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MEDICARE		

Specialty Hospitals	• HHS must develop a strategic plan on physician investment in limited-service hospitals by six months after enactment, with an interim report at the three-month point. The plan is to include appropriate legislative and regulatory actions recommended the HHS. Issues that must be addressed:
	  • Proportionality of investment return
	  • Bona fide investment
	  • Annual disclosure of investment information
	  • Provision of charity care and care to Medicaid enrollees
	  • Appropriate enforcement.
	• While the plan is being developed, HHS must continue its suspension on the issuance of new Medicare provider numbers to such hospitals. The plan and suspension covers the same types of limited-service hospitals covered by the MMA's moratorium on physician self-referrals to new cardiac, orthopedic, and surgical hospitals. The suspension ends when the plan is submitted to Congress or six months after enactment, whichever is first. However, a two-month extension of the deadline may occur if HHS fails to complete the plan in six months.	

Rehab 75% Rule	Retains the 60% threshold for the second-year phase-in of the Rehab 75% Rule. Adds a second year at the 60% level, before the phase-in continues to increase the threshold to 65% in 2007 and 75% in 2008.	$100 million
Public Reporting of Inpatient Hospital Quality Data	• Requires the Secretary to expand the number of measures that a hospital must report to qualify to receive a full market basket update in FY 2007 by including measures from among the 22 used by the Hospital Quality Alliance, the three leaps used by the Leapfrog group (computerized physician order entry systems, intensivists, and volume related referrals), and the new HCAHPS survey of patients' experience of care in the hospital. • For 2008 and beyond, the Secretary shall add measures that reflect consensus among the affected parties (such as those represented by the Hospital Quality Alliance), and, to the extent feasible and practicable, include measures endorsed by national consensus bodies (such as the National Quality Forum). • Beginning in 2007, increases the reduction from the market basket update from 0.4% to 2.0% for hospitals that do not report required quality information to CMS.	-$300 million for all three hospital quality provisions
Value-Based Purchasing for Hospital Services	Requires the Medicare Payment Advisory Commission and the Secretary to develop reports to Congress detailing how Medicare value-based purchasing could be implemented for hospitals by FY 2009. The reports are due June 1, 2007 and August 1, 2007, respectively. *****THESE TWO REPORTS WERE REMOVED FROM THE SENATE PASSED VERSION OF THE CONFERENCE AGREEMENT.**	
Changes to DRG Assignment for Cases with Infections	Beginning in FY 2009, the presence of specified hospital acquired infections for some patients will not be treated as a complication that moves a patient from a relatively simple DRG into a more complicated DRG. The Secretary, in consultation with the Centers for Disease Control and Prevention, will select situations in which the presence of a specified type of hospital-associated infection that the hospital could have prevented results in a higher payment to the hospital. In such situations, the hospital will no longer receive the payment for the complicated DRG to which the patient would have been assigned; instead, the hospital will receive the payment associated with the DRG for patients with that condition, but without complications.	

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Medicare Dependent Hospitals (MDH)	• Provides a 5-year extension of the MDH program for discharges occurring before October 1, 2011. • Allows MDHs to rebase their payment rate using FY 2002 cost report if it increases payment. • Increases MDH payment from 50% to 75% of the difference between the target amount and the federal rate. • Removes the 12% Medicare disproportionate share cap for MDHs.	$14 million
Medicare DSH	Codifies a provision in the FY 2004 IPPS Final Rule that states that patients who qualify for Medicaid under an 1115 waiver may only be counted in the Medicare DSH calculation if they are eligible for Medicaid inpatient hospital services (i.e. provision excludes Medicaid days in pharmacy only 1115 waivers).	-$1.2 billion
Outpatient PPS Hold Harmless	Extends hold harmless payments for rural hospitals with 100 or fewer beds that are not sole community hospitals for three additional years, but reduces the amount that these hospitals would receive in hold harmless payment by 5% in 2006, by 10% in 2007 and by 15% in 2008.	$100 million
Physician Update	Freezes physician fee schedule payment rates at the 2005 levels, thereby preventing the expected 4.5% cut in payments for physician services. Clarifies that this change is not to be treated as a change in law and regulations in determining the sustainable growth rate (SGR). Requires that MedPAC prepare a report by March 1, 2007 on a mechanism that could be used to replace the SGR system.	$7.3 billion
Imaging Services	Reduces physician payments for imaging services in 2006 and 2007 when multiple imaging procedures are done on contiguous body parts during the same imaging session. Beginning Jan. 1, 2006, CMS applied a 50% reduction to multiple imaging procedures in its final rule for the 2006 physician fee schedule; however, CMS' rule redistributed savings from imaging services by increasing payments for all other physician services. This provision would prevent CMS from implementing the policy change in a budget neutral manner. Also, requires that payment rates for imaging services provided in physician offices do not exceed payment rates for the same services provided in hospital outpatient departments.	-$2.8 billion
Ambulatory Surgery Centers (ASCs)	Ensures that payment rates for ASC services do not exceed payment rates for the same services provided in hospital outpatient departments. Effective for services furnished after Jan. 1, 2007 and before implementation of the new ASC payment system.	- $300 million
Therapy Caps	Allows therapy caps to be implemented beginning Jan. 1, 2006. Includes a provision that allows beneficiaries to obtain exemption from caps by proving medical necessity.	$500 million
Skilled Nursing Facilities	Reduces, from 100% to 70%, Medicare bad debt payments to skilled nursing facilities. Medicare bad debt for dually-eligible Medicare/Medicaid beneficiaries will continue to be fully reimbursed at 100%.	-$100 million
Home Health	• Freezes CY 2006 Medicare payments at the 2005 level. • Reinstates the 5% rural payment add-on for CY 2006. • Beginning in 2007, home health agencies that do not submit quality data determined by the Secretary will receive a 2% decrease in the market basket update.	-$2 billion
ESRD	Provides a 1.6% payment update to the composite rate for ESRD facilities.	$250 million

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Post Acute Care	By Jan. 2008, HHS must establish a demonstration project for selected diagnoses that require post acute care. Patient will receive a hospital discharge assessment to determine post-acute placement and a post acute episode discharge assessment. One post-acute instrument will measure function in all sites.	$6 million
Durable Medical Equipment (DME)	• Provides for beneficiary ownership of certain items of DME after the 13th month of rental (for items for which rental begins after January 1, 2006.) • Provides for beneficiary ownership of oxygen equipment after the 36th month of rental. • Pays for service and maintenance of such DME when such maintenance is actually provided. • Continues the current law first month purchase option for power wheelchairs.	-$2.9 billion
Medicare Demonstrations to Permit Gainsharing Arrangements	• HHS must establish a gainsharing demonstration project to test and evaluate methods and arrangements between hospitals (other than CAHs) and physicians to improve quality and efficiency of care and hospital performance. • No more than six demos allowed, two of which must be in rural areas. • Timeline: Solicit applications from providers within 90 days of enactment; project approval by Nov. 1, 2006; projects operational by Jan. 1, 2007 and ending on Dec. 31, 2009. • Reports: Initial report to Congress by Dec. 1, 2006, project update to Congress by Dec. 1, 2007, report on quality improvement and savings by Dec.1, 2008, and final report by May 1, 2010.	$6 million
Medicare Advantage	• Phases out budget neutrality for risk adjustment of payments made to Medicare Advantage plans. Includes a study to determine differences in coding patterns between hospitals and plans and, if appropriate, to adjust risk scores and the budget neutrality factor while still in effect. • Provides grant program for rural PACE (Programs for All-Inclusive Care for the Elderly) sites.	-$6.2 billion
MEDICAID		
Premiums and Cost Sharing Expansion	• States granted option to impose premiums on Medicaid beneficiaries with family income above 150% of poverty with some limitations (beneficiaries exempted – some groups of children under age 18 including low income children, children in adoption or foster care services also, pregnant women, hospice patients, and patients in medical or other facilities). • States allowed to impose copayments on Medicaid beneficiaries with family income above 150% with some beneficiaries and services exempted. Beneficiaries exempted include children below 100% of poverty, children in adoption or foster care services, and pregnant women and hospice patients and patients in medical or other facilities. Services exempted include preventive care for children and family planning services. • For families with income between 100% and 150% of poverty, their cost sharing cannot exceed 10% of the cost of an item or service and their annual copays may not exceed 5% of their family income. For families with income above 150% of poverty, premiums cannot exceed 5% of their family income and cost sharing cannot exceed 20% of the cost of such item or service. • States have the option to suspend eligibility for failure to pay premiums after 60 days. • Increases in nominal copays will be tied to medical care component of CPI. • States are allowed to impose copays for beneficiaries' use of drugs that are not on the state's preferred drug list. Copays are tiered based on income.	-$1.2 billion

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Emergency Department (ED) copays for non-emergency care	• States are granted an option to create a new copay for use of ED services for "non-emergency care." Hospital ED staff must, before providing non-emergency services, inform the patient of the following: a copay may be required by the hospital; provide the patient the name and location of a non-emergency provider; and provide the patient a referral to non-emergency provider and coordinate scheduling of treatment. The ED copayment does not relieve the hospitals of EMTALA requirements nor does it relieve managed care organizations of prudent layperson requirements. All beneficiaries are subject to ED copayments with some protections for beneficiaries with incomes below 100% of poverty. • Provides grant funds to states for establishing alternate non-emergency providers. • Hospitals and physicians are not held liable in civil action for imposing cost-sharing, absent a finding of gross negligence. *****LIABILITY PROTECTION IN THIS SECTION WAS REMOVED FROM THE SENATE PASSED VERSION OF THE CONFERENCE AGREEMENT.**	-$10 million
Benchmark Benefit Package Option	States granted option to change Medicaid benefits packages for certain beneficiaries. (Excluded beneficiaries include mandatory pregnant women, blind or disabled, dually eligible, hospice patients, medically needy populations, children in foster care or receiving adoption assistance, TANF and Section 1931 parents, medically needy.) The benchmark package (similar to SCHIP program) can be modeled after the Federal Employees Health Benefits Plan or equivalent, the State Employees Health Benefits Plan or equivalent, the HMO in the state with the largest non-Medicaid enrollment, or the Secretary's approved coverage. The benchmark package must include EPSDT for children through age 18. The Secretary's approved coverage includes basic services that are actuarially equivalent to one of the benchmark packages.	-$1.25 billion
Managed Care Default Payment for Out of Network Providers	Sets a default payment rate for emergency services provided to managed care enrollees by out of network providers. Default rate is Medicaid fee for service less indirect and direct costs of medical education. In state where rates are negotiated by contract and not publicly released the payment rate would be the average contract rate for applicable hospitals. Effective date is 1/01/2007.	-$50 million
Restrict Managed Care Organization (MCO) provider taxes	Requires that MCO provider taxes must meet the same restrictions as all other provider taxes effective on date of enactment. For MCO provider tax programs in place as if 12/08/2005, the new restrictions will not apply until 10/09/2009.	-$435 million
Prescription Drug Reforms	• Sets Federal Upper Limit (FUL) for multi-source drugs • Redefines Average Manufacturers Price to reflect discounts and rebates available retail pharmacies for pharmacy payments and calculation of best price. • Includes authorized generic drugs in best price calculation, • Sets new rules for data collection on physician administered drugs to ensure state gets proper rebate.	-$3.8 billion
Childrens Hospitals	Allows childrens hospitals to participate in the 340B drug pricing program that allows hospitals to purchase outpatient drugs at a significantly discounted rate.	-$50 million

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Long-Term Care (LTCH) – Asset Transfer	• Extends look-back period of any asset transfers to 5 years. • Changes start of penalty period from date of asset transfer to date of Medicaid eligibility. • Sets new provisions about disclosure and treatment of annuities. • Requires "Income First" rule in applying community spouse's income before assets in providing support of community spouse. • Sets new limits on long-term care eligibility for those with substantial home equity. • Sets new rules about spousal rights for institutionalized long-term care beneficiaries. • Clarifies that Continuing Care Retirement Community fees are countable resources.	-$2.4 billion
Long-Term Care – Partnership Program	• Repeals moratorium on LTC partnership programs allowing more states to participate.	$30 million
Targeted Case Management (TCM) Services	Clarifies definition of TCM to include assessment activities, care plan development and referral activities, excludes direct delivery of services.	-$760 million
Fraud, Waste and Abuse	Limit use of contingency fee contracts, provides incentives to implement False Claims Act, prohibits payments to drug claims already paid and the drugs restocked, enhances third-party recovery, and requires documentary evidence of US citizenship.	-$292 million
FMAP Changes for AK, DSH correction for DC, increase payments to insular areas	• Provides for a temporary increase in the FMAP for Alaska for FY 2006 and FY 2007 to keep the FMAP at FY 2005 level. • Raises DC DSH Allotment for FY 2000-FY 2002 from $32 million to $49 million. • Provides for an increase in Federal Medicaid funds for Puerto Rico, Virgin Islands, Guam, etc.	$125 AK FMAP, $100 DC DSH, $140 insular areas
Family Opportunity Act	• Buy-in option for disabled children living in families with income of 300% of the federal poverty level or below. • 10-state demonstration to enroll children with psychiatric disabilities. • Information and outreach centers for families. • Immediate coverage for children resumed eligible under SSI.	-$1.5 billion
SCHIP Shortfalls	• Redistrubutes SCHIP allotment surpluses. • Prohibits SCHIP waivers for non-pregnant adults.	$20 million
Money Follows the Person Demonstration	Authorizes demonstration projects to encourage community- based services to individuals with disabilities rather than institutional long-term care services.	$340 million
Health Opportunity Accounts	Authorizes demonstration projects to provide alternative Medicaid benefits through health opportunity accounts beginning in FY 2006.	$64 million

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Medicaid Transformation Grants	Provides payments to states to improve administrative efficiency and clinical outcomes for beneficiaries. Examples of supported innovations are electronic health record, PERM program, medication risk management program.	$150 million
Non-Emergency Medical Transportation Program	States granted option to establish non-emergency medical transportation program to provide beneficiaries transportation to providers for non-emergency services.	-$55 million
KATRINA RELIEF		
Katrina Relief	• Funds are made available to Katrina affected states through the Multi State Section 1115 Demonstration Project. The funds are appropriated dollars through the National Disaster Medical System. • Grant funds are made available for the enactment of the State High Risk Pool Funding Extension Act of 2005.	$2 billion $80 million
FMAP Hold Harmless for Katrina Impact	• For years after 2006, the Secretary does not have to include Katrina evacuees in the FMAP calculation for a state that is hosting Katrina evacuees.	