I. S.1932

Deficit Reduction Act of 2005 (Enrolled as Agreed to or Passed by Both House and Senate)

II. `STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE SHARE OF RECOVERIES

`SEC. 1909. (a) IN GENERAL- Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

`(b) REQUIREMENTS- For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

`(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a).

`(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code.

`(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

`(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code.

`(c) DEEMED COMPLIANCE- A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

`(d) NO PRECLUSION OF BROADER LAWS- Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.'.

(b) EFFECTIVE DATE- Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2007.

III. SEC. 6032. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.

(a) In General- Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended--

(1) in paragraph (66), by striking `and' at the end;

(2) in paragraph (67) by striking the period at the end and inserting `; and'; and

(3) by inserting after paragraph (67) the following:

`(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall--

`(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

`(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

`(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.'.

(b) EFFECTIVE DATE- Except as provided in section 6035(e), the amendments made by subsection (a) take effect on January 1, 2007.

IV. SEC. 6033. PROHIBITION ON RESTOCKING AND DOUBLE BILLING OF PRESCRIPTION DRUGS.

(a) IN GENERAL- Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 6002(b), is amended--

(1) in subparagraph (B), by striking `and' at the end;

(2) in subparagraph (C), by striking `; or' at the end and inserting `, and'; and

(3) by adding at the end the following:

`(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or'.

(b) EFFECTIVE DATE- The amendments made by subsection (a) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

V. SEC. 6034. MEDICAID INTEGRITY PROGRAM.

(a) Establishment of Medicaid Integrity Program- Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended--

(1) by redesignating section 1936 as section 1937; and

(2) by inserting after section 1935 the following:

VI. `MEDICAID INTEGRITY PROGRAM

`SEC. 1936. (a) In General- There is hereby established the Medicaid Integrity Program (in this section referred to as the `Program') under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

`(b) Activities Described- Activities described in this subsection are as follows:

`(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.

`(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including--

`(A) cost reports;

`(B) consulting contracts; and

`(C) risk contracts under section 1903(m).

`(3) Identification of overpayments to individuals or entities receiving Federal funds under this title.

`(4) Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

`(c) Eligible Entity and Contracting Requirements-

`(1) IN GENERAL- An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

`(2) ELIGIBILITY REQUIREMENTS- The requirements of this paragraph are the following:

`(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

`(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other

law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities.

`(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

`(D) The entity meets such other requirements as the Secretary may impose.

`(3) CONTRACTING REQUIREMENTS- The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

`(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

`(B) Competitive procedures to be used--

`(i) when entering into new contracts under this section;

`(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

`(iii) at any other time considered appropriate by the Secretary.

`(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

`(4) LIMITATION ON CONTRACTOR LIABILITY- The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

`(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY-

`(1) 5-YEAR PLAN- With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse.

`(2) CONSULTATION- Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services,

and State officials with responsibility for controlling provider fraud and abuse under State plans under this title.

`(e) APPROPRIATION-

`(1) IN GENERAL- Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation--

`(A) for fiscal year 2006, $5,000,000;

`(B) for each of fiscal years 2007 and 2008, $50,000,000; and

`(C) for each fiscal year thereafter, $75,000,000.

`(2) AVAILABILITY- Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

`(3) INCREASE IN CMS STAFFING DEVOTED TO PROTECTING MEDICAID PROGRAM INTEGRITY- From the amounts appropriated under paragraph (1), the Secretary shall increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

`(4) ANNUAL REPORT- Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies--

`(A) the use of funds appropriated pursuant to paragraph (1); and

`(B) the effectiveness of the use of such funds.'.

(b) STATE REQUIREMENT TO COOPERATE WITH INTEGRITY PROGRAM EFFORTS- Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 6033(a), is amended--

(1) in paragraph (67), by striking `and' at the end;

(2) in paragraph (68), by striking the period at the end and inserting `; and'; and

(3) by inserting after paragraph (68), the following:

`(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936.'.

(c) INCREASED FUNDING FOR MEDICAID FRAUD AND ABUSE CONTROL ACTIVITIES-

(1) IN GENERAL- Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of Health and Human Services, without further appropriation, $25,000,000 for each of fiscal years 2006 through 2010, for activities of such Office with respect to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES- Amounts appropriated pursuant to paragraph (1) shall--

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Office of the Inspector General of the Department of Health and Human Services for activities of such Office with respect to the Medicaid program.

(3) ANNUAL REPORT- Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Inspector General of the Department of Health and Human Services shall submit a report to Congress which identifies--

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(d) NATIONAL EXPANSION OF THE MEDICARE-MEDICAID (MEDI-MEDI) Data Match Pilot Program-

(1) REQUIREMENT OF THE MEDICARE INTEGRITY PROGRAM- Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended--

(A) in subsection (b), by adding at the end the following:

`(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).'; and

(B) by adding at the end the following:

`(g) MEDICARE-MEDICAID DATA MATCH PROGRAM-

`(1) EXPANSION OF PROGRAM-

`(A) IN GENERAL- The Secretary shall enter into contracts with eligible entities for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the `Medi-Medi Program') is conducted with respect to the program established under this title and State Medicaid programs under title XIX for the purpose of--

`(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to look for payment anomalies (including billing or billing patterns identified with respect to service, time, or patient that appear to be suspect or otherwise implausible);

`(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title; and

`(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures.

`(B) REPORTING REQUIREMENTS- The Secretary shall make available in a timely manner any data and statistical

information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1903(q)). Such information shall be disseminated no less frequently than quarterly.

`(2) LIMITED WAIVER AUTHORITY- The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).'.

(2) FUNDING- Section 1817(k)(4) of such Act (42 U.S.C. 1395i(k)(4)), as amended by section 5204 of this Act, is amended--

(A) in subparagraph (A), by striking `subparagraph (B)' and inserting `subparagraphs (B), (C), and (D)'; and

(B) by adding at the end the following:

`(D) EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PROGRAM- The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1893(b)(6) for the respective fiscal year:

`(i) $12,000,000 for fiscal year 2006.

`(ii) $24,000,000 for fiscal year 2007.

`(iii) $36,000,000 for fiscal year 2008.

`(iv) $48,000,000 for fiscal year 2009.

`(v) $60,000,000 for fiscal year 2010 and each fiscal year thereafter.'.

(e) DELAYED EFFECTIVE DATE FOR CHAPTER- Except as otherwise provided in this chapter, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

VII. SEC. 6035. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.

(a) CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE- Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (A), in the matter preceding clause (i)--

(A) by inserting `, self-insured plans' after `health insurers'; and

(B) by striking `and health maintenance organizations' and inserting `managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'; and

(2) in subparagraph (G)--

(A) by inserting `a self-insured plan,' after `1974,'; and

(B) by striking `and a health maintenance organization' and inserting `a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service'.

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA- Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (G), by striking `and' at the end;

(2) in subparagraph (H), by adding `and' after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

`(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

`(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

`(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

`(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

`(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the

claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

`(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

`(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;'.

(c) EFFECTIVE DATE- Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

VIII. SEC. 6036. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) In General- Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended--

(1) in subsection (i), as amended by section 104 of Public Law 109-91--

(A) by striking `or' at the end of paragraph (20);

(B) by striking the period at the end of paragraph (21) and inserting `; or'; and

(C) by inserting after paragraph (21) the following new paragraph:

`(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.'; and

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

`(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

`(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title--

`(A) and is entitled to or enrolled for benefits under any part of title XVIII;

`(B) on the basis of receiving supplemental security income benefits under title XVI; or

`(C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

`(3)(A) For purposes of this subsection, the term `satisfactory documentary evidence of citizenship or nationality' means--

`(i) any document described in subparagraph (B); or

`(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

`(B) The following are documents described in this subparagraph:

`(i) A United States passport.

`(ii) Form N-550 or N-570 (Certificate of Naturalization).

`(iii) Form N-560 or N-561 (Certificate of United States Citizenship).

`(iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

`(v) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

`(C) The following are documents described in this subparagraph:

`(i) A certificate of birth in the United States.

`(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).

`(iii) Form I-97 (United States Citizen Identification Card).

`(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).

`(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

`(D) The following are documents described in this subparagraph:

`(i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.

`(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

`(E) A reference in this paragraph to a form includes a reference to any successor form.'.

(b) Effective Date- The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(z) of the Social Security Act, as added by such amendments, was not previously met.

(c) IMPLEMENTATION REQUIREMENT- As soon as practicable after the date of enactment of this Act, the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(23) and (x) of section 1903 of the Social Security Act (as added by subsection (a)) about such requirements and how they may be satisfied.

IX. CHAPTER 4--FLEXIBILITY IN COST SHARING AND BENEFITS

X. SEC. 6041. STATE OPTION FOR ALTERNATIVE MEDICAID PREMIUMS AND COST SHARING.

(a) In General- Title XIX of the Social Security Act is amended by inserting after section 1916 the following new section:

XI. `STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING

`SEC. 1916A. (a) State Flexibility-

`(1) IN GENERAL- Notwithstanding sections 1916 and 1902(a)(10)(B), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) section 1916(g).

`(2) DEFINITIONS- In this section:

`(A) PREMIUM- The term `premium' includes any enrollment fee or similar charge.

`(B) COST SHARING- The term `cost sharing' includes any deduction, copayment, or similar charge.

`(b) Limitations on Exercise of Authority-

`(1) INDIVIDUALS WITH FAMILY INCOME BETWEEN 100 AND 150 PERCENT OF THE POVERTY LINE- In the case of an individual whose family income exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved, subject to subsections (c)(2) and (e)(2)(A)--

`(A) no premium may be imposed under the plan; and

`(B) with respect to cost sharing--

`(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

`(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

`(2) INDIVIDUALS WITH FAMILY INCOME ABOVE 150 PERCENT OF THE POVERTY LINE- In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, subject to subsections (c)(2) and (e)(2)(A)--

`(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

`(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

`(3) ADDITIONAL LIMITATIONS-

`(A) PREMIUMS- No premiums shall be imposed under this section with respect to the following:

`(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

`(ii) Pregnant women.

`(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

`(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

`(v) Women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

`(B) COST SHARING- Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

`(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

`(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

`(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

`(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

`(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

`(vi) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

`(vii) Family planning services and supplies described in section 1905(a)(4)(C).

`(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

`(C) CONSTRUCTION- Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

`(4) DETERMINATIONS OF FAMILY INCOME- In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this title.

`(5) POVERTY LINE DEFINED- For purposes of this section, the term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

`(6) CONSTRUCTION- Nothing in this section shall be construed--

`(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

`(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

`(C) as affecting any such waiver of requirements in effect under this title before the date of the enactment of this

section with regard to the imposition of premiums and cost sharing.

`(d) Enforceability of Premiums and Other Cost Sharing-

`(1) PREMIUMS- Notwithstanding section 1916(c)(3) and section 1902(a)(10)(B), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

`(2) COST SHARING- Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this title for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.'.

(b) Indexing Nominal Cost Sharing and Conforming Amendment- Section 1916 of such Act (42 U.S.C. 1396o) is amended--

(1) in subsection (f), by inserting `and section 1916A' after `(b)(3)'; and

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

`(h) In applying this section and subsections (c) and (e) of section 1916A, with respect to cost sharing that is `nominal' in amount, the Secretary shall increase such `nominal' amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.'.

(c) Effective Date- The amendments made by this section shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.

XII. SEC. 6042. SPECIAL RULES FOR COST SHARING FOR PRESCRIPTION DRUGS.

(a) In General- Section 1916A of the Social Security Act, as inserted by section 6041(a), is amended by inserting after subsection (b) the following new subsection:

`(c) Special Rules for Cost Sharing for Prescription Drugs-

`(1) IN GENERAL- In order to encourage beneficiaries to use drugs (in this subsection referred to as `preferred drugs') identified by the

State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may--

`(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under section 1916, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

`(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not otherwise be imposed under subsection (b)(3)(B).

`(2) LIMITATIONS-

`(A) BY INCOME GROUP- In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed--

`(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1916); or

`(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

`(B) LIMITATION TO NOMINAL FOR EXEMPT POPULATIONS- In the case of an individual who is otherwise not subject to cost sharing due to the application of subsection (b)(3)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1916).

`(C) CONTINUED APPLICATION OF AGGREGATE CAP- In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be.

`(3) WAIVER- In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

`(4) EXCLUSION AUTHORITY- Nothing in this subsection shall be construed as preventing a State from excluding specified drugs or classes of drugs from the application of paragraph (1).'.

(b) Effective Date- The amendment made by subsection (a) shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.

XIII. SEC. 6043. EMERGENCY ROOM COPAYMENTS FOR NON-EMERGENCY CARE.

(a) In General- Section 1916A of the Social Security Act, as inserted by section 6041 and as amended by section 6042, is further amended by adding at the end the following new subsection:

`(e) State Option for Permitting Hospitals To Impose Cost Sharing for Non-Emergency Care Furnished in an Emergency Department-

`(1) IN GENERAL- Notwithstanding section 1916 and section 1902(a)(1) or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this title, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

`(A) ACCESS TO NON-EMERGENCY ROOM PROVIDER- The individual has actually available and accessible (as such terms are applied by the Secretary under section 1916(b)(3)) an alternate non-emergency services provider with respect to such services.

`(B) NOTICE- The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1867 and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

`(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

`(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

`(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

`(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

`(2) LIMITATIONS-

`(A) FOR POOREST BENEFICIARIES- In the case of an individual described in subsection (b)(1), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under section 1916, subject to the percent of income limitation otherwise applicable under subsection (b)(1).

`(B) APPLICATION TO EXEMPT POPULATIONS- In the case of an individual who is otherwise not subject to cost sharing under subsection (b)(3), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1916) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

`(C) CONTINUED APPLICATION OF AGGREGATE CAP; RELATION TO OTHER COST SHARING- In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a).

`(3) CONSTRUCTION- Nothing in this section shall be construed--

`(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867; or

`(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

`(4) DEFINITIONS- For purposes of this subsection:

`(A) NON-EMERGENCY SERVICES- The term `non-emergency services' means any care or services furnished in an emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1867.

`(B) ALTERNATE NON-EMERGENCY SERVICES PROVIDER- The term `alternative non-emergency services provider' means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would

be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this title.'.

(b) Grant Funds for Establishment of Alternate Non-Emergency Services Providers- Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 6037(a)(2), is amended by adding at the end the following new subsection:

`(y) Payments for Establishment of Alternate Non-Emergency Services Providers-

`(1) PAYMENTS- In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

`(2) LIMITATION- The total amount of payments under this subsection shall not exceed $50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

`(3) PREFERENCE- In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that--

`(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

`(B) are in partnership with local community hospitals.

`(4) FORM AND MANNER OF PAYMENT- Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).'.

(c) Effective Date- The amendments made by this section shall apply to non-emergency services furnished on or after January 1, 2007.

XIV. SEC. 6044. USE OF BENCHMARK BENEFIT PACKAGES.

(a) IN GENERAL- Title XIX of the Social Security Act, as amended by section 6035, is amended by redesignating section 1937 as section 1938 and by inserting after section 1936 the following new section:

XV. `STATE FLEXIBILITY IN BENEFIT PACKAGES

`SEC. 1937. (a) State Option of Providing Benchmark Benefits-

`(1) AUTHORITY-

`(A) IN GENERAL- Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in coverage that provides--

`(i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

`(ii) for any child under 19 years of age who is covered under the State plan under section 1902(a)(10)(A), wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).

`(B) LIMITATION- The State may only exercise the option under subparagraph (A) for an individual eligible under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.

`(C) OPTION OF WRAP-AROUND BENEFITS- In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.

`(D) TREATMENT AS MEDICAL ASSISTANCE- Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

`(2) APPLICATION-

`(A) IN GENERAL- Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

`(B) LIMITATION ON APPLICATION- A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

`(i) MANDATORY PREGNANT WOMEN- The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

`(ii) BLIND OR DISABLED INDIVIDUALS- The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or

disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).
`(iii) DUAL ELIGIBLES- The individual is entitled to benefits under any part of title XVIII.
`(iv) TERMINALLY ILL HOSPICE PATIENTS- The individual is terminally ill and is receiving benefits for hospice care under this title.
`(v) ELIGIBLE ON BASIS OF INSTITUTIONALIZATION- The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
`(vi) MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS- The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).
`(vii) BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES- The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).
`(viii) CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE- The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
`(ix) TANF AND SECTION 1931 PARENTS- The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after the welfare reform effective date defined in section 1931(i)).
`(x) WOMEN IN THE BREAST OR CERVICAL CANCER PROGRAM- The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).
`(xi) LIMITED SERVICES BENEFICIARIES- The individual--
`(I) qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII); or

`(II) is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

`(C) FULL-BENEFIT ELIGIBLE INDIVIDUALS-

`(i) IN GENERAL- For purposes of this paragraph, subject to clause (ii), the term `full-benefit eligible individual' means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1905(a) which are covered under the State plan under this title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for all such services under this title, as determined by the Secretary.

`(ii) EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS- Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

`(b) Benchmark Benefit Packages-

`(1) IN GENERAL- For purposes of subsection (a)(1), each of the following coverages shall be considered to be benchmark coverage:

`(A) FEHBP-EQUIVALENT HEALTH INSURANCE COVERAGE- The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

`(B) STATE EMPLOYEE COVERAGE- A health benefits coverage plan that is offered and generally available to State employees in the State involved.

`(C) COVERAGE OFFERED THROUGH HMO- The health insurance coverage plan that--

`(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

`(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

`(D) SECRETARY-APPROVED COVERAGE- Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

`(2) BENCHMARK-EQUIVALENT COVERAGE- For purposes of subsection (a)(1), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

`(A) INCLUSION OF BASIC SERVICES- The coverage includes benefits for items and services within each of the following categories of basic services:

`(i) Inpatient and outpatient hospital services.

`(ii) Physicians' surgical and medical services.

`(iii) Laboratory and x-ray services.

`(iv) Well-baby and well-child care, including age-appropriate immunizations.

`(v) Other appropriate preventive services, as designated by the Secretary.

`(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE- The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

`(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE- With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

`(i) Coverage of prescription drugs.

`(ii) Mental health services.

`(iii) Vision services.

`(iv) Hearing services.

`(3) DETERMINATION OF ACTUARIAL VALUE- The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

`(A) by an individual who is a member of the American Academy of Actuaries;

`(B) using generally accepted actuarial principles and methodologies;

`(C) using a standardized set of utilization and price factors;

`(D) using a standardized population that is representative of the population involved;

`(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

`(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

`(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

`(4) COVERAGE OF RURAL HEALTH CLINIC AND FQHC SERVICES- Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless--

`(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2); and

`(B) payment for such services is made in accordance with the requirements of section 1902(bb).'.

(b) EFFECTIVE DATE- The amendment made by subsection (a) takes effect on March 31, 2006.

XVI. CHAPTER 5--STATE FINANCING UNDER MEDICAID

XVII. SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) In General- Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

`(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).'.

(b) Effective Date-

(1) IN GENERAL- Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) DELAY IN EFFECTIVE DATE-

(A) IN GENERAL- Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

(B) SPECIFIED STATES- For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a Medicaid managed care organization with a contract under section 1903(m) of the Social Security Act as of December 8, 2005.

(c) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS-

(1) IN GENERAL- Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that

such use of funds is proper and in the interest of the program under title XIX.

(2) CENTER DESCRIBED- A center described in this paragraph is a publicly-owned regional medical center that--

(A) provides level 1 trauma and burn care services;

(B) provides level 3 neonatal care services;

(C) is obligated to serve all patients, regardless of State of origin;

(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

(E) serves as a tertiary care provider for patients residing within a 125-mile radius; and

(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act in at least one State other than the one in which the center is located.

(3) EFFECTIVE PERIOD- This subsection shall apply through December 31, 2006.

XVIII. SEC. 6052. REFORMS OF CASE MANAGEMENT AND TARGETED CASE MANAGEMENT.

(a) IN GENERAL- Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) is amended by striking paragraph (2) and inserting the following:

`(2) For purposes of this subsection:

`(A)(i) The term `case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

`(ii) Such term includes the following:

`(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services.