Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

Section of the Law	Link to CMS Implementing Document	Subject	Effective Date	Release Date	Status / Additional Information
5001 (a[1])	REGULATION – Inpatient Prospective Payment System Proposed Rule REGULATION – Inpatient Prospective Payment System Final Rule	**Hospital quality improvement.** The Secretary is directed to expand the set of quality measures collected. For purposes of the FY 2007 update, the Secretary must start to collect the baseline measures set forth by the Institute of Medicine in its November 2005 report—these measures include the 22 Hospital Quality Alliance measures, HCAHPS, and 3 process measures.	**10/1/06**	**Display 4/12/06 Publish 4/25/06 Display 8/1/06 Publish 8/18/06**	
5001 (a[2])	REGULATION – Inpatient Prospective Payment System Proposed Rule REGULATION – Inpatient Prospective Payment System Final Rule	**Hospital quality improvement.** Sets the annual payment update for hospitals for fiscal year 2007 and subsequent fiscal years. Hospitals that report the required set of quality measures to the Secretary will receive the full market basket. Hospitals that do not report quality measures will receive the market basket minus 2 percentage points. For purposes of the FY 2008 update and subsequent years, the Secretary must add other measures that reflect consensus among affected parties. Also allows the Secretary to replace measures and requires the Secretary to post measures on the internet.	**10/1/06**	**Display 4/12/06 Publish 4/25/06 Display 8/1/06 Publish 8/18/06**	
5001 (b)	REGULATION – Inpatient Prospective Payment System Proposed Rule REGULATION – Inpatient Prospective Payment System Final Rule	**Hospital quality improvement.** It requires that the Secretary select, by Oct 1, 2007, diagnosis codes for at least two conditions that: (1) are high cost or high volume, (2) result in the assignment of a case to a DRG that has a higher payment classification when present as a secondary diagnosis, and (3) are reasonably preventable with the application of evidence-based guidelines. The Secretary may revise the codes selected so long as there are diagnosis codes associated with at least two conditions during any fiscal year. Requires hospitals to submit the secondary diagnosis of the individual at admission when reporting information for payment for discharges on or after October 1, 2007.	**10/1/06**	**Display 4/12/06 Publish 4/25/06 Display 8/1/06 Publish 8/18/06**	
5001 (c)	REGULATION – Inpatient Prospective Payment System Proposed Rule REGULATION – Inpatient Prospective Payment System Final Rule	**Hospital quality improvement.** Requires the Secretary to develop a plan to implement a value based purchasing program for hospitals beginning in FY 2009. Adjusts the payment for discharges occurring on or after October 1, 2008 in cases where a selected diagnosis code is present as a secondary diagnosis. Such cases would be paid as though the secondary	**10/1/06**	**Display 4/12/06 Publish 4/25/06 Display 8/1/06 Publish**	

	NOTICE - Plan for Medicare Hospital Value-Based Purchasing Listening Session—January 17, 2007	diagnosis is not present.		**8/18/06 Display 11/22/06 Publish 11/24/06**	
5003	REGULATION – Inpatient Prospective Payment System Proposed Rule REGULATION – Inpatient Prospective Payment System Final Rule	**Improvements to the Medicare-dependent hospital (MDH) program.** Extends the current Medicare Dependent Hospital Program for 5 years (from 2006 to 2011). It permits such hospitals to use 2002 as the base year for payment purposes. It also provides enhanced payment for the amount by which such hospitals' target amounts exceed the prospective payment system rate. The provision also exempts such hospitals from the cap on Medicare DSH payments.	**4/12/06** **10/1/06**	**Display 4/12/06 Publish 4/25/06** **Display 8/1/06 Publish 8/18/06**	
5004	Issuance – cost report instructions REGULATION – Inpatient Prospective Payment System Proposed Rule REGULATION – Inpatient Prospective Payment System Final Rule	**Reduction in payments to skilled nursing facilities for bad debt.** Reduces the payment amount for Medicare-allowable skilled nursing facility (SNF) bad debt from 100 percent to 70 percent, except for the bad debt attributable to beneficiaries eligible for both Medicare and Medicaid, effective for cost reporting periods beginning on or after October 1, 2005.	**4/12/06** **10/1/06**	**4/12/06** **Display 4/12/06 Publish 4/25/06** **Display 8/1/06 Publish 8/18/06**	
5005	Issuance REGULATION – Inpatient Rehabilitation Prospective Payment System Proposed Rule REGULATION – Inpatient Rehabilitation Prospective Payment System Final Rule	**Extended Phase-in of the Inpatient Rehabilitation Facility Classification Criteria.** Modifies the phase-in established in the May 7, 2004 final rule, which updated the classification criteria for inpatient rehabilitation facilities under the Medicare program. The revised phase-in is as follows: (1) For cost reporting periods during the 12-month period beginning on July 1, 2006, the compliance threshold is 60 percent (formerly it was 65 %). (2) For cost reporting periods during the 12-month period beginning on July 1, 2007, the compliance threshold is 65 percent (formerly it was 75 %). (3) For cost reporting periods *beginning on or after July 1, 2008*, the compliance threshold is 75 percent.	**4/14/06** **10/1/06**	**4/14/06** **Display 5/8/06 Publish 5/15/06** **Display 8/1/06 Publish 8/18/06**	

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

5006	Joint Signature memo	**Development of a strategic plan regarding physician investment in specialty hospitals.** Last summer, CMS temporarily suspended enrollment of new specialty hospitals while the agency reviewed its procedures for enrollment. The DRA continues that suspension until the earlier of six months after enactment (August 9, 2006) or CMS's release of a final report on specialty hospitals required by the DRA. The DRA directs CMS to develop a strategic and implementing plan addressing the proportionality of investment return; whether the investment is a bona fide investment; and whether the Secretary should require annual disclosure of investment information. In addition, the DRA requires the Secretary to consider the provision by specialty hospitals of care to: (a) Medicaid patients; (b) patients receiving medical assistance under a State demonstration project approved under title XI of the Act; and (c) patients receiving charity care. The DRA also requires the strategic and implementing plan to address the issue of appropriate enforcement.	**2/15/06**	**2/15/06**	
5007	Federal Register Demonstration Notice	**Medicare demonstration projects to permit gainsharing arrangements.** Within 90-days of enactment, the Secretary must solicit applications for approval of demonstration projects under the program. The Secretary must establish a demonstration program by 11/1/06. The provision limits the program to no more than 6 projects, at least 2 of which must be located in a rural area. Projects must be operational no later than Jan 1, 2007.		**Display 9/13/06 Publish 9/18/06**	
5008		**Post-acute care payment reform demonstration program.** Directs the Secretary to establish a demonstration program to better understand costs and outcomes across different post-acute care sites by January 1, 2008. Under the program: • An individual who receives treatment for a certain diagnosis must receive a single comprehensive assessment on the date of discharge concerning the needs of the patient to determine the appropriate placement of such patient in a post-acute care site; • A standardized patient assessment instrument must be used across the post-acute care sites to measure functional status and other factors during the treatment and discharge from each provider;			

		• Participants in the demonstration program will be required to submit information on the fixed and variable costs for each individual; and • An additional comprehensive assessment must be provided at the end of the episode of care.			

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

5101	First Issuance to address provider education for both subsections (a) and (b). Issuances Systems Issuance Systems Issuance REGULATION – Competitive Acquisition for Certain DMEPOS Proposed Rule REGULATION – Home Health Proposed Rule REGULATION – Home Health Final Rule	**Beneficiary ownership of certain DME.** Revises the period of payment for capped rental DME items from 15 to 13 months. Eliminates semi-annual maintenance and servicing payments and instead allows for maintenance and servicing payments for beneficiary-owned items on a reasonable and necessary basis. Applies where the first month of rental occurs on or after January 1, 2006. Retains current requirement that suppliers of power-driven wheelchairs must offer the beneficiary the option to purchase the power-wheelchair at the time the supplier furnishes the item. Limits to 36 the total number of continuous months for which Medicare will pay for oxygen equipment. After the 36th month, the beneficiary will own the oxygen equipment. Allows for maintenance and servicing payments on beneficiary-owned equipment on a reasonable and necessary basis. After beneficiary owns oxygen tanks, continues to pay for oxygen contents. Effective for items furnished beginning 1/1/2006. Beneficiaries currently renting oxygen equipment will have a new rental period that begins 1/1/06.	**4/30/06** **1/1/06** **1/1/06** **1/1/07**	**4/28/06** **11/24/06** **11/24/06** **Display 4/24/06** **Publish 5/1/06** **Display 7/27/06** **Publish 8/3/06** **Display 11/1/06** **Publish 11/9/06**	
5102	Issuances REGULATION – Physician Fee Schedule Proposed Rule REGULATION – Physician Fee Schedule Final Rule	**Adjustments in payment for imaging services.** Limits the payment under the physician fee schedule for performing certain imaging services to the payment amount determined under the outpatient prospective payment system. The payment rate for interpretation of the image is not affected. Exempts from budget neutrality requirements this adjustment and reductions in payments for multiple imaging procedures.	**1/1/07** **1/1/07**	**10/27/06** **Display 8/8/06** **Publish 8/22/06** **Display 11/1/06** **Publish 12/1/06**	
5103	REGULATION – Outpatient Prospective Payment System Proposed	**Limitation on payments for procedures in ambulatory surgical centers.** Limits payments for services provided in ambulatory surgical centers prior to the implementation of the revised payment system		**Display 8/8/06** **Publish**	

	Rule Issuances	(which is to begin no later than January 1, 2008), to the fee schedule amount determined under the outpatient prospective payment system.	**1/1/07** **1/1/07**	**8/23/06** **12/20/06**	
5104	Issuance to Medicare Contractors to pay the 0% update beginning 2 business days after the DRA is signed and to reprocess (at 0%) those claims paid at the -4.4% rate. Issuance to announce second ParDoc Enrollment Period from 2/15/06 thru 3/31/06. Joint Signature Memo - to Medicare Contractors announcing that the DRA was signed into law. REGULATION – Physician Fee Schedule Proposed Rule REGULATION – Physician Fee Schedule Final Rule	**Update for physicians' services for 2006.** Provides for a 0 percent update in 2006 for services under the physician fee schedule. The 2006 update will not affect future year updates under the sustainable growth rate (SGR) methodology.	**1/1/06** **1/1/06** **2/8/06** **1/1/07**	**2/1/06** **2/10/06** **2/8/06** **Display 8/8/06 Publish 8/22/06** **Display 11/1/06 Publish 12/1/06**	
5105	Issuance REGULATION – Outpatient Prospective Payment System Proposed Rule	**Three-year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services.** Extends through 2008 a portion of the hold harmless protection that ensures that rural hospitals with fewer than 100 beds do not receive less under the outpatient prospective payment system (OPPS) than they would have received under the reasonable cost payment system.	**2/24/06**	**2/24/06** **Display 8/8/06 Publish 8/23/06**	

	REGULATION - Outpatient Prospective Payment System Final Rule	Payments will be 95% (in 2006), 90% (in 2007), and 85% (in 2008) of the difference between the OPPS amount and the reasonable cost amount.	**1/1/07**	**Display 11/1/06 Publish 11/24/06**	
5106	Issuance - On 1/31/06 CMS made ESRD Pricer software available to contractors. On 2/10/06, a change request was released allowing claims to be paid under revised rates, with reprocessing of prior claims to be completed by 7/1/06. REGULATION – Physician Fee Schedule Proposed Rule REGULATION – Physician Fee Schedule Final Rule	**Update to the composite rate component of the basic case-mix adjusted prospective payment system for dialysis services.** Increases the amount of the composite rate component of payment for dialysis services *on or after January 1, 2006* by 1.6 percent.	**1/31/06** **2/10/06** **1/1/07**	**1/31/06** **2/10/06** **Display 8/8/06 Publish 8/22/06** **Display 11/1/06 Publish 12/1/06**	
5107 (a)	Issuance Joint Signature Memo REGULATION – Physician Fee Schedule Proposed Rule REGULATION – Physician Fee Schedule Final Rule	**Revisions to payments for therapy services.** Requires establishment of a process to allow exceptions to the financial limits on therapy services for services furnished in 2006 if such services are determined to be medically necessary.	**1/1/07** **1/1/07** **1/1/07**	**2/13/06** **2/15/06** **Display 8/8/06 Publish 8/22/06** **Display 11/1/06 Publish 12/1/06**	

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

5107 (b)	Issuance	**Revisions to payments for therapy services.** Requires the implementation of clinically appropriate code edits for therapy services including edits for clinically illogical combinations of procedure codes and other edits to control and eliminate improper payments.	**1/1/06**	**2/15/06**	
5111	Federal Register Notice- Annual Part B premium announcement	**Accelerated implementation of income-related reduction in Part B premium subsidy.** Shortens the phase-in of the income-related Part B premium from 5 years to 3 years.	**1/1/07**	**Display 9/12/06 Publish 9/18/06**	
5112	REGULATION – Physician Fee Schedule Proposed Rule REGULATION – Physician Fee Schedule Final Rule Issuances	**Medicare coverage of ultrasound screening for abdominal aortic aneurysms.** Adds this procedure to the list of screening services for which physicians must provide education, counseling and referral during the "Welcome to Medicare" exam. Adds Medicare coverage for one ultrasound screening for abdominal aortic aneurysms for certain beneficiaries receiving a "Welcome to Medicare" exam, including those with a family history or other risk factors identified by the U.S. Preventive Services Task Force, and waives the Part B deductible for such screening.	**1/1/07**	**Display 8/8/06 Publish 8/22/06** **Display 11/1/06 Publish 12/1/06**	
5113	REGULATION – Physician Fee Schedule Proposed Rule REGULATION – Physician Fee Schedule Final Rule Issuances	**Improving patient access to, and utilization of, colorectal cancer screening.** Exempts the colorectal cancer screening benefit from the Part B deductible.	**1/1/07**	**Display 8/8/06 Publish 8/22/06 Display 11/1/06 Publish 12/1/06**	
5114	Issuance	**Delivery of services at Federally Qualified Health Centers (FQHC).** Adds self management training for diabetics and medical nutrition therapy for beneficiaries with diabetics or renal disease to the list of Medicare-reimbursed services under the FQHC benefit. Allows an FQHC to bill on behalf of health professionals who are under contract with the center for services furnished to its patients. Expands the definition of FQHC to include Health Care for the Homeless grantees.	**1/1/06**	**3/31/06**	

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

5115		**Waiver of part B late enrollment penalty for certain international volunteers.** Provides for the waiver of the Part B late enrollment penalty and establishment of a special enrollment period for beneficiaries who are volunteering outside of the U.S. through a 12-month or longer program sponsored by a tax-exempt organization defined under section 501(c)(3) of the Internal Revenue Code and who have other health insurance coverage.			
5201 (a), (b) & (c[1])	Issuances Joint Signature Memo REGULATION – Home Health Proposed Rule REGULATION – Home Health Final Rule	**Home health payments.** Sets the 2006 home health update at 0 percent and reinstitutes the 5 percent add-on for home health services furnished to beneficiaries residing in rural areas for episodes and visits beginning on or after January 1, 2006 and before January 1, 2007. Also adjusts the annual payment update for home health agencies for 2007 and subsequent years, if quality data are not submitted.	**1/1/07** **1/1/07** **1/1/07**	**2/10/06** **1/27/06** **Display 7/27/06** **Publish 8/3/06** **Display 11/1/06** **Publish 11/9/06**	
5201 (c[2])	REGULATION – Home Health Proposed Rule REGULATION – Home Health Final Rule	**Home health payments.** Home health agencies that report quality measures to the Secretary will receive the full market basket percentage increase. Home health agencies that do not report quality measures will receive the market basket percentage increase minus 2 percentage points.	 **1/1/07**	**Display 7/27/06** **Publish 8/3/06** **Display 11/1/06** **Publish 11/9/06**	
5202	Issuance	**Revision of period for providing payment for claims that are not submitted electronically.** Changes the timing requirement for the payment of paper claims. Claims must be paid within 28 calendar days (formerly 26 calendar days) after the claim is received. Applies to claims submitted on or after January 1, 2006.	**1/1/06**	**2/10/06**	
5203	Issuance	**Timeframe for part A and B payments.** Requires that payments that would have been made during the period beginning on September 22, 2006, and ending on September 30, 2006 must be paid on the first business day of October 2006. No interest or late penalty will apply.	**7/22/06**	**2/10/06**	
5301	45-Day Notice	**Phase-out of risk adjustment budget neutrality in determining the**	**1/1/07**	**4/3/06**	

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

		amount of payments to Medicare Advantage organizations. Beginning in 2007, establishes a single risk ratebook for monthly capitation rates related to payment of Medicare Advantage plans. Codifies the phase out schedule of the budget neutrality adjustment from 2007-2010 that the Administration announced in September 2005. Identifies the adjustments to be made to the budget neutrality calculation during these phases out years.			
5302	Solicitation - Grant Notice Grant Award	**Rural PACE provider grant program.** Creates a program to award site development grants to up to 15 rural PACE pilot sites. Requires the Secretary to establish a technical assistance program that will provide outreach and education to State agencies and provider organizations interested in establishing PACE programs in rural areas, and technical assistance necessary to support rural PACE pilot sites.	 **9/29/06**	**6/14/06** **9/29/06**	
6001 (a) (2)	REGULATION –Proposed Rule	**Federal upper payment limit for multiple source drugs and other drug payment provisions.** Sets the federal upper reimbursement limit (FUL) as 250% of the average manufacturer price (AMP), (without prompt pay discounts extended to wholesalers) for drugs on the FUL list. Expands the number of drugs subject to the FUL by requiring a FUL to be established for each multiple source drug for which the FDA has rated two or more products therapeutically and pharmaceutically equivalent.	**12/22/06**	**Display 12/15/06 Publish 12/22/06**	
6001 (b) & (e)	Pharmacy Bulletin (Update to the Medicaid Management System)	**Federal upper payment limit for multiple source drugs and other drug payment provisions.** Beginning July 1, 2006, the Secretary shall provide to States on a monthly basis, the most recently reported AMP for single source drugs and for multiple source drugs. The Secretary may contract for services of a vendor to determine retail survey prices (RSP) for covered outpatient drugs. The vendor must update the Secretary each time a therapeutically equivalent drug becomes available and the Secretary must make a determination within 7 days after receiving the update if the drug is eligible for inclusion on the FUL list. In contracting for such services, the Secretary must competitively bid for an outside vendor. In addition, the provision requires the Secretary to provide information on RSP to states on a monthly basis.	**7/5/06**	**7/5/06**	
6001 (c) (3) (B)	REGULATION –Proposed Rule	**Federal upper payment limit for multiple source drugs and other drug payment provisions.** The Secretary must publish a regulation that clarifies the requirements and manner in which average	**1/1/07**	**Display 12/15/06 Publish**	

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

		manufacturer prices are determined.		**12/22/06**	
6002[1]	State Medicaid Director Letter	**Collection and submission of utilization data for certain physician administered drugs.** Beginning Jan 1, 2006, states must provide for the submission of utilization data and coding (such as the National Drug Code and the J-Code) for all physician administered single source drugs under the Medicaid program.	**7/11/06**	**7/11/06**	
6002[2]	State Medicaid Director Letter REGULATION –Proposed Rule	**Collection and submission of utilization data for certain physician administered drugs.** No later than January 1, 2007, for multiple source drugs, the Secretary will publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of dispensing in Medicaid. Not later than January 1, 2007, the information submitted for single and multiple source drugs must be using NDC codes unless the Secretary specifies than all alternative coding system should be used. The Secretary may grant a hardship waiver to individual states that, due to extenuating circumstances, need additional time to implement these provisions.	**7/11/06** **1/1/07**	**7/11/06** **Display 12/15/06 Publish 12/22/06**	
6002[3]	State Medicaid Director Letter	**Collection and submission of utilization data for certain physician administered drugs.** After January 1, 2008, in order to receive payment for those 20 multiple source drugs, the state will submit utilization data and coding (such as J-codes and NDC numbers) as the Secretary may specify to collect rebates.	**7/11/06**	**7/11/06**	
6003	REGULATION –Proposed Rule	**Improved regulation of drugs sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act.** Requires manufacturers to include authorized generics when they report their Average Manufacturer Price (AMP) and Best Price for covered outpatient drugs to the Secretary.	**1/1/07**	**Display 12/15/06 Publish 12/22/06**	
6011	State Medicaid Director Letter State Plan Amendment	**Lengthening look-back period; change in beginning date for period of ineligibility.** Lengthens the "look-back" period from 36 months to 60 months. The "look-back" period is the amount of time for which states are required to determine whether an individual transferred or gifted assets for less than fair market value. Currently, states are required to look as far back in time as 36 months from the date an individual applies for medical assistance, and this provision extends the 'look-back' period to 60 months. Individuals who transfer or gift assets for less than fair market value within the "look-back" period are subject to the "penalty period".	**2/8/06** **2/8/06**	**7/27/06** **7/27/06**	TOAEnclosure.pdf

		Currently, the penalty period begins on the first day of the first month in which assets have been improperly transferred. For cases in which the "penalty period" causes extreme hardship, the provision requires that each state provide for a hardship waiver process that allows individuals to apply for an undue hardship waiver. Also gives states the option of providing bed hold payments to a nursing home while an undue hardship waiver is pending, for no more than 30 days.			
6012	State Medicaid Director Letter	**Disclosure and treatment of annuities.** Requires states to require, as a condition of receiving Medicaid LTC services, applicants to disclose a description of any interest the individual or community spouse has in an annuity regardless of whether the annuity is irrevocable or is treated as an asset. Expands the term 'assets' to include an annuity purchased by or on behalf of an annuitant unless certain conditions are met.	**2/8/06**	**7/27/06**	TOAEnclosure.pdf
6013	State Medicaid Director Letter	**Application of "income-first" rule in applying community spouse's income before assets in providing support of community spouse.** When calculating the community spouse resource allowance, requires states to require income of the institutionalized individual to be considered as available to the community spouse before additional amounts of the institutionalized individual's resources are protected for the benefit of the community spouse.	**2/8/06**	**7/27/06**	TOAEnclosure.pdf
6014	State Medicaid Director Letter	**Disqualification for long-term care assistance for individuals with substantial home equity.** Individuals shall not be eligible for long term care assistance if the individual's equity interest in the individual's home exceeds $500,000. The State may elect to change the $500,000 home equity limit up to $750,000. State Plan Amendment under development. The Secretary is to establish a process where this requirement is waived in cases of demonstrated hardship.	**2/8/06**	**7/27/06**	TOAEnclosure.pdf
6015	State Medicaid Director Letter	**Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts.** Specifies that individuals may be required to spend down resources declared for admission into CCRCs, before applying for Medicaid. Entrance fees must be considered as an individual's resource and will	**2/8/06**	**7/27/06**	TOAEnclosure.pdf

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

		be used to determine medical assistance eligibility.			
6016	State Medicaid Director Letter State Plan Amendment	**Additional reforms of Medicaid asset transfer rules.** Requires states to impose partial months of ineligibility for improper asset transfers. States can accumulate multiple transfers into one penalty period. The term assets will now include the transfer of certain notes, loan, or mortgage and the purchase of a life estate interest in another individual's home.	**2/8/06** **2/8/06**	**7/27/06** **7/27/06**	TOAEnclosure.pdf
6021 (a)	State Medicaid Director Letter	**Expansion of State Long-Term Care Partnership Program.** Establishes authority for all states (outside of original 4 state demonstrations) to implement LTC partnership plans that provide dollar-to-dollar disregard of assets or resources equal to the insurance benefit payments on behalf of the individual. Directs the Secretary to develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of Partnership long term care insurance policies. The Department shall receive the data and create an online data set to assist in eligibility determinations. The Department shall review changes to the National Association of Insurance Commissioners (NAIC) model regulation and model act for long-term care insurance within 12 months of NAIC enactment to determine if the changes should be incorporated into the required consumer protection standards for Partnership programs. Directs the Secretary to publish regulations that specify the type and format of program data and information to be reported and the frequency with which such reports are to be made. These reports must be made available to states.	**2/8/06**	**7/27/06**	LTCEnclosure.pdf
6021 (b)	State Medicaid Director Letter	**Expansion of State Long-Term Care Partnership Program.** Provides standards for reciprocity among partnership states unless they notify the Secretary of their decision to exempt themselves. Standards will be established by the Secretary no later than January 1, 2007.	**2/8/06**	**7/27/06**	LTCEnclosure.pdf
6021 (d)	Governors letter soliciting proposals Announcement about states selected for the awareness campaign and website	**Expansion of State Long-Term Care Partnership Program** Establishes a National Clearinghouse for education of beneficiaries on all types of long term care insurance.	**5/11/06** **9/25/06**	**5/11/06** **9/25/06**	

	launch				
6031	State Medicaid Director Letter	**Encouraging the enactment of State False Claims Acts.** States that have in effect a State False Claims Act that meets certain Federal requirements will receive an incentive FMAP payment for any amounts recovered as a result of enforcing their state False Claims Acts.	**1/1/07**	**9/19/06**	
6032	State Medicaid Director Letter State Plan Amendment	**Employee education about false claims recovery.** Requires any entity (i.e., those that receive or make annual Medicaid payments under the state plan of at least $5 million) to provide Federal False Claims Act education to their employees.	**1/1/07**	**12/13/06**	
6033	State Medicaid Director Letter	**Prohibition on restocking and double billing of prescription drugs.** Medicaid payment is prohibited for the ingredient cost of a drug which the pharmacy has already received payment under Medicaid (other than a reasonable restocking fee).	**4/1/06**	**3/22/06**	
6035	State Medicaid Director letter	**Enhancing third party identification and payment.** Clarifies the list of third parties and health insurers from which states or local agencies must cost avoid and seek third party liability (TPL) recovery. These additional payers include self-insured plans, pharmacy benefit managers, and other parties that are by statute, contract, or agreement legally responsible for payment of a claim. States are required to enact laws that mandate that all such parties provide information to the state needed to facilitate determination of liability, cooperate with the state in determining liability, and except the state from administrative timing and other procedural requirements for claims if the claims are submitted within 3 years and pursued within 6 years.	**12/15/06**	**12/15/06**	SMD121506QandA.pdf SMD121506Encl.pdf
6036 (a-b)	State Medicaid Director Letter State Plan Amendment REGULATION – Interim Final Rule	**Improved enforcement of documentation requirements**. In order to qualify for Medicaid, the provision requires individuals who declare themselves to be US citizens or nationals to provide satisfactory documentary evidence of citizenship or nationality. Specifies what is considered to be satisfactory evidence of citizenship or nationality.	**6/9/06** **7/6/06**	**6/9/06** **Display 7/6/06 Publish 7/12/06**	
6036 (c)	State Medicaid Director Letter State Plan Pre-print	**Improved enforcement of documentation requirements**. The Secretar must establish an outreach program that is designed to educate individuals who are likely to be affected by this provision.	**7/1/06**	**6/9/06**	
6041	State Medicaid Director	**State option for alternative Medicaid premiums and cost-sharing.**	**3/31/06**	**6/16/06**	

Deficit Reduction Act of 2005
All CMS Provisions
As of February 28, 2006

	letter	Allows states to impose premiums and cost sharing that would otherwise not be permitted under section 1916 of the Medicaid statute for any group of individuals (as specified by the state) and for any type of services other than drugs for which cost sharing may be imposed under section 6042 (and may vary such premiums and cost-sharing among such groups or types). In addition, this section requires the Secretary to increase levels of nominal cost sharing under Section 1916(c) and Section 1916(e) by the annual percentage increase in the medical care component of the consumer price index.			
6042	State Medicaid Director letter	**Special rules for cost sharing for prescription drugs.** Establishes special rules for cost sharing for prescription drugs. For one or more groups of beneficiaries, states are permitted to increase cost sharing over current nominal levels for non-preferred drugs or waive or reduce cost sharing otherwise applicable for preferred drugs. States may not apply cost sharing beyond nominal amounts for preferred drugs for individuals statutorily exempt from cost sharing.	**3/31/06**	**6/16/06**	
6043	State Medicaid Director letter	**Emergency room copayments for non-emergency care.** Allows states to permit hospitals to impose cost sharing for non-emergency care furnished to individuals in an emergency department provided that specified conditions are met and an alternate non-emergency provider is available and accessible. Cost sharing limitations based on income and eligibility groups are included. The aggregate limits on all alternative cost sharing apply to cost sharing for emergency room services.			Mentioned in the 6/16/06 SMD letter but not implemented.
6044	State Medicaid Director letter	**Use of benchmark benefit packages.** Allows states to provide Medicaid coverage to one or more groups of individuals (as specified by the state) through enrollment in coverage that provides benchmark or benchmark equivalent coverage. A State may not require certain categories of individuals to enroll in benchmark or benchmark equivalent coverage. Benchmark coverage is one of four types of coverage: Blue Cross/ Blue Shield standard FEHBP coverage; state employee coverage; coverage of the largest commercial HMO in the state; and Secretary-approved coverage. States may also offer wrap-around or additional coverage to supplement the benchmark or benchmark equivalent package. Children under age 19 enrolled in a benchmark plan will continue to receive EPSDT benefits through wrap-around coverage.	**3/31/06**	**6/16/06**	6044benchmarkpreprint.pdf
6052		**Reforms of case management and targeted case management.**			

		Seeks to clarify what is reimbursable under the Medicaid case management and targeted case management (TCM) benefit. Defines the activities that are Medicaid reimbursable and excludes Federal Medicaid reimbursement for the "direct delivery" of any underlying medical, educational, social or other service to which an eligible individual has been referred. Clarifies what "direct delivery" means with respect to children in foster care under the Title IV-E program and provides an enumerated list of what the benefit would not cover. For case management and TCM services, it requires that States allocated case management costs in accordance with OMB Circular A-87 in determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.			
6053 (b)	Federal Register Notice	**Additional FMAP Adjustments.** Adjusts the FMAP rates for any year after FY 2006 for states the Secretary determines have a significant number of Katrina evacuees by disregarding income attributable to these evacuees for purposes of calculating their FMAP rates.	**11/30/06**	**11/30/06**	
6054	Federal Register Notice – DSH Allotments	**DSH allotment for the District of Columbia.** Provides a prospective adjustment to the District's DSH allotment. The District's DSH allotment for FY2002 is raised from $32 million to $49 million for expenditures (effectively raising the DSH adjustment expenditures applicable to FY 2006 and subsequent fiscal years).	**10/3/06**	**Display 9/29/06 Publish 10/3/06**	
6055	Grants	**Increase in Medicaid payments to insular areas.** Increases the cap on Federal Medicaid matching funds for each of the five insular areas for FY 06 and FY 07 (including: PR, U.S. Virgin Islands, Guam, Northern Mariana Islands, and American Samoa). Uses the higher FY 07 amounts as the new base amounts for current-law inflation-based increases in future years. This would result in additional costs of $48 million for FY 06-07 and $28 million plus inflation adjustments for years beginning in 2008.	**3/10/06**	**3/10/06**	
6062	State Medicaid Director Letter	**Opportunity for families of disabled children to purchase Medicaid coverage for such children.** Provides states with the option to permit families with disabled children with incomes up to 300% of the federal poverty level to buy into Medicaid coverage for their disabled children. Monthly premiums for enrollment in Medicaid would be based on a sliding scale, based on family income. Such a premium requirement could only be applied if specific caps on	**11/28/06**	**11/28/06**	

		aggregate payments for cost-sharing for employer-sponsored family coverage are met.			
6065	State Medicaid Manual Update	**Restoration of Medicaid eligibility for certain SSI beneficiaries**. Enables individuals under 21 who are eligible for SSI to begin receiving Medicaid benefits when their eligibility is determined.	**3/15/06**	**3/15/06**	
6071	Three Solicitations will be issued: 1 for the demonstration sites, 1 for the technical evaluation contract, and 1 for a technical assistance provider	**Money Follows the Person Rebalancing Demonstration.** The Money Follows the Person (MFP) demonstration authorizes the Secretary to award grants to states through a competitive process to pay, an MFP-enhanced FMAP rate for the provision of home and community-based services, for a period of one year, to individuals who transition from institutional long-term settings to home or community-based settings of their choice. For states awarded a grant, the MFP-enhanced FMAP is based on the SCHIP model and will increase their regular FMAP by 50 percent of the number of percentage points by which the state's FMAP is less than 100 percent, and the MFP-enhanced FMAP cannot exceed 90 percent. The demonstration project shall include at least two consecutive fiscal years within the grant period *beginning January 1, 2007 and ending September 30, 2011*.		**7/26/06** **8/21/06** **8/21/06**	
6081	State Medicaid Director Letter #1 State Medicaid Director Letter #2	**Medicaid transformation grants.** Grants of $75 million per year are made available to states in FY 2007 and FY 2008 for the adoption of innovative methods to improve the effectiveness and efficiency in providing Medicaid. Grant money may be awarded for a variety of approaches, including reducing patient error rates, improving rates of estate collection, reducing waste, fraud and abuse including improper payment rates as measured by the annual payment error rate measurement (PERM) project rates, implementation of medication risk management programs, reducing expenditures for covered outpatient drugs with high utilization and substituting generic drugs, and methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.	**7/25/06**	**7/25/06**	072506EnclA.pdf 072506EnclB.pdf
6082		**Health Opportunity Accounts.** A five year demonstration project is established beginning on January 1, 2007, allowing the Secretary to establish no more than 10 state demonstration programs. For each state demonstration plan, Health Opportunity Accounts (HOA) must address patient awareness of the high cost of medical care, provide incentives to patients to seek preventative care services,			

		reduce inappropriate use of health care services, enable patients to take responsibility for health outcomes, provide enrollment counselors and ongoing education activities, provide transactions involving HOAs to be conducted electronically and without cash, and provide access to negotiated provider payment rates consistent with the HOA provision.			
6083	State Medicaid Director Letter	**State option to establish non-emergency medical transportation program.** Establishes a state option for the establishment of a non-emergency medical transportation brokerage program in order to more effectively provide transportation for individuals eligible for Medicaid but who have no access to transportation including wheelchair van, taxi, stretcher car, bus passes and tickets, and secured transportation. The Secretary is authorized to issue requirements related to conflicts of interest and prohibitions on referrals to ensure program integrity.	**3/31/06**	**3/31/06**	
6085	State Medicaid Director Letter	**Emergency services furnished by non-contract providers for Medicaid managed care enrollees.** A Medicaid provider that does not have a contract with a Medicaid managed care plan must accept as payment in full no more than the amount otherwise applicable under the state plan outside of managed care less any payments for indirect costs of medical education and direct costs of graduate medical education.	**1/1/07**	**3/31/06**	
6086		**Expanded access to home and community-based services for the elderly and disabled.** Home and community based services (HCBS) for the elderly and disabled would become an optional benefit for states under their state plan without a waiver. States will also be required to project the number of individuals to be provided the HCBS services and may limit the number of individuals who are eligible for the HCBS benefit and establish waiting lists. States are required to provide recipients of the HCBS services with individualized care plans and states have the option to offer self-directed services. Acting through the Director of the Agency for Healthcare Research and Quality, the Secretary shall develop program performance indicators and measures of client satisfaction for home and community based services offered under State Medicaid programs. The Secretary shall use the indicators to assess the outcomes of such services offered and make best practices publicly available.			
6101	Federal Register Notice - Redistribution of	**Additional allotments to eliminate fiscal year 2006 funding shortfalls.** Appropriates $283,000,000 for FY 2006 to states	**4/21/06**	**Display 4/19/06**	

	Unexpended SCHIP Funds from the Appropriation for FY 2003	experiencing SCHIP budget shortfalls. The Secretary will allot to each shortfall state an amount the Secretary determines will eliminate the estimated shortfall for the state. Establishes a one-year period of availability in which states must spend their FY 2006 allotments by September 30, 2006. There will be no redistribution of unspent allotments, and any unspent portion of the allotments will revert to the Treasury on Oct 1, 2006.		**Publish 4/21/06**	
6102	State Medicaid Director Letter	**Prohibition against covering non-pregnant childless adults with SCHIP funds.** Prohibits the use of SCHIP funds for the coverage of non-pregnant childless adults, other than caretaker relatives (does not apply to any current waivers or to the extension, renewal, or amendment of any existing waivers).	**3/31/06**	**3/31/06**	
6201	Payment of State Claims 1115 Waiver Template Approvals.	**Additional Federal payments under hurricane-related multi-state section 1115 demonstrations.** Appropriates $2 billion for payments by the Secretary to eligible states for health care needs of areas affected by Hurricane Katrina. Funds are available until expended. Payments shall be made for the following purposes, without any specified priority order: • The non-federal share of Medicaid and SCHIP expenditures for evacuees and in-state individuals receiving temporary eligibility under a Hurricane Katrina section 1115 waiver. These payments end no later than June 30, 2006, in accordance with the section 1115 waiver. • Total uncompensated care costs under a Hurricane Katrina section 1115 waiver for evacuees and in-state individuals who do not have any other source of health coverage, as well as total costs of uncompensated care for services not covered by the state Medicaid plan for evacuees and in-state individuals receiving temporary eligibility under a waiver. These payments end January 31, 2006, in accordance with the section 1115 waiver. Payment may not be made for items or services funded by another public or private hurricane relief effort. • Reasonable administrative costs, as determined by the Secretary, relating to health care provided under a Hurricane Katrina section 1115 waiver. • For affected counties and parishes (defined as those counties and parishes for which a disaster declaration is made with respect to Hurricane Katrina, the non-Federal share of regular Medicaid and	**3/31/06**	**3/31/06**	

		SCHIP costs for regular Medicaid and SCHIP eligibles. • For other purposes approved by the Secretary in his discretion to restore health care in impacted communities.			
6202	State Health Official Letter Grant Solicitation Grant Awards	**State High Risk Health Insurance Pool Funding.** Authorizes and appropriates $90 mil for FY 06 to carry out the state high risk pool program under section 2745 of the Public Health Service Act. Of that amount, $15 mil is for seed grants for states that have not established high risk pools and $75 mil is for operational grants for states with existing high risk pools.	 **10/02/06**	**3/31/06** **5/1/06** **10/02/06**	

Note: Section of the Law must be in numerical order.