

# CRS Report for Congress

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## **Medicaid and SCHIP: The President's FY2006 Budget Proposals**

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# Medicaid and SCHIP: The President's FY2006 Budget Proposals

## Summary

The President's FY2006 budget contains a number of proposals that would impact the Medicaid or State Children's Health Insurance Program (SCHIP) programs. While some proposals are expansions of the current Medicaid program, or a re-authorization of SCHIP, other proposals are designed to reduce federal spending for one or both programs. The Medicaid related proposals are contained within four broad categories:

- Medicaid and SCHIP Modernization — to provide more flexibility for states to expand Medicaid coverage for low-income families and individuals.
- New Freedom Initiative Proposals — to increase the ability of individuals with a disability to live in a home or community-based setting instead of an institution.
- Other Medicaid Legislative Proposals — to create expansions of the current program including changes for children, temporary medical assistance and Medicare premium assistance. These expansions are offset by proposals designed to reduce federal spending on Medicaid.
- Other Legislative Proposals with a Medicaid Impact — to make changes in other federal programs including a Social Security Administration management proposal to establish a standard for Supplemental Security Income (SSI) disability awards, and an outreach program for children eligible, but not enrolled, in Medicaid or SCHIP.

In addition to these four categories of Medicaid related proposals, the proposal for re-authorization of the SCHIP program will have an impact on Medicaid.

For each proposal in these four categories, and for the SCHIP re-authorization proposal, this report: (1) describes the proposal and provides an estimate of the cost or savings based on publicly available information; (2) provides a brief background for the proposal; and (3) provides a listing of current Congressional Research Service (CRS) reports related to the proposal. In addition, this report contains a listing of CRS staff contacts by topic for the Medicaid and SCHIP programs. This report will not be updated.

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# Medicaid and SCHIP: The President's FY2006 Budget Proposals

## Introduction

The President's FY2006 budget contains a number of proposals that would impact the Medicaid and State Children's Health Insurance (SCHIP) program. While some proposals are expansions of the current Medicaid program, others are designed to reduce current or future federal spending for the program.

The Medicaid related proposals, as detailed by the Department of Health and Human Services (HHS),<sup>1</sup> are contained within four broad categories: (1) Medicaid and SCHIP modernization; (2) New Freedom Initiative proposals; (3) other Medicaid legislative proposals; and (4) other legislative proposals with a Medicaid impact. In addition to these four categories for Medicaid related proposals, the re-authorization of SCHIP will have an impact on Medicaid.

For each proposal related to the Medicaid and SCHIP programs, this report:

- describes the proposal based on publicly available information;
- provides relevant background for the proposal; and
- provides a listing of Congressional Research Service (CRS) reports for additional background and/or analysis related to the proposal.

The description for each proposal also contains the HHS estimate of the cost or savings from the proposal for FY2006, and for the FY2006-2010 period. All of the estimates are from HHS,<sup>2</sup> and the methodology used to develop each estimate has not been reviewed by CRS. **Table 1**, at the end of this report, provides the cost estimate for each proposal in the order presented in this report.

**Table 2**, at the end of this report, provides a listing of CRS staff members and contact information by topic for the Medicaid and SCHIP programs.

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<sup>1</sup> Department of Health and Human Services, *Budget in Brief, Fiscal Year 2006*, Feb. 2006, available at [<http://www.hhs.gov/budget/06budget/FY2006BudgetinBrief.pdf>].

<sup>2</sup> Ibid.

## Medicaid and SCHIP Modernization

**Proposal.** The President's FY2006 budget proposes to provide more flexibility for states to expand Medicaid coverage for low-income families and individuals through the Medicaid and SCHIP programs. The HHS description of the proposal states that no additional federal costs will be required for the proposal, and Medicaid waivers will not be needed. While specifics on the proposal are not available, HHS states that the proposal will build on the SCHIP success in providing acute care to families and current efforts (through a number of means including the use of public health programs such as Medicaid and SCHIP, and tax credits) to decrease the number of uninsured individuals. HHS estimates that the proposal would have no cost impact in FY2006 or over the FY2006-2010 period.

**Background.** One of the federal requirements for state Medicaid programs is that generally all services must be provided to all enrollees in the program. For example, a state cannot differentiate between the services provided in the Medicaid program based on class of eligibility or geography. To reduce or expand certain benefits, a state must obtain a waiver, approved by the Centers for Medicare and Medicaid Services (CMS), limiting the impact of one or more of the federal requirements related to comparability, benefits or eligibility. A waiver may be for part, or all, of the state Medicaid population.

**Reports.** For more information on current waiver programs, see CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne P. Baumrucker.

## New Freedom Initiative Proposals

The President's New Freedom Initiative is a group of initiatives to increase the ability of individuals with a disability to live in a home or community-based setting instead of an institution.<sup>3</sup> The President's FY2006 budget proposes several demonstrations and legislative changes to advance this policy goal.

### Money Follows the Person Demonstration

**Proposal.** The President's FY2006 budget proposes a five-year demonstration project to be financed with 100% federal funds for one year of home and community-based waiver services under Section 1915(c) of the Social Security Act for individuals who move from certain institutions (e.g., nursing homes) into at-home

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<sup>3</sup> For additional information, CRS has released a series of reports that provide detailed information on state long-term care systems and efforts to provide home and community-based services. Reports are available for the following states: *Arizona*, CRS Report RL32065; *Florida*, CRS Report RL32054; *Illinois*, CRS Report RL32010; *Indiana*, CRS Report RL32295; *Maine*, CRS Report RL32166; *Oregon*, CRS Report RL32132; *Pennsylvania*, CRS Report RL31850; and *Texas*, CRS Report RL31968.

care. HHS estimates that the proposal would have no cost impact in FY2006, and cost \$500 million over the FY2006-FY2010 period.

**Background.** Currently all states except Arizona have Medicaid home and community-based waivers under Section 1915(c) of the Social Security Act. These waivers allow states to provide a broad range of home and community-based services to individuals who would otherwise be in certain types of institutions (e.g., a nursing facility). For example, services could include personal assistance, respite, and home modifications. As part of the waiver, states can define what services will be offered and can limit the number of individuals who can participate. Many states have waiting lists for these services.

Though it varies by state, on average the federal government covers 57% of the cost of Medicaid home and community-based services; states cover the remaining expenditures. This proposal intends to offer states a financial incentive to expand the number of individuals who can receive home and community-based services by covering 100% of the service expenditures for one year for individuals who are relocating from an institution into the community.

**Reports.** For additional information on home and community-based waivers, see CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.

## **Community Alternative to Children's Residential Treatment Facilities**

**Proposal.** The President's FY2006 budget proposes a 10-year demonstration project that would allow states to offer home and community-based services to children who would otherwise be in a psychiatric residential treatment facility. While conducting the demonstration HHS would evaluate the cost of providing these services outside of institutions. While there are no separate cost estimates for the three demonstration proposals (children's residential treatment, and respite for caregivers of adults with disabilities, and respite for caregivers of children with substantial disabilities), HHS estimates that the total cost for all three demonstrations in the New Freedom Initiative would be \$13 million in FY2006, and \$256 million over the FY2006-2010 period.

**Background.** As described earlier, states can request a Section 1915(c) waiver to cover a broad range of home and community-based services to individuals who would otherwise be in *certain* types of institutions including a hospital, nursing facility, or intermediate care facility for individuals with mental retardation. Under current law, Section 1915(c) waivers can not be developed for children who would otherwise be in a psychiatric residential treatment facilities. As a result, states have limited ability to cover Medicaid home and community-based waiver services for children with serious mental illness compared to children with other types of disabilities (e.g., developmental disabilities).

**Reports.** For additional information, see CRS Report RL32362, *Key Benefits Under Medicaid and the State Children's Health Insurance Program (SCHIP) for*

*Children With Mental Health and Substance Abuse Problems*, by Elicia Herz; and CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.

## **Respite for Caregivers of Disabled Adults**

**Proposal.** The President's FY2006 budget proposes a demonstration to increase the availability of respite services under the Medicaid program for caregivers of adults with disabilities. While there are no separate cost estimates for the three demonstration proposals (children's residential treatment, and respite for caregivers of adults with disabilities, and respite for caregivers of children with substantial disabilities), HHS estimates that the total cost for all three demonstrations in the New Freedom Initiative would be \$13 million in FY2006, and \$256 million over the FY2006-2010 period.

**Background.** Respite care is temporary relief for caregivers from their caregiving responsibilities. Providing care to an individual with a significant disability can be time-intensive and highly stressful. Respite care reduces primary caregiver "burn-out" that can lead to the institutionalization of the individual with the disability. Medicaid law currently limits respite care to Medicaid Section 1915(c) home and community-based waiver programs which may have significant waiting lists for services.

**Reports.** For additional information, see CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.

## **Respite for Caregivers of Children with a Substantial Disability**

**Proposal.** The President's FY2006 budget proposes a demonstration that will increase the availability of respite services to caregivers of children with substantial disabilities. While there are no separate cost estimates for the three demonstration proposals (children's residential treatment, and respite for caregivers of adults with disabilities, and respite for caregivers of children with substantial disabilities), HHS estimates that the total cost for all three demonstrations in the New Freedom Initiative would be \$13 million in FY2006, and \$256 million over the FY2006-FY2010 period.

**Background.** Most children with substantial disabilities live in a home or community-based setting. Providing care for these children can be time-intensive and highly stressful. Occasional periods of respite care can reduce some of this stress in the family and enhance the ability to keep the child at home and in the community. Medicaid law currently limits respite care to Medicaid Section 1915(c) home and community-based waiver programs which can have significant waiting lists.

**Reports.** For additional information, see CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.



## Spousal Exemption

**Proposal.** The President's FY2006 budget proposes to continue the Medicaid eligibility of an individual who is married to an individual who has a disability and who is participating in a work incentive program under Section 1619(b) of the Social Security Act. HHS estimates that the proposal would cost \$17 million in FY2006, and cost \$102 million over the FY2006-2010 period.

**Background.** Under current law, Section 1619(b) of the Social Security Act provides continued Medicaid coverage for recipients of the Supplemental Security Income (SSI) program when their earnings become too high to allow for an SSI cash payment. However, the continued eligibility for Medicaid does not extend to a person's spouse. Since a spouse's earnings are considered in determining eligibility for Medicaid, an individual could lose eligibility for Medicaid due to the earnings of his or her spouse. This proposal would extend the Medicaid eligibility for both the individual with a disability and his or her spouse.

**Reports.** For additional information, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone-Axelrad.

## Presumptive Eligibility

**Proposal.** The President's FY2006 budget would allow states to provide presumptive eligibility for individuals who are discharged from hospitals and who would be eligible for care in a nursing home but who could also be served in the community with home care and other services. HHS estimates that the proposal would have no cost impact in FY2006 or over the FY2006-FY2010 period.

**Background.** Current law allows presumptive eligibility for certain groups of children and women. The federal and state governments share the cost of care provided to those persons found ineligible for Medicaid. As one means of decreasing nursing home admissions and improving access to home and community-based services, many policy-makers, state officials, constituency groups, and provider organizations have suggested that there is a need to improve and expedite the way in which Medicaid's financial eligibility is determined. Currently, almost half of Medicaid's nursing home residents are admitted directly after discharge from a hospital.<sup>4</sup> Once they apply, Medicaid rules require states to make financial eligibility determinations within 45 days of the Medicaid application date and within 90 days for persons needing a disability determination. Once residing in a nursing home, individuals often find it difficult to reestablish residency in a home and community-based setting.

In general, nursing homes are likely to admit individuals discharged from hospitals while their Medicaid applications are pending. For persons enrolled in Medicare, this initial stay is often covered by Medicare. (Medicare requires a prior-

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<sup>4</sup> David Stevenson, Joanne McDonald, and Brian Burwell. "Presumptive Eligibility for Individuals with Long Term Care Needs: An Analysis of a Potential State Option." Prepared for CMS, CMSO, DEHPG by the Medstat Group, Inc., Aug. 23, 2002.

hospitalization of at least three days as the first condition of eligibility for its nursing home benefit.) Once residing in a nursing home, staff generally conduct financial assessments of the resident to evaluate the ability to pay privately or a need to apply to Medicaid for coverage of the continuing long-term care needs. In addition, for persons determined to be Medicaid eligible, federal rules allow nursing homes to bill Medicaid retroactively for costs incurred between the application date and the date of enrollment in the program. For persons determined to be ineligible, nursing homes may charge residents for these services. Either the resident or family would be expected to pay.

Home and community-based service providers, on the other hand, may not be willing to take the financial risk that a person they serve will ultimately be ineligible for Medicaid. In addition to an eligibility determination, Medicaid payment for home and community-based services is also dependent on an individual's enrollment in a home and community-based waiver program (established under Section 1915(c) of the Social Security Act<sup>5</sup>) and many states have enrollment caps and waiting lists for these programs. Uncertainty about Medicaid eligibility and waiver enrollment often leads home and community-based providers to refuse referrals for individuals with pending Medicaid applications. Allowing for presumptive eligibility for persons discharged from hospitals who wish to go into home and community-based services may make it easier for these providers to accept such referrals. This might improve access to home and community-based services and reduce reliance on nursing homes.

**Reports.** Currently, no other CRS reports address this topic.

## Other Medicaid Legislative Proposals

The President's FY2006 budget proposals for Medicaid include expansions for children, temporary medical assistance and Medicare premium assistance. These expansion proposals are offset by proposals to reduce the federal spending on Medicaid through changes related to provider taxes imposed by states, claiming of administrative expenses by states, and additional reviews of state Medicaid and SCHIP programs.

### Transitional Medical Assistance

**Proposal.** The President's FY2006 budget proposal would extend transitional medical assistance (TMA) through September of 2006 (presumably the end of the month, but the exact date is not specified). In addition, it would simplify eligibility

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<sup>5</sup> Medicaid's home and community-based services waiver program, authorized under Section 1915(c) of the Social Security Act, is the major way the federal government finances home and community-based long-term care services for persons with disabilities. Section 1915(c) of the Medicaid statute allows the Secretary of the Department of Health and Human Services (DHHS) to waive certain requirements to allow states to cover a wide range of home and community-based services to persons who *otherwise* would need institutional care. Enacted in 1981, it was designed to alter the bias in the Medicaid program that favored institutional care over care in home-based settings.

for TMA benefits by giving states the option to offer 12 months of continuous TMA coverage to eligible participants; to waive income reporting requirements for beneficiaries; and to allow states that offer Medicaid for children and families up to 185% of poverty to waive the TMA requirements altogether. HHS estimates that this proposal would cost \$560 million in FY2006 only.

**Background.** States are required to offer TMA to certain individuals receiving Medicaid under Section 1931 of the Social Security Act. Under the TMA provision, states must continue providing Medicaid for six months to families that were receiving Medicaid under Section 1931 in at least three of the last six months. The extended Medicaid coverage is available to individuals and their families who would otherwise have lost such assistance due to increased work hours, increased earnings of the caretaker relative, or the loss of one of the time-limited earned income disregards. In addition, states are required to extend Medicaid coverage for a second six months to families that were covered during the entire first six-month TMA period, and whose earnings are below 185% of poverty. The provision authorizing TMA receipt for up to 12 months of coverage is due to sunset at the end of March 2005, although this date has been repeatedly extended. A small additional group of mandatory TMA-eligible persons are those who would otherwise lose Medicaid coverage under Section 1931 because of an increase in earned income, hours of employment, or child or spousal support. In these cases, families who receive Medicaid under Section 1931 in at least three of the preceding six months qualify for a four-month extension. If the provision authorizing 12-month TMA is not extended beyond March 2005, states will still be required to provide the four months of TMA to those families.

**Reports.** For more information on TMA, see CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.

## Long-Term Care Insurance Partnership Program

**Proposal.** The President's FY2006 budget proposes to promote the purchase of long-term care (LTC) insurance by eliminating the federal legislative ban on new long-term care partnership programs to allow any state in the nation the option of implementing a LTC insurance partnership program. HHS estimates that the proposal would have no cost impact in FY2006 or over the FY2006-FY2010 period.

**Background.** Under Medicaid's LTC insurance partnership program, persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without having to meet the same means-testing requirements as other groups of Medicaid eligibles. Medicaid law allows four states (California, Connecticut, Indiana, and New York) to operate partnership programs. These states disregard some or all the assets of applicants who apply to Medicaid after using their private LTC insurance benefits and exempt these assets from estate recovery after the beneficiary has died. There are no federal requirements concerning the operation of these programs.

Through the promise of Medicaid asset protection, the partnership program is designed to encourage people to purchase private LTC insurance when they might not otherwise do so. It is also intended to result in savings both to Medicaid, by

delaying or preventing spend-down to Medicaid eligibility, and to individuals, by having them rely on insurance policies to cover LTC expenditures that would otherwise be paid by personal income or savings. Only limited empirical data exists to demonstrate whether the asset protection promised under the partnership program is a sufficient and necessary incentive to encourage the purchase of policies by persons who would not otherwise purchase them. Based on the available data, it is reasonable to conclude that for some the promise of Medicaid asset protection plays a significant role in the decision to purchase a partnership policy, while for others it plays a smaller role. Regardless, the partnership program allows for asset protection for persons who eventually seek Medicaid (after exhausting their private LTC insurance benefits), and these assets are not available to defray Medicaid expenditures. Owning a LTC insurance policy likely prevents spend-down to Medicaid eligibility for some persons who live long enough to actually use long-term care services; it likely delays eligibility for others; and probably has little impact on still others.

**Reports.** For more information on the LTC insurance partnership, including data on participation and policies sold, see CRS Report RL32610, *Medicaid's Long-Term Care Insurance Partnership Program*, by Julie Stone-Axelrad.

## Medicare Premium Assistance

**Proposal.** The President's FY2006 budget proposes to extend Medicare premium assistance for one year, through the end of FY2006, for Medicare beneficiaries whose income is between 120 and 135% of the federal poverty level. This group is referred to as "Qualified Individuals (QI)." HHS estimates that the proposal would cost \$230 million in FY2006 only.

**Background.** Under the QI program, Medicaid pays the Medicare Part B premiums (\$78.20 per month in 2005) for Medicare beneficiaries with incomes between 120 and 135% of poverty. This group was originally established in the *Balanced Budget Act of 1997* (P.L. 105-33) and was originally due to expire at the end of FY2002. Since then Congress has passed temporary extensions that continued coverage for this group. The most recently enacted legislation (P.L. 108-448) extended coverage for this group through September 30, 2005.

**Reports.** For additional information, see CRS Report RL32582, *Medicare: Part B Premiums*, by Jennifer O'Sullivan.

## Vaccines for Children Expansion

**Proposal.** The President's FY2006 budget proposes to improve vaccine access by allowing underinsured children to receive Vaccines for Children (VFC) vaccines at state and local health clinics, rather than only at federally qualified health centers (FQHCs) and rural health clinics. HHS estimates that the proposal would cost \$140 million in FY2006, and cost \$700 million over the FY2006-FY2010 period.

**Background.** The VFC program is funded entirely by federal Medicaid appropriations and administered by the Centers for Disease Control and Prevention

(CDC). Under Section 1928 of the Social Security Act, children who are (1) Medicaid recipients, (2) uninsured, (3) American Indians or Alaska Natives, or (4) “underinsured” because their health insurance does not cover qualified pediatric immunizations are entitled to receive VFC vaccines free of charge. Currently, children in the first three categories may receive VFC vaccines from any program-registered provider (as defined in Section 1928(c) of the Social Security Act), while underinsured children may receive VFC vaccines at FQHCs or federally designated rural health clinics only.

In calendar year (CY) 2002, there were approximately 42,000 active VFC provider sites (30,000 private and 10,000 public).<sup>6</sup> In CY2000, an estimated 57% of children receiving VFC vaccines were eligible because they were Medicaid recipients. Another 36% receiving VFC vaccines were uninsured, while 5% were underinsured and 2% were American Indians or Alaska Natives.<sup>7</sup>

**Reports.** For general information on FQHCs and rural health clinics, see CRS Report RL32046, *Federal Health Centers Program*, by Sharon Kearney Coleman.

## **Payment for Net Provider Expenditures Only (Restricting Intergovernmental Transfers)**

**Proposal.** The President’s FY2006 budget proposes to provide federal matching funds to states only for those benefit payments that Medicaid providers keep. That is, for payments in excess of the usual Medicaid payment rate, the federal government proposes to stop matching any portion that providers are required to return to the state. HHS estimates that the proposal would have no cost impact in FY2006, and save \$4.6 billion over the FY2006-FY2010 period.

**Background.** Under Medicaid law, the federal and state governments share in the cost of Medicaid. The state-specific matching rate for benefits is determined by a formula set in law that establishes higher matching rates for states with low per capita income levels compared to the national average (and vice versa for states with high per capita income levels). The federal government pays at least 50% of Medicaid costs, and the federal share can be as high as 83% (statutory upper boundary). States can finance up to 60% of the state share of Medicaid costs with local government funds. Also, the state share cannot be comprised of any federal dollars. In some cases, through what are called intergovernmental transfers (IGTs), states have required local government providers (e.g., county-run nursing homes or municipal hospitals) to transfer back to the state some or all of the federal Medicaid funds originally paid to those providers that exceed the usual Medicaid payment rate. States may use these transferred funds for Medicaid or for other purposes such as to fill state budget gaps for other programs or to draw down additional federal Medicaid dollars. The 108<sup>th</sup> Congress held hearings on this issue, and both GAO and the OIG

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<sup>6</sup> Centers for Disease Control and Prevention, *VFC Program Data*, available at [[http://www.cdc.gov/nip/vfc/st\\_immz\\_proj/data/data.htm](http://www.cdc.gov/nip/vfc/st_immz_proj/data/data.htm)].

<sup>7</sup> Institute of Medicine, *Calling the Shots: Immunization Finance Policies and Practices* (Washington: National Academy Press, 2000), pp. 77-85.

have recommended that these state practices be halted. (See below for a related discussion on upper payment limits.)

**Reports.** Intergovernmental transfers are discussed in various contexts in several CRS reports including CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia Herz; CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne; and CRS Report RL31773, *Medicaid and the Current State Fiscal Crisis*, by Christine Scott.

## **Limiting Government Provider Payment to Actual Costs (Restricting Upper Payment Limits)**

**Proposal.** The President's FY2006 budget proposes to change the permissible upper payment limit for services delivered by local government providers (e.g., county-run nursing homes or municipal hospitals) from the Medicare payment rate to no more than the cost of providing services. The FY2006 budget documents do not provide a specific definition for "cost of providing services." HHS estimates that the proposal would have no cost impact in FY2006, and save \$1.2 billion over the FY2006-FY2010 period.

**Background.** Aggregate Medicaid payments to specific groups of providers (e.g., hospitals and nursing facilities) cannot exceed a reasonable estimate of what would have been paid under Medicare payment principles. This is called the Medicaid upper payment limit (UPL) rule. In many states, Medicare payment rates for hospital and nursing home care are higher than corresponding Medicaid payment rates. The UPL based on Medicare payment principles has enabled some states to draw down additional federal dollars that exceed what they would have received based on Medicaid payment rates. These additional funds are paid to government providers which are sometimes required by states to transfer all or a portion of the extra payments received (i.e., some or all of the difference between the Medicare and Medicaid payment rates) back to the state through an intergovernmental transfer (see above). Instead of financing more or improved Medicaid services, in some cases states have used the additional federal dollars for non-health services, or to make up part of the state share of Medicaid costs to draw down another round of federal dollars. During 2000-2002, Congress and the Clinton and Bush Administrations revised UPL rules by changing permissible accounting methods used to claim federal matching payments. These changes significantly reduced the excess federal dollars states received under approved UPL plans that involved IGTs. However, these reforms did not eliminate all such excess payments because no changes were made to the Medicaid UPL standard which remains tied to the Medicare payment rate, nor to federal statute or regulations governing IGTs.

**Reports.** See CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia Herz.

## Phase-down of Limitation on Provider Taxes

**Proposal.** The President's FY2006 budget proposes to phase the current safe-harbor of 6% for provider taxes down to 3%. HHS estimates that the proposal would save \$231 million in FY2006, and \$2.8 billion over the FY2006-FY2010 period.

**Background.** Under current law and regulations, the federal match for health care related provider taxes used by states to fund their Medicaid programs has limitations. The limitations are that health care related provider taxes cannot generally exceed 25% of the state (or non-federal) share of Medicaid expenditures, and that the state cannot provide a guarantee to the provider that the taxes will be returned. However, there is a safe harbor. If the taxes returned to a provider are less than 6% of the provider's revenues, the return of the taxes does not violate the prohibition on a guarantee for returning provider taxes to providers. As a result, a state could impose a provider tax of 6% of revenues, receive a federal match for the funds, and then return the tax monies back to the provider. In effect, the state has temporarily borrowed funds from the provider to receive additional federal funds.

**Reports.** For a review of the history of provider donations and taxes, and the restrictions imposed, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

## Managed Care and Provider Taxes

**Proposal.** The President's FY2006 budget proposes to treat managed care organizations (MCO) like other providers for purposes of provider taxes. HHS estimates that the proposal would have no cost impact in FY2006, and save \$399 million over the FY2006-FY2010 period.

**Background.** Under current law and regulations, the federal match for health care related provider taxes used by states to fund their Medicaid programs has limitations. The limitations are that health care related provider taxes cannot generally exceed 25% of the state (or non-federal) share of Medicaid expenditures, and that the state cannot provide a guarantee to the provider that the taxes will be returned (as noted in the description of the previous proposal, there is a hold harmless provision). Under current law and regulations, managed care organization premiums paid to ensure enrollment or coverage are not considered a health related item or service when determining if a provider tax is a health care related tax and subject to the federal match limitation. As a result, a state may tax the premiums paid to a managed care organization to fund the state Medicaid program and receive the full federal match for the taxes, as this provider tax is currently not subject to the federal match limitations.

**Reports.** For a review of the history of provider donations and taxes, and the limitations, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

## Cost-Shifting for Targeted Case Management and Other Services

**Proposal.** The President's FY2006 budget proposes to clarify which services may be claimed as Medicaid targeted case management costs. HHS estimates that the proposal would have no cost impact in FY2006, and save \$2.0 billion over the FY2006-FY2010 period.

**Background.** Under current Medicaid law, case management is a benefit that includes services to assist an individual eligible under the state Medicaid plan in gaining access to needed medical, social, educational and other services. The term "targeted case management" refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of individuals (e.g., those with AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, or children in foster care) or persons who reside in a specific area. Since case management is not an administrative activity, the federal government matches payments for such services at the rate applicable to benefits. This rate ranges from 50% to 83% (statutory upper boundary) depending on the state. The Administration has stated that states are shifting costs into Medicaid that are the obligations of other programs, and are, in addition, using expanded definitions of allowable services. Based on recent findings, the Department of Health and Human Services, Office of the Inspector General (OIG) recommended that CMS review the use of targeted case management specifically for foster care children across states to ensure that such care is consistent with CMS's requirements. CMS concurred with this recommendation. Other OIG studies have reported "excessive" payments for targeted case management in school settings.<sup>8</sup>

**Reports.** Currently, no other CRS reports address this topic.

## Matching Rate for Targeted Case Management

**Proposal.** The President's FY2006 budget proposes to change the reimbursement level for targeted case management to the 50% matching rate that states currently receive for most Medicaid administrative costs. HHS estimates that the proposal would save \$129 million in FY2006, and save \$1.0 billion over the FY2006-FY2010 period.

**Background.** Under current Medicaid law, case management is a benefit that includes services to assist an individual eligible under the state Medicaid plan in gaining access to needed medical, social, educational and other services. The term "targeted case management" refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of individuals (e.g., those with AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, or children in foster care) or persons who reside in a specific area. Since case management is not an administrative activity, the federal government matches payments for such services at the rate

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<sup>8</sup> The HHS, OIG Reports referenced above can be found at [<http://oig.hhs.gov/oei/reports/oei-02-00-00363.pdf>], [<http://oig.hhs.gov/oas/reports/region2/20101024.pdf>], and [<http://oig.hhs.gov/oas/reports/region1/10300004.pdf>].



applicable to benefits. This rate ranges from 50% to 83% (statutory upper boundary) depending on the state. This proposal will not affect states for which the matching rate for benefits is 50% (e.g., 12 states in FY2006).

**Reports.** Currently, no other CRS reports address this topic.

## Codifying Medicaid “Free Care” Policy

**Proposal.** The President’s FY2006 budget proposes to codify through regulation the Medicaid “free care” policy. HHS estimates that this regulatory change will have no budget impact.

**Background.** Generally, the “free care” principle applies in school settings, and is described in guidance issued by the Administration to education agencies in 1997 and 2003.<sup>9</sup> Under the free care principle, Medicaid will not pay for the costs of Medicaid-coverable services (and related administrative activities) which are generally available to all students without charge, and for which no other sources of reimbursement are pursued. For example, Medicaid will not reimburse schools for routine school-based vision and hearing screens, or other primary or preventive services, such as school nurse and school psychologist services, provided free of charge to all students. There are specific exceptions to the free care principle: (1) for services provided to Medicaid eligible children that are included in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Education Act (IDEA); (2) for services provided under the Women, Infants and Children (WIC) program; and (3) for services provided by Title V (Maternal and Child Health Block Grant) grantees. Services and related administrative activities would not be considered to be free, and thus potentially eligible for Medicaid reimbursement, if schools: (1) establish a fee scale; (2) determine whether every individual serviced by the school has any third-party coverage; and (3) bill the beneficiary or third parties for the services.

**Reports.** For additional information on IDEA and Medicaid, see CRS Report RL31722, *Individuals with Disabilities Education Act (IDEA) and Medicaid*, by Richard Apling and Elicia Herz.

## Asset Transfers for Long-Term Care

**Proposal.** The President’s FY2006 budget proposes to amend Medicaid law on transfer of assets to limit the circumstances under which persons may transfer assets without incurring a penalty denying eligibility. No detail is provided on specific changes. HHS estimates that the proposal would save \$99 million in FY2006, and save \$1.5 billion over the FY2006-FY2010 period.

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<sup>9</sup> Centers for Medicare & Medicaid Services, *Medicaid and School Health: A Technical Assistance Guide*, Aug. 1997; and *Medicaid School-Based Administrative Claiming Guide*, May, 2003.

**Background.**<sup>10</sup> Medicaid estate planning is a means by which elderly people shelter their assets to qualify for Medicaid's coverage of long-term care services sooner than they otherwise would. Such practices include (1) converting "countable assets" into "exempt assets," (2) sheltering assets in trusts, annuities, and other financial instruments that are deemed "not available" to the Medicaid applicant, or (3) transferring assets through joint bank accounts. Medicaid law includes provisions establishing penalties to discourage this behavior for individuals who transfer assets for less than fair market value. Specifically, Medicaid law requires states to delay Medicaid eligibility for persons needing institutional coverage (including nursing home care) and certain home and community-based services who transfer assets on or before a "look-back date." For most assets, this date is 36 months (three years) prior to Medicaid application. For irrevocable trusts, this date is 60 months (five years). The law also prohibits the spouses of these applicants from transferring assets during this period. Certain transfers are permitted to spouses, minor or disabled children, or trusts if they are intended solely for the benefit of disabled persons under 65.

The length of the period of ineligibility (or delay in eligibility) for Medicaid applicants is determined by dividing the total cumulative uncompensated value of all assets transferred on or before the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth \$60,000, divided by a \$5,000 average monthly private-pay rate, results in a 12-month penalty period. There is no limit to the length of the penalty period. This period of ineligibility begins with the first month during which the assets were transferred. A recent study showed that asset transfers do increase with the self-assessed probability of nursing home entry within five years,<sup>11</sup> but this and a 1997 GAO study indicate that the incidence of transfers may be relatively low.<sup>12</sup> The GAO study found that from 13 to 22% of people who applied for nursing home and other long-term care benefits in Massachusetts and Minnesota had transferred assets. Both studies suggest that the amount of assets transferred per person varies and can sometimes be less than the cost of a single month of nursing home care.<sup>13</sup> GAO noted that it is unclear what impact these transfers have on Medicaid spending.

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<sup>10</sup> In general, for the elderly and persons with disabilities, Medicaid eligibility requires limited assets. To qualify, such persons may retain countable assets up to a \$2,000 limit for an individual and up to \$3,000 for a couple. Countable assets do not, however, include all assets that an individual may own. They exclude a home of any value, as long as it is used as the applicant's principal place of residence, up to \$2,000 of household goods and personal effects, an automobile with a market value of \$4,500 or less, among others.

<sup>11</sup> William Basset, *Medicaid's Nursing Home Coverage and Asset Transfers*, Board of Governors of the Federal Reserve System, Mar. 26, 2004.

<sup>12</sup> William Basset, *Medicaid's Nursing Home Coverage and Asset Transfers*. Board of Governors of the Federal Reserve System, Mar. 26, 2004; General Accounting Office, GAO/HEHS-97-185R, *Medicaid Divestiture of Assets*.

<sup>13</sup> *Ibid.*

**Reports.** For more information on Medicaid eligibility see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone and CRS Report RL32277, *How Medicaid Works: Program Basics*.

## Allotment for State Administrative Costs

**Proposal.** The President's FY2006 budget proposes to establish individual state allotments for Medicaid administrative costs. HHS estimates that the proposal would have no cost impact in FY2006, and save \$1.1 billion over the FY2006-FY2010 period.

**Background.** The federal government pays a share of every state's spending on Medicaid services and program administration. For Medicaid services, this share is called the federal medical assistance percentage (FMAP). The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vice versa); it has a statutory minimum of 50% and maximum of 83%. All states receive a 90% match for providing family planning services and supplies. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive a higher federal match. Those receiving a 75% match include:

- compensation or training of skilled professional medical personnel (and staff directly supporting such personnel) of the state Medicaid or other public agency;
- preadmission screening and resident review activities for mentally ill and mentally retarded individuals who are admitted to nursing facilities;
- survey and certification of nursing facilities;
- operation of an approved Medicaid Management Information System (MMIS) for claims processing and information retrieval;
- performance of medical and utilization review or external independent review of managed care activities; and
- operation of a state Medicaid fraud control unit (MFCU).

In the case of MMISs and MFCUs, the federal match is 90% for startup expenses. There is a 100% match for the implementation and operation of immigration status verification systems. Section 1903(a)(7) of the Social Security Act specifies that a 50% match will be provided for remaining expenditures that are found necessary by the Secretary of Health and Human Services for the proper and efficient administration of the state Medicaid plan.

While states are not currently limited in the amount they can claim, CMS has the authority to review and deny claims for excessive administrative expenditures. In recent years, expenditures for program administration have grown at about the same rate as expenditures for Medicaid services, and as a result administrative costs have remained a relatively constant share of total Medicaid expenditures.

**Reports.** Currently, no other CRS reports address this topic.

## Medicaid and SCHIP Financial Management

**Proposal.** The President's FY2006 budget proposes to allocate additional funds (\$20 million from the Health Care Fraud and Abuse Account and \$5 million from discretionary funds) to CMS to be used to continue efforts to find erroneous and fraudulent uses of Medicaid and SCHIP funding and provide an increase in audits and evaluations of state Medicaid programs. HHS estimates that the proposal would have no cost impact in FY2006 or over the FY2006-FY2010 period.

**Background.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established the Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance Trust Fund. Funds are appropriated for HCFAC for transfer to federal agencies involved in controlling fraud and abuse in health plans: the Department of Justice and HHS. Within HHS, funds are transferred to the Office of the Inspector General (OIG), Office of the General Counsel, and CMS (for Medicaid/SCHIP program integrity and other efforts). In FY2005, \$17 million is to be transferred from the HCFAC to CMS.

**Reports.** Currently, no other CRS reports address this topic.

## Amending the Medicaid Drug Rebate Formula

**Proposal.** The President's FY2006 budget proposes to replace the "best price" formula for calculating Medicaid prescription drug rebates with a "budget neutral" flat rebate amount. No detail was provided on the calculation of the "budget neutral" flat rebate amount. The purpose of the provision, according to HHS budget explanatory material, is to allow private purchasers the ability to negotiate lower payment rates than Medicaid programs. The provision is intended to be budget neutral; thus HHS estimates that the proposal would have no cost impact in FY2006 or over the FY2006-FY2010 period.

**Background.** Pharmaceutical manufacturers that participate in the Medicaid program are required to enter into rebate agreements with the Secretary of HHS on behalf of states. The rebate agreements require manufacturers to pay states rebates for pharmaceutical products used by Medicaid beneficiaries. The rebates are calculated based on a formula that is intended to assure that the Medicaid program pays the best available price in the market, although there are certain exceptions to this best price policy for certain government-purchased pharmaceuticals.

**Reports.** For more information Medicaid prescription drug prices and rebates, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne and April Grady, and CRS Report RL32440, *Implications of the Medicare Prescription Drug Benefit for State Budgets*, by April Grady and Christine Scott.

## Restructure Pharmacy Reimbursement

**Proposal.** The President's FY2006 budget proposes to change Medicaid reimbursement for prescription drugs so that payments for Medicaid prescription products are more closely aligned with pharmacy acquisition costs. Specifically, the

proposal would require states to reimburse the average sales price (ASP) of a drug plus a 6% fee for storage, dispensing, and counseling. ASP is the weighted average of all non-federal sales from manufacturers. Reimbursements set at ASP plus 6% is consistent with Medicare reimbursement for Part B covered drugs as established by the Medicare Modernization Act. HHS estimates that the proposal would save \$542 million in FY2006, and \$5.4 billion over the FY2006-FY2010 period.

**Background.** The prices that state Medicaid agencies pay for prescription drugs — before rebates are applied — are subject to a federal upper payment limit. The upper limits for multiple source drugs are equal to 150% of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating upper payment limits are the lowest of the “average wholesale prices” for each group of drug equivalents. Average wholesale prices (AWPs) are published annually in compendia by the pharmaceutical industry. Over a number of recent years, reports have been produced by the Inspector General of HHS and lawsuits have been concluded finding that AWP as published by the industry have been inflated, significantly overstating the prices that pharmacies pay for drugs. The purpose of those inflated AWP has ostensibly been to obtain higher Medicare and Medicaid prices as well as improve market share for retailers selling drugs with inflated AWP. In 2004, the Medicare Modernization Act included a provision that changed the basis for Medicare Part B drugs from AWP to ASP plus 6%.

**Reports.** For more information on Medicaid prescription drug prices and rebates, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne and April Grady; and CRS Report RL32440, *Implications of the Medicare Prescription Drug Benefit for State Budgets*, by April Grady and Christine Scott.

## Health Insurance Portability and Accountability Act Proposals

**Proposal.** The President’s FY2006 budget proposal includes two provisions relating to the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA established a number of rules for employer-based health insurance plans to improve access to and portability of those plans. The first would define a determination of Medicaid or SCHIP eligibility as a qualifying event allowing for a special enrollment period into employer-based health insurance plans. This provision is intended to improve Medicaid and SCHIP programs’ ability to coordinate coverage with private employer-offered coverage. In addition, a second proposal would require SCHIP programs to issue certificates of creditable coverage. This provision is intended to improve the reach of HIPAA’s portability provisions by recognizing SCHIP coverage as prior creditable coverage. Both of these interpretations have previously been promulgated in a final regulation implementing HIPAA’s portability for group health plan provisions<sup>14</sup>. HHS estimates that the proposal would have no cost impact in FY2006 or over the FY2006-FY2010 period.

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<sup>14</sup> 69 FR 78720, *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV*, Dec. 30, 2004.

**Background.** Under current HIPAA law, pre-existing condition exclusions are limited based on a person's length of prior creditable coverage. Prior creditable coverage is verified using certificates issued by insurers at the end of each year. Because HIPAA was created in law before SCHIP was established, SCHIP was not included as qualified creditable coverage.

**Reports.** For general information on HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, and Stephen Redhead.

## Other Legislative Proposals with a Medicaid Impact

The President's FY2006 budget proposals for some other programs will have a Medicaid impact. Included in these proposals are a one-year extension of the refugee and asylee exemption, a Social Security Administration management proposal to establish a standard for Supplemental Security Income (SSI) disability awards, an outreach program for children eligible, but not enrolled, in Medicaid or SCHIP, a mandatory review of child support orders in Temporary Assistance for Needy Families (TANF) cases every three years, and a medical child support proposal that requires states to consider both parents' access to health insurance coverage when establishing child support orders.

## Child Support Enforcement Proposals

**Proposal.** The President's FY2006 budget includes two modifications to the Child Support Enforcement programs that are estimated to have a budgetary impact on the Medicaid program. The first change would allow states to seek medical child support for children from both custodial as well as non-custodial parents. The second change would require states to review child support orders for families receiving assistance under the Temporary Assistance for Needy Families (TANF) program every three years. The two changes are expected to reduce the number of Medicaid-eligible children by improving their access to private employment-based health insurance. HHS estimates that the proposal would have no cost impact in FY2006, and save \$45 million over the FY2006-FY2010 period.

**Background.** The Child Support Enforcement Program, within the Administration for Children and Families, provides assistance in obtaining support (both financial and medical) to children through locating parents, establishing paternity and support obligations, and enforcing those obligations. The activities of the program are authorized and defined by statute, Title IV-D of the Social Security Act. The federal government has a major role in determining the main components of state programs, funding, monitoring, and providing technical assistance, but the basic responsibility of administering the Child Support Enforcement Program is left to the states. State Child Support Enforcement agencies review child support orders every three years if instructed to do so by the custodial parent or at the state's own discretion.

Provisions for health insurance coverage, called medical support, are required to be included in support orders. Under current law, medical support may be sought but only from the non-custodial parent (NCP). Sometimes, however, custodial parents may have access to employer-based health insurance that could be made available to the child or children.

**Reports.** For general information on medical support, see CRS Report RL32135, *A Review of Medical Child Support: Background, Policy, and Issues*, by Carmen Solomon-Fears.

## Refugee Exemption Extension

**Proposal.** The President's FY2006 budget proposes extending the exemption from the first seven years they reside in the United States to the first eight years they reside in the United States to allow refugees and asylees during this period to participate in SSI (and thus, SSI-related Medicaid). The proposal would allow refugees and asylees additional time to complete the citizenship process. HHS estimates that the proposal would cost \$40 million to Medicaid in FY2006 and \$145 million over the FY2006-FY2010 period.

**Background.** Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date are not eligible for SSI, and thereby SSI-related Medicaid, until they have resided in the country for five years or have obtained citizenship. Refugees and asylees on SSI are currently exempted from this ban for the first seven years they reside in the United States.

**Reports.** For general background information see CRS Report RL31269, *Refugee Admissions and Resettlement Policy*, by Andorra Bruno; CRS Report RL31630, *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses*, by Alison M. Siskin; and CRS Report RL31114, *Noncitizen Eligibility for Major Federal Public Assistance Programs: Policies and Legislation*, by Ruth Wasem.

## Social Security Administration Initial State Disability Review

**Proposal.** The President's FY2006 budget proposes to establish a standard for accuracy in Supplemental Security Income (SSI) disability awards identical to the one that applies to the Social Security Disability Insurance Program, helping to ensure that only individuals who are disabled will receive SSI disability benefits and related Medicaid coverage. HHS estimates that the proposal would save \$2 million in FY2006, and save \$113 million over the FY2006-FY2010 period.

**Background.** SSI is a federal program that provides monthly cash payments to people with limited income and resources who are age 65 or older, blind, or disabled. For adults, disability is defined as the inability to engage in substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment expected to result in death or last at least 12 months. Generally, the person must be unable to do any kind of work that exists in the national economy, taking into account age, education, and work experience. A child under age 18 may

qualify as disabled if he or she has an impairment that results in “marked and severe” functional limitations. Individuals who receive SSI automatically qualify for Medicaid coverage in all but 11 states (referred to as “209(b)” states) that may elect to use more restrictive Medicaid eligibility criteria for SSI recipients.

Social Security Disability Insurance (SSDI) is a federal program that provides monthly cash payments to disabled workers under the full retirement age (and their spouses, surviving disabled spouses, and children) in amounts related to their former earnings in covered employment. SSI and SSDI have similar application and disability determination processes, and although they are federal programs, state agencies determine under both programs whether an individual meets the level of blindness or disability needed to qualify for benefits. Local Social Security Administration (SSA) field offices, which are federal, determine whether an individual meets the other criteria for SSI and SSDI eligibility. Under Section 221(b)(3) of the Social Security Act, SSA must review at least 50% of favorable SSDI disability and blindness determinations made by state agencies, plus an additional amount to the extent necessary to assure a high level of accuracy in such decisions. No such requirement currently exists for SSI determinations.

**Reports.** For more information, see CRS Report RL32279, *Primer on Disability Benefits: Social Security Disability Insurance and Supplemental Security Income*, by Laura Haltzel; and CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone.

## “Cover the Kids” Outreach Campaign

**Proposal.** The President’s FY2006 budget proposes a grant to provide \$1.0 billion over two years (\$500 million in FY2006) to states, schools, and community organizations to enroll Medicaid- and SCHIP-eligible children into these two programs. The grant is not part of the Medicaid or SCHIP budget proposals, but rather is a component of the State Grants and Demonstrations budget proposal under CMS’ jurisdiction. Since the purpose of the grant is to enroll new children in Medicaid and SCHIP, HHS estimates that this new outreach will cost Medicaid \$389 million in FY2006, and \$4.1 billion for the FY2006-FY2010 period. Likewise, SCHIP costs are estimated at \$129 million in FY2006, and \$535 million over the FY2006-FY2010 period.

**Background.** According to the latest available official statistics, in FY2003, the number of children ever enrolled in SCHIP reached 5.9 million. In FY2002, the number of children ever enrolled in Medicaid during that year reached 25.4 million. There have been ongoing concerns about participation among children who meet eligibility standards but are not covered by these two programs. Estimates of the number of children eligible but not enrolled in Medicaid or SCHIP have varied considerably over time. By 2002, national survey data showed that 2.8 million



children under age 19 were uninsured but eligible for SCHIP, and an additional 3.4 million were uninsured but eligible for Medicaid.<sup>15</sup>

Outreach can also be financed under the Medicaid and SCHIP programs. Under Medicaid, the federal matching rate for administrative expenses, which include outreach activities, is set at 50% for all states. There is a limit on federal spending for SCHIP administrative expenses, which also include outreach. For federal matching purposes, a 10% cap applies to state administrative expenses. This cap is tied to the dollar amount that a state draws down from its annual SCHIP allotment to cover benefits, as opposed to 10% of a state's total annual allotment. (States that were unable to fully expend their FY1998 allotments by the three-year time limit on availability were permitted to use up to 10% of the portion of unspent funds they were allowed to retain through FY2004 for outreach activities. This outreach allowance was over and above spending for such activities under the general administrative cap under SCHIP. All FY1998 funds have now expired.)

**Reports.** Currently, no other CRS reports address this topic.

## SCHIP Reauthorization

**Description.** Prior to the end of the current period of authorization (through FY2007), the President's FY2006 budget proposes to reauthorize the State Children's Health Insurance Program (SCHIP) at current law levels. The stated goal of early reauthorization is to better target SCHIP funds in a more timely manner. The period for the new reauthorization and the appropriation amounts by year are not specified. The proposal includes \$670 million in FY2006 for redistribution among states, and \$457 for the FY2006-FY2010 period. The HHS document<sup>16</sup> is silent on the source of these figures.

**Background.** The Balanced Budget Act of 1997 established SCHIP. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. States may choose among three benefit options when designing their SCHIP programs. They may enroll targeted low-income children in Medicaid, create a separate state program, or devise a combination of both approaches. All states, the District of Columbia, and five territories have SCHIP programs. The original enactment appropriated nearly \$40 billion for SCHIP for the ten-year period FY1998 through FY2007. The authorized appropriation for FY2006 is \$4.05 billion (rising to \$5.0 billion in FY2007). Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children, and low-income uninsured children in the state, and includes a cost factor that represents the average health service industry wages in the state compared to the national

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<sup>15</sup> Statistics taken from T. Selden, J. Hudson, and J. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2000," *Health Affairs*, vol. 23, no. 5, pp. 39-50.

<sup>16</sup> *Budget in Brief, Fiscal Year 2006*

average. States have three years to spend each annual allotment (e.g., states have until the end of FY2005 to spend their FY2003 allotments). At the end of the applicable three-year period, unspent funds are redistributed among states based on year-specific rules.

**Reports.** For more information, see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia Herz and Peter Kraut.

**Table 1. Cost (Savings) For Each Medicaid/SCHIP Proposal in the President's FY2006 Budget**

<b>Proposal</b>	<b>Cost (savings) for FY2006</b>	<b>Cost (savings) for the FY2006-FY2010 period</b>
Medicaid and SCHIP modernization	\$0	\$0
Money follows the person demonstration	\$0	\$500 million
Community alternative to children's residential treatment facilities	\$13 million	\$256 million
Respite for caregivers of disabled adults		
Respite for caregivers of children with a substantial disability		
Spousal exemption	\$17 million	\$102 million
Presumptive eligibility	\$0	\$0
Transitional medical assistance	\$560 million	\$560 million (proposal is for FY2006 only)
Long-term care insurance partnership program	\$0	\$0
Medicare premium assistance	\$230 million	\$230 million (proposal is for FY2006 only)
Vaccines for Children expansion	\$140 million	\$700 million
Payment for net provider expenditures only	\$0	(\$4.6 billion)
Limiting government provider payment to actual costs	\$0	(\$1.2 billion)
Phase-down limitation on provider taxes	(\$231 million)	(\$2.8 billion)
Managed care and provider taxes	\$0	(\$399 million)
Cost shifting for targeted case management and other services	\$0	(\$2.0 billion)
Matching rate for targeted case management	(\$129 million)	(\$1.0 billion)
Codifying Medicaid "free care" policy	\$0	\$0
Asset transfers for long-term care	(\$99 million)	(\$1.5 billion)
Allotment for state administrative costs	\$0	(\$1.1 billion)

<b>Proposal</b>	<b>Cost (savings) for FY2006</b>	<b>Cost (savings) for the FY2006-FY2010 period</b>
Medicaid and SCHIP financial management	\$0	\$0
Amending the drug rebate formula	\$0	\$0
Restructure pharmacy reimbursement	(\$542 million)	(\$5.4 billion)
Health Insurance Portability and Accountability Act	\$0	\$0
Child support enforcement	\$0	(\$45 million)
Refugee exemption extension	\$40 million	\$145 million
Social Security Administration initial disability review	(\$2 million)	(\$113 million)
“Cover the Kids” outreach campaign	Medicaid — \$389 million SCHIP — \$129 million	Medicaid — \$4.1 billion SCHIP — \$535 million
SCHIP reauthorization	budget includes \$670 million for redistribution among states in FY2006	\$457 million (source not specified)

**Source:** Table prepared by the Congressional Research Service (CRS) using information provided in Department of Health and Human Services, *Budget in Brief, Fiscal Year 2006*, Feb. 2006.

**Table 2. Congressional Research Service (CRS) Staff Contacts by Topic for the Medicaid and SCHIP Programs**

<b>Medicaid Topic</b>	<b>Staff Member</b>	<b>Phone</b>
<i>Administration</i>	April Grady	7-9578
<i>Benefits and eligibility</i>		
Aged	Julie Stone-Axelrad	7-1386
Children, Families, Immigrants, Other non-disabled adults	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
Individuals with Disabilities Medically needy	Julie Stone-Axelrad Karen Tritz	7-1386 7-4898
<i>Consumer-directed care</i>	Karen Tritz	7-4898
<i>Expenditure data</i>	April Grady Karen Tritz	7-9578 7-4898
<i>Dual-eligibles</i>	Karen Tritz	7-4898
<i>Financing</i>		
Disproportionate share	Jean Hearne	7-7362
FMAP	Christine Scott	7-7366
General issues	Jean Hearne Elicia Herz Christine Scott	7-7362 7-1377 7-7366
Intergovernmental transfers	Jean Hearne Elicia Herz Christine Scott	7-7362 7-1377 7-7366
State and local	Christine Scott	7-7366
Upper payment limits	Elicia Herz	7-1377
<i>Long-term care</i>	Carol O'Shaughnessy Julie Stone-Axelrad Karen Tritz	7-7329 7-1386 7-4898
<i>Managed care</i>	Elicia Herz Karen Tritz	7-1377 7-4898
<i>Prescription drugs</i>	Jean Hearne	7-7362
<i>Provider payment issues</i>	Jean Hearne Karen Tritz	7-7362 7-4898

<b>Medicaid Topic</b>	<b>Staff Member</b>	<b>Phone</b>
<i>SCHIP</i>	Evelyne Baumrucker Bernadette Fernandez Elicia Herz Chris Peterson	7-8913 7-0322 7-1377 7-4681
<i>Territories</i>	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
<i>Waivers</i>		
Section 1115	Evelyne Baumrucker Elicia Herz	7-8913 7-1377
Section 1915(c)	Karen Tritz	7-4898