



Sec. 3134. Health opportunity accounts.  
Sec. 3135. Money follows the person rebalancing demonstration.

CHAPTER 5—OTHER PROVISIONS

Sec. 3141. Increase in medicaid payments to insular areas.  
Sec. 3142. Managed care organization provider tax reform.  
Sec. 3143. Medicaid transformation grants.  
Sec. 3144. Enhancing third party identification and payment.  
Sec. 3145. Improved enforcement of documentation requirements.  
Sec. 3146. Reforms of targeted case management.

1 **SEC. 3100. SHORT TITLE OF SUBTITLE; RULE OF CON-**  
2 **STRUCTION WITH REGARD TO KATRINA**  
3 **EVACUEES.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the  
5 “Medicaid Reconciliation Act of 2005”.

6 (b) **RULE OF CONSTRUCTION WITH REGARD TO**  
7 **KATRINA EVACUEES.**—None of the provisions of the fol-  
8 lowing chapters of this subtitle shall apply during the 11-  
9 month period beginning September 1, 2005, to individuals  
10 entitled to medical assistance under title XIX of the Social  
11 Security Act by reason of their residence in a parish in  
12 the State of Louisiana, or a county in the State of Mis-  
13 sissippi or Alabama, for which a major disaster has been  
14 declared in accordance with section 401 of the Robert T.  
15 Stafford Disaster Relief and Emergency Assistance Act  
16 (42 U.S.C. 5170) as a result of Hurricane Katrina and  
17 which the President has determined, before September 14,  
18 2005, warrants individual and public assistance from the  
19 Federal Government under such Act.

1                   **CHAPTER 1—PAYMENT FOR**  
2                   **PRESCRIPTION DRUGS**

3 **SEC. 3101. FEDERAL UPPER LIMIT (FUL).**

4           (a) IN GENERAL.—Subsection (e) of section 1927 of  
5 the Social Security Act (42 U.S.C. 1396r–8) is amended  
6 to read as follows:

7           “(e) PHARMACY REIMBURSEMENT LIMITS.—

8                   “(1) FEDERAL UPPER LIMIT FOR INGREDIENT  
9 COST OF COVERED OUTPATIENT DRUGS.—

10                           “(A) IN GENERAL.—Subject to subpara-  
11 graph (B), no Federal financial participation  
12 shall be available for payment for the ingredient  
13 cost of a covered outpatient drug in excess of  
14 the Federal upper limit for that drug estab-  
15 lished under paragraph (2).

16                           “(B) OPTIONAL CARVE OUT.—A State may  
17 elect not to apply subparagraph (A) to payment  
18 for either or both of the following:

19                                   “(i) Drugs dispensed by specialty  
20 pharmacies (such as those dispensing only  
21 immunosuppressive drugs), as defined by  
22 the Secretary.

23                                   “(ii) Drugs administered by a physi-  
24 cian in a physician’s office.

25                   “(2) FEDERAL UPPER LIMIT.—

1           “(A) IN GENERAL.—Except as provided in  
2           subparagraph (D) and subject to paragraph  
3           (5), the Federal upper limit established under  
4           this paragraph for the ingredient cost of a—

5                   “(i) single source drug, is 106 percent  
6                   of the RAMP (as defined in subparagraph  
7                   (B)(i)) for that drug; and

8                   “(ii) multiple source drug, is 120 per-  
9                   cent of the volume weighted average  
10                  RAMP (as defined under subparagraph  
11                  (C)) for that drug.

12           A drug product that is a single source drug and  
13           that becomes a multiple source drug shall con-  
14           tinue to be treated under this subsection as a  
15           single source drug until the Secretary deter-  
16           mines that there is sufficient data to compile  
17           the volume weighted average RAMP for that  
18           drug.

19           “(B) RAMP AND RELATED PROVISIONS.—  
20           For purposes of this subsection:

21                   “(i) RAMP DEFINED.—The term  
22                   ‘RAMP’ means, with respect to a covered  
23                   outpatient drug by a manufacturer for a  
24                   calendar quarter and subject to clause (ii)  
25                   and (iii), the average price paid to a manu-

1            manufacturer for the drug in the United States  
2            in the quarter by wholesalers for drugs dis-  
3            tributed to retail pharmacies, excluding—

4                    “(I) customary prompt pay dis-  
5                    counts; and

6                    “(II) service fees that are paid by  
7                    the manufacturer to an entity and  
8                    that represent fair market value for a  
9                    bona-fide service provided by the enti-  
10                   ty.

11                   “(ii) SALES EXEMPTED FROM COM-  
12                   PUTATION.—The RAMP under clause (i)  
13                   shall exclude any of the following:

14                           “(I) Sales exempt from inclusion  
15                           in the determination of best price  
16                           under subsection (c)(1)(C)(i).

17                           “(II) Such other sales as the Sec-  
18                           retary identifies as sales to an entity  
19                           that are merely nominal in amount  
20                           under subsection (c)(1)(C)(ii)(III).

21                           “(iii) SALE PRICE NET OF DIS-  
22                           COUNTS.—In calculating the RAMP under  
23                           clause (i), such RAMP shall include any of  
24                           the following:

1                   “(I) Cash discounts and volume  
2 discounts.

3                   “(II) Free goods that are contin-  
4 gent upon any purchase requirement.

5                   “(III) Sales at a nominal price  
6 that are contingent upon any pur-  
7 chase requirement or agreement.

8                   “(IV) Chargebacks, rebates (not  
9 including rebates provided under an  
10 agreement under this section), or any  
11 other direct or indirect discounts.

12                   “(V) Any other price concessions,  
13 which may be based on recommenda-  
14 tions of the Inspector General of the  
15 Department of Health and Human  
16 Services, that would result in a reduc-  
17 tion of the cost to the purchaser.

18                   “(iv) RETAIL PHARMACY.—For pur-  
19 poses of this subsection, the term ‘retail  
20 pharmacy’ does not include mail-order only  
21 pharmacies or any pharmacy at a nursing  
22 facility or home.

23                   “(C) VOLUME WEIGHTED AVERAGE RAMP  
24 DEFINED.—For purposes of subparagraph (A),  
25 for all drug products included within the same

1 multiple source drug billing and payment code  
2 (or such other methodology as may be specified  
3 by the Secretary), the volume weighted average  
4 RAMP is the volume weighted average of the  
5 RAMPs reported under section  
6 1927(b)(3)(A)(iv) determined by—

7 (i) computing the sum of the products  
8 (for each National Drug Code assigned to  
9 such drug products) of—

10 (I) the manufacturer's RAMP (as  
11 defined in subparagraph (B)); and

12 (II) the total number of units  
13 specified under section 1847A(b)(2)  
14 sold; and

15 (ii) dividing the sum determined  
16 under clause (i) by the sum of the total  
17 number of units under clause (i)(II) for all  
18 National Drug Codes assigned to such  
19 drug products.

20 “(D) EXCEPTION FOR INITIAL SALES PE-  
21 RIODS.—

22 “(i) IN GENERAL.—In the case of a  
23 single source drug during an initial sales  
24 period (not to exceed 2 calendar quarters)  
25 in which data on sales for the drug are not

1 sufficiently available from the manufac-  
2 turer to compute the RAMP or the weight-  
3 ed average RAMP under subparagraph  
4 (C), the Federal upper limit for the ingre-  
5 dient cost of such drug during such period  
6 shall be the wholesale acquisition cost (as  
7 defined in clause (ii)) for the drug.

8 “(ii) WHOLESALE ACQUISITION  
9 COST.—For purposes of clause (i), the  
10 term ‘wholesale acquisition cost’ means,  
11 with respect to a drug or biological, the  
12 manufacturer’s list price for the drug or  
13 biological to wholesalers or direct pur-  
14 chasers in the United States, not including  
15 prompt pay or other discounts, rebates or  
16 reductions in price, for the most recent  
17 month for which the information is avail-  
18 able, as reported in wholesale price guides  
19 or other publications of drug or biological  
20 pricing data.

21 “(E) UPDATES; DATA COLLECTION.—

22 “(i) FREQUENCY OF DETERMINA-  
23 TION.—The Secretary shall update the  
24 Federal upper limits applicable under this  
25 paragraph on at least a quarterly basis,

1 taking into account the most recent data  
2 collected for purposes of determining such  
3 limits and the Food and Drug Administra-  
4 tion's most recent publication of 'Approved  
5 Drug Products with Therapeutic Equiva-  
6 lence Evaluations'.

7 “(ii) COLLECTION OF DATA.—Data on  
8 RAMP is collected under subsection  
9 (b)(3)(A)(iv).

10 “(F) AUTHORITY TO ENTER CON-  
11 TRACTS.—The Secretary may enter into con-  
12 tracts with appropriate entities to determine  
13 RAMPS and other data necessary to calculate  
14 the Federal upper limit for a covered outpatient  
15 drug established under this subsection and to  
16 calculate that payment limit.

17 “(3) DISPENSING FEES.—

18 “(A) IN GENERAL.—A State which pro-  
19 vides medical assistance for covered outpatient  
20 drugs shall pay a dispensing fee for each cov-  
21 ered outpatient drug in accordance with this  
22 paragraph. A State may vary the amount of  
23 such dispensing fees, including taking into ac-  
24 count the special circumstances of pharmacies  
25 that are serving rural or underserved areas or

1           that are sole community pharmacies, so long as  
2           such variation is consistent with subparagraph  
3           (B).

4           “(B) DISPENSING FEE PAYMENT FOR  
5           MULTIPLE SOURCE DRUGS.—A State shall es-  
6           tablish a dispensing fee under this title for a  
7           covered outpatient drug that is treated as a  
8           multiple source drug under paragraph (2)(A)  
9           (whether or not it may be an innovator multiple  
10          source drug) in an amount that is not less than  
11          \$8 per prescription unit. The Secretary shall  
12          define what constitutes a prescription unit for  
13          purposes of the previous sentence.

14          “(4) EFFECT ON STATE MAXIMUM ALLOWABLE  
15          COST LIMITATIONS.—This section shall not super-  
16          sede or affect provisions in effect prior to January  
17          1, 1991, or after December 31, 1994, relating to  
18          any maximum allowable cost limitation established  
19          by a State for payment by the State for covered out-  
20          patient drugs, and rebates shall be made under this  
21          section without regard to whether or not payment by  
22          the State for such drugs is subject to such a limita-  
23          tion or the amount of such a limitation.

24          “(5) EVALUATION OF USE OF RETAIL SURVEY  
25          PRICE METHODOLOGY.—

1           “(A) IN GENERAL.—The Secretary may  
2           develop a methodology to set the Federal upper  
3           limit based on the reported retail survey price,  
4           as most recently reported under subparagraph  
5           (C), instead of a percentage of RAMP or vol-  
6           ume weighted average RAMP as described in  
7           paragraph (2).

8           “(B) INITIAL APPLICATION.—For 2007,  
9           the Secretary may use this methodology for a  
10          limited number of covered outpatient drugs, in-  
11          cluding both single source and multiple source  
12          drugs, selected by the Secretary in a manner so  
13          as to representative of the classes of drugs dis-  
14          pensed under this title.

15          “(C) DETERMINATION OF RETAIL SURVEY  
16          PRICE FOR COVERED OUTPATIENT DRUGS.—

17                 “(i) USE OF VENDOR.—The Secretary  
18                 may contract services for the determina-  
19                 tion of retail survey prices for covered out-  
20                 patient drugs that represent a nationwide  
21                 average of pharmacy sales costs for such  
22                 drugs, net of all discounts and rebates.  
23                 Such a contract shall be awarded for a  
24                 term of 2 years.

1           “(ii) USE OF COMPETITIVE BID-  
2           DING.—In contracting for such services,  
3           the Secretary shall competitively bid for an  
4           outside vendor that has a demonstrated  
5           history in—

6                   “(I) surveying and determining,  
7                   on a representative nationwide basis,  
8                   retail prices for ingredient costs of  
9                   prescription drugs;

10                   “(II) working with retail phar-  
11                   macies, commercial payors, and States  
12                   in obtaining and disseminating such  
13                   price information; and

14                   “(III) collecting and reporting  
15                   such price information on at least a  
16                   monthly basis.

17           “(iii) ADDITIONAL PROVISIONS.—A  
18           contract with a vendor under this subpara-  
19           graph shall include such terms and condi-  
20           tions as the Secretary shall specify, includ-  
21           ing the following:

22                   “(I) The vendor must monitor  
23                   the marketplace and report to Sec-  
24                   retary each time there is a new cov-

1           ered outpatient drug available nation-  
2           wide.

3                   “(II) The vendor must update  
4           the Secretary no less often than  
5           monthly on the retail survey prices for  
6           multiple source drugs.

7                   “(III) The vendor must apply  
8           methods for independently confirming  
9           retail survey prices.

10                   “(iv) AVAILABILITY OF INFORMATION  
11           TO STATES.—Information on retail survey  
12           prices obtained under this subparagraph,  
13           including applicable information on single  
14           source drugs, shall be provided to States  
15           on an ongoing, timely basis.

16                   “(D) STATE USE OF RETAIL SURVEY  
17           PRICE DATA.—

18                   “(i) DISTRIBUTION OF PRICE DATA.—  
19           The Secretary shall devise and implement  
20           a means for electronic distribution to each  
21           State agency designated under 1902(a)(5)  
22           with responsibility for the administration  
23           or supervision of the administration of the  
24           State plan under this title of the retail sur-  
25           vey price determined under this paragraph.

1                   “(ii) AUTHORITY TO ESTABLISH PAY-  
2                   MENT RATES BASED ON DATA.—A State  
3                   may use the price data received in accord-  
4                   ance with clause (ii) in establishing pay-  
5                   ment rates for the ingredient costs and dis-  
6                   pensing fees for covered outpatient drugs  
7                   dispensed to individuals eligible for medical  
8                   assistance under this title.

9                   “(6) LIMITATION ON JUDICIAL REVIEW.—There  
10                  shall be no administrative or judicial review of—

11                   “(A) the Secretary’s determinations of  
12                   Federal upper limits, RAMPs, and volume  
13                   weighted average RAMPs under this subsection,  
14                   including the assignment of National Drug  
15                   Codes to billing and payment classes;

16                   “(B) the Secretary’s disclosure to States of  
17                   the average manufacturer price, RAMP, volume  
18                   weighted average RAMP, and retail survey  
19                   price;

20                   “(C) determinations under this subsection  
21                   by the Secretary of covered outpatient drugs  
22                   which are dispensed by a specialty pharmacy or  
23                   administered by a physician in a physician’s of-  
24                   fice;

1           “(D) the contracting and calculations proc-  
2           ess under this subsection.

3           “(E) the method to allocate rebates,  
4           chargebacks, and other price concessions to a  
5           quarter if specified by the Secretary.”.

6           (b) CONFORMING AMENDMENTS.—

7           (1) REPORTING RAMP-RELATED INFORMA-  
8           TION.—Subsection (b)(3)(A) of such section is  
9           amended—

10           (A) by striking “and” at the end of clause  
11           (ii);

12           (B) by striking the period at the end of  
13           clause (iii) and inserting “; and”; and

14           (C) by inserting after clause (iii) the fol-  
15           lowing new clause:

16           “(iv) for calendar quarters beginning on or  
17           after July 1, 2006, in conjunction with report-  
18           ing required under clause (i) and by National  
19           Drug Code (including package size)—

20           “(I) the manufacturer’s RAMP  
21           (as defined in subsection (e)(2)(B)(i))  
22           and the total number of units re-  
23           quired to compute the volume weight-  
24           ed average RAMP under subsection  
25           (e)(2)(C);

1                   “(II) if required to make pay-  
2                   ment under subsection (e)(2)(D), the  
3                   manufacturer’s wholesale acquisition  
4                   cost, as defined in clause (ii) of such  
5                   subsection; and

6                   “(III) information on those sales  
7                   that were made at a nominal price or  
8                   otherwise described in subsection  
9                   (e)(2)(B)(ii)(II);

10                   for all covered outpatient drugs.”.

11                   (2) DISCLOSURE TO STATES.—Subsection  
12                   (b)(3)(D) of such section is amended—

13                   (A) by striking “and” at the end of clause  
14                   (ii);

15                   (B) by striking the period at the end of  
16                   clause (iii) and inserting “, and”; and

17                   (C) by inserting after clause (iv) the fol-  
18                   lowing new clause:

19                   “(iv) to States to carry out this  
20                   title.”.

21                   (3) LIMITATIONS ON FEDERAL FINANCIAL PAR-  
22                   TICIPATION.—Section 1903(i) of such Act (42  
23                   U.S.C. 1396b(i)) is amended—

24                   (A) in paragraph (10)(A), by striking  
25                   “and” at the end;

1 (B) in paragraph (10)(B), by striking “or”  
2 at the end and inserting “and”;

3 (C) by adding at the end of paragraph  
4 (10) the following:

5 “(C) with respect to any amount expended for  
6 the ingredient cost of a covered outpatient drug that  
7 exceeds the Federal upper limit for that drug estab-  
8 lished and applied under section 1927(e); or”; and

9 (D) in paragraph (21), as inserted by sec-  
10 tion 104(b) of Public Law 109-91, by inserting  
11 before the period at the end the following: “or  
12 described in subparagraph (B) or (C) of section  
13 1927(d)(2)”..

14 (c) EFFECTIVE DATE.—The amendments made by  
15 this section take effect with respect to a State on the later  
16 of—

17 (1) January 1, 2007; or

18 (2) the date that is 6 months after the close of  
19 the first regular session of the State legislature that  
20 begins after the date of the enactment of this Act.

21 (d) GAO STUDY ON DISPENSING FEES.—The Comp-  
22 troller General of the United States shall conduct a study  
23 on the appropriateness in payment levels to pharmacies  
24 for dispensing fees under the medicaid program, including  
25 payment to specialty pharmacies. Not later than 9 months

1 after the date of the enactment of this Act, the Comp-  
2 troller General shall submit to Congress a report on such  
3 study.

4 (e) IG REPORT ON USE OF RAMP AND RETAIL SUR-  
5 VEY PRICES.—Not later than 2 years after the date of  
6 the enactment of this Act, the Inspector General in the  
7 Department of Health and Human Services shall submit  
8 to Congress a report on the appropriateness of using the  
9 RAMP and retail survey prices, rather than the average  
10 manufacturer price or other price measures, as the basis  
11 for establishing a Federal upper limit for reimbursement  
12 for covered outpatient drugs under the medicaid program.

13 **SEC. 3102. COLLECTION AND SUBMISSION OF UTILIZATION**  
14 **DATA FOR CERTAIN PHYSICIAN ADMINIS-**  
15 **TERED DRUGS.**

16 (a) IN GENERAL.—Section 1927(a) of the Social Se-  
17 curity Act (42 U.S.C. 1396r–8(a)) is amended by adding  
18 at the end the following new paragraph:

19 “(7) REQUIREMENT FOR SUBMISSION OF UTILI-  
20 ZATION DATA FOR CERTAIN PHYSICIAN ADMINIS-  
21 TERED DRUGS.—

22 “(A) SINGLE SOURCE DRUGS.—In order  
23 for payment to be available under section  
24 1903(a) for a covered outpatient drug that is a  
25 single source drug or biological that is physician

1 administered (as determined by the Secretary),  
2 and that is administered on or after January 1,  
3 2006, the State shall provide for the submission  
4 of such utilization data and coding (such as J-  
5 codes and National Drug Code numbers) for  
6 each such drug as the Secretary may specify as  
7 necessary to identify the manufacturer of the  
8 drug in order to secure rebates under this sec-  
9 tion for drugs administered for which payment  
10 is made under this title.

11 “(B) MULTIPLE SOURCE DRUGS.—

12 “(i) IN GENERAL.—Not later than  
13 January 1, 2007, the information shall be  
14 submitted under subparagraph (A) using  
15 National Drug Code codes unless the Sec-  
16 retary specifies that an alternative coding  
17 system should be used.

18 “(ii) IDENTIFICATION OF MOST FRE-  
19 QUENTLY PHYSICIAN ADMINISTERED MUL-  
20 TIPLE SOURCE DRUGS.—Not later than  
21 January 1, 2007, the Secretary shall pub-  
22 lish a list of the 20 physician administered  
23 multiple source drugs that the Secretary  
24 determines have the highest dollar volume  
25 of physician administered dispensing under

1           this title. The Secretary may modify such  
2           list from year to year to reflect changes in  
3           such volume.

4                   “(iii) REQUIREMENT.—In order for  
5           payment to be available under section  
6           1903(a) for a covered outpatient drug that  
7           is a multiple source drug that is physician  
8           administered (as determined by the Sec-  
9           retary), that is on the list published under  
10          clause (ii), and that is administered on or  
11          after January 1, 2008, the State shall pro-  
12          vide for the submission of such utilization  
13          data and coding (such as J-codes and Na-  
14          tional Drug Code numbers) for each such  
15          drug as the Secretary may specify as nec-  
16          essary to identify the manufacturer of the  
17          drug in order to secure rebates under this  
18          section.

19                   “(C) HARDSHIP WAIVER.—The Secretary may  
20          delay the application of subparagraph (A) or (B), or  
21          both, in the case of a State to prevent hardship to  
22          States which require additional time to implement  
23          the reporting system required under the respective  
24          subparagraph.”.

1 (b) LIMITATION ON PAYMENT.—Section 1903(i)(10)  
2 of such Act (42 U.S.C. 1396b(i)(10)), as amended by sec-  
3 tion 3101(b)(2), is amended—

4 (1) by striking “and” at the end of subpara-  
5 graph (B);

6 (2) by striking “; or” at the end of subpara-  
7 graph (C) and inserting “, and”; and

8 (3) by adding at the end the following new sub-  
9 paragraph:

10 “(D) with respect to covered outpatient drugs  
11 described in section 1927(a)(7), unless information  
12 respecting utilization data and coding on such drugs  
13 that is required to be submitted under such section  
14 is submitted in accordance with such section; or”.

15 **SEC. 3103. IMPROVED REGULATION OF DRUGS SOLD**  
16 **UNDER A NEW DRUG APPLICATION AP-**  
17 **PROVED UNDER SECTION 505(C) OF THE FED-**  
18 **ERAL FOOD, DRUG, AND COSMETIC ACT.**

19 (a) INCLUSION WITH OTHER REPORTED AVERAGE  
20 MANUFACTURER AND BEST PRICES.—Section  
21 1927(b)(3)(A) of the Social Security Act (42 U.S.C.  
22 1396r-8(b)(3)(A)) is amended—

23 (1) by striking clause (i) and inserting the fol-  
24 lowing:

1                   “(i) not later than 30 days after the  
2                   last day of each rebate period under the  
3                   agreement—

4                                 “(I) on the average manufacturer  
5                                 price (as defined in subsection (k)(1))  
6                                 for covered outpatient drugs for the  
7                                 rebate period under the agreement  
8                                 (including for all such drugs that are  
9                                 sold under a new drug application ap-  
10                                proved under section 505(c) of the  
11                                Federal Food, Drug, and Cosmetic  
12                                Act); and

13                                “(II) for single source drugs and  
14                                innovator multiple source drugs (in-  
15                                cluding all such drugs that are sold  
16                                under a new drug application ap-  
17                                proved under section 505(c) of the  
18                                Federal Food, Drug, and Cosmetic  
19                                Act), on the manufacturer’s best price  
20                                (as defined in subsection (e)(1)(C))  
21                                for such drugs for the rebate period  
22                                under the agreement;” and

23                                (2) in clause (ii), by inserting “(including for  
24                                such drugs that are sold under a new drug applica-

1           tion approved under section 505(c) of the Federal  
2           Food, Drug, and Cosmetic Act)” after “drugs”.

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

5           (1) in subsection (c)(1)(C)—

6                   (A) in clause (i), in the matter preceding  
7                   subclause (I), by inserting after “or innovator  
8                   multiple source drug of a manufacturer” the  
9                   following: “(including any other such drug of a  
10                   manufacturer that is sold under a new drug ap-  
11                   plication approved under section 505(c) of the  
12                   Federal Food, Drug, and Cosmetic Act)”; and

13                   (B) in clause (ii)—

14                           (i) in subclause (II), by striking  
15                           “and” at the end;

16                           (ii) in subclause (III), by striking the  
17                           period at the end and inserting “; and”;  
18                           and

19                           (iii) by adding at the end the fol-  
20                           lowing:

21                                   “(IV) in the case of a manufac-  
22                                   turer that approves, allows, or other-  
23                                   wise permits any other drug of the  
24                                   manufacturer to be sold under a new  
25                                   drug application approved under sec-

1                   tion 505(c) of the Federal Food,  
2                   Drug, and Cosmetic Act, shall be in-  
3                   clusive of the lowest price for such au-  
4                   thorized drug available from the man-  
5                   ufacturer during the rebate period to  
6                   any wholesaler, retailer, provider,  
7                   health maintenance organization, non-  
8                   profit entity, or governmental entity  
9                   within the United States, excluding  
10                  those prices described in subclauses  
11                  (I) through (IV) of clause (i).”; and

12                  (2) in subsection (k)—

13                   (A) in paragraph (1)—

14                   (i) by striking “The term” and insert-  
15                   ing the following:

16                   “(A) IN GENERAL.—The term”; and

17                   (ii) by adding at the end the fol-  
18                   lowing:

19                   “(B) INCLUSION OF SECTION 505(C)  
20                   DRUGS.—In the case of a manufacturer that  
21                   approves, allows, or otherwise permits a any  
22                   drug of the manufacturer to be sold under a  
23                   new drug application approved under section  
24                   505(c) of the Federal Food, Drug, and Cos-  
25                   metic Act, such term shall be inclusive of the

1 average price paid for such authorized drug by  
2 wholesalers for drugs distributed to the retail  
3 pharmacy class of trade, after deducting cus-  
4 tomary prompt pay discounts.”.

5 (c) EFFECTIVE DATE.—The amendments made by  
6 this section take effect on the date of the enactment of  
7 this Act.

## 8 CHAPTER 2—REFORM OF ASSET

### 9 TRANSFER RULES

#### 10 SEC. 3111. LENGTHENING LOOK-BACK PERIOD; CHANGE IN 11 BEGINNING DATE FOR PERIOD OF INELIGI- 12 BILITY.

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

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

23 (1) by striking “(D) The date” and inserting  
24 “(D)(i) In the case of a transfer of asset made be-

1 fore the date of the enactment of the Medicaid Rec-  
2 onciliation Act of 2005, the date”; and

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

5 “(ii) In the case of a transfer of asset made on or  
6 after the date of the enactment of the Medicaid Reconcili-  
7 ation Act of 2005, the date specified in this subparagraph  
8 is the first day of a month during or after which assets  
9 have been transferred for less than fair market value, or  
10 the date on which the individual is eligible for medical as-  
11 sistance under the State plan and is receiving services de-  
12 scribed in subparagraph (C), whichever is later, and which  
13 does not occur during any other period of ineligibility  
14 under this subsection.”.

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

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

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

1 (A) of medical care such that the individ-  
2 ual's health or life would be endangered; or

3 (B) of food, clothing, shelter, or other ne-  
4 cessities of life; and

5 (2) which provides for—

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

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

11 (C) a process under which an adverse de-  
12 termination can be appealed.

13 (e) ADDITIONAL PROVISIONS ON HARDSHIP WAIV-  
14 ERS.—

15 (1) APPLICATION BY FACILITY.—Section  
16 1917(e)(2) of the Social Security Act (42 U.S.C.  
17 1396p(e)(2)) is amended—

18 (A) by striking the semicolon at the end of  
19 subparagraph (D) and inserting a period; and

20 (B) by adding after and below such sub-  
21 paragraph the following:

22 “The procedures established under subparagraph (D)  
23 shall permit the facility in which the institutionalized indi-  
24 vidual is residing to file an undue hardship waiver applica-

1 tion on behalf of the individual with the consent of the  
2 individual or the legal guardian of the individual.”.

3           (2) **AUTHORITY TO MAKE BED HOLD PAYMENTS**  
4 **FOR HARDSHIP APPLICANTS.**—Such section is fur-  
5 ther amended by adding at the end the following:  
6 “While an application for an undue hardship waiver  
7 is pending under subparagraph (D) in the case of an  
8 individual who is a resident of a nursing facility, if  
9 the application meets such criteria as the Secretary  
10 specifies, the State may provide for payments for  
11 nursing facility services in order to hold the bed for  
12 the individual at the facility, but not in excess of  
13 payments for 30 days.”.

14 **SEC. 3112. DISCLOSURE AND TREATMENT OF ANNUITIES**  
15 **AND OF LARGE TRANSACTIONS.**

16           (a) **IN GENERAL.**—Section 1917 of the Social Secu-  
17 rity Act is amended by redesignating subsection (e) as  
18 subsection (f) and by inserting after subsection (d) the fol-  
19 lowing new subsection:

20           “(e)(1) In order to meet the requirements of this sub-  
21 section for purposes of section 1902(a)(18), a State shall  
22 require, as a condition for the provision of medical assist-  
23 ance for services described in subsection (e)(1)(C)(i) (re-  
24 lating to long-term care services) for an individual, the ap-  
25 plication of the individual for such assistance (including

1 any recertification of eligibility for such assistance) shall  
2 disclose the following:

3           “(A) A description of any interest the individual  
4 has in an annuity (or similar financial instrument  
5 which provides for the conversion of a countable  
6 asset to a noncountable asset, as may be specified by  
7 the Secretary), regardless of whether the annuity is  
8 irrevocable or is treated as an asset.

9           “(B) Full information (as specified by the Sec-  
10 retary) concerning any transaction involving the  
11 transfer or disposal of assets during the previous pe-  
12 riod of 60 months, if the transaction exceeded  
13 \$100,000, without regard to whether the transfer or  
14 disposal was for fair market value. For purposes of  
15 applying the previous sentence under this subsection,  
16 all transactions of \$5,000 or more occurring within  
17 a 12-month period shall be treated as a single trans-  
18 action. The dollar amounts specified in the first and  
19 second sentences of this subparagraph shall be in-  
20 creased, beginning with 2007, from year to year  
21 based on the percentage increase in the consumer  
22 price index for all urban consumers (all items;  
23 United States city average), rounded to the nearest  
24 \$1,000 in the case of the first sentence and \$100 in  
25 the case of the second sentence.

1 Such application or recertification form shall include a  
2 statement that under paragraph (2) the State becomes a  
3 remainder beneficiary under such a annuity or similar fi-  
4 nancial instrument by virtue of the provision of such med-  
5 ical assistance.

6       “(2)(A) In the case of any annuity in which an insti-  
7 tutionalized individual has an interest, if medical assist-  
8 ance is furnished to the individual for services described  
9 in subsection (c)(1)(C)(i), by virtue of the provision of  
10 such assistance the State becomes the remainder bene-  
11 ficiary in the first position for the total amount of such  
12 medical assistance paid on behalf of the individual under  
13 this title.

14       “(B) In the case of disclosure concerning an annuity  
15 under paragraph (1)(A), the State shall notify issuer of  
16 the annuity of the right of the State under subparagraph  
17 (A) as a preferred remainder beneficiary in the annuity  
18 for medical assistance furnished to the individual. Nothing  
19 in this paragraph shall be construed as preventing such  
20 an issuer from notifying persons with any other remainder  
21 interest of the State’s remainder interest under subpara-  
22 graph (A).

23       “(C) In the case of such an issuer receiving notice  
24 under subparagraph (B), the State may require the issuer  
25 to notify the State when there is a change in the amount

1 of income or principal being withdrawn from the amount  
2 that was being withdrawn at the time of the most recent  
3 disclosure described in paragraph (1)(A). A State shall  
4 take such information into account in determining the  
5 amount of the State's obligations for medical assistance  
6 or in the individual's eligibility for such assistance.

7       “(3)(A) For purposes of subsection (c)(1), a trans-  
8 action described in paragraph (1)(B) shall be deemed as  
9 the transfer of an asset for less than fair market value  
10 unless the individual demonstrates to the satisfaction of  
11 the State that the transfer of the asset was for fair market  
12 value.

13       “(B) The Secretary may provide guidance to States  
14 on categories of arms length transactions (such as the pur-  
15 chase of a commercial annuity) that could be generally  
16 treated as a transfer of asset for fair market value.

17       “(4) Nothing in this subsection shall be construed as  
18 preventing a State from denying eligibility for medical as-  
19 sistance for an individual based on the income or resources  
20 derived from an annuity described in paragraph (1)(A).”.

21       (b) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to transactions (including the pur-  
23 chase of an annuity) occurring on or after the date of the  
24 enactment of this Act.

1 **SEC. 3113. APPLICATION OF “INCOME-FIRST” RULE IN AP-**  
2 **PLYING COMMUNITY SPOUSE’S INCOME BE-**  
3 **FORE ASSETS IN PROVIDING SUPPORT OF**  
4 **COMMUNITY SPOUSE.**

5 (a) IN GENERAL.—Section 1924(d) of the Social Se-  
6 curity Act (42 U.S.C. 1396r–5(d)) is amended by adding  
7 at the end the following new paragraph:

8 “(6) APPLICATION OF ‘INCOME FIRST’ RULE  
9 FOR FUNDING COMMUNITY SPOUSE MONTHLY IN-  
10 COME ALLOWANCE.—For purposes of this subsection  
11 and subsection (e), any transfer or allocation made  
12 from an institutionalized spouse to meet the need of  
13 a community spouse for a community spouse month-  
14 ly income allowance under paragraph (1)(B) shall be  
15 first made from income of the institutionalized  
16 spouse and then only when the income is not avail-  
17 able from the resources of such institutionalized  
18 spouse.”.

19 (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) shall apply to transfers and allocations  
21 made on or after the date of the enactment of this Act  
22 by individuals who become institutionalized spouses on or  
23 after such date.

1 **SEC. 3114. DISQUALIFICATION FOR LONG-TERM CARE AS-**  
2 **SISTANCE FOR INDIVIDUALS WITH SUBSTAN-**  
3 **TIAL HOME EQUITY.**

4 (a) IN GENERAL.—Section 1917 of the Social Secu-  
5 rity Act, as amended by section 3112, is further amended  
6 by redesignating subsection (f) as subsection (g) and by  
7 inserting after subsection (e) the following new subsection:

8 “(f)(1) Notwithstanding any other provision of this  
9 title, subject to paragraph (2), in determining eligibility  
10 of an individual for medical assistance with respect to  
11 nursing facility services or other long-term care services,  
12 the individual shall not be eligible for such assistance if  
13 individual’s equity interest in the individual’s home ex-  
14 ceeds \$500,000. The dollar amount specified in the pre-  
15 ceding sentence shall be increased, beginning with 2011,  
16 from year to year based on the percentage increase in the  
17 consumer price index for all urban consumers (all items;  
18 United States city average), rounded to the nearest  
19 \$1,000.

20 “(2) Paragraph (1) shall not apply with respect to  
21 an individual if—

22 “(A) the spouse of such individual, or

23 “(B) such individual’s child who is under age  
24 21, or (with respect to States eligible to participate  
25 in the State program established under title XVI) is  
26 blind or permanently and totally disabled, or (with

1       respect to States which are not eligible to participate  
2       in such program) is blind or disabled as defined in  
3       section 1614,

4       is lawfully residing in the individual's home.

5       “(3) Nothing in this subsection shall be construed as  
6       preventing an individual from using a reverse mortgage  
7       or home equity loan to reduce the individual's total equity  
8       interest in the home.

9       “(4) The Secretary shall establish a process whereby  
10       paragraph (1) is waived in the case of a demonstrated  
11       hardship.”.

12       (b) **EFFECTIVE DATE.**—The amendment made by  
13       subsection (a) shall apply to individuals who are deter-  
14       mined eligible for medical assistance with respect to nurs-  
15       ing facility services or other long-term care services based  
16       on an application filed on or after January 1, 2006.

17       **SEC. 3115. ENFORCEABILITY OF CONTINUING CARE RE-**  
18                               **TIREMENT COMMUNITIES (CCRC) AND LIFE**  
19                               **CARE COMMUNITY ADMISSION CONTRACTS.**

20       (a) **ADMISSION POLICIES OF NURSING FACILITIES.**—  
21       Section 1919(c)(5) of the Social Security Act (42 U.S.C.  
22       1396r(c)(5)) is amended—

23               (1) in subparagraph (A)(i)(II), by inserting  
24       “subject to clause (v),” after “(II)”; and

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

3                           “(v) TREATMENT OF CONTINUING  
4                           CARE RETIREMENT COMMUNITIES ADMIS-  
5                           SION CONTRACTS.—Notwithstanding sub-  
6                           clause (II) of subparagraph (A)(i), subject  
7                           to section 1924(c), contracts for admission  
8                           to a State licensed, registered, certified, or  
9                           equivalent continuing care retirement com-  
10                          munity or life care community, including  
11                          services in a nursing facility that is part of  
12                          such community, may require residents to  
13                          spend on their care resources declared for  
14                          the purposes of admission before applying  
15                          for medical assistance.”.

16       (b) TREATMENT OF ENTRANCE FEES.—Section  
17 1917 of such Act (42 U.S.C. 1396p) is amended by adding  
18 at the end the following new subsection:

19                           “(f) TREATMENT OF ENTRANCE FEES OF INDIVID-  
20                           UALS RESIDING IN CONTINUING CARE RETIREMENT  
21                           COMMUNITIES.—

22                           “(1) IN GENERAL.—For purposes of deter-  
23                           mining an individual’s eligibility for, or amount of,  
24                           benefits under a State plan under this title, the rules  
25                           specified in paragraph (2) shall apply to individuals

1       residing in continuing care retirement communities  
2       or life care communities that collect an entrance fee  
3       on admission from such individuals.

4           “(2) TREATMENT OF ENTRANCE FEE.—For  
5       purposes of this subsection, an individual’s entrance  
6       fee in a continuing care retirement community or  
7       life care community shall be considered a resource  
8       available to the individual to the extent that—

9           “(A) the individual has the ability to use  
10       the entrance fee, or the contract provides that  
11       the entrance fee may be used, to pay for care  
12       should other resources or income of the indi-  
13       vidual be insufficient to pay for such care;

14           “(B) the individual is eligible for a refund  
15       of any remaining entrance fee when the indi-  
16       vidual dies or terminates the continuing care re-  
17       tirement community or life care community  
18       contract and leaves the community; and

19           “(C) the entrance fee does not confer an  
20       ownership interest in the continuing care retire-  
21       ment community or life care community.

22           “(3) TREATMENT IN RELATION TO SPOUSAL  
23       SHARE.—To the extent that an entrance fee is deter-  
24       mined to be an available resource to an individual  
25       applying for medical assistance and the individual

1 has a community spouse as defined in section  
2 1924(h), the entrance fee shall be considered in the  
3 computation of spousal share pursuant to section  
4 1924(e).”.

5 **CHAPTER 3—FLEXIBILITY IN COST-**  
6 **SHARING AND BENEFITS**

7 **SEC. 3121. STATE OPTION FOR ALTERNATIVE MEDICAID**  
8 **PREMIUMS AND COST-SHARING.**

9 (a) IN GENERAL.—Title XIX of the Social Security  
10 Act is amended by inserting after section 1916 the fol-  
11 lowing new section:

12 “STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST-  
13 SHARING

14 “SEC. 1916A. (a) STATE FLEXIBILITY.—

15 “(1) IN GENERAL.—Notwithstanding sections  
16 1916 and 1902(a)(10)(B), a State, at its option and  
17 through a State plan amendment, may impose pre-  
18 miums and cost-sharing for any group of individuals  
19 (as specified by the State) and for any type of serv-  
20 ices (and may vary such premiums and cost-sharing  
21 among such group or type, including through the  
22 use of tiered cost-sharing for prescription drugs)  
23 consistent with the limitations established under this  
24 section. Nothing in this section shall be construed as  
25 superseding (or preventing the application of) sec-  
26 tion 1916(g).

1           “(2) DEFINITIONS.—In this section:

2                   “(A) PREMIUM.—The term ‘premium’ in-  
3                   cludes any enrollment fee or similar charge.

4                   “(B) COST-SHARING.—The term ‘cost-  
5                   sharing’ includes any deduction, deductible, co-  
6                   payment, or similar charge.

7           “(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—

8                   “(1) INDIVIDUALS WITH FAMILY INCOME  
9                   BELOW 100 PERCENT OF POVERTY LEVEL.—In the  
10                  case of an individual whose family income does not  
11                  exceed 100 percent of the Federal poverty level ap-  
12                  plicable to a family of the size involved, subject to  
13                  subsections (c)(2)(B) and (e)(2)(B), the limitations  
14                  otherwise provided under subsections (a) and (b) of  
15                  section 1916 shall continue to apply and no enroll-  
16                  ment fee, premium, or similar charge will be im-  
17                  posed under the plan, except that the total annual  
18                  aggregate amount of cost-sharing imposed (including  
19                  any increase cost-sharing imposed under subsection  
20                  (c) or (e)) for all individuals in the family may not  
21                  exceed 5 percent of the family income of the family  
22                  involved for the year involved.

23                  “(2) INDIVIDUALS WITH FAMILY INCOME  
24                  ABOVE 100 PERCENT OF POVERTY LEVEL.—In the  
25                  case of an individual whose family income exceeds

1       100 percent of the Federal poverty level applicable  
2       to a family of the size involved, the total annual ag-  
3       gregate amount of premiums and cost-sharing im-  
4       posed (including any increase cost-sharing imposed  
5       under subsection (c) or (e)) for all individuals in the  
6       family may not exceed 5 percent of the family in-  
7       come of the family involved for the year involved.

8           “(3) ADDITIONAL LIMITATIONS.—Subject to  
9       subsections the succeeding provisions of this section,  
10       no cost-sharing shall be imposed under this section  
11       with respect to the following:

12           “(A) Services furnished to individuals  
13       under 18 years of age that are required to be  
14       provided medical assistance under section  
15       1902(a)(10)(A)(i), and including services fur-  
16       nished to individuals with respect to whom  
17       adoption or foster care assistance is made avail-  
18       able under part E of title IV without regard to  
19       age.

20           “(B) Preventive services (such as well baby  
21       and well child care and immunizations) pro-  
22       vided to children under 18 years of age regard-  
23       less of family income.

24           “(C) Services furnished to pregnant  
25       women, if such services relate to the pregnancy

1 or to any other medical condition which may  
2 complicate the pregnancy.

3 “(D) Services furnished to a terminally ill  
4 individual who is receiving hospice care (as de-  
5 fined in section 1905(o)).

6 “(E) Services furnished to any individual  
7 who is an inpatient in a hospital, nursing facil-  
8 ity, intermediate care facility for the mentally  
9 retarded, or other medical institution, if such  
10 individual is required, as a condition of receiv-  
11 ing services in such institution under the State  
12 plan, to spend for costs of medical care all but  
13 a minimal amount of the individual’s income re-  
14 quired for personal needs.

15 “(F) Emergency services (as defined by  
16 the Secretary for purposes of section  
17 1916(a)(2)(D)).

18 “(G) Family planning services and supplies  
19 described in section 1905(a)(4)(C).

20 Nothing in this paragraph shall be construed as pre-  
21 venting a State from exempting additional classes of  
22 individuals or services from cost-sharing under this  
23 section.

1           “(4) INDEXING NOMINAL AMOUNTS.—In apply-  
2           ing section 1916 under paragraph (1) with respect  
3           to cost-sharing that is ‘nominal’ in amount—

4                   “(A) the Secretary shall phase-in an in-  
5                   crease in such amount over a 3 year period (be-  
6                   ginning January 1, 2006) so that—

7                           “(i) a \$3 nominal amount in 2005  
8                           would be increased to be a \$5 nominal  
9                           amount in 2008; and

10                           “(ii) other nominal amounts would be  
11                           increased by a proportional amount (with  
12                           appropriate rounding) during such period;  
13                           and

14                           “(B) the Secretary shall increase such  
15                           ‘nominal’ amounts for each subsequent year  
16                           (beginning with 2009) by the annual percentage  
17                           increase in the medical care component of the  
18                           consumer price index for all urban consumers  
19                           (U.S. city average) as rounded up in an appro-  
20                           priate manner.

21           “(6) DETERMINATIONS OF FAMILY INCOME.—  
22           In applying this subsection, family income shall be  
23           determined in a manner specified by the State for  
24           purposes of this subsection, including the use of  
25           such disregards as the State may provide. Family in-

1       come shall be determined for such period and at  
2       such periodicity as the State may provide under this  
3       title.

4               “(7) POVERTY LINE DEFINED.—For purposes  
5       of this subsection, the term ‘poverty line’ has the  
6       meaning given such term in section 673(2) of the  
7       Community Services Block Grant Act (42 U.S.C.  
8       9902(2)), including any revision required by such  
9       section.

10              “(8) CONSTRUCTION.—Nothing in this section  
11       shall be construed—

12                      “(A) as preventing a State from further  
13       limiting the premiums and cost-sharing imposed  
14       under this section beyond the limitations pro-  
15       vided under this subsection;

16                      “(B) as affecting the authority of the Sec-  
17       retary through waiver to modify limitations on  
18       premiums and cost-sharing under this sub-  
19       section; or

20                      “(C) as affecting any such waiver of re-  
21       quirements in effect under this title before the  
22       date of the enactment of this section with re-  
23       gard to the imposition of premiums and cost-  
24       sharing.

1       “(d) ENFORCEABILITY OF PREMIUMS AND OTHER  
2 COST-SHARING.—

3           “(1) PREMIUMS.—Notwithstanding section  
4 1916(e)(3) and section 1902(a)(10)(B), a State  
5 may, at its option, condition the provision of medical  
6 assistance for an individual upon prepayment of a  
7 premium authorized to be imposed under this sec-  
8 tion, or may terminate eligibility for such medical  
9 assistance on the basis of failure to pay such a pre-  
10 mium but shall not terminate eligibility of an indi-  
11 vidual for medical assistance under this title on the  
12 basis of failure to pay any such premium until such  
13 failure continues for a period of not less than 60  
14 days. A State may apply the previous sentence for  
15 some or all groups of beneficiaries as specified by  
16 the State and may waive payment of any such pre-  
17 mium in any case where the State determines that  
18 requiring such payment would create an undue hard-  
19 ship.

20           “(2) COST-SHARING.—Notwithstanding section  
21 1916(e) or any other provision of law, a State may  
22 permit a provider participating under the State plan  
23 to require, as a condition for the provision of care,  
24 items, or services to an individual entitled to medical  
25 assistance under this title for such care, items, or

1 services, the payment of any cost-sharing authorized  
2 to be imposed under this section with respect to  
3 such care, items, or services. Nothing in this para-  
4 graph shall be construed as preventing a provider  
5 from reducing or waiving the application of such  
6 cost-sharing.”.

7 (b) CONFORMING AMENDMENT.—Section 1916(f) of  
8 such Act (42 U.S.C. 1396o(f)) is amended by inserting  
9 “and section 1916A” after “(b)(3)”.

10 (c) GAO STUDY OF IMPACT OF PREMIUMS AND  
11 COST-SHARING.—The Comptroller General of the United  
12 States shall conduct a study of the impact of premiums  
13 and cost-sharing under the medicaid program on access  
14 to, and utilization of, services. Not later than January 1,  
15 2008, the Comptroller General shall submit a report to  
16 the Congress on such study.

17 (d) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to cost-sharing imposed for items  
19 and services furnished on or after January 1, 2006.

20 **SEC. 3122. SPECIAL RULES FOR COST-SHARING FOR PRE-**  
21 **SCRIPTION DRUGS.**

22 (a) IN GENERAL.—Section 1916A of the Social Secu-  
23 rity Act, as inserted by section 3121, is amended by insert-  
24 ing after subsection (b) the following new subsection:

1       “(c) SPECIAL RULES FOR COST-SHARING FOR PRE-  
2       SCRIPTION DRUGS.—

3               “(1) IN GENERAL.—In order to encourage  
4       beneficiaries to use drugs (in this subsection referred  
5       to as ‘preferred drugs’) identified by the State as the  
6       least (or less) costly effective prescription drugs  
7       within a class of drugs (as defined by the State),  
8       with respect to one or more groups of beneficiaries  
9       specified by the State, subject to paragraphs (2) and  
10      (5), the State may—

11              “(A) may provide an increase in cost-shar-  
12      ing (above the nominal level otherwise per-  
13      mitted under section 1916 or subsection (b),  
14      but subject to paragraphs (2) and (3)) for any  
15      beneficiary with respect to drugs that are not  
16      preferred drugs within a class; and

17              “(B) waive or reduce the cost-sharing oth-  
18      erwise applicable for preferred drugs within  
19      such class and shall not apply any such cost-  
20      sharing for such preferred drugs for individuals  
21      for whom cost-sharing may not otherwise be im-  
22      posed under subsection (b)(3).

23              “(2) LIMITATIONS.—

24              “(A) BY INCOME GROUP AS A MULTIPLE  
25      OF NOMINAL AMOUNTS.—In no case may the

1 increase in cost-sharing under paragraph (1)(A)  
2 with respect to a non-preferred drug exceed, in  
3 the case of an individual whose family income  
4 is—

5 “(i) below 100 percent of the poverty  
6 line applicable to a family of the size in-  
7 volved, the amount of nominal cost sharing  
8 (as otherwise determined under subsection  
9 (b));

10 “(ii) at least 100 percent, but below  
11 150 percent, of the poverty line applicable  
12 to a family of the size involved, two times  
13 the amount of nominal cost sharing (as  
14 otherwise determined under subsection  
15 (b)); or

16 “(iii) at least 150 percent of the pov-  
17 erty line applicable to a family of the size  
18 involved, three times the amount of nomi-  
19 nal cost sharing (as otherwise determined  
20 under subsection (b)).

21 “(B) LIMITATION TO NOMINAL FOR EX-  
22 EMPT POPULATIONS.—In the case of an indi-  
23 vidual who is otherwise not subject to cost-shar-  
24 ing due to the application of subsection (b)(3),  
25 any increase in cost-sharing under paragraph

1 (1)(A) with respect to a non-preferred drug  
2 may not exceed a nominal amount (as otherwise  
3 determined under subsection (b)).

4 “(C) CONTINUED APPLICATION OF AGGREGATE CAP.—In addition to the limitations im-  
5 posed under subparagraphs (A) and (B), any  
6 increase in cost-sharing under paragraph (1)(A)  
7 continues to be subject to the aggregate cap on  
8 cost sharing applied under paragraph (1) or (2)  
9 of subsection (b), as the case may be.  
10

11 “(D) TRICARE PHARMACY BENEFIT PRO-  
12 GRAM LIMITATIONS.—In no case may a State—

13 “(i) treat as a non-preferred drug  
14 under this subsection a drug that is treat-  
15 ed as a preferred drug under the  
16 TRICARE pharmacy benefit program es-  
17 tablished under section 1074g of title 10,  
18 United States Code, as such program is in  
19 effect on the date of the enactment of this  
20 section ; or

21 “(ii) impose cost sharing under this  
22 subsection that exceeds the cost sharing  
23 imposed under the standards under such  
24 pharmacy benefit program, as such pro-

1                   gram is in effect as of the date of the en-  
2                   actment of this section.

3                   “(3) WAIVER.—In carrying out paragraph (1),  
4                   a State shall provide for the application of cost-shar-  
5                   ing levels applicable to a preferred drug in the case  
6                   of a drug that is not a preferred drug if the pre-  
7                   scribing physician determines that the preferred  
8                   drug for treatment of the same condition either  
9                   would not be as effective for the individual or would  
10                  have adverse effects for the individual or both.

11                  “(4) EXCLUSION AUTHORITY.—Nothing in this  
12                  subsection shall be construed as preventing a State  
13                  from excluding from paragraph (1) specified drugs  
14                  or classes of drugs.

15                  “(5) PRIOR AUTHORIZATION AND APPEALS  
16                  PROCESS.—A State may not provide for increased  
17                  cost-sharing under this subsection unless the State  
18                  has implemented for outpatient prescription drugs a  
19                  system for prior authorization and an appeals proc-  
20                  ess for determinations relating to prior authoriza-  
21                  tion.”.

22                  (b) EFFECTIVE DATE.—The amendment made by  
23                  subsection (a) shall apply to cost-sharing imposed for  
24                  items and services furnished on or after October 1, 2006.

1 **SEC. 3123. EMERGENCY ROOM COPAYMENTS FOR NON-**  
2 **EMERGENCY CARE.**

3 (a) IN GENERAL.—Section 1916A of the Social Secu-  
4 rity Act, as inserted by section 3121 and as amended by  
5 section 3122, is further amended by adding at the end  
6 the following new subsection:

7 “(e) STATE OPTION FOR IMPOSING COST-SHARING  
8 FOR NON-EMERGENCY CARE FURNISHED IN AN HOS-  
9 PITAL EMERGENCY ROOM.—

10 “(1) IN GENERAL.—Notwithstanding section  
11 1916 or the previous provisions of this section, but  
12 subject to the limitations of paragraph (2), a State  
13 may, by amendment to its State plan under this  
14 title, impose cost-sharing for non-emergency services  
15 furnished to an individual (within one or more  
16 groups of individuals specified by the State) in a  
17 hospital emergency department under this subsection  
18 if the following conditions are met:

19 “(A) ACCESS TO NON-EMERGENCY ROOM  
20 PROVIDER.—The individual has actually avail-  
21 able and accessible (as such terms are applied  
22 by the Secretary under section 1916(b)(3)) to  
23 an alternate non-emergency services provider  
24 with respect to such services.

25 “(B) NOTICE.—The physician or hospital  
26 must inform the beneficiary after the appro-

1           appropriate screening assessment, but before pro-  
2           viding the non-emergency services, of the fol-  
3           lowing:

4                   “(i) The hospital may require the pay-  
5                   ment of the State specified cost-sharing be-  
6                   fore the service can be provided.

7                   “(ii) The name and location of an al-  
8                   ternate non-emergency services provider  
9                   (described in subparagraph (A)) that is ac-  
10                  tually available and accessible (as described  
11                  in such subparagraph).

12                  “(iii) The fact that such alternate  
13                  provider can provide the services without  
14                  the imposition of the increase in cost-shar-  
15                  ing described in clause (i).

16                  “(iv) The hospital provides a referral  
17                  to coordinate scheduling of this treatment.

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

22                  “(2) LIMITATIONS.—

23                   “(A) FOR POOREST BENEFICIARIES.—In  
24                   the case of an individual described in subsection  
25                   (b)(1), the cost-sharing imposed under this sub-

1 section may not exceed twice the amount deter-  
2 mined to be nominal under this section, subject  
3 to the percent of income limitation otherwise  
4 applicable under subsection (b)(1).

5 “(B) APPLICATION TO EXEMPT POPU-  
6 LATIONS.—In the case of an individual who is  
7 otherwise not subject to cost-sharing under sub-  
8 section (b)(3), a State may impose cost-sharing  
9 under paragraph (1) for care in an amount that  
10 does not exceed a nominal amount (as otherwise  
11 determined under subsection (b)) so long as no  
12 cost-sharing is imposed to receive such care  
13 through an outpatient department or other al-  
14 ternative health care provider in the geographic  
15 area of the hospital emergency department in-  
16 volved.

17 “(C) CONTINUED APPLICATION OF AGGRE-  
18 GATE CAP.—In addition to the limitations im-  
19 posed under subparagraphs (A) and (B), any  
20 increase in cost-sharing under paragraph (1)  
21 continues to be subject to the aggregate cap on  
22 cost sharing applied under paragraph (1) or (2)  
23 of subsection (b), as the case may be.

24 “(3) CONSTRUCTION.—Nothing in this section  
25 shall be construed—

1           “(A) to limit a hospital’s obligations with  
2           respect to screening and stabilizing treatment  
3           of an emergency medical condition under sec-  
4           tion 1867; or

5           “(B) to modify any obligations under ei-  
6           ther State or Federal standards relating to the  
7           application of a prudent-layperson standard  
8           with respect to payment or coverage of emer-  
9           gency services by any managed care organiza-  
10          tion.

11          “(4) DETERMINATION STANDARD.—No hospital  
12          or physician that makes a determination with re-  
13          spect to the imposition of cost-sharing under this  
14          subsection shall be liable in any civil action or pro-  
15          ceeding for such determination absent a finding by  
16          clear and convincing evidence of gross negligence by  
17          the hospital or physician. The previous sentence  
18          shall not affect any liability under section 1867 or  
19          otherwise applicable under State law based upon the  
20          provision (or failure to provide) care.

21          “(5) DEFINITIONS.—For purposes of this sub-  
22          section:

23                 “(A) NON-EMERGENCY SERVICES.—The  
24                 term ‘non-emergency services’ means any care  
25                 or services furnished in a emergency depart-

1           ment of a hospital that the physician deter-  
2           mines do not constitute an appropriate medical  
3           screening examination or stabilizing examina-  
4           tion and treatment screening required to be  
5           provided by the hospital under section 1867.

6           “(B) ALTERNATE NON-EMERGENCY SERV-  
7           ICES PROVIDER.—The term ‘alternative non-  
8           emergency services provider’ means, with re-  
9           spect to non-emergency services for the diag-  
10          nosis or treatment of a condition, a health care  
11          provider, such as a physician’s office, health  
12          care clinic, community health center, hospital  
13          outpatient department, or similar health care  
14          provider, that provides clinically appropriate  
15          services for such diagnosis or treatment of the  
16          condition within a clinically appropriate time of  
17          the provision of such non-emergency services  
18          and that is participating in the program under  
19          this title.”.

20          (b) GRANT FUNDS FOR ESTABLISHMENT OF ALTER-  
21          NATE NON-EMERGENCY SERVICES PROVIDERS.—Section  
22          1903 of the Social Security Act (42 U.S.C. 1396b), as  
23          amended by section 3104, is further amended by adding  
24          at the end the following new subsection:

1           “(y) PAYMENTS FOR ESTABLISHMENT OF ALTER-  
2 NATE NON-EMERGENCY SERVICES PROVIDERS.—

3           “(1) PAYMENTS.—In addition to the payments  
4 otherwise provided under subsection (a), subject to  
5 paragraph (2), the Secretary shall provide for pay-  
6 ments to States under such subsection for the estab-  
7 lishment of alternate non-emergency service pro-  
8 viders (as defined in section 1916A(f)(6)(B)), or  
9 networks of such providers.

10           “(2) LIMITATION.—The total amount of pay-  
11 ments under this subsection shall be equal to, and  
12 shall not exceed, \$100,000,000 during the four-year  
13 period beginning with 2006. This subsection con-  
14 stitutes budget authority in advance of appropria-  
15 tions Acts and represents the obligation of the Sec-  
16 retary to provide for the payment of amounts pro-  
17 vided under this subsection.

18           “(3) PREFERENCE.—In providing for payments  
19 to States under this subsection, the Secretary shall  
20 provide preference to States that establish, or pro-  
21 vide for, alternate non-emergency services providers  
22 or networks of such providers that—

23           “(A) serve rural or underserved areas  
24 where beneficiaries under this title may not

1           have regular access to providers of primary care  
2           services; or

3                   “(B) are in partnership with local commu-  
4           nity hospitals.

5           “(4) FORM AND MANNER OF PAYMENT.—Pay-  
6           ment to a State under this subsection shall be made  
7           only upon the filing of such application in such form  
8           and in such manner as the Secretary shall specify.  
9           Payment to a State under this subsection shall be  
10          made in the same manner as other payments under  
11          section 1903(a).”.

12          (c) EFFECTIVE DATE.—The amendments made by  
13          this section shall apply to non-emergency services fur-  
14          nished on or after the date of the enactment of this Act.

15       **SEC. 3124. USE OF BENCHMARK BENEFIT PACKAGES.**

16          Title XIX of the Social Security Act is amended by  
17          redesignating section 1936 as section 1937 and by insert-  
18          ing after section 1935 the following new section:

19               “STATE FLEXIBILITY IN BENEFIT PACKAGES

20               “SEC. 1936. (a) STATE OPTION OF PROVIDING  
21          BENCHMARK BENEFITS.—

22                   “(1) AUTHORITY.—

23                           “(A) IN GENERAL.—Notwithstanding any  
24                   other provision of this title, a State, at its op-  
25                   tion as a State plan amendment, may provide  
26                   for medical assistance under this title to indi-

1           viduals within one or more groups of individuals  
2           specified by the State through enrollment in  
3           coverage that provides—

4                   “(i) benchmark coverage described in  
5                   subsection (b)(1); or

6                   “(ii) benchmark equivalent coverage  
7                   described in subsection (b)(2).

8                   “(B) OPTION OF WRAP-AROUND BENE-  
9                   FITS.—In the case of coverage described in sub-  
10                  paragraph (A), a State, at its option, may pro-  
11                  vide such wrap-around or additional benefits as  
12                  the State may specify.

13                  “(C) TREATMENT AS MEDICAL ASSIST-  
14                  ANCE.—Payment of premiums for such cov-  
15                  erage under this subsection shall be treated as  
16                  payment of other insurance premiums described  
17                  in the third sentence of section 1905(a).

18                  “(2) APPLICATION.—

19                   “(A) IN GENERAL.—Except as provided in  
20                   subparagraph (B), a State may require that a  
21                   full-benefit eligible individual (as defined in  
22                   subparagraph (C)) within a group obtain bene-  
23                   fits under this title through enrollment in cov-  
24                   erage described in paragraph (1)(A). A State

1           may apply the previous sentence to individuals  
2           within one or more groups of such individuals.

3           “(B) LIMITATION ON APPLICATION.—A  
4           State may not require under subparagraph (A)  
5           an individual to obtain benefits through enroll-  
6           ment described in paragraph (1)(A) if the indi-  
7           vidual is within one of the following categories  
8           of individuals:

9                   “(i) MANDATORY PREGNANT WOMEN  
10                   AND CHILDREN.—The individual is a preg-  
11                   nant woman or child under 18 years of age  
12                   who is required to be covered under the  
13                   State plan under section  
14                   1902(a)(10)(A)(i).

15                   “(ii) DUAL ELIGIBLES.—The indi-  
16                   vidual is entitled to benefits under any  
17                   part of title XVIII.

18                   “(iii) TERMINALLY ILL HOSPICE PA-  
19                   TIENTS.—The individual is terminally ill  
20                   and is receiving benefits for hospice care  
21                   under this title.

22                   “(iv) ELIGIBLE ON BASIS OF INSTITU-  
23                   TIONALIZATION.—The individual is an in-  
24                   patient in a hospital, nursing facility, in-  
25                   termediate care facility for the mentally re-

1           tarded, or other medical institution, if such  
2           individual is required, as a condition of re-  
3           ceiving services in such institution under  
4           the State plan, to spend for costs of med-  
5           ical care all but a minimal amount of the  
6           individual's income required for personal  
7           needs.

8           “(v) MEDICALLY FRAIL AND SPECIAL  
9           MEDICAL NEEDS INDIVIDUALS.—The indi-  
10          vidual is medically frail or otherwise an in-  
11          dividual with special medical needs (as  
12          identified in accordance with regulations of  
13          the Secretary).

14          “(vi) BENEFICIARIES QUALIFYING  
15          FOR LONG-TERM CARE SERVICES.—The in-  
16          dividual qualifies based on medical condi-  
17          tion for medical assistance for long-term  
18          care services described in section  
19          1917(c)(1)(C).

20          “(C) FULL-BENEFIT ELIGIBLE INDIVID-  
21          UALS.—

22          “(i) IN GENERAL.—For purposes of  
23          this paragraph, subject to clause (ii), the  
24          term ‘full-benefit eligible individual’ means  
25          for a State for a month an individual who

1 is determined eligible by the State for med-  
2 ical assistance for all services defined in  
3 section 1905(a) which are covered under  
4 the State plan under this title for such  
5 month under section 1902(a)(10)(A) or  
6 under any other category of eligibility for  
7 medical assistance for all such services  
8 under this title, as determined by the Sec-  
9 retary.

10 “(ii) EXCLUSION OF MEDICALLY  
11 NEEDY AND SPEND-DOWN POPULATIONS.—  
12 Such term shall not include an individual  
13 determined to be eligible by the State for  
14 medical assistance under section  
15 1902(a)(10)(C) or by reason of section  
16 1902(f) or otherwise eligible based on a re-  
17 duction of income based on costs incurred  
18 for medical or other remedial care.

19 “(b) BENCHMARK BENEFIT PACKAGES.—

20 “(1) IN GENERAL.—For purposes of subsection  
21 (a)(1), each of the following coverage shall be con-  
22 sidered to be benchmark coverage:

23 “(A) FEHBP-EQUIVALENT HEALTH IN-  
24 SURANCE COVERAGE.—The standard Blue  
25 Cross/Blue Shield preferred provider option

1 service benefit plan, described in and offered  
2 under section 8903(1) of title 5, United States  
3 Code.

4 “(B) STATE EMPLOYEE COVERAGE.—A  
5 health benefits coverage plan that is offered and  
6 generally available to State employees in the  
7 State involved.

8 “(C) COVERAGE OFFERED THROUGH  
9 HMO.—The health insurance coverage plan  
10 that—

11 “(i) is offered by a health mainte-  
12 nance organization (as defined in section  
13 2791(b)(3) of the Public Health Service  
14 Act), and

15 “(ii) has the largest insured commer-  
16 cial, non-medicaid enrollment of covered  
17 lives of such coverage plans offered by  
18 such a health maintenance organization in  
19 the State involved.

20 “(2) BENCHMARK-EQUIVALENT COVERAGE.—  
21 For purposes of subsection (a)(1), coverage that  
22 meets the following requirement shall be considered  
23 to be benchmark-equivalent coverage:

24 “(A) INCLUSION OF BASIC SERVICES.—  
25 The coverage includes benefits for items and

1 services within each of the following categories  
2 of basic services:

3 “(i) Inpatient and outpatient hospital  
4 services.

5 “(ii) Physicians’ surgical and medical  
6 services.

7 “(iii) Laboratory and x-ray services.

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

10 “(v) Other appropriate preventive  
11 services, as designated by the Secretary.

12 “(B) AGGREGATE ACTUARIAL VALUE  
13 EQUIVALENT TO BENCHMARK PACKAGE.—The  
14 coverage has an aggregate actuarial value that  
15 is at least actuarially equivalent to one of the  
16 benchmark benefit packages described in para-  
17 graph (1).

18 “(C) SUBSTANTIAL ACTUARIAL VALUE FOR  
19 ADDITIONAL SERVICES INCLUDED IN BENCH-  
20 MARK PACKAGE.—With respect to each of the  
21 following categories of additional services for  
22 which coverage is provided under the bench-  
23 mark benefit package used under subparagraph  
24 (B), the coverage has an actuarial value that is  
25 equal to at least 75 percent of the actuarial

1 value of the coverage of that category of serv-  
2 ices in such package:

3 “(i) Coverage of prescription drugs.

4 “(ii) Mental health services.

5 “(iii) Vision services.

6 “(iv) Hearing services.

7 “(3) DETERMINATION OF ACTUARIAL VALUE.—

8 The actuarial value of coverage of benchmark benefit  
9 packages shall be set forth in an actuarial opinion  
10 in an actuarial report that has been prepared—

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

13 “(B) using generally accepted actuarial  
14 principles and methodologies;

15 “(C) using a standardized set of utilization  
16 and price factors;

17 “(D) using a standardized population that  
18 is representative of the population involved;

19 “(E) applying the same principles and fac-  
20 tors in comparing the value of different cov-  
21 erage (or categories of services);

22 “(F) without taking into account any dif-  
23 ferences in coverage based on the method of de-  
24 livery or means of cost control or utilization  
25 used; and

1           “(G) taking into account the ability of a  
2           State to reduce benefits by taking into account  
3           the increase in actuarial value of benefits cov-  
4           erage offered under this title that results from  
5           the limitations on cost sharing under such cov-  
6           erage.

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

11 **SEC. 3125. STATE OPTION TO ESTABLISH NON-EMERGENCY**  
12 **MEDICAL TRANSPORTATION PROGRAM.**

13          (a) IN GENERAL.—Section 1902(a) of the Social Se-  
14          curity Act (42 U.S.C. 1396a(a)) is amended—

15                 (1) in paragraph (66), by striking “and” at the  
16                 end;

17                 (2) in paragraph (67) by striking the period at  
18                 the end and inserting “; and”; and

19                 (3) by inserting after paragraph (67) the fol-  
20                 lowing:

21                 “(68) at the option of the State and notwith-  
22                 standing paragraph (10)(B) or (23), provide for the  
23                 establishment of a non-emergency medical transpor-  
24                 tation program in order to more cost-effectively pro-  
25                 vide transportation for individuals eligible for med-

1 ical assistance under the State plan who need access  
2 to medical care or services and have no other means  
3 of transportation which—

4 “(A) may include wheelchair van, taxi,  
5 stretcher car, bus passes and tickets, secured  
6 transportation, and such other transportation  
7 as the Secretary determines appropriate; and

8 “(B) may be conducted under contract  
9 with a broker who—

10 “(i) is selected through a competitive  
11 bidding process based on the State’s eval-  
12 uation of the broker’s experience, perform-  
13 ance, references, resources, qualifications,  
14 and costs;

15 “(ii) has oversight procedures to mon-  
16 itor beneficiary access and complaints and  
17 ensure that transport personnel are li-  
18 censed, qualified, competent, and cour-  
19 teous;

20 “(iii) is subject to regular auditing  
21 and oversight by the State in order to en-  
22 sure the quality of the transportation serv-  
23 ices provided and the adequacy of bene-  
24 ficiary access to medical care and services;  
25 and

1                   “(iv) complies with such requirements  
2                   related to prohibitions on referrals and  
3                   conflict of interest as the Secretary shall  
4                   establish (based on the prohibitions on  
5                   physician referrals under section 1877 and  
6                   such other prohibitions and requirements  
7                   as the Secretary determines to be appro-  
8                   priate).”.

9           (b) EFFECTIVE DATE.—The amendments made by  
10 subsection (a) take effect on the date of the enactment  
11 of this Act.

12           (c) IG REPORT ON UTILIZATION.—Not later than  
13 January 1, 2007, the Inspector General of the Depart-  
14 ment of Health and Human Services shall submit to Con-  
15 gress a report that examines the non-emergency medical  
16 transportation programs implemented under section  
17 1902(a)(68) of the Social Security Act, as inserted by sub-  
18 section (a). The report shall include findings regarding  
19 conflicts of interest and improper utilization of transpor-  
20 tation services under such programs, as well as rec-  
21 ommendations for improvements in such programs.

1           **CHAPTER 4—EXPANDED ACCESS TO**  
2                           **CERTAIN BENEFITS**

3   **SEC. 3131. EXPANDED ACCESS TO HOME AND COMMUNITY-**  
4                           **BASED SERVICES FOR THE ELDERLY AND**  
5                           **DISABLED.**

6           (a) IN GENERAL.—Section 1905(a) of the Social Se-  
7   curity Act (42 U.S.C. 1396d(a)) is amended—

8                   (1) in paragraph (27), by striking “and” at the  
9   end;

10                  (2) by redesignating paragraph (28) as para-  
11   graph (29); and

12                  (3) by inserting after paragraph (27) the fol-  
13   lowing new paragraph:

14                   “(28) subject to section 1902(cc), home and  
15   community-based services (within the scope of serv-  
16   ices described in paragraph (4)(B) of section  
17   1915(e) for which the Secretary has the authority to  
18   approve a waiver and not including room and board)  
19   provided pursuant to a written plan or care for  
20   individuals—

21                   “(A) who are 65 years or age or older or  
22   who are disabled (as defined under the State  
23   plan), but who are not individuals with develop-  
24   mental disabilities or mentally retarded or per-  
25   sons with related conditions;

1           “(B) with respect to whom there has been  
2           a determination, in the manner described in  
3           paragraph (1) of such section, that but for the  
4           provision of such services the individuals would  
5           require the level of care provided in a hospital  
6           or a nursing facility the cost of which could be  
7           reimbursed under the State plan; and

8           “(C) who qualify for medical assistance  
9           under the eligibility standards in effect in the  
10          State (which may include standards in effect  
11          under an approved waiver) as of the date of the  
12          enactment of this paragraph; and”.

13          (b) CONDITIONS.—Section 1902 of such Act (42  
14          U.S.C. 1396a) is amended by adding at the end the fol-  
15          lowing new subsection:

16          “(cc) PROVISION OF HOME AND COMMUNITY-BASED  
17          SERVICES UNDER STATE PLAN.—

18                 “(1) CONDITIONS.—A State may provide home  
19                 and community-based services under section  
20                 1905(a)(28), other than through a waiver or dem-  
21                 onstration project under section 1915 or 1115, only  
22                 if the following conditions are met:

23                         “(A) EXPIRATION OF PREVIOUS WAIVER.—  
24                         Any State waiver or demonstration project  
25                         under either such section with respect to serv-

1           ices for individuals described in such section  
2           has expired.

3           “(B) INFORMATION.—The State must  
4           monitor and report to the Secretary, in a form  
5           and manner specified by the Secretary and on  
6           a quarterly basis, enrollment and expenditures  
7           for provision of such services under such sec-  
8           tion.

9           “(2) OPTIONS.—Notwithstanding any other  
10          provision of this title, in a State’s provision of serv-  
11          ices under section 1905(a)(28)—

12           “(A) a State is not required to comply with  
13           the requirements of section 1902(a)(1) (relating  
14           to statewideness), section 1902(a)(10)(B) (re-  
15           lating to comparability), and section  
16           1902(a)(10)(C)(i)(III) (relating to income and  
17           resource rules applicable in the community);

18           “(B) a State may limit the number of indi-  
19           viduals who are eligible for such services and  
20           may establish waiting lists for the receipt of  
21           such services; and

22           “(C) a State may limit the amount, dura-  
23           tion, and scope of such services.

24          Nothing in this section shall be construed as apply-  
25          ing the previous sentence of any items or services

1 other than home and community-based services pro-  
2 vided under section 1905(a)(28).”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to home and community-based  
5 services furnished on or after October 1, 2006.

6 **SEC. 3132. OPTIONAL CHOICE OF SELF-DIRECTED PER-**  
7 **SONAL ASSISTANCE SERVICES (CASH AND**  
8 **COUNSELING).**

9 (a) EXEMPTION FROM CERTAIN REQUIREMENTS.—  
10 Section 1915 of the Social Security Act (42 U.S.C. 1396n)  
11 is amended by adding at the end the following new sub-  
12 section:

13 “(i)(1) A State may provide, as ‘medical assistance’,  
14 payment for part or all of the cost of self-directed personal  
15 assistance services (other than room and board) under the  
16 plan which are provided pursuant to a written plan of care  
17 to individuals with respect to whom there has been a de-  
18 termination that, but for the provision of such services,  
19 the individuals would require and receive personal care  
20 services under the plan, or home and community-based  
21 services provided pursuant to a waiver under sub-section  
22 (c). Self-directed personal assistance services may not be  
23 provided under this subsection to individuals who reside  
24 in a home or property that is owned, operated, or con-

1 trolled by a provider of services, not related by blood or  
2 marriage.

3 “(2) The Secretary shall not grant approval for a  
4 State self-directed personal assistance services program  
5 under this section unless the State provides assurances  
6 satisfactory to the Secretary of the following:

7 “(A) Necessary safeguards have been taken to  
8 protect the health and welfare of individuals pro-  
9 vided services under the program, and to assure fi-  
10 nancial accountability for funds expended with re-  
11 spect to such services.

12 “(B) The State will provide, with respect to in-  
13 dividuals who—

14 “(i) are entitled to medical assistance for  
15 personal care services under the plan, or receive  
16 home and community-based services under a  
17 waiver granted under subsection (c);

18 “(ii) may require self-directed personal as-  
19 sistance services; and

20 “(iii) may be eligible for self-directed per-  
21 sonal assistance services,

22 an evaluation of the need for personal care under  
23 the plan, or personal services under a waiver granted  
24 under subsection (c).

1           “(C) Such individuals who are determined to be  
2           likely to require personal care under the plan, or  
3           home and community-based services under a waiver  
4           granted under subsection (c) are informed of the  
5           feasible alternatives, if available under the State’s  
6           self-directed personal assistance services program, at  
7           the choice of such individuals, to the provision of  
8           personal care services under the plan, or personal  
9           assistance services under a waiver granted under  
10          subsection (c).

11          “(D) The State will provide for a support sys-  
12          tem that ensures participants in the self-directed  
13          personal assistance services program are appro-  
14          priately assessed and counseled prior to enrollment  
15          and are able to manage their budgets. Additional  
16          counseling and management support may be pro-  
17          vided at the request of the participant.

18          “(E) The State will provide to the Secretary an  
19          annual report on the number of individuals served  
20          and total expenditures on their behalf in the aggre-  
21          gate. The State shall also provide an evaluation of  
22          overall impact on the health and welfare of partici-  
23          pating individuals compared to non-participants  
24          every three years.

1       “(3) A State may provide self-directed personal as-  
2       sistance services under the State plan without regard to  
3       the requirements of section 1902(a)(1) and may limit the  
4       population eligible to receive these services and limit the  
5       number of persons served without regard to section  
6       1902(a)(10)(B).

7       “(4)(A) For purposes of this subsection, the term  
8       ‘self-directed personal assistance services’ means personal  
9       care and related services, or home and community-based  
10      services otherwise available under the plan under this title  
11      or subsection (c), that are provided to an eligible partici-  
12      pant under a self-directed personal assistance services pro-  
13      gram under this section, under which individuals, within  
14      an approved self-directed services plan and budget, pur-  
15      chase personal assistance and related services, and per-  
16      mits participants to hire, fire, supervise, and manage the  
17      individuals providing such services.

18      “(B) At the election of the State—

19              “(i) a participant may choose to use any indi-  
20              vidual capable of providing the assigned tasks in-  
21              cluding legally liable relatives as paid providers of  
22              the services; and

23              “(ii) the individual may use the individual’s  
24              budget to acquire items that increase independence  
25              or substitute (such as a microwave oven or an acces-

1 sibility ramp) for human assistance, to the extent  
2 that expenditures would otherwise be made for the  
3 human assistance.

4 “(5) For purpose of this section, the term ‘approved  
5 self-directed services plan and budget’ means, with respect  
6 to a participant, the establishment of a plan and budget  
7 for the provision of self-directed personal assistance serv-  
8 ices, consistent with the following requirements:

9 “(A) SELF-DIRECTION.—The participant (or in  
10 the case of a participant who is a minor child, the  
11 participant’s parent or guardian, or in the case of an  
12 incapacitated adult, another individual recognized by  
13 state law to act on behalf of the participant) exer-  
14 cises choice and control over the budget, planning,  
15 and purchase of self-directed personal assistance  
16 services, including the amount, duration, scope, pro-  
17 vider and location of service provision.

18 “(B) ASSESSMENT OF NEEDS.—There is an as-  
19 sessment of the needs, strengths, and preferences of  
20 the participants for such services.

21 “(C) SERVICE PLAN.—A plan for such services  
22 (and supports for such services) for the participant  
23 has been developed and approved by the State based  
24 on such assessment through a person-centered proc-  
25 ess that—

1           “(i) builds upon the participant’s capacity  
2           to engage in activities that promote community  
3           life and that respects the participant’s pref-  
4           erences, choices and abilities; and

5           “(ii) involves families, friends, and profes-  
6           sionals in the planning or delivery of services or  
7           supports as desired or required by the partici-  
8           pant.

9           “(D) SERVICE BUDGET.—A budget for such  
10          services and supports for the participant has been  
11          developed and approved by the State based on such  
12          assessment and plan and on a methodology that uses  
13          valid, reliable cost data, is open to public inspection,  
14          and includes a calculation of the expected cost of  
15          such services if those services were not self-directed.  
16          The budget may not restrict access to other medi-  
17          cally necessary care and services furnished under the  
18          plan and approved by the state but not included in  
19          the budget.

20          “(E) APPLICATION OF QUALITY ASSURANCE  
21          AND RISK MANAGEMENT.—There are appropriate  
22          quality assurance and risk management techniques  
23          used in establishing and implementing such plan and  
24          budget that recognize the roles and responsibilities  
25          in obtaining services in a self-directed manner and



1 any assets or resources in an amount equal to the  
2 insurance benefit payments that are made to or on  
3 behalf of an individual who is a beneficiary under a  
4 long-term care insurance policy (including a certifi-  
5 cate issued under a group insurance contract), if the  
6 following requirements are met:

7 “(I) The policy covers an insured who was  
8 a resident of such State when coverage first be-  
9 came effective under the policy.

10 “(II) The policy is a qualified long-term  
11 care insurance policy (as defined in section  
12 7702B(b) of the Internal Revenue Code of  
13 1986) issued on or after the first day of the  
14 first calendar quarter in which the plan amend-  
15 ment was submitted to the Secretary.

16 “(III) If the policy does not provide some  
17 level of inflation protection, the insured was of-  
18 fered, before the policy was sold, a long-term  
19 care insurance policy that provides some level of  
20 inflation protection.

21 “(IV) The State Medicaid agency under  
22 section 1902(a)(5) provides information and  
23 technical assistance to the State insurance de-  
24 partment on the insurance department’s role of  
25 assuring that any individual who sells a long-

1 term care insurance policy under the partner-  
2 ship receives training or demonstrates evidence  
3 of an understanding of such policies and how  
4 they relate to other public and private coverage  
5 of long-term care.

6 “(V) The issuer of the policy provides reg-  
7 ular reports to the Secretary that include, in ac-  
8 cordance with regulations of the Secretary (pro-  
9 mulgated after consultation with the States),  
10 notification regarding when all benefits provided  
11 under the policy have been paid and the amount  
12 of such benefits paid, when the policy otherwise  
13 terminates, and such other information as the  
14 Secretary determines may be appropriate to the  
15 administration of such partnerships.

16 “(VI) The State does not impose any re-  
17 quirement affecting the terms or benefits of  
18 such a policy unless the State imposes such re-  
19 quirement on long-term care insurance policies  
20 without regard to whether the policy is covered  
21 under the partnership or is offered in connec-  
22 tion with such a partnership.

23 In the case of a long-term care insurance policy  
24 which is exchanged for another such policy, sub-

1 clause (I) shall be applied based on the coverage of  
2 the first such policy that was exchanged.

3 “(iv) The Secretary—

4 “(I) as appropriate, shall provide copies of  
5 the reports described in clause (iii)(V) to the  
6 State involved; and

7 “(II) shall promote the education of con-  
8 sumers regarding qualified State long-term care  
9 insurance partnerships.

10 “(v) The Secretary, in consultation with other  
11 appropriate Federal agencies, issuers of long-term  
12 care insurance, the National Association of Insur-  
13 ance Commissioners, and State insurance commis-  
14 sioners, shall develop recommendations for Congress  
15 to authorize and fund a uniform minimum data set  
16 to be reported electronically by all issuers of long-  
17 term care insurance policies under qualified State  
18 long-term care insurance partnerships to a secure,  
19 centralized electronic query and report generating  
20 mechanism that State, the Secretary, and other Fed-  
21 eral agencies can access.”.

22 (b) CONSTRUCTION.—Nothing in the amendments  
23 made by subsection (a) shall be construed as affecting the  
24 treatment of long-term care insurance policies that will be,  
25 are, or were provided under a State plan amendment de-

1 scribed in section 1917(b)(1)(C)(ii) of the Social Security  
2 Act that was approved as of May 14, 1993.

3 (c) EFFECTIVE DATE.—A State plan amendment  
4 that provides for a qualified State long-term care insur-  
5 ance partnership under the amendments made by sub-  
6 section (a) may provide that such amendment is effective  
7 for long-term care insurance policies issued on or after a  
8 date, specified in the amendment, that is not earlier than  
9 the first day of the first calendar quarter in which the  
10 plan amendment was submitted to the Secretary of Health  
11 and Human Services.

12 (d) STANDARDS FOR RECIPROCAL RECOGNITION  
13 AMONG PARTNERSHIP STATES.—In order to permit port-  
14 ability in long-term care insurance policies purchased  
15 under State long-term care insurance partnerships, the  
16 Secretary may develop, in consultation with the States and  
17 the National Association of Insurance Commissioners, uni-  
18 form standards for reciprocal recognition of such policies  
19 among States with qualified State long-term care insur-  
20 ance partnerships.

21 **SEC. 3134. HEALTH OPPORTUNITY ACCOUNTS.**

22 Title XIX of the Social Security Act, as amended by  
23 section 3124, is amended—

24 (1) by redesignating section 1937 as section  
25 1938; and

1           (2) by inserting after section 1936 the following  
2 new section:

3           “HEALTH OPPORTUNITY ACCOUNTS

4           “SEC. 1937. (a) AUTHORITY.—

5           “(1) IN GENERAL.—Notwithstanding any other  
6 provision of this title, the Secretary shall establish a  
7 demonstration program under which States may pro-  
8 vide under their State plans under this title (includ-  
9 ing such a plan operating under a statewide waiver  
10 under section 1115) in accordance with this section  
11 for the provision of alternative benefits consistent  
12 with subsection (c) for eligible population groups in  
13 one or more geographic areas of the State specified  
14 by the State. An amendment under the previous sen-  
15 tence is referred to in this section as a ‘State dem-  
16 onstration program’.

17           “(2) INITIAL DEMONSTRATION.—The dem-  
18 onstration program under this section shall begin on  
19 January 1, 2006. During the first 5 years of such  
20 program, the Secretary shall not approve more than  
21 10 State demonstration programs, with each State  
22 demonstration program covering one or more geo-  
23 graphic areas specified by the State. After such 5-  
24 year period—

25           “(A) unless the Secretary finds, taking  
26 into account cost-effectiveness, quality of care,

1 and other criteria that the Secretary specifies,  
2 that a State demonstration program previously  
3 implemented has been unsuccessful, such a  
4 demonstration program may be extended or  
5 made permanent in the State; and

6 “(B) unless the Secretary finds, taking  
7 into account cost-effectiveness, quality of care,  
8 and other criteria that the Secretary specifies,  
9 that all State demonstration program previously  
10 implemented were unsuccessful, other States  
11 may implement State demonstration programs.

12 “(3) APPROVAL.—The Secretary shall not ap-  
13 prove a State demonstration program under para-  
14 graph (1) unless the program includes the following:

15 “(A) Creating patient awareness of the  
16 high cost of medical care.

17 “(B) Providing incentives to patients to  
18 seek preventive care services.

19 “(C) Reducing inappropriate use of health  
20 care services.

21 “(D) Enabling patients to take responsi-  
22 bility for health outcomes.

23 “(E) Providing enrollment counselors and  
24 ongoing education activities.

1           “(F) Providing transactions involving  
2           health opportunity accounts to be conducted  
3           electronically and without cash.

4           “(G) Providing access to negotiated pro-  
5           vider payment rates consistent with this section.

6           Nothing in this section shall be construed as pre-  
7           venting a State demonstration program from pro-  
8           viding incentives for patients obtaining appropriate  
9           preventive care (as defined for purposes of section  
10          223(c)(2)(C) of the Internal Revenue Code of 1986),  
11          such as additional account contributions for an indi-  
12          vidual demonstrating healthy prevention practices.

13          “(4)           NO           REQUIREMENT           FOR  
14          STATEWIDENESS.—Nothing in this section or any  
15          other provision of law shall be construed to require  
16          that a State must provide for the implementation of  
17          a State demonstration program on a Statewide  
18          basis.

19          “(5) REPORTS.—The Secretary shall periodi-  
20          cally submit to Congress reports regarding the suc-  
21          cess of State demonstration programs.

22          “(b) ELIGIBLE POPULATION GROUPS.—

23          “(1) IN GENERAL.—A State demonstration pro-  
24          gram under this section shall specify the eligible

1 population groups consistent with paragraphs (2)  
2 and (3).

3 “(2) ELIGIBILITY LIMITATIONS DURING INITIAL  
4 DEMONSTRATION PERIOD.—During the initial 5  
5 years of the demonstration program under this sec-  
6 tion, a State demonstration project shall not apply  
7 to any of the following individuals:

8 “(A) Individuals who are 65 years of age  
9 or older.

10 “(B) Individuals who are disabled, regard-  
11 less of whether or not their eligibility for med-  
12 ical assistance under this title is based on such  
13 disability.

14 “(C) Individuals who are eligible for med-  
15 ical assistance under this title only because they  
16 are (or were within previous 60 days) pregnant.

17 “(D) Individuals who have been eligible for  
18 medical assistance for a continuous period of  
19 less than 3 months.

20 “(3) ADDITIONAL LIMITATIONS.—A State dem-  
21 onstration project shall not apply to any individual  
22 within a category of individual described in section  
23 1936(a)(2)(B).

24 “(4) LIMITATIONS.—

1           “(A) STATE OPTION.—This subsection  
2 shall not be construed as preventing a State  
3 from further limiting eligibility.

4           “(B) ON ENROLLEES IN MEDICAID MAN-  
5 AGED CARE ORGANIZATIONS.—Insofar as the  
6 State provides for eligibility of individuals who  
7 are enrolled in medicaid managed care organi-  
8 zations, such individuals may participate in the  
9 State demonstration project only if the State  
10 provides assurances satisfactory to the Sec-  
11 retary that the following conditions are met  
12 with respect to any such organization:

13           “(i) In no case may the number of  
14 such individuals enrolled in the organiza-  
15 tion who participate in the project exceed  
16 5 percent of the total number of individ-  
17 uals enrolled in such organization.

18           “(ii) The proportion of enrollees in  
19 the organization who so participate is not  
20 significantly disproportionate to the pro-  
21 portion of such enrollees in other such or-  
22 ganizations who participate.

23           “(iii) The State has provided for an  
24 appropriate adjustment in the per capita  
25 payments to the organization to account

1                   for such participation, taking into account  
2                   differences in the likely use of health serv-  
3                   ices between enrollees who so participate  
4                   and enrollees who do not so participate.

5                   “(5) VOLUNTARY PARTICIPATION.—An eligible  
6                   individual shall be enrolled in a State demonstration  
7                   project only if the individual voluntarily enrolls. Ex-  
8                   cept in such hardship cases as the Secretary shall  
9                   specify, such an enrollment shall be effective for a  
10                  period of 12 months, but may be extended for addi-  
11                  tional periods of 12 months each with the consent of  
12                  the individual.

13                  “(c) ALTERNATIVE BENEFITS.—

14                  “(1) IN GENERAL.—The alternative benefits  
15                  provided under this section shall consist, consistent  
16                  with this subsection, of at least—

17                         “(A) coverage for medical expenses in a  
18                         year for items and services for which benefits  
19                         are otherwise provided under this title after an  
20                         annual deductible described in paragraph (2)  
21                         has been met; and

22                         “(B) contribution into a health opportunity  
23                         account.

24                  Nothing in subparagraph (A) shall be construed as  
25                  preventing a State from providing for coverage of

1 preventive care (referred to in subsection (a)(3))  
2 within the alternative benefits without regard to the  
3 annual deductible.

4 “(2) ANNUAL DEDUCTIBLE.—The amount of  
5 the annual deductible described in paragraph (1)(A)  
6 shall be at least 100 percent, but no more than 110  
7 percent, of the annualized amount of contributions  
8 to the health opportunity account under subsection  
9 (d)(2)(A)(i), determined without regard to any limi-  
10 tation described in subsection (d)(2)(C)(ii).

11 “(3) ACCESS TO NEGOTIATED PROVIDER PAY-  
12 MENT RATES.—

13 “(A) FEE-FOR-SERVICE ENROLLEES.—In  
14 the case of an individual who is participating in  
15 a State demonstration project and who is not  
16 enrolled with a medicaid managed care organi-  
17 zation, the State shall provide that the indi-  
18 vidual may obtain demonstration project med-  
19 icaid services from—

20 “(i) any participating provider under  
21 this title at the same payment rates that  
22 would be applicable to such services if the  
23 deductible described in paragraph (1)(A)  
24 was not applicable; or

1           “(ii) any provider at payment rates  
2           that do not exceed 125 percent of the pay-  
3           ment rate that would be applicable to such  
4           services furnished by a participating pro-  
5           vider under this title if the deductible de-  
6           scribed in paragraph (1)(A) was not appli-  
7           cable.

8           “(B) TREATMENT UNDER MEDICAID MAN-  
9           AGED CARE PLANS.—In the case of an indi-  
10          vidual who is participating in a State dem-  
11          onstration project and is enrolled with a med-  
12          icaid managed care organization, the State shall  
13          enter into an arrangement with the organiza-  
14          tion under which the individual may obtain  
15          demonstration project medicaid services from  
16          any provider under such organization at pay-  
17          ment rates that do not exceed the payment rate  
18          that would be applicable to such services if the  
19          deductible described in paragraph (1)(A) was  
20          not applicable.

21          “(C) COMPUTATION.—The payment rates  
22          described in subparagraphs (A) and (B) shall  
23          be computed without regard to any cost-sharing  
24          that would be otherwise applicable under sec-  
25          tion 1916.

1                   “(D) DEFINITIONS.—For purposes of this  
2 paragraph:

3                   “(i) The term ‘demonstration project  
4                    medicaid services’ means, with respect to  
5                    an individual participating in a State dem-  
6                    onstration project, services for which the  
7                    individual would be provided medical as-  
8                    sistance under this title but for the appli-  
9                    cation of the deductible described in para-  
10                  graph (1)(A).

11                  “(ii) The term ‘participating provider’  
12                  means—

13                         “(I) with respect to an individual  
14                         described in subparagraph (A), a  
15                         health care provider that has entered  
16                         into a participation agreement with  
17                         the State for the provision of services  
18                         to individuals entitled to benefits  
19                         under the State plan; or

20                         “(II) with respect to an indi-  
21                         vidual described in subparagraph (B)  
22                         who is enrolled in a medicaid man-  
23                         aged care organization, a health care  
24                         provider that has entered into an ar-  
25                         rangement for the provision of serv-

1                   ices to enrollees of the organization  
2                   under this title.

3                   “(4) NO EFFECT ON SUBSEQUENT BENEFITS.—  
4           Except as provided under paragraphs (1) and (2),  
5           alternative benefits for an eligible individual shall  
6           consist of the benefits otherwise provided to the indi-  
7           vidual, including cost-sharing relating to such bene-  
8           fits.

9                   “(5) OVERRIDING COST-SHARING AND COM-  
10          PARABILITY REQUIREMENTS FOR ALTERNATIVE  
11          BENEFITS.—The provisions of this title relating to  
12          cost-sharing for benefits (including section 1916)  
13          shall not apply with respect to benefits to which the  
14          annual deductible under paragraph (1)(A) applies.  
15          The provisions of section 1902(a)(10)(B) (relating  
16          to comparability) shall not apply with respect to the  
17          provision of alternative benefits (as described in this  
18          subsection).

19                  “(6) TREATMENT AS MEDICAL ASSISTANCE.—  
20          Subject to subparagraphs (D) and (E) of subsection  
21          (d)(2), payments for alternative benefits under this  
22          section (including contributions into a health oppor-  
23          tunity account) shall be treated as medical assist-  
24          ance for purposes of section 1903(a).

1           “(7) USE OF TIERED DEDUCTIBLE AND COST-  
2 SHARING.—

3           “(A) IN GENERAL.—A State—

4           “(i) may vary the amount of the an-  
5 nual deductible applied under paragraph  
6 (1)(A) based on the income of the family  
7 involved so long as it does not favor fami-  
8 lies with higher income over those with  
9 lower income; and

10           “(ii) may vary the amount of the max-  
11 imum out-of-pocket cost-sharing (as de-  
12 fined in subparagraph (B)) based on the  
13 income of the family involved so long as it  
14 does not favor families with higher income  
15 over those with lower income.

16           “(B) MAXIMUM OUT-OF-POCKET COST-  
17 SHARING.—For purposes of subparagraph  
18 (A)(ii), the term ‘maximum out-of-pocket cost-  
19 sharing’ means, for an individual or family, the  
20 amount by which the annual deductible level ap-  
21 plied under paragraph (1)(A) to the individual  
22 or family exceeds the balance in the health op-  
23 portunity account for the individual or family.

24           “(8) CONTRIBUTIONS BY EMPLOYERS.—Noth-  
25 ing in this section shall be construed as preventing

1 an employer from providing health benefits coverage  
2 consisting of the coverage described in paragraph  
3 (1)(A) to individuals who are provided alternative  
4 benefits under this section.

5 “(d) HEALTH OPPORTUNITY ACCOUNT.—

6 “(1) IN GENERAL.—For purposes of this sec-  
7 tion, the term ‘health opportunity account’ means an  
8 account that meets the requirements of this sub-  
9 section.

10 “(2) CONTRIBUTIONS.—

11 “(A) IN GENERAL.—No contribution may  
12 be made into a health opportunity account  
13 except—

14 “(i) contributions by the State under  
15 this title; and

16 “(ii) contributions by other persons  
17 and entities, such as charitable organiza-  
18 tions.

19 “(B) STATE CONTRIBUTION.—A State  
20 shall specify the contribution amount that shall  
21 be deposited under subparagraph (A)(i) into a  
22 health opportunity account.

23 “(C) LIMITATION ON ANNUAL STATE CON-  
24 TRIBUTION PROVIDED AND PERMITTING IMPO-  
25 SITION OF MAXIMUM ACCOUNT BALANCE.—

1 “(i) IN GENERAL.—A State—

2 “(I) may impose limitations on  
3 the maximum contributions that may  
4 be deposited under subparagraph  
5 (A)(i) into a health opportunity ac-  
6 count in a year;

7 “(II) may limit contributions into  
8 such an account once the balance in  
9 the account reaches a level specified  
10 by the State; and

11 “(III) subject to clauses (ii) and  
12 (iii) and subparagraph (D)(i), may  
13 not provide contributions described in  
14 subparagraph (A)(i) to a health op-  
15 portunity account on behalf of an in-  
16 dividual or family to the extent the  
17 amount of such contributions (includ-  
18 ing both State and Federal shares)  
19 exceeds, on an annual basis, \$2,500  
20 for each individual (or family mem-  
21 ber) who is an adult and \$1,000 for  
22 each individual (or family member)  
23 who is a child.

24 “(ii) INDEXING OF DOLLAR LIMITA-  
25 TIONS.—For each year after 2006, the dol-

1 lar amounts specified in clause (i)(III)  
2 shall be annually increased by the Sec-  
3 retary by a percentage that reflects the an-  
4 nual percentage increase in the medical  
5 care component of the consumer price  
6 index for all urban consumers.

7 “(iii) BUDGET NEUTRAL ADJUST-  
8 MENT.—A State may provide for dollar  
9 limitations in excess of those specified in  
10 clause (i)(III) (as increased under clause  
11 (ii)) for specified individuals if the State  
12 provides assurances satisfactory to the Sec-  
13 retary that contributions otherwise made  
14 to other individuals will be reduced in a  
15 manner so as to provide for aggregate con-  
16 tributions that do not exceed the aggregate  
17 contributions that would otherwise be per-  
18 mitted under this subparagraph.

19 “(D) LIMITATIONS ON FEDERAL MATCH-  
20 ING.—

21 “(i) STATE CONTRIBUTION.—A State  
22 may contribute under subparagraph (A)(i)  
23 amounts to a health opportunity account in  
24 excess of the limitations provided under  
25 subparagraph (C)(i)(III), but no Federal

1 financial participation shall be provided  
2 under section 1903(a) with respect to con-  
3 tributions in excess of such limitations.

4 “(ii) NO FFP FOR PRIVATE CONTRIBU-  
5 TIONS.—No Federal financial participation  
6 shall be provided under section 1903(a)  
7 with respect to any contributions described  
8 in subparagraph (A)(ii) to a health oppor-  
9 tunity account.

10 “(E) APPLICATION OF DIFFERENT MATCH-  
11 ING RATES.—The Secretary shall provide a  
12 method under which, for expenditures made  
13 from a health opportunity account for medical  
14 care for which the Federal matching rate under  
15 section 1903(a) exceeds the Federal medical as-  
16 sistance percentage, a State may obtain pay-  
17 ment under such section at such higher match-  
18 ing rate for such expenditures.

19 “(3) USE.—

20 “(A) GENERAL USES.—

21 “(i) IN GENERAL.—Subject to the  
22 succeeding provisions of this paragraph,  
23 amounts in a health opportunity account  
24 may be used for payment of such health  
25 care expenditures as the State specifies.

1           “(ii) GENERAL LIMITATION.—In no  
2 case shall such account be used for pay-  
3 ment for health care expenditures that are  
4 not payment of medical care (as defined by  
5 section 213(d) of the Internal Revenue  
6 Code of 1986).

7           “(iii) STATE RESTRICTIONS.—In ap-  
8 plying clause (i), a State may restrict pay-  
9 ment for—

10           “(I) providers of items and serv-  
11 ices to providers that are licensed or  
12 otherwise authorized under State law  
13 to provide the item or service and may  
14 deny payment for such a provider on  
15 the basis that the provider has been  
16 found, whether with respect to this  
17 title or any other health benefit pro-  
18 gram, to have failed to meet quality  
19 standards or to have committed one  
20 or more acts of fraud or abuse; and

21           “(II) items and services insofar  
22 as the State finds they are not medi-  
23 cally appropriate or necessary.

24           “(iv) ELECTRONIC WITHDRAWALS.—  
25 The State demonstration program shall

1 provide for a method whereby withdrawals  
2 may be made from the account for such  
3 purposes using an electronic system and  
4 shall not permit withdrawals from the ac-  
5 count in cash.

6 “(B) MAINTENANCE OF HEALTH OPPOR-  
7 TUNITY ACCOUNT AFTER BECOMING INELI-  
8 GIBLE FOR PUBLIC BENEFIT.—

9 “(i) IN GENERAL.—Notwithstanding  
10 any other provision of law, if an account  
11 holder of a health opportunity account be-  
12 comes ineligible for benefits under this title  
13 because of an increase in income or  
14 assets—

15 “(I) no additional contribution  
16 shall be made into the account under  
17 paragraph (2)(A)(i);

18 “(II) subject to clause (iii), the  
19 balance in the account shall be re-  
20 duced by 25 percent; and

21 “(III) subject to the succeeding  
22 provisions of this subparagraph, the  
23 account shall remain available to the  
24 account holder for withdrawals under  
25 the same terms and conditions as if

1 the account holder remained eligible  
2 for such benefits.

3 “(ii) SPECIAL RULES.—Withdrawals  
4 under this subparagraph from an  
5 account—

6 “(I) shall be available for the  
7 purchase of health insurance coverage;  
8 and

9 “(II) may, subject to clause (iv),  
10 be made available (at the option of  
11 the State) for such additional expendi-  
12 tures (such as job training and tuition  
13 expenses) specified by the State (and  
14 approved by the Secretary) as the  
15 State may specify.

16 “(iii) EXCEPTION FROM 25 PERCENT  
17 SAVINGS TO GOVERNMENT FOR PRIVATE  
18 CONTRIBUTIONS.—Clause (i)(II) shall not  
19 apply to the portion of the account that is  
20 attributable to contributions described in  
21 paragraph (2)(A)(ii). For purposes of ac-  
22 counting for such contributions, with-  
23 draws from a health opportunity account  
24 shall first be attributed to contributions  
25 described in paragraph (2)(A)(i).

1                   “(iv) CONDITION FOR NON-HEALTH  
2                   WITHDRAWALS.—No withdrawal may be  
3                   made from an account under clause (ii)(II)  
4                   unless the accountholder has participated  
5                   in the program under this section for at  
6                   least 1 year.

7                   “(v) NO REQUIREMENT FOR CONTINU-  
8                   ATION OF COVERAGE.—An account holder  
9                   of a health opportunity account, after be-  
10                  coming ineligible for medical assistance  
11                  under this title, is not required to purchase  
12                  high-deductible or other insurance as a  
13                  condition of maintaining or using the ac-  
14                  count.

15                  “(4) ADMINISTRATION.—A State may coordi-  
16                  nate administration of health opportunity accounts  
17                  through the use of a third party administrator and  
18                  reasonable expenditures for the use of such adminis-  
19                  trator shall be reimbursable to the State in the same  
20                  manner as other administrative expenditures under  
21                  section 1903(a)(7).

22                  “(5) TREATMENT.—Amounts in, or contributed  
23                  to, a health opportunity account shall not be counted  
24                  as income or assets for purposes of determining eli-  
25                  gibility for benefits under this title.

1           “(6) UNAUTHORIZED WITHDRAWALS.—A State  
2           may establish procedures—

3                   “(A) to penalize or remove an individual  
4                   from the health opportunity account based on  
5                   nonqualified withdrawals by the individual from  
6                   such an account; and

7                   “(B) to recoup costs that derive from such  
8                   nonqualified withdrawals.

9   **SEC. 3135. MONEY FOLLOWS THE PERSON REBALANCING**  
10                   **DEMONSTRATION.**

11           (a) PROGRAM PURPOSE AND AUTHORITY.—The Sec-  
12           retary of Health and Human Services (in this section re-  
13           ferred to as the “Secretary”) is authorized to award, on  
14           a competitive basis, grants to States in accordance with  
15           this section for demonstration projects (each in this sec-  
16           tion referred to as a “MFP demonstration project”) de-  
17           signed to achieve the following objectives with respect to  
18           institutional and home and community-based long-term  
19           care services under State medicaid programs:

20                   (1) REBALANCING.—Increase the use of home  
21                   and community-based, rather than institutional,  
22                   long-term care services.

23                   (2) MONEY FOLLOWS THE PERSON.—Eliminate  
24                   barriers or mechanisms, whether in the State law,  
25                   the State medicaid plan, the State budget, or other-

1 wise, that prevent or restrict the flexible use of med-  
2 icaid funds to enable medicaid-eligible individuals to  
3 receive support for appropriate and necessary long-  
4 term services in the settings of their choice.

5 (3) CONTINUITY OF SERVICE.—Increase the  
6 ability of the State medicaid program to assure con-  
7 tinued provision of home and community-based long-  
8 term care services to eligible individuals who choose  
9 to transition from an institutional to a community  
10 setting.

11 (4) QUALITY ASSURANCE AND QUALITY IM-  
12 PROVEMENT.—Ensure that procedures are in place  
13 (at least comparable to those required under the  
14 qualified HCB program) to provide quality assur-  
15 ance for eligible individuals receiving medicaid home  
16 and community-based long-term care services and to  
17 provide for continuous quality improvement in such  
18 services.

19 (b) DEFINITIONS.—For purposes of this section:

20 (1) HOME AND COMMUNITY-BASED LONG-TERM  
21 CARE SERVICES.—The term “home and community-  
22 based long-term care services” means, with respect  
23 to a State medicaid program, home and community-  
24 based services (including home health and personal  
25 care services) that are provided under the State’s

1 qualified HCB program or that could be provided  
2 under such a program but are otherwise provided  
3 under the medicaid program.

4 (2) ELIGIBLE INDIVIDUAL.—The term “eligible  
5 individual” means, with respect to an MFP dem-  
6 onstration project of a State, an individual in the  
7 State—

8 (A) who, immediately before beginning  
9 participation in the MFP demonstration  
10 project—

11 (i) resides (and has resided, for a pe-  
12 riod of not less than six months or for  
13 such longer minimum period, not to exceed  
14 2 years, as may be specified by the State)  
15 in an inpatient facility;

16 (ii) is receiving medicaid benefits for  
17 inpatient services furnished by such inpa-  
18 tient facility; and

19 (iii) with respect to whom a deter-  
20 mination has been made that, but for the  
21 provision of home and community-based  
22 long-term care services, the individual  
23 would continue to require the level of care  
24 provided in an inpatient facility; and

1 (B) who resides in a qualified residence be-  
2 ginning on the initial date of participation in  
3 the demonstration project.

4 (3) INPATIENT FACILITY.—The term “inpatient  
5 facility” means a hospital, nursing facility, or inter-  
6 mediate care facility for the mentally retarded. Such  
7 term includes an institution for mental diseases, but  
8 only, with respect to a State, to the extent medical  
9 assistance is available under the State medicaid plan  
10 for services provided by such institution.

11 (4) MEDICAID.—The term “medicaid” means,  
12 with respect to a State, the State program under  
13 title XIX of the Social Security Act (including any  
14 waiver or demonstration under such title or under  
15 section 1115 of such Act relating to such title).

16 (5) QUALIFIED HCB PROGRAM.—The term  
17 “qualified HCB program” means a program pro-  
18 viding home and community-based long-term care  
19 services operating under medicaid, whether or not  
20 operating under waiver authority.

21 (6) QUALIFIED RESIDENCE.—The term “quali-  
22 fied residence” means, with respect to an eligible  
23 individual—

24 (A) a home owned or leased by the indi-  
25 vidual or the individual’s family member;

1 (B) an apartment with an individual lease,  
2 with lockable access and egress, and which in-  
3 cludes living, sleeping, bathing, and cooking  
4 areas over which the individual or the individ-  
5 ual's family has domain and control; and

6 (C) a residence, in a community-based res-  
7 idential setting, in which no more than 4 unre-  
8 lated individuals reside.

9 (7) QUALIFIED EXPENDITURES.—The term  
10 “qualified expenditures” means expenditures by the  
11 State under its MFP demonstration project for  
12 home and community-based long-term care services  
13 for an eligible individual participating in the MFP  
14 demonstration project, but only with respect to serv-  
15 ices furnished during the 12-month period beginning  
16 on the date the individual is discharged from an in-  
17 patient facility referred to in paragraph (2)(A)(i).

18 (8) SELF-DIRECTED SERVICES.—The term  
19 “self-directed” means, with respect to, home and  
20 community-based long-term care services for an eli-  
21 gible individual, such services for the individual  
22 which are planned and purchased under the direc-  
23 tion and control of such individual or the individ-  
24 ual's authorized representative (as defined by the  
25 Secretary), including the amount, duration, scope,

1 provider, and location of such services, under the  
2 State medicaid program consistent with the fol-  
3 lowing requirements:

4 (A) ASSESSMENT.—There is an assess-  
5 ment of the needs, capabilities, and preferences  
6 of the individual with respect to such services.

7 (B) SERVICE PLAN.—Based on such as-  
8 sessment, there is developed jointly with such  
9 individual or the individual's authorized rep-  
10 resentative a plan for such services for such in-  
11 dividual that is approved by the State and  
12 that—

13 (i) specifies those services, if any,  
14 which the individual or the individual's au-  
15 thorized representative would be respon-  
16 sible for directing;

17 (ii) identifies the methods by which  
18 the individual or the individual's author-  
19 ized representative or an agency designated  
20 by an individual or representative will se-  
21 lect, manage, and dismiss providers of such  
22 services;

23 (iii) specifies the role of family mem-  
24 bers and others whose participation is  
25 sought by the individual or the individual's

1 authorized representative with respect to  
2 such services;

3 (iv) is developed through a person-  
4 centered process that—

5 (I) is directed by the individual  
6 or the individual's authorized rep-  
7 resentative;

8 (II) builds upon the individual's  
9 capacity to engage in activities that  
10 promote community life and that re-  
11 spects the individual's preferences,  
12 choices, and abilities; and

13 (III) involves families, friends,  
14 and professionals as desired or re-  
15 quired by the individual or the indi-  
16 vidual's authorized representative;

17 (v) includes appropriate risk manage-  
18 ment techniques that recognize the roles  
19 and sharing of responsibilities in obtaining  
20 services in a self-directed manner and as-  
21 sure the appropriateness of such plan  
22 based upon the resources and capabilities  
23 of the individual or the individual's author-  
24 ized representative; and

1 (vi) may include an individualized  
2 budget which identifies the dollar value of  
3 the services and supports under the control  
4 and direction of the individual or the indi-  
5 vidual's authorized representative.

6 (C) BUDGET PROCESS.—With respect to  
7 individualized budgets described in subpara-  
8 graph (B)(vi), the State application under sub-  
9 section (c)—

10 (i) describes the method for calcu-  
11 lating the dollar values in such budgets  
12 based on reliable costs and service utiliza-  
13 tion;

14 (ii) defines a process for making ad-  
15 justments in such dollar values to reflect  
16 changes in individual assessments and  
17 service plans; and

18 (iii) provides a procedure to evaluate  
19 expenditures under such budgets.

20 (9) STATE.—The term “State” has the mean-  
21 ing given such term for purposes of title XIX of the  
22 Social Security Act.

23 (c) STATE APPLICATION.—A State seeking approval  
24 of an MFP demonstration project shall submit to the Sec-  
25 retary, at such time and in such format as the Secretary

1 requires, an application meeting the following require-  
2 ments and containing such additional information, provi-  
3 sions, and assurances, as the Secretary may require:

4           (1) ASSURANCE OF A PUBLIC DEVELOPMENT  
5           PROCESS.—The application contains an assurance  
6           that the State has engaged, and will continue to en-  
7           gage, in a public process for the design, develop-  
8           ment, and evaluation of the MFP demonstration  
9           project that allows for input from eligible individ-  
10          uals, the families of such individuals, authorized rep-  
11          resentatives of such individuals, providers, and other  
12          interested parties.

13          (2) OPERATION IN CONNECTION WITH QUALI-  
14          FIED HCB PROGRAM TO ASSURE CONTINUITY OF  
15          SERVICES.—The State will conduct the MFP dem-  
16          onstration project for eligible individuals in conjunc-  
17          tion with the operation of a qualified HCB program  
18          that is in operation (or approved) in the State for  
19          such individuals in a manner that assures continuity  
20          of medicaid coverage for such individuals so long as  
21          such individuals continue to be eligible for medical  
22          assistance.

23          (3) DEMONSTRATION PROJECT PERIOD.—The  
24          application shall specify the period of the MFP dem-  
25          onstration project, which shall include at least two

1 consecutive fiscal years in the 5-fiscal-year period  
2 beginning with fiscal year 2007.

3 (4) SERVICE AREA.—The application shall  
4 specify the service area or areas of the MFP dem-  
5 onstration project, which may be a Statewide area or  
6 one or more geographic areas of the State.

7 (5) TARGETED GROUPS AND NUMBERS OF INDI-  
8 VIDUALS SERVED.—The application shall specify—

9 (A) the target groups of eligible individuals  
10 to be assisted to transition from an inpatient  
11 facility to a qualified residence during each fis-  
12 cal year of the MFP demonstration project;

13 (B) the projected numbers of eligible indi-  
14 viduals in each targeted group of eligible indi-  
15 viduals to be so assisted during each such year;  
16 and

17 (C) the estimated total annual qualified ex-  
18 penditures for each fiscal year of the MFP  
19 demonstration project.

20 (6) INDIVIDUAL CHOICE, CONTINUITY OF  
21 CARE.—The application shall contain assurances  
22 that—

23 (A) each eligible individual or the individ-  
24 ual's authorized representative will be provided  
25 the opportunity to make an informed choice re-

1           garding whether to participate in the MFP  
2           demonstration project;

3           (B) each eligible individual or the individ-  
4           ual's authorized representative will choose the  
5           qualified residence in which the individual will  
6           reside and the setting in which the individual  
7           will receive home and community-based long-  
8           term care services;

9           (C) the State will continue to make avail-  
10          able, so long as the State operates its qualified  
11          HCB program consistent with applicable re-  
12          quirements, home and community-based long-  
13          term care services to each individual who com-  
14          pletes participation in the MFP demonstration  
15          project for as long as the individual remains eli-  
16          gible for medical assistance for such services  
17          under such qualified HCB program (including  
18          meeting a requirement relating to requiring a  
19          level of care provided in an inpatient facility  
20          and continuing to require such services).

21          (7) REBALANCING.—The application shall—

22                (A) provide such information as the Sec-  
23                retary may require concerning the dollar  
24                amounts of State medicaid expenditures for the  
25                fiscal year, immediately preceding the first fis-

1 cal year of the State's MFP demonstration  
2 project, for long-term care services and the per-  
3 centage of such expenditures that were for in-  
4 stitutional long-term care services or were for  
5 home and community-based long-term care  
6 services;

7 (B)(i) specify the methods to be used by  
8 the State to increase, for each fiscal year dur-  
9 ing the MFP demonstration project, the dollar  
10 amount of such total expenditures for home and  
11 community-based long-term care services and  
12 the percentage of such total expenditures for  
13 long-term care services that are for home and  
14 community-based long-term care services; and

15 (ii) describe the extent to which the MFP  
16 demonstration project will contribute to accom-  
17 plishment of objectives described in subsection  
18 (a).

19 (8) MONEY FOLLOWS THE PERSON.—The appli-  
20 cation shall describe the methods to be used by the  
21 State to eliminate any legal, budgetary, or other bar-  
22 riers to flexibility in the availability of medicaid  
23 funds to pay for long-term care services for eligible  
24 individuals participating in the project in the appro-  
25 priate settings of their choice, including costs to

1 transition from an institutional setting to a qualified  
2 residence.

3 (9) MAINTENANCE OF EFFORT AND COST-EF-  
4 FECTIVENESS.—The application shall contain or be  
5 accompanied by such information and assurances as  
6 may be required to satisfy the Secretary that—

7 (A) total expenditures under the State  
8 medicaid program for home and community-  
9 based long-term care services will not be less  
10 for any fiscal year during the MFP demonstra-  
11 tion project than for the greater of such ex-  
12 penditures for—

13 (i) fiscal year 2005; or

14 (ii) any succeeding fiscal year before  
15 the first year of the MFP demonstration  
16 project; and

17 (B) in the case of a qualified HCB pro-  
18 gram operating under a waiver under sub-  
19 section (c) or (d) of section 1915 of the Social  
20 Security Act (42 U.S.C. 1396n), but for the  
21 amount awarded under a grant under this sec-  
22 tion, the State program would continue to meet  
23 the cost-effectiveness requirements of subsection  
24 (c)(2)(D) of such section or comparable require-

1           ments under subsection (d)(5) of such section,  
2           respectively.

3           (10) WAIVER REQUESTS.—The application shall  
4           contain or be accompanied by requests for any modi-  
5           fication or adjustment of waivers of medicaid re-  
6           quirements described in subsection (d)(3), including  
7           adjustments to maximum numbers of individuals in-  
8           cluded and package of benefits, including one-time  
9           transitional services, provided.

10          (11) QUALITY ASSURANCE AND QUALITY IM-  
11          PROVEMENT.—The application shall include—

12                 (A) a plan satisfactory to the Secretary for  
13                 quality assurance and quality improvement for  
14                 home and community-based long-term care  
15                 services under the State medicaid program, in-  
16                 cluding a plan to assure the health and welfare  
17                 of individuals participating in the MFP dem-  
18                 onstration project; and

19                 (B) an assurance that the State will co-  
20                 operate in carrying out activities under sub-  
21                 section (f) to develop and implement continuous  
22                 quality assurance and quality improvement sys-  
23                 tems for home and community-based long-term  
24                 care services.

1           (12) OPTIONAL PROGRAM FOR SELF-DIRECTED  
2 SERVICES.—If the State elects to provide for any  
3 home and community-based long-term care services  
4 as self-directed services (as defined in subsection  
5 (b)(8)) under the MFP demonstration project, the  
6 application shall provide the following:

7           (A) MEETING REQUIREMENTS.—A descrip-  
8 tion of how the project will meet the applicable  
9 requirements of such subsection for the provi-  
10 sion of self-directed services.

11           (B) VOLUNTARY ELECTION.—A description  
12 of how eligible individuals will be provided with  
13 the opportunity to make an informed election to  
14 receive self-directed services under the project  
15 and after the end of the project.

16           (C) STATE SUPPORT IN SERVICE PLAN DE-  
17 VELOPMENT.—Satisfactory assurances that the  
18 State will provide support to eligible individuals  
19 who self-direct in developing and implementing  
20 their service plans.

21           (D) OVERSIGHT OF RECEIPT OF SERV-  
22 ICES.—Satisfactory assurances that the State  
23 will provide oversight of eligible individual's re-  
24 ceipt of such self-directed services, including  
25 steps to assure the quality of services provided

1           and that the provision of such services are con-  
2           sistent with the service plan under such sub-  
3           section.

4           Nothing in this section shall be construed as requir-  
5           ing a State to make an election under the project to  
6           provide for home and community-based long-term  
7           care services as self-directed services, or as requiring  
8           an individual to elect to receive self-directed services  
9           under the project.

10           (13) REPORTS AND EVALUATION.—The applica-  
11           tion shall provide that—

12                   (A) the State will furnish to the Secretary  
13                   such reports concerning the MFP demonstra-  
14                   tion project, on such timetable, in such uniform  
15                   format, and containing such information as the  
16                   Secretary may require, as will allow for reliable  
17                   comparisons of MFP demonstration projects  
18                   across States; and

19                   (B) the State will participate in and co-  
20                   operate with the evaluation of the MFP dem-  
21                   onstration project.

22           (d) SECRETARY'S AWARD OF COMPETITIVE  
23           GRANTS.—

24                   (1) IN GENERAL.—The Secretary shall award  
25                   grants under this section on a competitive basis to

1 States selected from among those with applications  
2 meeting the requirements of subsection (c), in ac-  
3 cordance with the provisions of this subsection.

4 (2) SELECTION AND MODIFICATION OF STATE  
5 APPLICATIONS.—In selecting State applications for  
6 the awarding of such a grant, the Secretary—

7 (A) shall take into consideration the man-  
8 ner in which and extent to which the State pro-  
9 poses to achieve the objectives specified in sub-  
10 section (a);

11 (B) shall seek to achieve an appropriate  
12 national balance in the numbers of eligible indi-  
13 viduals, within different target groups of eligi-  
14 ble individuals, who are assisted to transition to  
15 qualified residences under MFP demonstration  
16 projects, and in the geographic distribution of  
17 States operating MFP demonstration projects;

18 (C) shall give preference to State applica-  
19 tions proposing—

20 (i) to provide transition assistance to  
21 eligible individuals within multiple target  
22 groups; and

23 (ii) to provide eligible individuals with  
24 the opportunity to receive home and com-  
25 munity-based long-term care services as

1 self-directed services, as defined in sub-  
2 section (b)(8); and

3 (D) shall take such objectives into consid-  
4 eration in setting the annual amounts of State  
5 grant awards under this section.

6 (3) WAIVER AUTHORITY.—The Secretary is au-  
7 thORIZED to waive the following provisions of title  
8 XIX of the Social Security Act, to the extent nec-  
9 essary to enable a State initiative to meet the re-  
10 quirements and accomplish the purposes of this sec-  
11 tion:

12 (A) STATEWIDENESS.—Section  
13 1902(a)(1), in order to permit implementation  
14 of a State initiative in a selected area or areas  
15 of the State.

16 (B) COMPARABILITY.—Section  
17 1902(a)(10)(B), in order to permit a State ini-  
18 tiative to assist a selected category or categories  
19 of individuals described in subsection (b)(2)(A).

20 (C) INCOME AND RESOURCES ELIGI-  
21 BILITY.—Section 1902(a)(10)(C)(i)(III), in  
22 order to permit a State to apply institutional  
23 eligibility rules to individuals transitioning to  
24 community-based care.

1 (D) PROVIDER AGREEMENTS.—Section  
2 1902(a)(27), in order to permit a State to im-  
3 plement self-directed services in a cost-effective  
4 manner.

5 (4) CONDITIONAL APPROVAL OF OUTYEAR  
6 GRANT.—In awarding grants under this section, the  
7 Secretary shall condition the grant for the second  
8 and any subsequent fiscal years of the grant period  
9 on the following:

10 (A) NUMERICAL BENCHMARKS.—The  
11 State must demonstrate to the satisfaction of  
12 the Secretary that it is meeting numerical  
13 benchmarks specified in the grant agreement  
14 for—

15 (i) increasing State medicaid support  
16 for home and community-based long-term  
17 care services under subsection (c)(5); and

18 (ii) numbers of eligible individuals as-  
19 sisted to transition to qualified residences.

20 (B) QUALITY OF CARE.—The State must  
21 demonstrate to the satisfaction of the Secretary  
22 that it is meeting the requirements under sub-  
23 section (c)(9) to assure the health and welfare  
24 of MFP demonstration project participants.

1 (e) PAYMENTS TO STATES; CARRYOVER OF UNUSED  
2 GRANT AMOUNTS.—

3 (1) PAYMENTS.—For each calendar quarter in  
4 a fiscal year during the period a State is awarded  
5 a grant under subsection (d), the Secretary shall pay  
6 to the State from its grant award for such fiscal  
7 year an amount equal to the lesser of—

8 (A) 90 percent of the amount of qualified  
9 expenditures made during such quarter; or

10 (B) the total amount remaining in such  
11 grant award for such fiscal year (taking into  
12 account the application of paragraph (2)).

13 (2) CARRYOVER OF UNUSED AMOUNTS.—Any  
14 portion of a State grant award for a fiscal year  
15 under this section remaining at the end of such fis-  
16 cal year shall remain available to the State for the  
17 next four fiscal years, subject to paragraph (3).

18 (3) RE-AWARDING OF CERTAIN UNUSED  
19 AMOUNTS.—In the case of a State that the Sec-  
20 retary determines pursuant to subsection (d)(4) has  
21 failed to meet the conditions for continuation of a  
22 MFP demonstration project under this section in a  
23 succeeding year or years, the Secretary shall rescind  
24 the grant awards for such succeeding year or years,  
25 together with any unspent portion of an award for

1 prior years, and shall add such amounts to the ap-  
2 propriation for the immediately succeeding fiscal  
3 year for grants under this section.

4 (4) PREVENTING DUPLICATION OF PAYMENT.—

5 The payment under a MFP demonstration project  
6 with respect to qualified expenditures shall be in lieu  
7 of any payment with respect to such expenditures  
8 that could otherwise be paid under medicaid, includ-  
9 ing under section 1903(a) of the Social Security Act.  
10 Nothing in the previous sentence shall be construed  
11 as preventing the payment under medicaid for such  
12 expenditures in a grant year after amounts available  
13 to pay for such expenditures under the MFP dem-  
14 onstration project have been exhausted.

15 (f) QUALITY ASSURANCE AND IMPROVEMENT; TECH-  
16 NICAL ASSISTANCE; OVERSIGHT.—

17 (1) IN GENERAL.—The Secretary, either di-  
18 rectly or by grant or contract, shall provide for tech-  
19 nical assistance to and oversight of States for pur-  
20 poses of upgrading quality assurance and quality im-  
21 provement systems under medicaid home and com-  
22 munity-based waivers, including—

23 (A) dissemination of information on prom-  
24 ising practices;

1 (B) guidance on system design elements  
2 addressing the unique needs of participating  
3 beneficiaries;

4 (C) ongoing consultation on quality, in-  
5 cluding assistance in developing necessary tools,  
6 resources, and monitoring systems; and

7 (D) guidance on remedying programmatic  
8 and systemic problems.

9 (2) FUNDING.—From the amounts appro-  
10 priated under subsection (h) for each of fiscal years  
11 2007 through 2011, not more than \$2,400,000 shall  
12 be available to the Secretary to carry out this sub-  
13 section.

14 (g) RESEARCH AND EVALUATION.—

15 (1) IN GENERAL.—The Secretary, directly or  
16 through grant or contract, shall provide for research  
17 on and a national evaluation of the program under  
18 this section, including assistance to the Secretary in  
19 preparing the final report required under paragraph  
20 (2). The evaluation shall include an analysis of pro-  
21 jected and actual savings related to the transition of  
22 individuals to a qualified residences in each State  
23 conducting an MFP demonstration project.

24 (2) FINAL REPORT.—The Secretary shall make  
25 a final report to the President and the Congress, not

1 later than September 30, 2011, reflecting the eval-  
2 uation described in paragraph (1) and providing  
3 findings and conclusions on the conduct and effec-  
4 tiveness of MFP demonstration projects.

5 (3) FUNDING.—From the amounts appro-  
6 priated under subsection (h) for each of fiscal years  
7 2007 through 2011, not more than \$1,100,000 per  
8 year shall be available to the Secretary to carry out  
9 this subsection.

10 (h) APPROPRIATIONS.—

11 (1) IN GENERAL.—There are appropriated,  
12 from any funds in the Treasury not otherwise appro-  
13 priated, for grants to carry out this section—

14 (A) \$250,000,000 for fiscal year 2007;

15 (B) \$300,000,000 for fiscal year 2008;

16 (C) \$350,000,000 for fiscal year 2009;

17 (D) \$400,000,000 for fiscal year 2010;

18 and

19 (E) \$450,000,000 for fiscal year 2011.

20 (2) AVAILABILITY.—Amounts made available  
21 under paragraph (1) for a fiscal year shall remain  
22 available for the awarding of grants to States by not  
23 later than September 30, 2015.

1           **CHAPTER 5—OTHER PROVISIONS**

2   **SEC. 3141. INCREASE IN MEDICAID PAYMENTS TO INSULAR**  
3           **AREAS.**

4           Section 1108(g) of the Social Security Act (42 U.S.C.  
5 1308(g)) is amended—

6           (1) in paragraph (2), by inserting “and subject  
7 to paragraph (3)” after “subsection (f)”; and

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

10           “(3) FISCAL YEAR 2006 AND 2007 FOR CERTAIN  
11 INSULAR AREAS.—The amounts otherwise deter-  
12 mined under this subsection for Puerto Rico, the  
13 Virgin Islands, Guam, the Northern Mariana Is-  
14 lands, and American Samoa for fiscal year 2006 and  
15 fiscal year 2007 shall be increased by the following  
16 amounts:

17           “(A) For Puerto Rico, \$12,000,000 for fis-  
18 cal year 2006 and \$12,000,000 for fiscal year  
19 2007.

20           “(B) For the Virgin Islands, \$2,500,000  
21 for fiscal year 2006 and \$5,000,000 for fiscal  
22 year 2007.

23           “(C) For Guam, \$2,500,000 for fiscal year  
24 2006 and \$5,000,000 for fiscal year 2007.

1           “(D) For the Northern Mariana Islands,  
2           \$1,000,000 for fiscal year 2006 and \$2,000,000  
3           for fiscal year 2007.

4           “(E) For American Samoa, \$2,000,000 for  
5           fiscal year 2006 and \$4,000,000 for fiscal year  
6           2007.

7           Such amounts shall not be taken into account in ap-  
8           plying paragraph (2) for fiscal year 2007 but shall  
9           be taken into account in applying such paragraph  
10          for fiscal year 2008 and subsequent fiscal years.”.

11 **SEC. 3142. MANAGED CARE ORGANIZATION PROVIDER TAX**

12                           **REFORM.**

13          (a) **IN GENERAL.**—Section 1903(w)(7)(A)(viii) of the  
14 Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is  
15 amended to read as follows:

16                       “(viii) Services of managed care organiza-  
17                       tions (including health maintenance organiza-  
18                       tions, preferred provider organizations, and  
19                       such other similar organizations as the Sec-  
20                       retary may specify by regulation).”.

21          (b) **EFFECTIVE DATE.**—

22                       (1) **IN GENERAL.**—Subject to paragraph (2),  
23                       the amendment made by subsection (a) shall be ef-  
24                       fective as of the date of the enactment of this Act.

1           (2) GRANDFATHER.—In the case of a State  
2           that has had approved as of the date of the enact-  
3           ment of this Act a provider tax on services described  
4           in section 1903(w)(7)(A)(viii) of the Social Security  
5           Act, as amended by subsection (a), such amendment  
6           shall be effective as of October 1, 2007.

7   **SEC. 3143. MEDICAID TRANSFORMATION GRANTS.**

8           (a) IN GENERAL.—Section 1903 of the Social Secu-  
9           rity Act (42 U.S.C. 1396b), as amended by section 3104,  
10          is amended by adding at the end the following new sub-  
11          section:

12          “(y) MEDICAID TRANSFORMATION PAYMENTS.—

13                 “(1) IN GENERAL.—In addition to the pay-  
14                 ments provided under subsection (a), subject to  
15                 paragraph (4), the Secretary shall provide for pay-  
16                 ments under subsection (a) to States for the adop-  
17                 tion of innovative methods to improve the effective-  
18                 ness and efficiency in providing medical assistance  
19                 under this title.

20                 “(2) PERMISSIBLE USES OF FUNDS.—The fol-  
21                 lowing are examples of innovative methods for which  
22                 funds provided under this subsection may be used:

23                         “(A) Methods for reducing patient error  
24                         rates through the implementation and use of

1 electronic health records, electronic clinical deci-  
2 sion support tools, or e-prescribing programs.

3 “(B) Methods for improving rates of collec-  
4 tion from estates of amounts owed under this  
5 title.

6 “(C) Methods for reducing waste, fraud,  
7 and abuse under the program under this title,  
8 such as reducing improper payment rates as  
9 measured by annual payment error rate meas-  
10 urement (PERM) project rates.

11 “(D) Implementation of a medication risk  
12 management program as part of a drug use re-  
13 view program under section 1927(g).

14 “(3) APPLICATION; TERMS AND CONDITIONS.—

15 “(A) IN GENERAL.—No payments shall be  
16 made to a State under this subsection unless  
17 the State applied to the Secretary for such pay-  
18 ments in a form, manner, and time specified by  
19 the Secretary.

20 “(B) TERMS AND CONDITIONS.—Such pay-  
21 ments are made under such terms and condi-  
22 tions consistent with this subsection as the Sec-  
23 retary prescribes.

24 “(C) ANNUAL REPORT.—Payment to a  
25 State under this subsection is conditioned on

1 the State submitting to the Secretary an annual  
2 report on the programs supported by such pay-  
3 ment. Such report shall include information  
4 on—

5 “(A) the specific uses of such payment;

6 “(B) an assessment of quality improve-  
7 ments and clinical outcomes under such pro-  
8 grams; and

9 “(C) estimates of cost savings resulting  
10 from such programs.

11 “(4) FUNDING.—

12 “(A) LIMITATION ON FUNDS.—The total  
13 amount of payments under this subsection shall  
14 be equal to, and shall not exceed—

15 “(i) \$50,000,000 for fiscal year 2007;

16 and

17 “(ii) \$50,000,000 for fiscal year 2008.

18 This subsection constitutes budget authority in  
19 advance of appropriations Acts and represents  
20 the obligation of the Secretary to provide for  
21 the payment of amounts provided under this  
22 subsection.

23 “(B) ALLOCATION OF FUNDS.—The Sec-  
24 retary shall specify a method for allocating the  
25 funds made available under this subsection

1 among States. Such method shall provide pref-  
2 erence for States that design programs that  
3 target health providers that treat significant  
4 numbers of medicaid beneficiaries.

5 “(C) FORM AND MANNER OF PAYMENT.—  
6 Payment to a State under this subsection shall  
7 be made in the same manner as other payments  
8 under section 1903(a). There is no requirement  
9 for State matching funds to receive payments  
10 under this subsection.

11 “(5) MEDICATION RISK MANAGEMENT PRO-  
12 GRAM.—

13 “(A) IN GENERAL.—For purposes of this  
14 subsection, the term ‘medication risk manage-  
15 ment program’ means a program for targeted  
16 beneficiaries that ensures that covered out-  
17 patient drugs are appropriately used to opti-  
18 mize therapeutic outcomes through improved  
19 medication use and to reduce the risk of ad-  
20 verse events.

21 “(B) ELEMENTS.—Such program may in-  
22 clude the following elements:

23 “(i) The use of established principles  
24 and standards for drug utilization review  
25 and best practices to analyze prescription

1 drug claims of targeted beneficiaries and  
2 identify outlier physicians.

3 “(ii) On an ongoing basis provide  
4 outlier physicians—

5 “(I) a comprehensive pharmacy  
6 claims history for each targeted bene-  
7 ficiary under their care;

8 “(II) information regarding the  
9 frequency and cost of relapses and  
10 hospitalizations of targeted bene-  
11 ficiaries under the physician’s care;  
12 and

13 “(III) applicable best practice  
14 guidelines and empirical references.

15 “(iii) Monitor outlier physician’s pre-  
16 scribing, such as failure to refill, dosage  
17 strengths, and provide incentives and in-  
18 formation to encourage the adoption of  
19 best clinical practices.

20 “(C) TARGETED BENEFICIARIES.—For  
21 purposes of this paragraph, the term ‘targeted  
22 beneficiaries’ means Medicaid eligible bene-  
23 ficiaries who are identified as having high pre-  
24 scription drug costs and medical costs, such as  
25 individuals with behavioral disorder or multiple

1 chronic diseases who are taking multiple medi-  
2 cations.”.

3 **SEC. 3144. ENHANCING THIRD PARTY IDENTIFICATION AND**  
4 **PAYMENT.**

5 (a) CLARIFICATION OF THIRD PARTIES LEGALLY  
6 RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH  
7 CARE ITEM OR SERVICE.—Section 1902(a)(25) of the So-  
8 cial Security Act (42 U.S.C. 1396a(a)(25)) is amended—  
9 (1) in subparagraph (A), in the matter pre-  
10 ceding clause (i)—

11 (A) by inserting “, including self-insured  
12 plans” after “health insurers”; and

13 (B) by striking “and health maintenance  
14 organizations” and inserting “health mainte-  
15 nance organizations, pharmacy benefit man-  
16 agers, or other parties that are, by statute, con-  
17 tract, or agreement, legally responsible for pay-  
18 ment of a claim for a health care item or serv-  
19 ice”; and

20 (2) in subparagraph (G)—

21 (A) by inserting “a self-insured plan,”  
22 after “1974,”; and

23 (B) by striking “and a health maintenance  
24 organization” and inserting “a health mainte-  
25 nance organization, a pharmacy benefit man-

1           ager, or other party that is, by statute, con-  
2           tract, or agreement, legally responsible for pay-  
3           ment of a claim for a health care item or serv-  
4           ice”.

5           (b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE  
6 THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS  
7 DATA.—Section 1902(a)(25) of such Act (42 U.S.C.  
8 1396a(a)(25)) is amended—

9           (1) in subparagraph (G), by striking “and” at  
10          the end;

11          (2) in subparagraph (H), by adding “and” after  
12          the semicolon at the end; and

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

15                 “(I) that the State shall provide assur-  
16                 ances satisfactory to the Secretary that the  
17                 State has in effect laws requiring health insur-  
18                 ers, including self-insured plans, group health  
19                 plans (as defined in section 607(1) of the Em-  
20                 ployee Retirement Income Security Act of  
21                 1974), service benefit plans, health maintenance  
22                 organizations, pharmacy benefit managers, or  
23                 other parties that are, by statute, contract, or  
24                 agreement, legally responsible for payment of a

1 claim for a health care item or service, as a  
2 condition of doing business in the State, to—

3 “(i) provide eligibility and claims pay-  
4 ment data with respect to an individual  
5 who is eligible for, or is provided, medical  
6 assistance under the State plan, upon the  
7 request of the State;

8 “(ii) accept the subrogation of the  
9 State to any right of an individual or other  
10 entity to payment from the party for an  
11 item or service for which payment has been  
12 made under the State plan;

13 “(iii) respond to any inquiry by the  
14 State regarding a claim for payment for  
15 any health care item or service submitted  
16 not later than 3 years after the date of the  
17 provision of such health care item or serv-  
18 ice; and

19 “(iv) agree not to deny a claim sub-  
20 mitted by the State solely on the basis of  
21 the date of submission of the claim;”.

22 (c) EFFECTIVE DATE.—

23 (1) IN GENERAL.—Except as provided in para-  
24 graph (2), the amendments made by this section  
25 take effect on January 1, 2006.



1 (B) by inserting after paragraph (21) the  
2 following new paragraph:

3 “(22) with respect to amounts expended for  
4 medical assistance for an individual who declares  
5 under section 1137(d)(1)(A) to be a citizen or na-  
6 tional of the United States for purposes of estab-  
7 lishing eligibility for benefits under this title, unless  
8 the requirement of subsection (y) is met.”; and

9 (2) by adding at the end, as amended by section  
10 3104, the following new subsection:

11 “(y)(1) For purposes of subsection (i)(21), the re-  
12 quirement of this subsection is, with respect to an indi-  
13 vidual declaring to be a citizen or national of the United  
14 States, that, subject to paragraph (2), there is presented  
15 satisfactory documentary evidence of citizenship or nation-  
16 ality (as defined in paragraph (3)) of the individual.

17 “(2) The requirement of paragraph (1) shall not  
18 apply to an alien who is eligible for medical assistance  
19 under this title—

20 “(A) on the basis of being entitled or enrolled  
21 for benefits under any part of title XVIII;

22 “(B) on the basis of receiving supplemental se-  
23 curity income benefits under title XVI; or

24 “(C) such other basis as the Secretary may  
25 specify under which satisfactory documentary evi-

1       dence of citizenship or nationality had been pre-  
2       viously presented.

3       “(3)(A) For purposes of this subsection, the term  
4       ‘satisfactory documentary evidence of citizenship or na-  
5       tionality’ means—

6               “(i) any document described in subparagraph  
7       (B); or

8               “(ii) a document described in subparagraph (C)  
9       and a document described in subparagraph (D).

10       “(B) The following are documents described in this  
11       subparagraph:

12               “(i) A United State passport.

13               “(ii) Form N-550 or N-570 (Certificate of Nat-  
14       uralization).

15               “(iii) Form N-560 or N-561 (Certificate of  
16       United States Citizenship).

17               “(iv) Such other document as the Secretary  
18       may specify, by regulation, that provides proof of  
19       United States citizenship or nationality and that  
20       provides a reliable means of documentation of per-  
21       sonal identity.

22       “(C) The following are documents described in this  
23       subparagraph:

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

1           “(ii) Form FS-545 or Form DS-1350 (Certifi-  
2           cation of Birth Abroad).

3           “(iii) Form I-97 (United States Citizen Identi-  
4           fication Card).

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

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

11          “(D) The following are documents described in this  
12          subparagraph:

13               “(i) Any identity document described in section  
14               274A(b)(1)(D) of the Immigration and Nationality  
15               Act.

16               “(ii) Any other documentation of personal iden-  
17               tity of such other type as the Secretary finds, by  
18               regulation, provides a reliable means of identifica-  
19               tion.

20          “(E) A reference in this paragraph to a form includes  
21          a reference to any successor form.

22          (b) EFFECTIVE DATE.—The amendments made by  
23          subsection (a) shall apply to determinations of initial eligi-  
24          bility for medical assistance made on or after July 1,  
25          2006, and to redeterminations of eligibility made on or

1 after such date in the case of individuals for whom the  
2 requirement of section 1903(y) of the Social Security Act,  
3 as added by such amendments, was not previously met.

4 **SEC. 3146. REFORMS OF TARGETED CASE MANAGEMENT.**

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

8 “(2) For purposes of this subsection:

9 “(A)(i) The term ‘case management services’  
10 means services which will assist individuals eligible  
11 under the plan in gaining access to needed medical,  
12 social, educational, and other services.

13 “(ii) Such term includes the following:

14 “(I) Assessment of an eligible individual to  
15 determine service needs, including activities  
16 that focus on needs identification, to determine  
17 the need for any medical, educational, social, or  
18 other services. Such assessment activities in-  
19 clude the following:

20 “(aa) Taking client history.

21 “(bb) Identifying the needs of the in-  
22 dividual, and completing related docu-  
23 mentation.

24 “(cc) Gathering information from  
25 other sources such as family members,

1 medical providers, social workers, and edu-  
2 cators, if necessary, to form a complete as-  
3 sessment of the eligible individual.

4 “(II) Development of a specific care plan  
5 based on the information collected through an  
6 assessment, that specifies the goals and actions  
7 to address the medical, social, educational, and  
8 other services needed by the eligible individual,  
9 including activities such as ensuring the active  
10 participation of the eligible individual and work-  
11 ing with the individual (or the individual’s au-  
12 thorized health care decision maker) and others  
13 to develop such goals and identify a course of  
14 action to respond to the assessed needs of the  
15 eligible individual.

16 “(III) Referral and related activities to  
17 help an individual obtain needed services, in-  
18 cluding activities that help link eligible individ-  
19 uals with medical, social, educational providers  
20 or other programs and services that are capable  
21 of providing needed services, such as making re-  
22 ferrals to providers for needed services and  
23 scheduling appointments for the individual.

24 “(IV) Monitoring and followup activities,  
25 including activities and contacts that are nec-

1           essary to ensure the care plan is effectively im-  
2           plemented and adequately addressing the needs  
3           of the eligible individual, and which may be  
4           with the individual, family members, providers,  
5           or other entities and conducted as frequently as  
6           necessary to help determine such matters as—

7                   “(aa) whether services are being fur-  
8                   nished in accordance with an individual’s  
9                   care plan;

10                   “(bb) whether the services in the care  
11                   plan are adequate; and

12                   “(cc) whether there are changes in the  
13                   needs or status of the eligible individual,  
14                   and if so, making necessary adjustments in  
15                   the care plan and service arrangements  
16                   with providers.

17                   “(iii) Such term does not include the direct de-  
18                   livery of an underlying medical, educational, social,  
19                   or other service to which an eligible individual has  
20                   been referred, including, with respect to the direct  
21                   delivery of foster care services, services such as (but  
22                   not limited to) the following:

23                           “(I) Research gathering and completion of  
24                           documentation required by the foster care pro-  
25                           gram.

1                   “(II) Assessing adoption placements.

2                   “(III) Recruiting or interviewing potential  
3 foster care parents.

4                   “(IV) Serving legal papers.

5                   “(V) Home investigations.

6                   “(VI) Providing transportation.

7                   “(VII) Administering foster care subsidies.

8                   “(VIII) Making placement arrangements.

9                   “(B) The term ‘targeted case management serv-  
10 ices’ are case management services that are fur-  
11 nished without regard to the requirements of section  
12 1902(a)(1) and section 1902(a)(10)(B) to specific  
13 classes of individuals or to individuals who reside in  
14 specified areas.

15                  “(3) With respect to contacts with individuals who  
16 are not eligible for medical assistance under the State plan  
17 or, in the case of targeted case management services, indi-  
18 viduals who are eligible for such assistance but are not  
19 part of the target population specified in the State plan,  
20 such contacts—

21                  “(A) are considered an allowable case manage-  
22 ment activity, when the purpose of the contact is di-  
23 rectly related to the management of the eligible indi-  
24 vidual’s care; and

1           “(B) are not considered an allowable case man-  
2           agement activity if such contacts relate directly to  
3           the identification and management of the noneligible  
4           or nontargeted individual’s needs and care.

5           “(4)(A) In accordance with section 1902(a)(25), Fed-  
6           eral financial participation only is available under this title  
7           for case management services or targeted case manage-  
8           ment services if there are no other third parties liable to  
9           pay for such services, including as reimbursement under  
10          a medical, social, educational, or other program.

11          “(B) A State shall allocate the costs of any part of  
12          such services which are reimbursable under another feder-  
13          ally funded program in accordance with OMB Circular A-  
14          87 (or any related or successor guidance or regulations  
15          regarding allocation of costs among federally funded pro-  
16          grams) under an approved cost allocation program.”.

17          (b) EFFECTIVE DATE.—The amendment made by  
18          subsection (a) shall take effect on January 1, 2006.