensure that awards are based on data from a full 12-months when making a comparison against a threshold, and 24-months when measuring improvement over a prior year.

The Secretary would determine the amount of the value-based payments, but must ensure that the majority of funds go to plans that receive a payment because their health measures exceeded a threshold. In 2010 and each subsequent year, the percentage of the total amount available is greater than the percentage in a previous year.

Value based payments may only be used to invest in quality improvement programs or to enhance beneficiary benefits.

To be eligible for value based payments, an MA plan or reasonable cost contract would be required have collected, analyzed and reported the required data for the two previous years. Also, an MA plan would be required to provide the Secretary with an attestation that the value based payment program including payment adjustments made by reason of Section 6110(d)(2)(A)) had no effect on the integrity and actuarial soundness of the plan's bid.

The Secretary would ensure that the total of value based payments is equal to the amount made available for those payments. Payments for a particular year would be required to be made not later than March 1 of the subsequent year, in a manner determined by the Secretary.

By March 1, 2009, the Secretary would provide each MA organization with an estimate of how plan payments would have been affected if the value based payment system had been in effect in 2008.

The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as a result of amendments to fund the value-based payment system, as estimated by the Secretary. Payments to MA organizations would be drawn from the two trust funds in proportion to the relative weight that part A and part B benefits represent of the total actuarial value of Medicare benefits.

1860E-5. ESRD Provider and Facility Value-Based Purchasing Program

Current Law

No provision.

Explanation of Provision

Beginning in 2007, the Secretary would establish a program under which value-based payments are provided each year to providers of services and renal dialysis facilities that provide services to ESRD individuals enrolled under part B and that demonstrate the provision of high quality health care. Facilities with at least 50% of their patients under the age of 18, as well as

those providers and facilities currently participating in the bundled case-mix demonstration are excluded from this program.

Value-based payments would be made to a provider or facility, if the Secretary determines that the quality of care in that year has substantially improved over the prior year or exceeds a threshold established by the Secretary, using the quality measurement system.

The Secretary would determine the amount of a value-based payment and the allocation of the total amount available for all such payments, subject to certain requirements. The Secretary would ensure that the majority of the total amount available is awarded to those providers of services and renal dialysis facilities who provide high quality services. For 2007, the entire amount would be available for those who meet the requirements.

Beginning in 2007, each provider of services and renal dialysis facility would be required to submit data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the program. A provider or facility would be required to submit this data, in order to be eligible for a value-based payment for a year. The Secretary would establish procedures for making submitted data available to the public in a clear and understandable form and would ensure that a provider or facility first has the opportunity to review the data. The provider or facility would be required to provide an attestation that the data is complete and accurate.

The Secretary would establish payment amounts so that, as estimated by the Secretary, the total amount of value-based payments made in a year is equal to the total amount available. The payment of the awards would be based on a method as determined by the Secretary and must be paid no later than December 31 of the subsequent year. The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance (SMI) Trust Fund, as estimated by the Secretary. Payments to providers of services and renal dialysis facilities, under this section, would be made from the Federal SMI Trust Fund.

1860E-6. Home Health Agency Value-based Purchasing Program

Current Law

No current law.

Explanation of Provision

The Medicare statute would be amended by adding a new Section 1860E-6 which establishes the Home Health Agency Value-Based Purchasing Program. In 2008 and in subsequent years, the Secretary would make value-based payments to those home health agencies that, based on data submitted under the quality measurement system, have either

substantially improved quality of care over the prior year, or exceed a threshold established by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to home health agencies that qualify for payments because they exceed a quality threshold. Starting in 2009 and in each subsequent year, the percentage of total value-based payments made to agencies that exceed the quality threshold would be greater than the percentage made in the previous year. To be eligible for a value-based payment, home health agencies would be required to submit the required quality data and attest that it is complete and accurate.

The total amount of value-based payments made in a year would equal the total funds available for such payments. The payments would be based on the methods determined by the Secretary and would be made to home health agencies no later than the close of the following calendar year. The Secretary would provide each home health agency with a description of how its payments for a period determined appropriate by the Secretary would have been affected had the value-based payment program been in effect during that period.

Value-based payments would be made from Part A and Part B in the same proportion as payments for home health services are made.

(b) Hospitals

(1) Voluntary Submission of Hospital Quality Data

Current Law

Each year, Medicare's operating payments to acute general hospitals are increased or updated by a factor that is determined, in part, by the projected annual change in the hospital market basket (MB). Congress establishes the update for Medicare's inpatient prospective payment system (IPPS) for operating costs, often several years in advance. An IPPS hospital will receive an operating update of the MB from FY2005 through FY2007 if it submits data on the 10 quality indicators established by the Secretary as of November 1, 2003. The Secretary will specify the form, manner, and time of the data submission. A hospital that does not submit data to the Secretary will receive an update of the MB minus 0.4 percentage points for the fiscal year in question. The Secretary will not take into account this reduction when computing the applicable percentage increase in subsequent years. For FY2008 and subsequent fiscal years, hospitals will receive an update of the MB.

Explanation of Provision

In FY2007 and subsequent years, an IPPS hospital that does not submit the required quality data would receive an update of the MB minus two percentage points. This reduction would only apply to the fiscal year in question. In FY2007 and subsequently, an IPPS hospital receiving an update of the MB would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. Procedures for making the data available to the public would be

established. These procedures would be required to provide the hospitals with an opportunity to review the data before it is released to the public.

(2) Reduction in Payments in order to Fund Program

Current law

Outlier payments are intended to protect IPPS hospitals from the risk of financial losses associated with patients with exceptionally high costs or unusually long stays. Medicare cases qualify for outlier payments if they exceed a threshold or fixed loss amount that is established each year. As directed by statute, the total amount of any outlier payments for any year should equal no less than 5% nor more than 6% of total projected operating diagnosis related group (DRG) payments. Outlier payments are financed by a reduction in the national average standardized amount, typically set at 5.1%.

Explanation of Provision

The Secretary would be directed to reduce the average standardized amount by certain percentages to fund outlier payments and the hospital value-based purchasing program. Outlier payments would be established as no less than 5% and no more than 6% for fiscal years prior to 2007. In FY2007, outlier payments would be established as no less than 4% and no more than 5%. In FY2008, outlier payments would be established as no less than 3.75% and no more than 4.75%. In FY2009, outlier payments would be established as no less than 3.5% and no more than 4.5%. In FY2010, outlier payments would be established as no less than 3.25% and no more than 4.25%. In FY2011 and in subsequent years, outlier payments would be established as no less than 3% and no more than 4%.

The reduction factor will be equal to a calculation where the numerator is the sum of the additional outlier payments (as discussed above) plus a specified percentage of total projected DRG prospective payment rates for the quality pool divided by the total projected DRG prospective payment rates. The specific percentages for the quality pool would be 0% for fiscal years prior to 2007, 1% in FY2007, 1.25% in FY2008, 1.5% in FY2009, 1.75% in FY2010, and 2% in FY2011 and in subsequent years.

(3) Value-Based Purchasing Demonstration Program for Critical Access Hospitals

Current Law

No current law.

Explanation of Provision

The Secretary, within six months from enactment, would be required to establish a two-year value-based payment demonstration program at six representative CAHs, using such funds

as are necessary from the Part A trust fund. The Secretary would be required to report to Congress with recommendations within six months of completing the demonstration.

(c) Physicians and Practitioners

(1) Voluntary Submission of Physician and Practitioner Quality Data

Current law

No current law.

Explanation of Provision

In FY2007 and in subsequent years, physicians and providers who do not submit the required quality data would receive an update to the conversion factor minus two percentage points. This reduction would only apply to the fiscal year in question. In FY2007 and subsequently, physicians and practitioners would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. There will be a phased-in approach to the public reporting of data for physicians and practitioners. In the first phase, public reporting would identify physicians and practitioners who had reported data (without any information on what the data revealed). The next phase, public reporting would identify those physicians and practitioners who had been awarded value-based payments for high quality, efficient care and improvement. The last phase, public reporting would reveal the actual data being reported by physicians and practitioners on the quality measures. Procedures, established by the Secretary, would be required to provide the physicians and practitioners with an opportunity to review the data before it is released to the public. The Secretary would be allowed to make exceptions to the requirement for making data available to the public by taking into account the size and specialty representation of the practice involved when providing such exceptions.

(2) Reduction in Conversion Factor for Physicians and Practitioners that Submit Quality Data in order to Fund Program

Current law

Medicare payments under Part B are based on a fee schedule. The fee schedule reflects a set of weights that vary across the many procedures that encompass the range of activities and services that physicians and practitioners provide. These relative weights are converted to dollar amounts for payment under Medicare by applying a multiplicative conversion factor. The conversion factor is updated each year according to a formula that aims to place a restraint on overall increases in Medicare spending for Part B services.

Explanation of Provision

To fund the value-based purchasing program for physicians and practitioners, the conversion factor would be reduced as follows: 1.0% in 2009, 1.25% in 2010, 1.5% in 2011, 1.75% in 2012, and 2.0% in 2013 and subsequent years.

(d) Plans

(1) Submission of Quality Data

Current Law

Each Medicare Advantage (MA) organization has an ongoing quality improvement program. MA private fee-for-service plans, MSA plans and Medicare cost reimbursement plans are exempt from this requirement. Each MA organization collects, analyses and reports health outcomes and quality data. The quality improvement program for local preferred provider organizations only applies to providers that have contracts with the organization. The Secretary can collect only the types of data that were collected by the Secretary as of November 1, 2003. The Secretary can collect other types of data only after consulting with MA organizations and private accrediting bodies, and submitting a report to Congress.

Explanation of Provision

Beginning on or after January 1, 2006, the Secretary would also collect data necessary for the plan value-based purchasing program (Section 1860E-4). The Secretary would establish requirements for MA private fee-for-service plans and cost reimbursement plans with respect to the collection, analysis and reporting of data on health outcomes and quality. The Secretary would establish procedures for making health outcomes and quality data available to the public in a clear and understandable form. Prior to the data being made public, the Secretary would ensure that an MA organization has the opportunity to review the data for the plans it offers. The Secretary may change the type of data collected for the value-based purchasing program after complying with requirements for the development, update and implementation of the program.

The Secretary would take into account the data reporting requirements that plans must comply with under other federal and state programs and in the commercial market when establishing a time frame for data reporting requirements under the new program.

(2) Reduction in Payments to Organizations in order to Fund Program

Current Law

No provision.

Explanation of Provision

For those providers included in the value based program, including reasonable cost contracts, the monthly payment to plans would be reduced by 1% in 2009, 1.25% in 2010, 1.5% in 2011, 1.75% in 2012, and 2.0% for 2013 and each subsequent year. These reductions would not have any effect on determining whether the risk adjusted benchmark exceeds a plan's risk adjusted bid, or the amount of the difference.

(3) Requirements for Reporting on Use of Value-Based Payments

Current Law

No provision.

Explanation of Provision

Beginning on or after January 1, 2011, MA plans would submit information describing how the organization will use any value based payments received under the program. This information would be submitted by plans at the same time they submit plan bids. Beginning in 2010, not later than July 1 of each year, any reasonable cost reimbursement contract that received a value based payment would submit a report to the Secretary describing how the organization will use the value based payment.

(e) ESRD Providers and facilities

Current Law

No provision.

Explanation of Provision

No later than July 31, 2006, the Secretary would establish procedures for providers of services and renal dialysis facilities, who are paid based on the case-mix adjusted prospective payment system, to submit data that permits the measurement of health outcomes and other indices of quality.

In the case of any payment for an item or service furnished on or after January 1, 2007, the case-mix adjusted prospective payment amount would be reduced by the applicable percent, but only for those providers of services or renal facilities included in the value-based program. The applicable percent would be 1% for 2007, 1.25% for 2008, 1.5% for 2009, 1.75% for 2010, and 2% for each year thereafter.

Beginning January 1, 2007, the Secretary would implement a value-based purchasing program for providers and facilities participating in the bundled case-mix demonstration (as established under Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), in a manner similar to the value-based program established under Section 1860E-5 of this bill, including the funding of the program.

(f) Home Health Agencies

Current Law

No provision.

Explanation of Provision

In 2007 and subsequent years, a home health agency that does not submit to the Secretary the required quality data would receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. For 2007 and subsequently, each home health agency receiving an update of the MB would be required to submit data necessary for a value-based purchasing system in the form, manner, and time period specified by the Secretary. Procedures for making the data available to the public would be established. These procedures require that home health agencies be given an opportunity to review the data before it released to the public.

To fund the program, spending under the trust funds for home health services would be reduced by a percent applied to the standard prospective payment amount made to all agencies that comply with the data submission requirements. The percent reduction would be 1% in 2008, 1.25% in 2009, 1.5% in 2010, 1.75% in 2011, and 2% in 2012 and subsequent years.

(g) Skilled Nursing Facilities

(1) Requirement for Skilled Nursing Facilities to Report Functional Capacity of Medicare Residents Upon Admission and Discharge

Current Law

Medicare law requires nursing homes to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Under the law, this assessment must describe the resident's capability of performing daily life functions and significant impairments in functional capacity and be based on a uniform minimum data set specified by the Secretary, or specified by the state with the Secretary's approval. If specified by a state, it must be consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

As a result, the Minimum Data Set (MDS), designed by the Secretary, consists of a core set of screening, clinical and functional status elements, including common definitions and coding categories which form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. MDS is designed to facilitate and standardize resident assessments, which are structured, problem-oriented frameworks for

organizing MDS information, and examining additional clinically relevant information about an individual. These resident assessments help identify social, medical and psychological problems and form the basis for individualized care planning. MDS is also used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement.

In general, MDS resident assessments are conducted on the 5th, 14th, 30th, 60th, and 90th days of post-hospital SNF care. SNFs also conduct other assessments that may be needed to account for changes in patient care needs.

Explanation of Provision

This provision would amend section 1819(b) of the Social Security Act by adding a requirement that on or after October 1, 2006, a SNF would be required to submit a report to the Secretary on the functional capacity of each resident who is entitled to SNF benefits at the time of his or her admission and discharge. This report would be required to be submitted within 10 days of the admission or discharge as the case may be.

(2) Voluntary Submission of Skilled Nursing Facility Data

Current Law

As described above, the MDS submitted to CMS by states is intended to provide information on the quality of care provided to residents in SNFs. In recent years, CMS has attempted to make available additional quality measures. CMS posts data on nursing home's care records from complaint surveys, staffing levels, and number and types of residents, facility ownership and 15 quality measure scores on a website entitled Nursing Home Compare. This site is available to the public and is intended to assist individuals in choosing a Medicare- and Medicaid-certified nursing home by state, county, city, zip code, or by facility name. Additional research into the development of quality measures, staffing, and best practices is currently underway through CMS contracts with Quality Improvement Organizations (QIOs).

Explanation of Provision

This provision would require SNFs to submit quality data for the measurement of health outcomes and other indices of quality to the Secretary for FY 2008 and each subsequent fiscal year. Data required would be determined by the Secretary after conducting a study in consultation with certain nationally recognized quality measurement entities, researchers, health care provider organizations, and other appropriate groups and consult with, and take into account, recommendations of, the entity that the Secretary has an arrangement with based on criteria specified in section 6110(e) of this bill. The Secretary would also be required to consult with entities that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures and that involve representatives of health care providers, health plans, consumers,

employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care. The Secretary would be required to establish procedures for making this data available to the public in a clear and understandable form. Such procedures would be required to ensure that a facility has the opportunity to review the data that is being made public with respect to the facility prior to such data being made public.

For FY 2009 and each subsequent year, a SNF that does not submit to the Secretary the required quality data would receive an update of the market basket percentage reduced by two percentage points. Such reductions would apply only with respect to the fiscal year involved.

Section 6111. Phase-out of Risk Adjustment Budget Neutrality in Determining the Amount of Payments to Medicare Advantage Organizations

Current Law

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 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.

Explanation of Provision

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 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 this 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. The Secretary shall conduct an analysis of differences in coding patterns for the purposes of making such adjustments. The Secretary may take into account estimated health risk of enrollees in preferred provider organizations (including MA regional plans) for the year.

The Secretary can not make 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.

Section 6112. Elimination of the Medicare Advantage Regional Plan Stabilization Fund

Current Law

The Secretary will establish an MA Regional Plan Stabilization Fund to provide incentives for plan entry in each region and plan retention in certain MA regions with below average MA penetration. Initially, $10 billion will be available for expenditures from the Fund beginning on January 1, 2007 and ending on December 31, 2013. Additional funds will be available in an amount equal to 12.5% of average per capita monthly savings from regional plans that bid below the benchmark

Explanation of Provision

This section is repealed effective as of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

This section also provides that any payment from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) for claims submitted under part A or B of title XVIII of such Act for items and services furnished under such part A or B, respectively, that would otherwise be payable during the period beginning on September 22, 2006, and ending on September 30, 2006, shall be paid on the first business day of October 2006; and no interest or late penalty shall be paid to an entity or individual for any delay in a payment during such period.

Section 6113. Rural PACE Provider Grant Program

Current Law

The Program of All-Inclusive Care for the Elderly (PACE) is a program providing comprehensive Medicare and Medicaid services under a managed care service delivery model to individuals over age 55 who are eligible for a nursing home level of care. PACE organizations, which are public or private non-profit entities, receive a fixed monthly Medicare and Medicaid payment to cover a comprehensive set of services for PACE participants. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.

The PACE program was modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through federal demonstration projects that began in the mid-1980s. Under the Balanced Budget Act of 1997 (BBA97), PACE became a permanent service delivery option within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option. The Medicaid state plan must include PACE as an optional Medicaid benefit before the state and the Secretary of the Department of Health and Human Services (HHS) can enter into program agreements with PACE providers.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Under the Medicare program, the monthly capitation rate paid by the Centers for Medicare and Medicaid Services (CMS) to the PACE provider is a blend of two formulas; (1) the Medicare Advantage county rate multiplied by a uniform PACE frailty adjuster, and (2) a risk adjusted payment methodology to account for higher cost enrollees. This blend will transition to 100% risk adjustment in 2008. Under the Medicaid program, the monthly capitation rate is negotiated between the PACE provider and the State Medicaid Agency and is specified in the contract between them. The capitation rate is fixed during the contract year regardless of changes in the participant's health status. The rates are considered payment in full.

Federal regulations require approved PACE organizations to demonstrate a fiscally-sound operation with regard to total assets, cash flow, and net operating surplus. PACE organizations must also have a documented plan in the event of insolvency and be able to demonstrate that in the event of insolvency, it has arrangements to cover one month's total capitation revenue and one month's average payment to all contractors. During the first 3 years of operation, (the trial period), a PACE organization is subject to comprehensive annual reviews of the operations of the organization including an assessment of the organization's fiscal soundness.

Currently, most PACE organizations are located in urban settings. The HHS, Health Resources Services Administration has funded the National PACE Association and the National Rural Health Association to implement a rural PACE technical assistance program. The goals of the program are to: 1) develop strategies for successfully adapting PACE to rural communities; 2) identify health professional training needs to support PACE in rural communities; and 3) provide education and technical assistance to rural providers interested in exploring rural PACE opportunities.

Explanation of provision

This proposal would create site development grants and provide technical assistance to establish PACE providers in rural areas. The proposal would also create a fund for rural PACE providers to provide partial reimbursement for incurred expenditures above a certain level. A rural area would be considered any area outside of a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or a similar area as defined by the HHS Secretary through regulation.

The proposal would require the Secretary to establish a process and criteria for awarding up to $7.5 million in site development grants 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. Site development grants could be used for expenses incurred to establish or deliver PACE program services in a rural area including:

- feasibility analysis and planning, interdisciplinary team development;
- development of a provider network, including contract development;
- development or adaptation of claims processing systems;
- preparation of special education and outreach efforts required for the PACE program;
- development of expense reporting required for calculation of outlier payments or reconciliation processes;
- development of any special quality of care or patient satisfaction data collection efforts;
- establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size;
- startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS; and
- any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

The proposal would also require the Secretary to establish a technical assistance program to provide 1) outreach and education to state agencies and provider organizations interested in establishing PACE programs in rural areas, and 2) technical assistance necessary to support rural PACE pilot sites. In selecting an entity to provide technical assistance, the Secretary shall give preference to those with previous experience in providing such technical assistance and consider the entity's familiarity with the delivery of health services to frail elderly individuals who reside in a rural area.

The proposal would require the Secretary to establish an outlier fund to reimburse rural PACE pilot sites for outlier costs incurred for eligible participants who reside in rural areas. Outlier costs include inpatient and related physician and ancillary costs incurred for an eligible participant within a given 12-month period. Outlier costs may not be included in more than one 12-month period for purposes of calculating an outlier expense payment. A rural PACE pilot site would receive and outlier expense payment equal to 80% of the outlier costs for an eligible participant with inpatient and related physician and ancillary costs in excess of $50,000 in a given 12-month period.

The total amount of an outlier expense payment to a rural PACE pilot site for an eligible participant shall not exceed $100,000 for the 12-month period used to calculate the payment, and no site may receive more than $500,000 in total outlier expense payments in a 12-month period. The total amount of outlier expense payments made under this section may not exceed $10 million. Each rural PACE pilot site's access to outlier cost protection shall be limited to its first three years of operation.

Prior to receiving the outlier expense payment, a rural PACE pilot site would be required to access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves required by federal regulations to maintain a fiscally-sound operation) and any working capital established through a site development grant awarded under this bill.

Not later than 60 months after the effective date of this proposal, the Secretary shall submit to Congress an evaluation of the experience of rural PACE pilot sites.

Section 6114. Waiver of Part B Late Enrollment Penalty for Certain International Volunteers

Current Law

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 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.

Explanation of Provision

The provision would permit certain individuals to delay enrollment in Part B without a delayed enrollment penalty. Those individuals permitted to delay enrollment would be those who volunteered outside of the United States through a 12-month or longer program sponsored by a tax-exempt organization defined under section 501(c)(3) of the Internal Revenue Code. 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.

Section 6115. Delivery of Services at Federally Qualified Health Centers

Current Law

The Omnibus Budget Reconciliation Act (OBRA) of 1989 amended the Social Security Act (SSA) to create a new category of facility under Medicare and Medicaid known as a federally qualified health center (FQHC). According to statute, a FQHC is required to provide certain primary care services by physicians and appropriate mid-level practitioners as well as other preventive health services including those required under certain sections of the Public Health Service (PHS) Act (specifically Sections 329, 330, and 340 of the PHS).

Prior to the enactment of MMA, FQHC services were covered by a skilled nursing facility's (SNF) consolidated billing requirement. FQHC services were bundled into the SNF'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.

Explanation of Provision

The provision would allow FQHCs to provide diabetes outpatient self-management training services and medical nutrition therapy services provided by a registered dietician or nutrition professional.

The provision would modify the definition of FQHC services so that only the primary preventative services required under Section 330 of the PHS 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.

The provision would also allow FQHCs to be eligible for Health Care for the Homeless grants.

CBO's Estimate of the Budgetary Effects of the Senate Finance Committee's Reconciliation Proposals

Based on the legislative language ERN05935, dated October 24, 2005.

Date: October 24, 2005

Figures are outlays by fiscal year, in millions of dollars. Costs or savings of less than $500,000 are noted with an asterisk.

Section		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-10	2006-15
	SUBTITLE A -- MEDICAID												
	Chapter 1 -- Prescription drugs												
6001	Upper limits on pharmacy reimbursement	-70	-750	-1,025	-1,250	-1,500	-1,700	-1,925	-2,150	-2,400	-2,675	-4,595	-15,445
6002	Increase rebates for brand-name and generic drugs	-230	-255	-265	-305	-345	-375	-415	-455	-505	-550	-1,400	-3,700
6003	Include authorized generics in best price calculation	-15	-30	-40	-45	-50	-60	-70	-80	-90	-105	-180	-585
6004	Collect rebates on physician-administered drugs	-10	-35	-35	-35	-35	-35	-35	-35	-40	-40	-150	-335
	Chapter 2 -- Long-term care												
6011	Revisions to asset transfer rules	-36	-59	-70	-85	-85	-85	-110	-110	-120	-130	-335	-890
6012	Repeal moratorium on Partnership programs	0	0	0	5	5	5	5	5	5	5	10	35
	Chapter 3 -- Fraud, waste, and abuse												
6021	Third-party recovery provisions	-20	-70	-110	-140	-140	-150	-160	-170	-170	-190	-480	-1,320
6022	Limit use of contingency fees	0	0	0	0	0	0	0	0	0	0	0	0
6023	Encourage states to enact False Claims Acts	0	1	-1	-7	-18	-32	-44	-60	-77	-96	-25	-333
6024	Require False Claims Act education programs	0	0	-1	-2	-4	-7	-9	-12	-16	-19	-7	-70
6025	Prohibit double payments on prescription drug claims	*	*	*	*	*	*	*	*	*	*	*	*
6026	Medicaid integrity program	59	75	75	94	100	79	75	75	75	75	403	781
	Chapter 4 -- State financing												
6031	Tighten definition of TCM services	-30	-100	-180	-230	-220	-230	-250	-260	-280	-290	-760	-2,070
6032	FMAP increases for AK, AL, LA, and MS	1,875	65	0	0	0	0	0	0	0	0	1,940	1,940
6033	Restrict provider taxes on MCOs	-5	-15	-15	-20	-20	-20	-25	-25	-25	-30	-75	-200
6034	Require states to cover podiatry services	10	10	10	10	15	15	15	15	15	20	55	135
6035	Increase DSH payments for District of Columbia	20	20	20	20	20	21	21	22	22	23	100	209
6036	Institutions for Mental Diseases demonstration	10	20	0	0	0	0	0	0	0	0	30	30
	Chapter 5 -- Medicaid / SCHIP expansions												
6042	Allow states to cover certain disabled children	0	0	10	160	550	780	930	1,000	1,080	1,170	720	5,680
6043	Demonstration programs for certain disabled children	0	2	8	11	15	31	14	13	10	6	36	110
6044	Family-to-family health information centers	0	2	3	4	2	*	*	0	0	0	11	11
6045	Restore Medicaid eligibility for certain SSI recipients	0	20	25	30	30	35	40	40	45	50	105	315
6051-54	SCHIP provisions and all SCHIP interactions	165	245	-90	-70	-110	-110	-90	-155	-95	-95	140	-405
6055	Funding for outreach activities	0	10	20	20	15	10	10	10	10	5	65	110
6061	Money Follows the Person demonstration	0	0	0	20	85	210	350	460	400	285	105	1,810
	Chapter 6 -- Option to delay application												
6071	Allow Katrina states to delay application of provisions	2	0	0	0	0	0	0	0	0	0	2	2
	Total, Subtitle A	1,725	-844	-1,661	-1,815	-1,689	-1,618	-1,673	-1,872	-2,156	-2,581	-4,285	-14,184

CBO's Estimate of the Budgetary Effects of the Senate Finance Committee's Reconciliation Proposals

Based on the legislative language ERN05935, dated October 24, 2005.

Date: October 24, 2005

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Section	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-10	2006-15
SUBTITLE B -- MEDICARE												
6101 Extend Medicare-dependent hospital program	0	3	3	4	4	4	0	0	0	0	14	18
6102 Cut bad debt payments to SNFs	0	-10	-50	-90	-100	-110	-120	-130	-140	-150	-250	-900
6103 Extend 50% threshold for determining IRFs	30	70	5	0	0	0	0	0	0	0	105	105
6104 Prohibit certain physician self-referrals	-4	-4	-4	-5	-5	-5	-5	-6	-6	-6	-22	-50
6105 Payment updates for physician services	2,000	3,200	3,200	2,500	-100	-2,300	-3,100	-2,900	-2,100	-1,100	10,800	-700
6106 Extend hold harmless provision for certain hospitals	130	40	0	0	0	0	0	0	0	0	170	170
6107 Increase composite rate for dialysis services	60	100	110	120	130	140	150	150	160	170	520	1,290
6108 Extend moratorium on therapy caps for 1 year	530	180	0	0	0	0	0	0	0	0	710	710
6109 Require purchase of DME rentals after 13 months	-140	-190	-190	-190	-200	-210	-230	-250	-270	-290	-910	-2,160
6110 Pay-for-performance proposals	0	-1,220	-860	-1,450	-980	-1,020	-680	-600	-220	-190	-4,510	-7,220
6111 Phase-out risk adjustment payments to MA plans	0	0	-1,440	-2,090	-2,930	-3,610	-3,320	-3,880	-4,270	-4,490	-6,460	-26,030
6112 Eliminate MA regional stabilization fund and payment holiday	-5,160	4,060	-1,450	-1,450	-1,440	-1,530	-1,390	-1,420	-390	0	-5,440	-10,170
6113 Development grants for rural PACE programs	5	9	9	7	7	7	7	8	8	9	37	76
6114 Waive Part B late enrollment penalty for certain individuals	0	4	5	5	6	6	7	7	8	9	20	57
6115 Allow FQHCs to bill Medicare for additional services	5	5	10	10	10	15	15	15	20	20	40	125
Medicare Advantage interaction	0	80	200	170	50	-110	-200	-230	-220	-160	500	-420
Premium interaction	0	-1,195	-370	-45	565	1,165	1,300	1,320	1,000	750	-1,045	4,490
Total, Subtitle B	-2,544	5,132	-822	-2,504	-4,983	-7,558	-7,566	-7,916	-6,420	-5,428	-5,721	-40,609
Net effect of all provisions on deficit	**-819**	**4,288**	**-2,483**	**-4,320**	**-6,672**	**-9,176**	**-9,239**	**-9,787**	**-8,576**	**-8,009**	**-10,006**	**-54,794**

Abbreviations:

DME = durable medical equipment
DSH = disproportionate share hospital
FMAP = federal medical assistance percentage
FQHC = federally-qualified health center
IRF = inpatient rehabilitation facility
MCO = managed care organization
MA = Medicare Advantage
PACE = Program for All-Inclusive Care for the Elderly
SCHIP = State Children's Health Insurance Program
SNF = skilled nursing facility
SSI = Supplemental Security Income
TCM = targeted case management

SUMMARY

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

SPENDING REDUCTIONS

MEDICAID

Prescription Drug Payment Reforms

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

-$4.595 billion / 5 years

Reform of Medicaid Asset Transfer Rules and Loopholes

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

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

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

-$335 million / 5 years

Fraud, Waste and Abuse

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

-$512 million / 5 years

State Financing of Medicaid

MCO Provider Tax Reform

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

-$75 million / 5 years

Targeted Case Management Reforms

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

-$760 million / 5 years

Drug Rebate and Related Provisions

Close Authorized Generics Loophole

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

-$180 million / 5 years

Increase Flat Rebate Amount to 17% in 2006

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

-$1.400 billion / 5 years

Physician Administered Drugs

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

-$150 million / 5 years

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

MEDICARE

PART A

Extend Medicare Bad Debt Policy to Skilled Nursing Facilities

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

-$250 million / 5 years

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

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

-$22 million / 5 years

PART B

DME Payment and Maintenance Fee Reforms

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

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

-$910 million / 5 years

PART C

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

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

-$6.460 billion / 5 years

Eliminate Regional Medicare Advantage PPO Stabilization Fund

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

-$5.440 billion / 5 years

OTHER MEDICARE

Pay for Performance

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

-$4.510 billion / 5 years

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

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

PROGRAM IMPROVEMENTS

MEDICAID AND SCHIP

IMPROVED FRAUD AND ABUSE OVERSIGHT

Health Care Fraud and Abuse Control Program / Medicaid Integrity Fund

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

$403 million / 5 years

PRESERVING AND IMPROVING ACCESS TO HEALTH CARE

Family Opportunity Act

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

$872 million / 5 years

Addressing SCHIP Shortfalls

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

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

$205 million / 5 years

Money Follows the Person Demonstration

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

$105 million / 5 years

IMPROVED LONG TERM CARE OPTIONS

Expand Long-Term Care Partnership Program

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

$10 million / 5 years

Other Provisions

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

$1.940 billion / 5 years

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

$100 million / 5 years

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

$55 million / 5 years

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

$30 million / 5 years

Subtotal Medicaid Spending: $3.722 billion / 5 years

MEDICARE

PART A

Rehabilitation 75% Rule

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

$105 million / 5 years

Extend and Improve Medicare Dependant Hospital (MDH) Program

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

$14 million / 5 years

PART B

Short Term Physician Payment Update

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

$10.8 billion / 5 years

Therapy Cap Moratorium

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

$710 million / 5 years

Hold Harmless Payments for Rural Hospital Outpatient Departments

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

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

$170 million / 5 years

ESRD Composite Update

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

$520 million / 5 years

Expand Availability of PACE in Rural Areas

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

$37 million / 5 years

International Volunteers

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

$20 million / 5 years

Medicare Payment Adjustment to Federal Qualified Health Centers

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

$40 million / 5 years

Subtotal Medicare Spending: $12.916 billion / 5 years

SUBTOTAL – GROSS SPENDING: $16.638 BILLION / 5 YEARS

PACKAGE TOTALS

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

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

Senate Finance Committee Reconciliation Package

ACHIEVES SIGNIFICANT BUDGET SAVINGS, REDUCES WASTEFUL SPENDING, TARGETS RESOURCES TO IMPROVE MEDICAID AND MEDICARE

Strengthens and Improves Medicaid and SCHIP:

- ***Directs resources where they are needed*** by achieving state and federal savings and improving access to health care for vulnerable populations.
- ***Promotes access to health care.***
  - Ensures continuity of health coverage for low income children by providing funding to states that face shortfalls in the State Children's Health Insurance Program (SCHIP) and expanding outreach and enrollment activities to get more kids covered. (Sec. 6051-6054.)
  - Expands Medicaid benefits through the Family Opportunity Act so that parents of severely disabled children can go to work and earn above-poverty wages while maintaining vital services for their severely disabled children. (Sec. 6041-6045.)
- ***Achieves savings, preserves services, protects beneficiaries.***
  - Helps state Medicaid programs obtain millions in payments owed by third party payors each year. (Sec. 6021.)
  - Ends drug manufacturer gaming of the system by closing the authorized generic loophole so that appropriate rebates are paid to states. (Sec. 6003.)
  - Balances savings from pharmacy payment changes with an increase in the rebate paid by drug manufacturers to 17%. (Sec. 6002.)
- ***Cracks down on Medicaid fraud and abuse.***
  - Encourages states to aggressively pursue Medicaid fraud by implementing state false claims acts, which at the federal level is the single most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud every year. (Sec. 6023.)
  - Requires employers who do business with Medicaid to have a false claims act education program so that those with evidence of fraud against Medicaid know they may pursue claims, on behalf of the government, in order to recover the stolen funds. (Sec. 6024.)
  - Dramatically increases resources to fight fraud and abuse in Medicaid, which will protect state and federal budgets and generate savings of at least 13:1 from this investment. (Sec. 6026.)
- ***Ends overpayments to pharmacies*** by reforming the broken AWP system used to reimburse pharmacists for prescription drugs. (Sec. 6001.)
- ***Protects Medicaid benefits for long term care coverage.***
  - Provides new options for private coverage of long term care through Long-term Care Partnerships. (Sec. 6012.)
  - Closes loopholes that permit the unscrupulous "gaming" of Medicaid eligibility rules to intentionally shelter assets to qualify for taxpayer-financed long term care coverage in Medicaid. (Sec. 6011.)
  - Promotes availability of PACE in rural areas. (Sec. 6113)

- ***Makes a down payment to respond to the health care needs of low income families affected by Hurricane Katrina*** by providing $1.8 billion to protect Medicaid benefits in Alabama, Louisiana, and Mississippi. (Sec. 6032.)

Preserves and Protects Medicare for Future Generations:

- ***Begins implementation of Value-based Purchasing in Medicare,*** which makes critical and necessary systematic changes to Medicare payment policies to encourage and reward quality and patient safety while controlling rising health care costs. (Sec. 6110.)
- ***Preserves access to health care*** for seniors and individuals with disabilities in Medicare:
  - All providers paid under the Medicare Physician Fee Schedule will see a 1.0% payment rate increase instead of a 4.4% payment cut in 2006. (Sec. 6105.)
  - Ensures beneficiaries are not denied access to critical inpatient rehabilitation facility services by freezing implementation of the "75% rule" at the 50% level.
  - Ensures all beneficiaries needing extensive therapy services are not denied these needed services by extending the moratorium on therapy caps. (Sec. 6108.)
  - Ensures access to ESRD facilities that provide high quality dialysis services to over 430 thousand beneficiaries with kidney disease. (Sec. 6107.)
- ***Fights waste in the Medicare program*** by preventing unnecessary payments to durable medical equipment suppliers for maintenance of capped rental equipment. (Sec. 6109.)
- ***Protects access for international volunteers.***
  - Waives the Part B late enrollment penalty for international volunteers and provides a special enrollment period. (Sec. 6114.)
- ***Protects access for rural beneficiaries.***
  - Extends the hold-harmless provisions for small rural hospitals and sole community hospitals from implementation of the hospital outpatient prospective payment system. (Sec. 6106.)
  - Extends the Medicare Dependent Hospital program, which provides financial protections to rural hospitals with less than 100 beds that have a greater than 60 percent share of Medicare patients. (Sec. 6101.)
  - Expands coverage of additional preventive benefits under Federal Qualified Health Centers. (Sec. 6115.)
- ***Preserves access to community hospital care*** by ending unfair competition from physician-owned limited service hospitals. Prohibits new physician-owned limited service hospitals from having any ownership or investment interest by physicians who refer Medicare and Medicaid patients to the facility. (Sec. 6104.)

Package Totals:

Medicaid	Savings: $-8.007 billion Spending: $3.722 billion Net: -$4.285 billion	**Medicare**	Savings: -$18.637 billion Spending: $12. 916 billion Net: -$5.721 billion

(Figures are over five years.)

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

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HEADLINE: New York Medicaid Fraud May Reach Into Billions

SERIES: PROGRAM DISORDER: Exploiting a Safety Net

BYLINE: By CLIFFORD J. LEVY and MICHAEL LUO

BODY:

It was created 40 years ago to provide health care for the poorest New Yorkers, offering a lifeline to those who could not afford to have a baby or a heart attack. But in the decades since, New York State's Medicaid program has also become a $44.5 billion target for the unscrupulous and the opportunistic.

It has drawn dentists like Dr. Dolly Rosen, who within 12 months somehow built the state's biggest Medicaid dental practice out of a Brooklyn storefront, where she claimed to have performed as many as 991 procedures a day in 2003. After The New York Times discovered her extraordinary billings through a computer analysis and questioned the state about them, Dr. Rosen and two associates were indicted on charges of stealing more than $1 million from the program.

It has drawn van services, intended as medical transportation for patients who cannot walk unaided, that regularly picked up scores of people who walked quite easily when a reporter was watching nearby. In cooperation with medical offices that order these services, the ambulettes typically cost the taxpayers more than $50 a round trip, adding up to $200 million a year. In some cases, the rides that the state paid for may never have taken place.

School officials around the state have enrolled tens of thousands of low-income students in speech therapy without the required evaluation, garnering more than $1 billion in questionable Medicaid payments for their districts. One Buffalo school official sent 4,434 students into speech therapy in a single day without talking to them or reviewing their records, according to federal investigators.

Nursing home operators have received substantial salaries and profits from Medicaid payments, while keeping staffing levels below the national average. One operator took in $1.5 million in salary and profit in the same year he was fined for neglecting the home's residents.

Medicaid has even drawn several criminal rings that duped the program into paying for an expensive muscle-building drug intended for AIDS patients that was then diverted to bodybuilders, at a cost of tens of millions. A single doctor in Brooklyn prescribed $11.5 million worth of the drug, the vast majority of it after the state said it had tightened rules for covering the drug.

New York's Medicaid program, once a beacon of the Great Society era, has become so huge, so complex and so lightly policed that it is easily exploited. Though the program is a vital resource for 4.2 million poor people who rely on it for their health care, a yearlong investigation by The Times found that the program has been misspending billions of dollars annually because of fraud, waste and profiteering. A computer analysis of several million records obtained under

the state Freedom of Information Law revealed numerous indications of fraud and abuse that the state had never looked into.

"It's like a honey pot," said John M. Meekins, a former senior Medicaid fraud prosecutor in Albany who said he grew increasingly disillusioned before he retired in 2003. "It truly is. That is what they use it for."

State health officials denied in interviews that Medicaid was easily cheated, saying that they were doing an excellent job of overseeing the program.

"This continues to be an area where we think that we have made substantial progress," said Dennis P. Whalen, executive deputy commissioner of the State Health Department. "But by no means are we sitting back and resting on the accomplishments that we have made."

Nonetheless, after being informed of The Times's findings, the Republican majority in the State Senate began a push recently to overhaul the system intended to protect Medicaid, which has been sharply reduced even as Gov. George E. Pataki and lawmakers have nearly doubled the program's budget over the last decade. The Democratic majority in the Assembly has remained on the sidelines. So has Mr. Pataki.

New York's Medicaid program is by far the most expensive and most generous in the nation. It spends far more -- now $44.5 billion annually -- than that of any other state, even California, whose Medicaid program covers about 55 percent more people. New York's Medicaid budget is larger than most states' entire budgets, and it spends nearly twice the national average -- roughly $10,600, more than any other state -- on each of its 4.2 million recipients, one in every five New Yorkers.

That generosity was born of good intentions when Gov. Nelson A. Rockefeller signed the program into law in 1966, following the state's tradition of creating big antipoverty programs. But Medicaid has become far more than the child of that altruism, having morphed into an economic engine that fuels one of the state's biggest industries, leaving fraud and unnecessary spending to grow in its wake.

There are no precise estimates for the cost to the state's program. Officials who have spent their careers chasing unscrupulous doctors and other providers in New York Medicaid say the losses to taxpayers here are probably higher than typical estimates of overall health care fraud. The Government Accountability Office in Washington and others have estimated that 10 percent of all health care spending nationally is lost to "fraud and abuse."

James Mehmet, who retired in 2001 as chief state investigator of Medicaid fraud and abuse in New York City, said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal. "So we're talking about 40 percent of all claims are questionable," Mr. Mehmet said -- an amount that would approach $18 billion a year.

Despite the debate, and the enormous sums at stake, Albany has never formally studied how much of the huge government investment in Medicaid is lost to criminal activity and abuse.

For their part, federal auditors have made New York a leading target for inspection as Washington has begun to crack down on Medicaid spending abuses. The federal government shares the cost of Medicaid with the states. In New York, it pays half the bill; Albany splits the rest of the cost with its counties and New York City.

The lax regulation of the program did not come about by chance. Doctors, hospitals, health care unions and drug companies have long resisted attempts to increase the policing of Medicaid. The pharmaceutical industry, which has spent millions of dollars annually on political contributions and lobbying in Albany, has defeated several attempts to limit the drugs covered by Medicaid; other states have saved hundreds of millions of dollars annually with such restrictions.

Earlier this year, after the Legislature agreed to impose such a limit and steer patients to generic drugs, the industry won a major loophole that allowed any doctor to substitute a higher-priced brand name with a simple phone call to the state.

Governor Pataki would not be interviewed about Medicaid for this article, and his aides referred questions to the State Department of Health, which is part of his administration. The health commissioner, Dr. Antonia C. Novello, also declined to be interviewed.

In defending the department's performance, Mr. Whalen, the executive deputy commissioner, said it had saved $9.3 billion in recent years through investigations of providers, a new computer system and other measures.

Asked repeatedly to provide an in-depth explanation of their claim of major savings or for any state records or other documentation to back up the figures, department officials would not supply any.

The Times investigation drew upon interviews with scores of current and former officials and health-care providers, including several former investigators who say they left the state disillusioned about its commitment to fighting fraud. A review of thousands of pages of state, federal and local records turned up repeated examples of cost savings and waste reduction used by the federal government and other states, but not by New York.

The investigation found audits on Medicaid spending that were brushed aside, and reports on waste that appear to have been shelved. There have been multiple warnings from watchdog agencies in New York and in Washington that indicate that the program is becoming increasingly porous. Prosecutors said state regulators had all but lost interest in bringing Medicaid thieves to justice, preferring instead to focus on recouping money through a few civil cases that have little deterrent value.

The Dentist

On the streets of Downtown Brooklyn, the young men would regularly fan out to drum up business for Fulton Gentle Family Dentistry.

"Got a Medicaid card?" one of the men shouted one day last November. "Come in and get your free CD player right now!"

But inside the office at 575 Fulton Street, Dr. Dolly Rosen seemed to make money whether or not the barkers did their job. She simply invented the dental work she did, according to state prosecutors alerted by The Times, and then billed it to Medicaid. And the breadth of her deception was enormous, the prosecutors said.

In 2003, less than two years after joining Medicaid, Dr. Rosen and an associate reaped $5.4 million, more than the amounts garnered by 98 percent of providers of all types in the entire New York program, according to the analysis of Medicaid billings.

Dr. Rosen claimed to be doing thousands of procedures every month, far more than any group of dentists could possibly perform, according to the analysis and interviews with dental experts.

In September 2003, she charged Medicaid roughly $725,000 for 9,500 individual dental procedures, many of them expensive and complicated, such as filling cavities that had rotted away much of the tooth. On a single day that month, she billed for 991 procedures, or more than 100 an hour in a typical workday.

In criminal complaints, an investigator said that more than 80 percent of the procedures for which the dental office billed were not performed, were unnecessary or were improper.

Dr. Rosen, who is 48 and lives in Manhattan, was licensed in 1995 and joined the Medicaid program in 2002. Since then, she has billed taxpayers more than $7 million.

She and her lawyer, Jeffrey A. Granat, would not comment.

The allegations of fraud in this case involved dentistry, but in the world of New York Medicaid, this kind of scheme is not unusual in any specialty, although it rarely occurs on such a scale. Many doctors, clinics, pharmacists and other

providers routinely exaggerate their billings, investigators say, often claiming to do more work than they really performed, or substituting an expensive procedure for a minor one. Others invent visits that never occurred.

"This is an age-old problem in New York," said Professor Malcolm Sparrow of Harvard, who has written extensively on health care fraud.

Albany stood by as Dr. Rosen's Medicaid billings went from zero in 2001 to $4 million in 2003, according to the analysis of her billing records.

Her 2003 billings were by far the highest of the 50,000 dentists or doctors in New York Medicaid -- $1 million more than those of the next highest, the records show.

Dr. Rosen had an associate in the Brooklyn office, Dr. Alex Silman, who sent his own bills to Medicaid. His billings showed a similar spike, rising to $1.4 million in 2003 from $115,000 in 2002, records show.

The Department of Health and the state attorney general's office blamed each other for failing to stop Dr. Rosen and Dr. Silman. The department said it had alerted the office that it should investigate possible improprieties with their practices. The office said the department had botched its inquiry.

Last fall, The Times brought its findings on Dr. Rosen and Dr. Silman to the attention of the Medicaid Fraud Control Unit, which is in the state attorney general's office. On March 24, prosecutors in the unit had Dr. Rosen and Dr. Silman arrested.

This month, the two were indicted on charges of first-degree grand larceny, each accused of stealing more than $1 million from the program. Another associate, David Ibragimov, who handled billing for the office, was also indicted. All three have pleaded not guilty.

The Times found Dr. Rosen's extraordinary billings using a laptop computer and commonly available software after spending a few hours studying New York Medicaid billings. And she was only one of scores of medical providers who turned up in the search with similar spikes in revenues, including three Brooklyn pharmacies, a Manhattan doctor and a Queens medical supply company. None had even been audited by the state.

The AIDS Drug

The woman said her name was Pamela Borden, but it was not. She told the doctor that she had AIDS and had been losing weight rapidly, but she did not have AIDS and was overweight. Yet when she walked out of Dr. Mikhail Makhlin's Brooklyn office in February 2002, she was clutching a prescription for a very expensive synthetic growth hormone intended to treat wasting syndrome, a side effect of AIDS.

The cost of the drug, entirely borne by taxpayers, was $6,400 a month.

The woman's real intention for the synthetic hormone, Serostim, had nothing to do with AIDS. Serostim is highly sought in a thriving black market among bodybuilders, who use it like a steroid to bulk up.

And Dr. Makhlin wrote far more prescriptions for Serostim than any other Medicaid doctor in the state, more than even prominent AIDS specialists with large practices. From 2000 to 2003, Dr. Makhlin prescribed 12 percent of all the Serostim purchased by New York Medicaid, costing the program $11.5 million, according to the Times analysis of Medicaid billings.

Medical records and interviews with state officials suggest that the woman's visit was part of an elaborate series of scams involving Serostim that stole tens of millions of dollars from New York Medicaid, long after other states realized what was going on. In 2000, New York Medicaid paid $7 million for Serostim, but the following year, after the schemes took off, the state spent $50 million on the drug.

The money was spent despite national publicity that had led other states to realize that Serostim was being abused, and to begin reining in their spending on the drug. Florida, for example, put restrictions on Medicaid payments for Serostim in 1997. The same year, federal officials broke up a Medicaid fraud ring that recruited people from Washington Square Park and paid them $20 to $50 to get Serostim illegally.

At the Health Department, Mr. Whalen and his aides described the department's handling of the drug as a success. They said they had detected the increase in Serostim prescriptions and required doctors to get special approval to prescribe the drug after January 2002. But billing records show that Dr. Makhlin wrote 80 percent of his Serostim prescriptions after the restrictions were adopted.

Serostim was approved in the mid-1990's to treat wasting syndrome, a side effect of AIDS. It is injected under the skin and causes a significant increase in lean body mass and weight.

The drug's manufacturer, Serono Laboratories, is the subject of an extensive federal criminal investigation into whether its executives paid kickbacks to doctors to prescribe Serostim. The company said it was cooperating with the inquiry.

Federal authorities would not say whether Dr. Makhlin had been questioned in the federal inquiry. What is clear is that Dr. Makhlin played a pivotal role in the epidemic of Serostim abuse on the East Coast. Even now, he retains his Medicaid privileges and medical license, and has not been a subject of a state criminal inquiry.

Dr. Makhlin, who was educated in Russia and arrived in New York in 1989, maintains that he was unwittingly duped by a parade of patients he tried to help, and that he received no benefit for prescribing a drug he considered necessary. But he and his lawyer, Nathan Dembin, will not explain how he ended up prescribing far more Serostim under Medicaid than any other doctor in the state. Thirty of his patients each received more than $100,000 worth of the drug.

The State Department of Health did not try to discipline Dr. Makhlin until late 2003, seeking to suspend him from the program for five years and fine him $164,000. But Dr. Makhlin has successfully fought the penalties, and retains his Medicaid privileges while an administrative law judge in the department weighs his case.

"I did not intentionally or knowingly violate any Medicaid regulations," Dr. Makhlin said in court papers. "I was simply exercising my best medical, professional judgment."

It was not until 2004 that the amount of Serostim purchased by New York Medicaid returned to where it was before the spike.

The true identity of the woman who received the prescriptions from him in February 2002 will probably never be known. The real Pamela Borden was found in Brooklyn and said her Medicaid card had been stolen in late 2001. She said no one from the state had contacted her about Dr. Makhlin.

The Ambulettes

With an immense public transit system and fleets of taxis and car services, New York is one of the nation's easiest cities to get around in, even for the old and the sick. But instead of reimbursing patients for a $2 bus ride to their doctor's office, or a $10 fare for a car service, Medicaid typically pays $25 or $31 each way for these rides, and it adds up.

New York Medicaid paid far more than any other state to get patients to hospitals and doctor's appointments: $316 million in 2003. The state accounts for about 15 percent of all the nonemergency Medicaid transportation spending in the country, according to a 2001 report by the Community Transportation Association of America, and spends more than the next three states -- California, New Jersey and Florida -- combined.

The largest chunk of the $316 million spent on transportation went to some 450 ambulette services, about a fifth of which are clustered in Brooklyn.

And much of that spending appears to be entirely unnecessary.

That was clear on a recent afternoon in southern Brooklyn, when an elderly woman strolled out of a doctor's office and clambered into the front seat of a van owned by M.J. Trans Corporation, a medical transport company that billed Medicaid for more than $2 million last year. After a 25-minute ride across the borough, she got out in front of her apartment, again without help, and walked inside.

The van is called an ambulette, and Medicaid is supposed to pay for it only when a patient cannot walk without help or requires a wheelchair. In fact, the state refers to the service as an "invalid coach." But on three days spent following M.J. vans over several months, a Times reporter found that almost all of the company's passengers walked easily, without assistance. The pattern was repeated as recently as last month.

Many doctors, therapists and clinics regularly order ambulette transportation for their patients when cheaper alternatives should have been used instead, according to a 2003 audit of Medicaid transportation expenses in New York City by the state comptroller, Alan G. Hevesi.

The state has known about abuses in the ambulette industry for years, and about the neighborhoods where kickbacks and other questionable activity takes place. In the early 1990's, regulators discovered that a quarter of the entire state's transportation billings were coming from Brighton Beach, Brooklyn, where a few companies had cornered the market with an elaborate set of kickback arrangements, according to a 1996 report on waste in the industry by the New York City public advocate's office. The report, along with others on the industry, suggested that many ambulette services billed Medicaid for rides that were never delivered.

But even though these schemes date back years, government records show that the state has spent almost no time looking into the ambulette industry. Prosecutors and outside auditors say that fraud, including the kind in which van services pay kickbacks to medical offices that order rides, remains rampant.

Only five ambulette providers who billed Medicaid in the 2004 state fiscal year had even a portion of their billings audited by state officials, according to state records.

Mr. Whalen, the senior state health official, maintained that the industry was properly regulated, adding that in an effort to detect fraud, the department had begun requiring providers to supply more information on their operations. "Transportation and ambulettes are on our radar screen as an active area of inquiry," he said.

One of the ambulette companies that has never been audited is M.J. Trans, though it had more billings per vehicle than almost any other of its size in the state. Its Medicaid billings jumped to more than $2 million annually in 2004 and 2003 from $700,000 in 2001.

Yuri Levitas, a manager at the ambulette company, said none of its billings were illegal or improper.

"We do only legal business," he said.

In fact, an analysis of its Medicaid billings raises questions about whether the company is abusing the system, or possibly allowing individual patients and doctors to do so. The records indicate that the company has business relationships with medical practices in southern Brooklyn that often bill Medicaid for what seem an inordinate number of trips.

A doctor at a pair of clinics that specialize in pain relief and massage therapy often ordered more than 90 trips a day, as did a colleague of his.

At another doctor's office, Medicaid was billed 153 times by M.J. for transporting a single passenger in 2003, or essentially two or three times a week for an entire year. Another recipient went 152 times. Still others made the trip in M.J. vans more than 130 times.

M.J. Trans said most of those rides were ordered by the office for recipients receiving physical therapy there.

"They order, and we go," Mr. Levitas said, adding that he was not responsible for ensuring that the rides were necessary.

Several physical therapists expressed skepticism that anyone would need so much therapy.

"There is always the difficult or complicated case here and there that requires extensive and intensive therapy, but as a general rule, 153 visits would seem excessive," said Gabriel E. Yankowitz, a physical therapist for more than two decades and an official with the New York Physical Therapy Association.

But Gail Bednik, the manager of the office, at 280 Quentin Road in Gravesend, that is in the records as having ordered the 153 rides, said there was nothing surprising about the patients who took scores of ambulettes annually at taxpayer expense.

"It's old people," Ms. Bednik said. "They want to come every day because they're bored at home."

The School Districts

In just a few hours on a single day in September 2000, a senior official in the Buffalo school system wielded a rubber signature stamp and cost millions of dollars in questionable Medicaid payments for children.

Her name was Sheryl Carswell, and at the time she was Buffalo's director of special education. Moving her rubber stamp with assembly-line speed that day, she put 4,434 special-education students on the Medicaid rolls by recommending that they receive speech therapy, according to a federal audit. That represented nearly 60 percent of the district's special-education population, roughly twice the national average of special-education students who require speech therapy.

Yet she had not evaluated more than a few of those 4,434 students, according to the audit, issued by the inspector general of the federal Department of Health and Human Services, nor had she reviewed their case files.

Ms. Carswell was not stealing the money for herself or maliciously abusing the system. Instead, she was doing business in a way that has become increasingly common in Buffalo, New York City and around the state, collecting millions of Medicaid dollars for her school district by putting students into health and speech programs, often without any apparent effort to see if the students really needed them.

All told, the schools in New York State misspent $1.2 billion in Medicaid payments on speech services from 1993 to 2001, federal audits concluded.

In an interview, Ms. Carswell said she was simply following longstanding school procedures. "I just filled out the paper," she said. "Nobody bothered me about it."

Since 1990, schools in New York have been able to bill Medicaid for speech, hearing, and other school health services, and the state has become the most aggressive in the nation at taking advantage of this benefit. Around the state, school districts short on cash discovered in Medicaid a new revenue source. As a result, in recent years, school health services have become an $800 million annual expense, rising to the point that New York accounts for 44 percent of this type of Medicaid spending nationally, according to federal statistics.

Licensed speech professionals quickly realized what was happening, and many have complained that schools are cutting corners and using the funds to pay for services that have nothing to do with helping poor children speak or hear better. "We have been seeing a lot of very suspicious billing practices in New York," said James G. Potter, director of government relations and public policy at the American Speech-Language-Hearing Association, which has 118,000 members. "At times, folks in the schools have been just plain making it up out there when it comes to billing."

This spending was routinely approved by the state, but the federal government was not as credulous. The questionable spending touched off two audits in 2002 by the inspector general, and a civil inquiry by the federal Department of Justice.

In an audit released last month, the inspector general revealed that in New York City schools, 86 percent of the Medicaid claims that were paid from 1993 to 2001 lacked any explanation for why the services had been ordered or violated other program rules. In Buffalo and other upstate schools, the auditors concluded that the figure was 56 percent for the same period, according to a report released last year.

The audits should not have come as a shock. In the mid 1990's, a private consultant told New York City school officials that their record-keeping was in such disarray that 51 percent of attendance forms for speech students could not be found. Yet school officials did not change their practices, according to the subsequent audit.

When the upstate school districts found out about the audits in 2002, some tried to cover their tracks, the inspector general found. Digging through their filing cabinets, they backdated records to justify Medicaid spending for services performed as many as eight years earlier.

Now, after the audits, federal officials say Washington is likely to begin demanding its money back, and so this misuse of Medicaid money could haunt either the districts that spent it, or the state, or both. Many districts are worried that the repayment could devastate their education budgets.

School officials, including those in New York City, have sharply disputed the audits, and called for them to be withdrawn.

The Justice Department suspended its civil inquiry after complaints from Senator Charles E. Schumer, Democrat of New York, and other politicians, and federal health officials have agreed, for now, not to seek restitution from school districts. But the state itself could still be liable, and could then in turn penalize the districts.

Pataki administration officials say Washington has never been clear about what kind of school services it will pay for and how children should be referred to these programs, accusing Washington of changing the rules.

"There is no question that school districts actually provided health services to poor, disabled children," wrote Kathryn Kuhmerker, a deputy health commissioner, in her response to the upstate audit.

The state, however, did not meet its responsibility to make sure the money was properly spent, the federal audit found. The State Health Department reviewed the books of the Buffalo district only once from 1993 to 2001, and told the district its records were "well organized."

The Executives

Among the biggest beneficiaries of the Medicaid program have been executives of the state's nursing homes and clinics, many of whom earn substantial salaries and profits from the program.

According to records obtained from the Health Department under the Freedom of Information Law, 70 executives of nursing homes and clinics personally made more than $500,000 in 2002, the last year for which figures are available. Twenty-five executives made more than $1 million.

For the nursing home executives, that money was earned in salaries and profits, most of which came directly from the daily fee that Medicaid pays for caring for each low-income patient, usually in the range of $200. Salaries are earned by employees of the homes, and profit is earned by owners, although owners are often executive directors or chief executives of the homes, allowing them to benefit in both ways.

Consider three homes in the Bronx. The operator of the Laconia Nursing Home, which receives 90 percent of its revenues from Medicaid, earned $3 million in salary and profit. At the Grand Manor Nursing Home, also 90 percent financed by Medicaid, the operator and three family members earned a total of $2.4 million in salaries and profit. The owner and operator of the Morris Park home, 75 percent financed by Medicaid, took in $1.5 million in salary and profit.

Advocates for nursing home residents acknowledge that the homes' operators and executives are entitled to make decent profits and salaries. But the advocates insist that it is unseemly for the profits and salaries to reach such high levels, given what the advocates contend is the industry's longstanding record of poor care. They point out that at New York nursing homes, the staffing levels are lower than the national average, a crucial indicator. All three of the Bronx homes have staffing levels lower than the national average, according to federal statistics.

"It's unconscionable to give yourself high salaries and not give some more money to hire people so some of these quality problems can be dealt with," said Cynthia Rudder, executive director of the Long Term Care Community Coalition, an advocacy group for nursing home residents.

Trade groups representing nursing homes counter that most homes in the state are actually in financial distress because Medicaid does not pay enough.

Many hospital executives in New York also receive high salaries, but hospitals earn significant revenues from sources other than government social programs, including H.M.O.'s and private insurance. The 550 public, private and nonprofit nursing homes around the state, by contrast, earn more than two-thirds of their revenues from Medicaid, taking in roughly $6 billion last year from the program, according to state records. Many clinics receive most of their revenues from Medicaid as well.

Morris Berkowitz, operator of the Morris Park home, said he deserved his profits because he worked long hours and provided excellent care.

"Do you know how much I have invested in this place?" he said. "A lot of money. And I am constantly investing in this place."

Earlier this year, after residents repeatedly wandered from Morris Park, federal and state officials accused the home of grievously poor supervision, and it was fined $86,000.

Mr. Berkowitz said the home had done nothing wrong. "It was a political thing, and we got caught up in it," he said. "People with power, they abuse their power."

Martin Liebman, operator of Grand Manor, said it was misleading to focus on salaries and profits.

"This is a family-owned business," said Mr. Liebman, an officer of the state trade group of private nursing homes. "I'm third generation in the business. We have taken care of thousands of residents and given quality care for many, many years."

Barry Braunstein, operator of the Laconia home, did not respond to three calls seeking comment.

Besides their high salaries, some executives profiting from Medicaid were also taking part in another tradition: cheating the program.

In 2002, the two owners of the AllCity Family Healthcare clinics in Brooklyn collected a total of $1.4 million in salaries, according to state records. Last year, the company was forced to return $6 million to the state, and one of its owners, Rossia Pokh, pleaded guilty to grand larceny in a case brought by the attorney general.

At the AllCity clinics, it turns out, thousands upon thousands of the Medicaid claims were fraudulent.

Medicaid in New York

This is the first of a series of articles that will examine the security, the effectiveness and the cost of New York's Medicaid program, the largest of its kind in the nation and the state's biggest expense.

Tomorrow: How the state's protections against fraud have grown increasingly frail.

URL: http://www.nytimes.com

GRAPHIC: Photos: Dr. Dolly Rosen, a dentist, with her lawyer, Jeffrey A. Granat. She is charged with Medicaid fraud. (Photo by Andrea Mohin/The New York Times)(ph. A1)
$5.4 Million for Dental Work in 2003 -- A barker lured customers to Dr. Dolly Rosen's Brooklyn office, which had extraordinarily high Medicaid billings. (pg. B4)
$2 Million for Brooklyn Rides Billed by an Ambulette Company in 2004 -- Though intended for patients who need help walking, M.J. Trans Corporation's medical vans regularly transported people who required no assistance.
$1.5 Million in Salary and Profit to Nursing Home Executive -- The Morris Park Nursing Home in the Bronx, which receives 75 percent of its revenue from Medicaid, was fined for poor supervision. (Photograph by Andrea Mohin/The New York Times)(pg. B5)Chart: "All in a Day's Work"A Brooklyn dentist, Dolly Rosen, was paid by New York Medicaid for 991 procedures on a single day in September 2003, costing $63,967. Here are the claims.(X) = multiplyFilling X 454 = $41,803Cleaning X 178 = $10,249X-ray X 203 = $4,588Examination X 89 = $2,566Tooth removal X 35 = $2,070Dentures X 6 = $1,702Tooth sealant X 11 =$387Other X 11 = $387(Source by State Medicaid records The New York Times)(pg. B4)Chart: "A Growing Burden"New York's annual Medicaid spending dwarfs that of other states, including California, which has far more recipients . . .N.Y.RECIPIENTS (millions): 4.2SPENDING (billions): $44.5Calif.RECIPIENTS (millions): 6.6SPENDING (billions): 33.4Tex.RECIPIENTS (millions): 2.8SPENDING (billions): 17.3Fla.RECIPIENTS (millions): 2.1SPENDING (billions): 14.4Pa.RECIPIENTS (millions): 1.7SPENDING (billions): 13.3Ill.RECIPIENTS (millions): 2.0SPENDING (billions): 11.2OhioRECIPIENTS (millions): 1.7SPENDING (billions): 10.6. . . and it spends far more even after adjusting for the numbers of recipients and state residents.SPENDING PER RECIPIENTN.Y.: $10,644Pa.: 7,626Fla.: 6,706Ohio: 6,206Tex.: 6,158Ill.: 5,818Calif.: 5,038SPENDING PER CAPITAN.Y.: $2,314Pa.: 1,072Calif.: 930Ohio: 921Ill.: 881Fla.: 827Tex.: 769New York's spending on Medicaid has risen rapidly . . .Graph tracks total spending on Medicaid by New York State since 1995.. . . and is consuming an increasing proportion of the state's budget.Graph tracks Medicaid spending as a percentage of all New York State spending since 1995.Despite this growth, the New York State Department of Health has been recovering less from fraud and abuse investigations.Graph tracks fraud and abuse recoveries as a percentage of Medicaid budget since 1997.(Sources by State Medicaid programs
New York State Division of the Budget
Centers for Medicare and Medicaid Services
U.S. Census Bureau)(pg. B4)

LOAD-DATE: July 18, 2005

1. Republican to Propose Bill On Medicaid Fraud Cases , The New York Times, August 3, 2005 Wednesday, Late Edition - Final, Section B; Column 4; Metropolitan Desk; Pg. 3, 686 words, By MICHAEL LUO

2. Spitzer Hones Campaign Themes as G.O.P. Seeks Candidate for Governor, The New York Times, July 29, 2005 Friday, Late Edition - Final, Section B; Column 1; Metropolitan Desk; Pg. 5, 789 words, By AL BAKER, ALBANY, July 28

3. Stopping Medicaid Fraud, The New York Times, July 26, 2005 Tuesday, Late Edition - Final, Section A; Column 4; Editorial Desk; Pg. 16, 174 words

4. Spitzer Makes Push for New Laws to Help Punish Medicaid Fraud, The New York Times, July 21, 2005 Thursday, Late Edition - Final, Section B; Column 1; Metropolitan Desk; Pg. 3, 521 words, By MICHAEL LUO

5. GOVERNOR ADDS MUSCLE TO CURB MEDICAID FRAUD, The New York Times, July 20, 2005 Wednesday, Late Edition - Final, Section A; Column 2; Metropolitan Desk; Pg. 1, 1188 words, By CLIFFORD J. LEVY and MICHAEL LUO; Michael Cooper contributed reporting from Albany for this article.

6. As Medicaid Balloons, Watchdog Force Shrinks, The New York Times, July 19, 2005 Tuesday, Late Edition - Final, Section A; Column 1; Metropolitan Desk; Pg. 1, 3461 words, By MICHAEL LUO and CLIFFORD J. LEVY

7. New York Medicaid Fraud May Reach Into Billions, The New York Times, July 18, 2005 Monday, Late Edition - Final, Section A; Column 5; Metropolitan Desk; Pg. 1, 5510 words, By CLIFFORD J. LEVY and MICHAEL LUO

Record

AARP

October 25, 2005

The Honorable John Kerry
United States Senate
304 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Kerry:

AARP supports your amendment to the Senate Finance Committee's 2006 Budget Reconciliation bill to exclude the cost of the nearly $11 billion payment increase for physicians from the determination of the Medicare Part B premium.

Over the last three years, Medicare beneficiary premiums have increased 50 percent, or roughly $30 a month. Part B premiums will increase by another 13 percent in 2006.

The Congressional Budget Office estimates that the physician payment update included in the reconciliation bill will cost nearly $11 billion over five years. Even with some of the offsetting Part B spending reductions included in the bill, beneficiaries will still pay over $1 billion in higher premiums to finance the increase in physician reimbursement. Furthermore, beneficiary coinsurance will also increase due to higher physician reimbursement.

If Part B premiums continue to escalate, many beneficiaries will find it difficult to pay for the medical services they need. AARP believes your amendment is necessary to ensure health care does not become unaffordable. We look forward to working with you and your colleagues on both sides of the aisle to protect Medicare beneficiaries from burdensome out of pocket costs.

Sincerely,

David P. Sloane

David P. Sloane
Senior Managing Director,
Government Relations and Advocacy

Statement of the Honorable Orrin G. Hatch
Consideration of Budget Reconciliation Legislation
Senate Finance Committee
October 25, 2005

Mr. Chairman,

This is a very serious business and I have to say the Committee was charged with close to an impossible task.

You and your capable staff faced pressures from all directions, and it is only because of your leadership as Chairman of the Finance Committee that we are here today, considering the budget reconciliation mark.

That being said, this package is not perfect. In fact, while there is much in the package with which I agree, I still have several concerns.

While the mark achieves our goal of finding $10 billion in savings, it also spends a significant amount of money when our national focus needs to be on saving money. The most updated number that I have for spending in this legislation is over $16 billion. That is a lot of spending.

I also am troubled by how we are paying for this spending – close to $5 billion comes from eliminating the MedicareAdvantage Regional Plan Stabilization Fund – something I strongly oppose. Mr. Chairman, you know how hard we fought to include the stabilization fund in the Medicare Modernization Act to help states, like Utah, that have trouble attracting and keeping managed care plans.

If Utah's experience with the Medicare+Choice program is any indicator, this fund is necessary. The stabilization fund helps provide incentives to MedicareAdvantage plans so they will continue providing services in certain regions of the country. I do not understand why on earth we would be getting rid of this fund, especially before the Medicare drug plan program is even operational. It just does not make good policy sense and that is why I oppose it.

When the President first recommended reducing the rate of growth in Medicaid by some $60 billion over the next decade, many Utahns were up in arms. I shared those concerns.

However, many were assuaged by the fact that the majority of savings were projected to come from tightening up areas like assets transfer and fraud and abuse, areas that do not have a direct impact on beneficiary coverage.

It is disappointing that we have ended up with limited Medicaid fraud and abuse provisions in this bill. Mr. Chairman, you have been a true leader in eliminating fraud and abuse in government programs so I am certain that you share my concerns. I want to remind my colleagues about the article which appeared in the New York Times on July 18, 2005 about the fraud and abuse occurring in the New York Medicaid program – claims of approximately $18 billion per year in the state of New York are questionable.

Mr. Chairman, I would like to make this article part of the record?

As the Senate Finance Committee, we have a responsibility to address these issues facing the Medicaid program and, if we do not, we have failed the American people miserably.

Likewise, I am extremely disappointed that more extensive restrictions on asset transfers and intergovernmental transfers were not included in the package. Both policies

would have severely curtailed activities where individuals and some state governments have intentionally defrauded the Medicaid program.

I have heard the arguments about why we shouldn't have included them in the proposal. Mr. Chairman, I don't buy those arguments.

As far as asset transfers are concerned, I do not want to hurt innocent seniors who transfer their assets and then become sick. In Utah, we have appeals mechanisms in place to protect seniors facing those circumstances. We try to be fair in Utah and I am certain that other states in the country follow similar practices.

The arguments about why we should not include the IGT policy are equally unconvincing. Just because the Centers of Medicare and Medicaid Services (CMS) is addressing this issue administratively, I would like to know what is wrong with fixing this problem, once and for all, right now? I do not understand why we would permit states to continue these practices and I believe both asset transfers and IGT transfers need to be included in the legislation.

More aggressive legislating in these three areas would preclude some of the other reductions necessitated in this bill, such as those for the stabilization fund.

The provisions on payment for prescription drugs under the Medicaid program are another deep concern of mine. You know my specific criticisms of these policies and I appreciate your willingness to work with me.

Let me say that while I agree that changes are necessary and, in fact, needed, I am very worried about the current approach included in your proposal. I am not sure that the new definitions created for Average Manufacturer's Price (AMP), Weighted Average Manufacturer's Price (WAMP) and the new formula which you created for the Federal Upper Payment Limit (FUL) will address the criticisms of the current policy. In fact, these new definitions could make the situation worse.

For example, I am very worried about the impact of changing the Federal Upper Payment Limit formula. Why is it necessary to price each individual drug instead of having an aggregate cap to give the states and CMS some flexibility? The policy in the mark would direct CMS to collect price information of over 55,000 drugs (which I believe is impossible since these prices are always changing).

I also am worried about the states being given this sensitive information about drug pricing --- I believe that you could run into serious problems with distributing propriety information

Therefore, I urge you to continue discussions with the various stakeholders who have a vested interest in making this policy work – in particular, the pharmacists and the pharmaceutical companies.

I was going to offer amendments to address my concerns with these matters but since I have your commitment that you will work with me, I will withdraw them.

Mr. Chairman, I commend you on bringing a proposal forward and I will support you on moving this package through the Senate Finance Committee. However, I want you and other Committee members to understand my concerns and that I intend to continue working with you on improving the package. I know this was an extremely difficult task for you and I appreciate your hard work.

Statement of Senator Olympia J. Snowe
Senate Finance Committee Entitlement Reform Markup
October 25, 2005

Mr. Chairman, I want to congratulate you on putting together a reconciliation package that has been subject to immense pressure and scrutiny. At a time when our current fiscal climate exhorts us to exercise restraint on both the spending and revenue sides of the ledger, we are faced with increasing demands upon Medicare and Medicaid, two bedrocks of American health care, as well as the recent unexpected natural disasters.

While I have long supported fiscal restraint and good government, I stated early on in this process that I could not support a package that achieved savings at the expense of our seniors and neediest citizens. I further felt that any savings must be spread evenly across both Medicaid and Medicare, without overly-penalizing either program. *I firmly believe that we must not create savings by limiting benefits that aid the least advantaged and most vulnerable Americans.*

I believe this package meets that test: these savings are derived *not* from reducing benefits but rather from making needed reforms and eliminating unneeded spending, while also including spending for initiatives that *bolster* and *strengthen* the programs. They are also spread equitably, with $4.3 billion in savings coming from Medicaid, and $5.8 billion derived from Medicare. This plan is strong for beneficiaries, and it is strong fiscally.

First, this package protects the 53 million low-income pregnant women, children, individuals with disabilities, and seniors who rely upon Medicaid – including 300,000 of them in my home state of Maine. At a time when uninsured Americans number more than 45 million, the Medicare program is *essential* in assuring *access* to health care for them and the 35 million seniors

and 6 million Americans with disabilities at an affordable price. I *thank* the Chairman for his *willingness to address my concerns that home health care not be impacted.* ....as well as my request to provide reimbursement to nonpublic community psychiatric hospitals for *emergency care for Medicaid-eligible adults* through a three year demonstration project to be established in ten states...and by preserving access to primary and preventative care services for Medicare beneficiaries through *improved payments to community health centers* for these new benefits.

Rather than subjecting these fellow citizens to cuts in their benefits, the Finance Committee package wisely achieves savings by reforming the prescription drug payment policies for pharmacies. These savings are balanced with increased rebates from pharmaceutical manufacturers and provides additional resources to target fraud, waste, and abuse...and I am pleased to note that we met our target *without changing the existing asset transfer date rules.* Under this package we also will begin to develop and implement value-based purchasing programs under Medicare with quality measurements for hospitals, physicians, and other health providers, and eliminate unnecessary incentives for the Medicare Advantage program.

Second, this package achieves meaningful savings in Medicare, again without taking away from our senior citizens. The Chairman's plan requires that all providers paid under the physician's fee schedule – doctors, nurses, and other health care practitioners – see a payment increase of 1 percent for 2006, instead of the 4.4% decrease they were scheduled to receive. This keeps medical professionals in business and ensures access to health care for all

We also ensure that Medicare beneficiaries have access to inpatient rehabilitation services by freezing the implementation of the "75% rule" at the 50% level for the next two years, so that facilities are not required to turn away beneficiaries who desperately need these services in order to meet an

artificially high and unrealistic case load mix – this has been a particular concern in Maine. And, for rural areas in the state , the current "hold harmless" provisions will be extended until 2007 to provide financial protections to rural hospitals with no more than 100 beds and sole community hospitals located in rural areas.

In closing, I would underscore that in exercising sound fiscal judgment, we must look ahead at the impact of this budget next year and beyond. This will be no easy challenge, and I look forward to working with Chairman Grassley and my colleagues to ensure that we do not undermine our essential health care programs in the name of savings.

October 25, 2005

Opening Statement
Finance Budget Reconciliation Mark Up
Senator Jon Kyl

Thank you, Mr. Chairman, for your leadership in this budget-reconciliation process and for delivering a package for us to consider. I appreciate your willingness to work with me and with my staff, and I am committed to continuing to work with you to achieve good policy and to meet the goals set forth by the Budget Committee.

As we go through this process, I want to underscore how necessary it is to reform the Medicaid system. When we started in March of this year, I thought we had the objective of reaching the budget targets set before the Committee, while also reducing federal Medicaid spending. We are aware of how unwieldy the Medicaid system is now, and the future looks to be just as problematic.

Today, Medicaid has ballooned to become the federal government's second largest health-care program. With the federal government matching anywhere from 50 percent to 83 percent of the Medicaid expenditures incurred by a state, Medicaid accounts for more than 40 percent of federal grant funding to states.

Medicaid funding also weighs heavily on many states. My Senate colleagues and I have discussed the fiscal challenges facing the states due in large part to Medicaid spending and growth. As states have sought to expand their programs and extend Medicaid services to optional populations, the challenge of

paying for those new populations or those new services has at times been overwhelming.

When we started this process, I looked forward to the development of a budget-reconciliation package that enacted good policy: A proposal that continues and strengthens care for those who needed it, one that fulfills the promise we made in 1965 to assist those in need. And I looked forward to honoring our commitment to impose fiscal responsibility on this program, to eradicate the fraud, waste, and abuse that have crept into Medicaid.

I have reviewed the Medicaid policies in this package, some of which I support and some of which cause me concern.

For example, I am troubled that one way we are offsetting Medicaid costs is raising more money from pharmaceutical companies and the pharmacists. Out of the $7.577 billion in savings, $4.570 billion – 60 percent – comes from pharmaceutical payment changes. Coupled with the authorized generic provisions and the increase in the drug rebate percentages, the pharmaceutical industry has been singled out for $5.86 billion of the Medicaid savings in this package. So, little Medicaid reform; but a politically correct "pay for". We're on the way to European style drug pricing, and it is a journey we will regret starting.

It was the decision of the Chairman to seek more offsets from Medicare, so let me touch on a couple of issues related to that program. First, we cannot fulfill

the promise to the poor of this country or our seniors unless doctors, hospitals and health plans are compensated appropriately. Traditionally, the federal government has not been a good, reliable payer for health-care services. The exit of many HMOs in the late 1990s and physician retirements are just two of the problems caused by the government's erratic and inadequate reimbursement system.

Since Medicare was included in this budget-reconciliation package, it is the appropriate place to provide adequate reimbursement to physicians in 2006. In the Medicare Modernization Act of 2003, we provided a 1.5 percent increase in 2004 and 2005, far below the inflation rate, let alone the health inflation rate. Without congressional action, physicians would face a cut in their reimbursement of 4.4 percent. Physicians from my state and across the country have told me that this severe cut would compromise patient access to services. As we continue to expect more from our providers, we continue to pay them less. We can't do this with others who provide the government with services. Physicians should also be able to have stable, predictable payments, without the need for Congress to step in correctively each year. So in addition to the work we are doing, Mr. Chairman, I also want to work with you and other Senators to work with the administration to develop a long term strategy for properly paying all health care providers.

I am also concerned that we have not adequately considered the best way to implement the "pay-for-performance" system. Second guessing the professionals

who provide care in order to determine how much to pay them could lead to less quality care (in order to save money); and by withholding one percent of payments each year until the next year, the government is taking advantage of the 'float' to the disadvantage of the providers.

Finally, I must mention the inclusion of the stabilization fund as a "savings" mechanism in this package. The need for the stabilization fund is not in the first year of the new program, but later, when conditions may require it.

With the advent of the new prescription-drug plan and the new, regional Medicare Advantage plans, Congress wanted to make sure that enrollees would not have to contend with the exit of plans from the market if and when market conditions became more difficult for plans. We saw that the exit of HMOs left states and rural areas with few or no options for managed-care coverage. We hoped to avoid that in this new program by setting aside funds that could be tapped into by regional plans in the event that regional plans were considering withdrawing. We included criteria for use of this fund and we certainly hope that we will continue to see plans remain in the regions without assistance - but it is our responsibility to plan for even the worst case – the exit of PPO plans for entire Medicare regions.

To pull this fund out of the Medicare Advantage program before it even begins sends the wrong message to regional plans – they have to worry once again about the government's commitment to pay appropriately.

Mr. Chairman, I look forward to working with you as this budget reconciliation moves forward so that we can fulfill our promises to the Medicaid and Medicare programs, and especially to the intended beneficiaries who rely so much on these services. Thank you.

STATEMENT of SENATOR GORDON H. SMITH
FINANCE COMMITTEE RECONCILIATION MARKUP
OCTOBER 25, 2005

Last March, we began a long and contentious process toward reconciling the budget with the wide-ranging priorities of the American people. Today, we will pass an important milestone in that process dealing with the future of health care coverage for some of our most vulnerable citizens. I believe the proposal we consider today strikes the right balance in meeting the requirements of the budget, while doing so in a manner that does not harm Medicaid or Medicare beneficiaries or jeopardize their access to care and coverage.

I know that throughout this day I will have to vote against proposals that I normally would support. I believe my constituents in Oregon will understand that I am willing to do so to protect the delicate balance that Chairman Grassley and Majority Leader have helped secure.

As with all legislation, some may object to the policies incorporated into this proposal, but when taken in its totality I believe this legislative package strikes the right balance between eliminating fraud, waste and abuse and protecting people. It also includes new ideas such as the one created by my bill – the Money Follows the Person Act.
This proposal is modeled after Oregon's innovative program that removes the bias from Medicaid that traditionally pushes people into nursing homes. Instead, we will allow states to care for people in their homes and communities. Over time, not only will we enhance individuals' quality of life, but I believe our state and federal coffers also will benefit.

However, as I said, the path has not been traveled without controversy or disagreement. But, after all, we are discussing two programs that taken together provide health care coverage to almost 100 million Americans – that is one-third of the entire population in the United States.

What's more, these programs – Medicaid and Medicare – help the oldest, sickest, poorest and frailest among us. Therefore, I am heartened that this process has been so arduous because it means that we did not enter into decisions rashly or without thought. Instead, we were deliberate and cautious and this plan is indicative of the care we took.

I know that my colleagues on the other side of the aisle are likely to oppose this package. But I don't believe it is because of the policies that are included, rather they have concerns that we could have spent more money and expanded access further. To this I urge caution. Spending money means cutting funding from the programs and risking diminished access to care.

I am disappointed that this bill will not receive bipartisan support because I truly believe it should. In the end the most important marker of our success is how the proposal translates to the average beneficiary. And against that measure, I am confident it will be scored a success.

Hubert Humphrey once said "the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life – the sick, the needy, and the handicapped." In light of this standard, the reconciliation package that the Finance Committee will pass today is a success and I offer it my full support.

I thank Chairman Grassley for his tenacious effort to compile this bill and to Majority Leader Frist for his hard work. It was not easy, but I appreciate your willingness to work with me to reach the common ground that was so important throughout this process. I believe it has resulted in an outstanding bill.

Thank you.

Open Executive Session Markup to achieve the Senate Finance Committee's Budget Reconciliation Instructions to Reduce the Growth of Outlays as Contained in H.Con.Res.95

Statement of U.S. Senator Rick Santorum

Tuesday October 25, 2005

Working together we can strengthen the Medicaid program so that it continues to serve its primary purpose, to provide benefits to the most vulnerable Americans. We can and must work together to ensure that federal and state choices with regard to Medicaid are policy-driven and do not overburden already strained budgets. Most importantly, we must ensure that policies do not harm beneficiaries, and in fact help beneficiaries through a stronger program that gets resources to people in need, rather than squandering precious taxpayer dollars on fraud, waste, and abuse.

Medicaid is the fastest growing, and in many cases already the largest, line item on most Governors' budgets. The bipartisan National Governors Association (NGA) has strongly expressed that the Medicaid program is unsustainable in its current form. To its credit, the NGA has eschewed political rhetoric and focused on finding solutions to the Medicaid crisis. The NGA Medicaid Working Group, comprised of 13 Democrat and Republican Governors, recommended a variety of changes to ensure Medicaid is strengthened and sustained. Responding to this request, the Senate Finance Committee members and staff have been diligently working through a very policy-driven, deliberative process to find savings to the program.

On July 18th of this year, *The New York Times* published a shocking article that underscored the need for policies that combat fraud, waste, and abuse. A yearlong investigation of the program found that about 40% of the claims, representing approximately $18 billion annually, were misspent because of fraud, waste, and abuse – billions of dollars that could have been used to better serve the people who rely on Medicaid. Many of the policies that the Senate Finance Committee considered would give states the tools and incentives to address fraud, waste, and abuse. Everyone wins when fraud, waste, and abuse are eliminated - beneficiaries, taxpayers, and the budgets of state and federal government.

This budget reconciliation process affords us a meaningful opportunity to put in place good policy that strengthens this vital safety-net program. I have worked closely with my fellow Finance Committee members to put together a package that does not harm beneficiaries one bit – in fact, savings are put back into programs that help those most in need.

I thank the Chairman and his staff for working with me on a number of provisions that are vitally important to the Commonwealth of Pennsylvania, including addressing Medicare payments for rehabilitation hospitals, protecting hospital and home health payments, and providing a composite rate update for ESRD patients.

Rehabilitation hospitals are an essential provider of post-acute hospital care that is often vital to allowing patients to return home and live independently. The Commonwealth of Pennsylvania has 102 licensed rehabilitation hospitals, with over 10,000 employees. Besides the detrimental impact that lack of quality, necessary healthcare has on patients, limiting the number of patients who can be admitted and receive the appropriate level of reimbursement makes it extremely difficult for many of these providers to retain their current levels of business and employment. The role of CMS is not to reimburse for medical services that patients do not need, nor is it to subsidize any sector of the economy. It is, however, to provide the patients it serves with the most appropriate

and highest quality health care possible. I will continue to make it a priority to ensure that Medicare patients receive the most appropriate care in the most appropriate setting.

There are many good policies and reforms in this package. However, I do have concerns about a number of provisions. Increasing the rebate on pharmaceutical manufacturers does not constitute substantive, policy-driven Medicaid reform – it will have no effect on slowing the growth of Medicaid and is just another tax, a cost shift borne by biopharmaceutical manufacturers– an industry that is very important to the Commonwealth of Pennsylvania.

I support the Chairman's efforts to address the very important and complex policy of appropriate Medicaid reimbursement for pharmaceuticals. For too long, the federal government has overpaid for the acquisition cost of many drugs in the Medicaid program. Congress must make certain that the Medicaid program is a prudent purchaser of pharmaceuticals. However, I am concerned about using Average Manufacturer Price for both branded and generic drugs. Congress needs to find an approach that will leverage competition in the marketplace and encourage appropriate dispensing of generic products. I urge you to take a look at how the House is approaching pharmacy reimbursement reforms. They have taken a different approach – one that we may wish to consider as we move forward in this process. It is my hope that we will continue to explore a payment policy that will foster competition, preserve patient access, and generate savings for the Medicaid program.

Before this legislation goes to the floor, I also hope that the Committee will address another issue critical to pharmacy reimbursement reform, the treatment of prompt pay discounts in the new reimbursement formula. Prompt pay discounts increase efficiencies in the marketplace, which ultimately lowers the costs of handling and delivering drugs for consumers. If distributors and pharmacies pay manufacturers promptly for their products, everyone – federal and state government, pharmacies, distributors, and patients – will save money. I ask the Committee to carefully consider how prompt pay discounts are treated in this package, and ensure that these terms are not used to artificially lower payment for pharmacy or negatively affect the distributors.

The package also sets the federal upper payment limit for multiple source drugs at 115% of weighted AMP for all forms of a drug that are 'therapeutically equivalent' and 'bioequivalent'. We must ensure that these terms are defined as they have been under federal statute for some time, by having 'therapeutic equivalent' relate to the rating found in the FDA's 'Orange Book'.

Furthermore, eliminating the regional Medicare Advantage PPO stabilization fund is not policy-driven Medicare reform and may harm beneficiary access in future years.

Recognizing that this is but one of many steps in our budget reconciliation process, I hope as we move forward in this process we can continue to look for provisions that are good policy to improve the Medicaid and Medicare programs. I introduced four amendments – a demonstration program for integrated health care centers, a technical correction to allow children's hospitals to participate in the 340b drug discount program, improved access to life-saving colorectal cancer screenings, and anti-fraud provisions for long-term care. I will continue to work with my colleagues on these important initiatives.

Opening Statement
Senator Mike Crapo
Senate Finance Committee—Budget Reconciliation
October 25, 2005

Mr. Chairman, let me first thank you for your leadership in this process. I know the road getting to a reconciliation package mark-up here has not been easy.

In order to move this process forward, many of us, myself included, have been obliged to put aside some of our philosophical tenets and policy positions on restructuring our federal healthcare programs.

It is said that that if everyone was happy, it would not be a reconciliation package—that certainly seems to be the case here today.

In the middle of June and throughout the summer, we talked extensively with the National Governors Association and were provided with a detailed plan, endorsed by all the Governors, on restructuring Medicaid. The NGAs request was straightforward: more flexibility and less regulation. Specifically, the NGA laid out proposals to: reform prescription drug payments policies; limit asset transfers and shelter assets; allow states to treat differently different beneficiary groups; provide latitude in state cost-sharing regimens; and ease the bureaucratic waiver process.

The Committee went away from this hearing with a virtual grocery list of areas to shop around to bring much needed reform to Medicaid.

In late June, this Committee also held two days of hearings taking an overview of the Medicaid program's efforts to uncover and correct vast fields of waste, fraud and abuse. The committee heard from numerous panels of experts that keyed in on specific areas where more work needs to be done, from prohibiting improper asset transfers to states' questionable efforts to maximize federal cost-sharing and improving the way prescription drugs are paid for in the Medicaid program. These hearings added further weight to the NGAs reform proposals and redoubled our efforts and energy to make sure Medicaid resources are being properly spent at both the federal and state level. In sum, our grocery list of reforms grew longer.

But while our list was expansive and detailed, it does not seem we were able to buy much in the way of reform.

Of particular note, this legislation does not fulfill the NGAs goal of providing states the ability to implement common-sense, cost-sharing programs. I believe that states should be given the tools to better inform Medicaid beneficiaries of their healthcare costs and contribute towards such as appropriate. In the same vein, states also should have increased flexibility to treat Medicaid beneficiaries according to their health needs and respect medically different populations.

I also support the need to increase the states' ability to prevent inappropriate transfer of assets for Medicaid qualification purposes. States lack the proper authority at present to best protect their programs from illegal gouging. Reforms should be made to avoid trying to recover funds after the fact and instead have individuals be responsible upfront for their healthcare costs.

Furthermore, there is a clearly-defined need to ensure that states institute fair provider reimbursement policy and do not wrongfully submit claims for matching federal funds. States should not reimburse Medicaid providers in excess of the actual costs of services and should be prohibited from practicing shell games utilizing intergovernmental transfers. In a similar vein, I support the Chairman's goal of encouraging accountability and incentivizing the collection of bad debt by skilled nursing facilities. However, I do see the need to differentiate between debt owned by individuals and debt owed by states.

I am also not wholly confident we have achieved the best Medicaid pharmacy reimbursement reform policy. The current payment regime is based on inaccurate prices and skewed reporting that results in confusion by all parties and inaccurate federal and state payments. In restructuring this program, we must make sure we do not trade one flawed payment methodology in for another.

I strongly hope this committee process today is only a first step and that we do stock up on more rigorous, policy-based Medicaid reform in the upcoming days.

I also have strong reservations about including Medicare alterations in this package. I agree with the President in that we passed the Medicare Modernization Act just two years ago, and most features of it have not yet had a chance even to go into effect—is now the time to rework various facets of that legislation?

A central tenet of the Medicare Act was to restructure the way we look at Medicare and to provide seniors with an array of affordable, high-quality private health plan choices. In so doing, we established the fund to provide incentives for private plans to enter and remain in the Medicare Advantage program. This last point is most important. In Idaho, five Medicare Advantage plans are active—but many of our citizens, particularly in the more rural areas, do not have access to private health care options. This stabilization fund is designed to meet the needs of these citizens by expanding and preserving beneficiary choice in the

hard-to-serve areas so that the people of Sandpoint, Pocatello and Rexburg have the same choice in benefit as people from Los Angeles, Chicago or Miami.

Moreover, Medicare's private plan choices are a clear way to improve the efficiency and quality of caring for the baby boom generation. Medicare Advantage-modeled plans, with their strong emphasis on preventative and coordinated care, outperform Medicare fee-for-service plans; several studies have already demonstrated this, and I am sure once Medicare Advantage plan once they are up and running will continue to show this time and time again. But these Advantage plans need to be funded sufficiently—a role the stabilization fund was designed to serve.

Some wrongfully have commented that the stabilization fund is little more than a "slush fund." But for whom—for beneficiaries, so they do not have to live worrying about if their health plan will leave them in a year's time? I was not a member of this Committee when the Medicare Modernization Act was crafted, but I do know the lengths to which many members went to support the creation of this program. I do not think that now, before a dollar has been tapped and before any plans have begun operating, is the time to jettison the stabilization fund.

I look forward to working with the Committee and the Senate Budget Committee as we move forward in this reconciliation process.

Statement for the Record
SFC FY2006 Budget Reconciliation Mark-Up
Senator Jay Rockefeller
October 25, 2005

Thank you, Chairman Grassley. I would like to begin by commending you for your hard work on this reconciliation package. It is clear from the mark that you attempted to be a moderating force among disparate interests. I would like to specifically thank you for including the language on authorized generics from the Generic Prescription Drug Fairness Act. You and I have been working together on this policy for several months now, and I look forward to continuing our work to get this legislation passed this year.

Unfortunately, Mr. Chairman, I cannot in good conscience support this mark. The fact of the matter is that this budget cuts critical safety net programs – such as Medicaid, food stamps, and housing – in order to provide tax cuts to wealthy Americans. It is just plain wrong to tax the poor in order to give to the wealthy, but that is exactly what this budget does. The moral fabric of our democracy dictates that our government protect its most vulnerable citizens. Yet, instead of a democracy for all, our government has become a democracy for a privileged few.

This reconciliation mark is yet another example of Congress' misguided priorities. It fails to meaningfully address the health care needs of the thousands of Americans displaced by hurricane Katrina, including hundreds of evacuees in my home state of West Virginia. This mark provides a one percent physician fee update for 2006 – something we all support – but does nothing to shield beneficiaries from having to shoulder the burden of that increase in the form of higher Medicare premiums. Furthermore, this mark offers higher-income individuals who can afford private long-term care insurance protection against impoverishment, but has no such provision for the truly low-income who need similar protection against Medicaid estate recovery. There is no honor in balancing our nation's budget on the backs of those least able to give.

Finally, Mr. Chairman, I would like to briefly mention amendments - over one hundred amendments have been filed. While some of these amendments clearly deal with the mark itself, many are focused on issues within the jurisdiction of this Committee that we have yet to address in regular order – issues such as the impact of Medicaid policy changes on beneficiaries and providers, federal Medicaid waiver oversight, long-term care, and end-of-life care planning.

One issue that is on all of our minds is implementation of the Medicare prescription drug benefit, and many of the amendments on our side reflect our concerns. The Administration has implemented a code of silence on Medicare Part D – a don't ask, don't tell policy on Medicare prescription drug coverage that hurts the very beneficiaries that this benefit was supposedly designed to help. As you know, I have never been silent about my concerns regarding the Medicare drug law. And, implementation of the prescription drug benefit to-date has confirmed some of my worst fears.

I want to be clear that this isn't about pointing fingers – if Democrats had passed a comprehensive prescription drug bill, we would have had implementation problems too based on the sheer magnitude of such a benefit. However, this is about the Finance Committee doing its job, and we have yet to have a hearing on implementation of the Medicare prescription drug benefit, despite concerns expressed by seniors across the country and despite early missteps by the Centers for Medicare and Medicaid Services that could delay access to the drug benefit for many. I urge the Members of this Committee to break the code of silence on the Medicare prescription drug benefit and to do what's best for our nation's seniors and disabled.

Moreover, I urge this Committee to hold regular hearings on the health issues within its jurisdiction. As the Ranking Member of the Subcommittee on Health Care, I stand ready to work with you in order to facilitate that process. I thank the Chair.

Colloquy with Senator Grassley on SCHIP Provisions included in Chairman's FY2006 Budget Reconciliation Mark
October 25, 2005

Mr. Rockefeller. Chairman Grassley, I would like to begin by commending you for the SCHIP provisions included in the mark. It is clear that you put a lot of time and effort into the SCHIP policies and tried to address the wide range of concerns that have been expressed by the distinguished members of this Committee.

Although no one got 100% of what their state might have wanted, your mark is a good compromise that will help to prevent any state from having to reduce coverage for needy children.

Mr. Grassley. Thank you, Senator Rockefeller. You understand as well as anybody the difficulty of getting Members, particularly the Members of this Committee, to agree on anything. I certainly appreciate the leadership that you, Senator Hatch and Senator Snowe have shown on SCHIP, and I am glad we were able to get something done that help states keep coverage for kids. I promised you a year ago that I would work something out, and while this package may not be exactly what everyone wants on SCHIP, I agree with you that it is a good consensus package.

Mr. Rockefeller. As you know, the main component of the SCHIP legislation that Senator Snowe and I offered last year was the recapturing of over $1 billion in expired SCHIP funds that reverted to the federal Treasury. I hope the policy included in your mark will protect health care coverage for these children. However, if the policy included today does not meet our mutual goals, I hope we can we work together to create a contingency fund or another mechanism to guarantee vital health care coverage for these kids.

Mr. Grassley. I certainly do not want states to have to reduce or eliminate services for targeted low income children and I want to continue to work with my colleagues on the Finance committee to ensure that states have the resources they need in order to provide critical health care coverage.