

CRS Report for Congress

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Medicaid Issues for the 109th Congress

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Jean Hearne
Specialist in Social Legislation
Domestic Social Policy Division

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Summary

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own state program under broad federal guidelines. Accordingly, state variation in eligibility, covered services, and the delivery of, and reimbursement for, services is the rule rather than the exception.

President Bush's establishment of a Medicaid Commission in the spring of 2005 called on its members to advise the Secretary of the Department of Health and Human Services (DHHS) on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in financially sustainable ways. The Commission was created in part in response to reconciliation instructions for the 2006 budget year from the budget committees of the House of Representatives and the Senate recommending reductions in Medicaid spending. Congress since passed an omnibus budget bill for 2006. The Deficit Reduction Act of 2005 (P.L. 109-171) includes provisions intended to reduce program spending and, at the same time, introduce significant new flexibilities for the state-run programs.

During the past few years, the nation's Governors have asked Congress to provide them with relief from the increasing costs of Medicaid programs and, through the National Governors Association (NGA), have developed their own Medicaid reform plan. Other health and advocacy organizations propose expanding Medicaid to take on a greater role in providing access to medical care for the ever increasing number of individuals without health insurance.

The different perspectives of Medicaid's major stakeholders generate seemingly opposing proposals to modify the program, and reflect what each group considers the program's major weaknesses. Those weaknesses, depending on the stakeholder's perspective, include overall high costs, the unpredictability of Medicaid's budget, its reliance on state funding, and its inability to do more for the uninsured. All of these perceived weaknesses are likely to become exacerbated by the long-term demographic outlook of the U.S. population. As more baby boomers retire and more long-term care services are needed by an ever-growing population of elderly individuals, Medicaid's role and cost are likely to become even more scrutinized.

How is Congress to respond to the numerous proposals to move Medicaid forward into the near and long term? This document lays out some of these issues, explains the factors underlying them, and provides links to CRS products that can help Members of Congress and their staff prepare to discuss Medicaid's role today and into the future. This report will be updated as legislative action occurs.

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Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own state program under broad federal guidelines. Accordingly, state variation in eligibility, covered services, and the delivery of, and reimbursement for, services is the rule rather than the exception. President Bush's recent establishment of a Medicaid Commission¹ in the spring of 2005, called on its membership to advise the Secretary of the Department of Health and Human Services (DHHS) on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in financially sustainable ways. The Commission was created in part in response to reconciliation instructions for the 2006 budget year from the budget committees of the House of Representatives and the Senate that recommended reductions in Medicaid program spending.² Congress since passed an omnibus budget bill for 2006. The Deficit Reduction Act of 2005 (P.L. 109-171) includes provisions intended to reduce program spending and, at the same time, introduce significant new flexibilities for the state-run programs.³

In addition, though, the Commission is a response to calls to overhaul the Medicaid program. The annual budget proposals offered by the White House have, for each year since President Bush took office, included Medicaid reform proposals. Congress has, both recently and in the past, proposed making major structural changes to the Medicaid program. During 2005, Medicaid was expanded to provide immediate response for Hurricane Katrina and Rita victims.⁴ In contrast, Medicaid block grants are being offered as a way to offset the increased spending in response to the hurricanes.⁵ A previous attempt by Congress to cap the Medicaid program was vetoed by then President Clinton in 1995.

Congress and the White House are not the only sources that have called for major changes to Medicaid. During the past few years, the nation's Governors have asked Congress to provide them with relief from the increasing costs of Medicaid programs and, through the National Governors Association (NGA), developed their

¹ See the Medicaid Commission website at [<http://www.cms.hhs.gov/FACA/>].

² The House and Senate agreed to the conference report to accompany the FY2006 budget resolution (H.Con.Res. 95, H.Rept. 109-62) on Apr. 28, 2005.

³ The President signed the Deficit Reduction Act into law on February 8, 2006.

⁴ These expansions are being established through a special authority that allows the Secretary of Health and Human Services to waive existing program limitations. That authority exists in Section 1115 of the Social Security Act.

⁵ The Republican Study Committee, a group of 100 Republican Members of Congress have offered "Operation Offset" to find savings in the federal budget to pay for hurricane relief. See [http://johnshadegg.house.gov/rsc/RSC_Budget_Options_2005.doc].

own Medicaid reform plan.⁶ Other health advocacy organizations propose expanding Medicaid to take on a greater role in providing access to medical care for the ever increasing number of individuals without health insurance.

The different perspectives of Medicaid's major stakeholders generate seemingly opposing proposals to modify the program, and reflect what each group considers the program's major weaknesses to be. Those weaknesses, depending on the particular stakeholder's perspective, include overall high costs, the unpredictability of Medicaid's budget, its reliance on state funding, and its inability to do more for the uninsured. All of these perceived weaknesses are likely to become exacerbated by the long term demographic outlook of the U.S. population. As more baby boomers retire and more long-term care services are needed by an ever growing population of elderly individuals, Medicaid's role and cost is likely to become even more scrutinized.

How is Congress to respond to the numerous proposals to move Medicaid forward into the near and long term? This document lays out some of the issues driving calls for reform, explains the factors underlying them, and provides links to CRS products that can help Members of Congress and their staff prepare to discuss Medicaid's role today and into the future.

Background

In general, federal rules limit eligibility for Medicaid to certain categories or groups of individuals: low-income children; pregnant women; parents of dependent children; people with disabilities; and the elderly. To qualify for Medicaid coverage, an individual must meet both categorical and financial eligibility requirements. Financial requirements govern the amount of income and assets that individuals may have and still qualify for Medicaid, as well as how these amounts are calculated (e.g., whether a portion of earned income or the value of a car may be disregarded). Although Medicaid is targeted at individuals with low income, not all of the poor are eligible, and not all those covered are poor.⁷

Individuals who do not meet categorical eligibility requirements (e.g., non-elderly adults who are not disabled and do not have children) generally cannot qualify for Medicaid coverage even if they are poor. However, as discussed later in this report, research and demonstration waivers available under Section 1115 of the

⁶ View the National Governors Association's work on Medicaid reform at [<http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF>].

⁷ For more information on Medicaid eligibility see CRS Report RL33019, *Medicaid Eligibility for Adults and Children*, by Jean Hearne; and CRS Report RL31413, *Medicaid — Eligibility for the Aged and Disabled*, by Julie Stone.

Social Security Act⁸ allow for exceptions to these eligibility rules in states with approved demonstrations.

State Medicaid programs cover a wide array of medical services and providers. States are required to cover certain mandatory services listed in federal statute. Examples of those include (1) inpatient and outpatient hospital services, (2) federally qualified health center (FQHC) services, (3) lab and X-ray services, (4) physician services, (5) certain nurse practitioner services, (6) pregnancy-related services (including postpartum care), (7) early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21, (8) nursing facility care for persons age 21 and over, and (9) home health care for persons entitled to nursing facility care. The statute also lists additional services that are optional — that is, states can choose to include them in their state Medicaid plans. Some of these optional benefits include eyeglasses and prosthetic devices, the services of psychologists, physical therapy, and prescription drugs.⁹

Medicaid is also an important financing mechanism for long-term care (LTC). LTC refers to a wide range of supportive and health services generally provided on an ongoing basis for persons who have limitations in functioning because of a mental or physical disability or chronic condition. Both institutional services such as nursing home care, and home and community-based care are covered by state Medicaid programs.

The states and the federal government share the cost of Medicaid's benefits by way of a formula that takes into account each state's average per capita income. The federal government's share of a state's expenditures for Medicaid services is called the federal medical assistance percentage (FMAP). Determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). For FY2006, the FMAPs range from 50% to 76% depending on the state.¹⁰

Behind the Calls for Medicaid Reforms

While Medicaid reform has been raised as an agenda item for this Congress, deliberation over Medicaid reforms is not new. A Medicaid reform proposal has been included in each of the annual White House budget plans since President Bush took office. One reason for the recurring calls for Medicaid reform is that the stakes of Medicaid failure are very high. If Medicaid's funding mechanism is failing or in

⁸ Section 1115 allows the Secretary of Health and Human Services (HHS) to waive certain statutory Medicaid requirements for purposes of conducting research and demonstration projects so long as those projects are consistent with the objective of Medicaid statute.

⁹ See CRS Report RL32277, *How Medicaid Works — Program Basics*, by Elicia Herz, et al.

¹⁰ For more information on the federal matching formula see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Christine Scott.

jeopardy, it will affect at least three levels of government: federal; state; and local. Medicaid impacts millions of health care providers, tens of millions of Medicaid beneficiaries and provides what are often life-saving services for the destitute and sickest in our country. With healthcare comprising one-seventh of the nation's economy, Medicaid plays a major role in many local job markets, particularly in rural areas where the community hospital is often the largest employer.

The President's budget proposals have not been specific enough to evaluate their potential impact. The message they convey, however, is that the White House would support Congress if it were to take up major Medicaid reform. In 2005, Congress responded. The House and Senate agreed, in the conference report to accompany the FY2006 budget resolution (H.Con.Res. 95, H.Rept. 109-62), to direct the authorizing committees to develop proposals to reduce mandatory program spending. The recommendations included significant budget reductions for the Medicaid program. Those recommendations were addressed in the provisions of the Deficit Reduction Act of 2005 (DRA 2005). The bill included both targeted reductions in specific program areas and also significant new flexibilities for states on cost-sharing and benefits. Nonetheless, it is instructive to understand why concerns remain regarding Medicaid's ability to sustain its current form into the future, to understand whether fundamental program reform is possible, and what shape such a reform might take.

The impetus behind calls for Medicaid reforms fall under four general categories: the program's size and cost; certain features of its structure; the relationship between the states and the federal government with respect to the program's administration and funding; and the program's mission.

Medicaid's Size and Expenditures

The Medicaid program is the third largest entitlement spending item in the federal budget behind Social Security and Medicare. For states, it is the second largest spending item after education. In almost every year since the program's start, Medicaid's costs have grown faster than inflation, and recently those growth rates have accelerated.

The cost of Medicaid is shared by the federal government and states, and at states' option, local governments. Before the disastrous 2005 hurricane season, Medicaid was expected to cost \$329 billion this year, making it as large as Medicare. Even more striking is the rate of growth. Medicaid is expected to represent 2.6% of GDP this year, 13 times its share in 1966, its first full year of operation. It has grown partly because medical care keeps getting more expensive, and partly because it now covers far more people for far more benefits than its founders ever envisaged. Program spending has grown by more than 49% since 2000, exceeding growth in general and medical inflation, and the rates of growth in spending for both Medicare and Social Security.¹¹

¹¹ Congressional Budget Office Analysis, *Monthly Budget Review*, Nov. 4, 2004, at [http://www.cbo.gov/showdoc.cfm?index=6002&sequence=0].

Medicaid's cost is not the program's only large feature.¹²

- In 2002, the last year for which data are available, Medicaid covered 51.5 million enrollees, almost 18% of the U.S. population.
- Medicaid is now the primary insurer for almost 40% of all births.¹³
- In many states, coverage for children has been extended to those in families with income above the federal poverty level.¹⁴
- Almost one-half of all long-term care services provided in the U.S. are paid by Medicaid.¹⁵

The challenges of funding Medicaid's state share has driven states to make trade-offs between meeting the program's financial requirements and meeting the health care needs of the states' population. In recent years, many states have enacted program changes that have reduced benefits, tightened eligibility rules, and/or established documentation requirements intended to restrict eligibility. Many of these changes were implemented during the 2000-2003 recession. States also requested and received fiscal relief from Congress. In 2003, Congress passed the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-27) which provided temporary fiscal relief to states through a combination of grants and an increase in the federal medical assistance percentage.¹⁶

In addition, states have been experimenting with broader changes intended to bring more budgetary discipline to Medicaid. For example, Vermont is operating the state's Medicaid program, and Florida has just received approval from HHS to operate their Medicaid program, under expenditure ceilings. South Carolina has submitted a proposal to make Medicaid beneficiaries more financially responsible for their medical care. Under the South Carolina proposal, beneficiaries would be provided with health spending accounts coupled with high deductible Medicaid coverage. Utah has implemented a demonstration program that provides a limited benefit plan, which excludes inpatient hospital services, to Medicaid enrollees.

Despite its rapid cost growth and large budget, Medicaid is viewed as a cost efficient program. For Medicaid's non-disabled populations, per person costs are no higher than private health insurance.¹⁷ The percentage of the program's spending on administrative costs (3 to 4%) are small compared to the administrative costs of

¹² [<http://www.kff.org/medicaid/upload/Key%20Medicare%20and%20Medicaid%20Statistics.pdf>].

¹³ [<http://preview.nga.org/Files/pdf/0508MCHUPDATE.PDF>].

¹⁴ The federal poverty level in 2005 equals \$16,090 for family of three in the 48 contiguous states.

¹⁵ CRS analysis of National Health Expenditure Data, Centers for Medicare and Medicaid Services (CMS), CY2003.

¹⁶ For more information on the fiscal relief under JGTRRA, see CRS Report RL31773, *Medicaid and the Current State Fiscal Crisis*, by Christine Scott.

¹⁷ [<http://www.cbpp.org/2-4-05health.pdf>].

private health insurance plans (often in excess of 20%).¹⁸ Because Medicaid covers high-cost populations, primarily people with disabilities and those needing long-term care services, insurance costs are held down for all others who are covered under private plans. Many of the people who are on Medicaid, however, would be rejected from private coverage if they were to seek private health insurance coverage on their own.

Nonetheless, the cost and growth issue makes Medicaid a target for budget cutters and those who are concerned that government spending is out of control.

Medicaid Structure

A number of structural features of the Medicaid program contribute to the perceived need for reforms. The federal statute describes Medicaid as an entitlement program that states operate under broad federal rules. The impact of the entitlement combined with the challenge of meeting the many and complicated federal rules fuel many of the states' calls for reforms. Some reform proposals would address categorical eligibility rules that keep certain poor people off the program regardless of their income. Those proposals would extend Medicaid to all of those below poverty and/or ensure uniform availability of health benefits.

In general, federal Medicaid law establishes an entitlement to Medicaid covered services. Individuals who are determined to be eligible for the program are entitled to receive the benefits described in the states' Medicaid plans. The "entitlement nature" of Medicaid creates for states, however, a budgetary environment for which there is little control from the top. By entitling Medicaid's beneficiaries to coverage under state programs, the program's original authors intended to ensure that medical care be available to the most vulnerable Americans. On the other hand, the entitlement nature of the program prevents states from being able to set a budget and keep the program spending within those budgeted amounts. In an entitlement environment, if more Medicaid beneficiaries meet the eligibility requirements, then the state is obligated to provide coverage whether or not the costs of such coverage exceed any particular budgeted amount. This feature of the program raises considerably more difficulty for states when there is an economic downturn. During such periods, states may experience reduced revenues at the same time that residents lose their jobs, thus raising the number of people who may become entitled to Medicaid.

Medicaid's federal requirements generate complaints from state officials about the program's perceived inflexibility and contribute to the governors' calls for reform. Medicaid is a state-administered program in each state that chooses to participate — and at this time all states do. Each state makes a large number of choices on how to define eligibility, which benefits to offer, how to manage care provided to enrollees, and how much to pay providers. The state choices, however, must be consistent with a broad federal outline established in Title XIX of the Social Security Act. The broad federal outline is actually comprised of a large number of

¹⁸ Private insurance administration includes a number of functions, such as marketing and advertising, that are not included in Medicaid administrative expenditures.

requirements. For example, there are over 50 different eligibility groups identified in federal statute alone. Most of those requirements were established by Congress and the Centers for Medicare and Medicaid Services (CMS), and its predecessor, the Health Care Financing Administration, to reduce variation among the states and create more consistency in the coverage provided under the programs — but can be complicated to administer. For example, federal rules regarding Medicaid benefits and coverage conflict with many of the Medicare program rules. The conflicts sometimes impede states from enrolling “dual eligibles” — people eligible for the benefits of both programs — into cost controlling managed care organizations. Other rules require states to effectively apply two separate sets of eligibility rules to the same individuals. For children qualifying for the State Children’s Health Insurance Program (SCHIP), states must prove that they are NOT eligible for Medicaid, and for low-income families who qualify through liberalized income and assets rules, states must determine whether they would have also been eligible under Aid for Dependent Children (AFDC) programs that existed in 1996.

Based on the work of the NGA and many testimonies before Congress over the years, states’ experience of federal “inflexibility” stem from both the number of federal requirements and from particular rules that limit states’ ability to experiment with benefits and delivery systems. State officials want greater flexibility to decide how Medicaid money should be spent because Medicaid constitutes such a large part of their budgets. Particular rules that are often included in discussion of the inflexibility of the program include federal limitations on the cost-sharing (such as co-payments, deductibles, premiums and enrollment fees) that states may require of beneficiaries, and federal requirements that comparable benefits be provided to all beneficiaries within each eligibility group statewide. Both of the areas of cost sharing and benefits flexibilities were addressed in DRA 2005 as enacted earlier in the year.¹⁹ Once implemented, these provisions will be watched carefully to determine if they resolve some of the complaints about inflexibility and to evaluate the impact of the new options on Medicaid’s beneficiaries.

The complex rules have contributed to efforts among states to reorganize Medicaid programs without congressional reforms, efforts that have been supported and even encouraged by recent White House occupants. A number of states have enacted statewide demonstration programs that have established more simplified eligibility and benefits, sometimes with less variation by eligibility group.²⁰ A number of other major reforms are currently under consideration through Section 1115 demonstration waivers, raising the question of whether such large scale reform of the third largest federal entitlement program should proceed without congressional oversight or involvement. With the announcements of several new and controversial

¹⁹ States were given new options for raising cost sharing amounts for certain Medicaid enrollees and for implementing more narrow benefits packages. For a complete description of the provisions of DRA 2005, see CRS Report RL33131; *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children’s Health Insurance Program (SCHIP) Provisions*.

²⁰ For more information on research and demonstration waivers, see CRS Report RS21054, *Medicaid and SCHIP Section 1115 Research and Demonstration Waivers*, by Evelyne Baumrucker.

waiver plans, there are indications that oversight of the waiver approval process may be an important issue for the remaining session of the 109th Congress.

State-Federal Relationship

Medicaid's shared financing and administration requires the cooperation and concerted efforts of federal, state, and often local units of government. The relationship has created an uneasy alliance. Because the program is financed in part by the federal government, but administered by states, states have incentives to administer their programs in ways that maximize federal reimbursements of program expenses. Approaches to maximize the federal share of Medicaid costs have varied from clever interpretations of current law to what some in Congress have seen as outright fraud and abuse.²¹ "Medicaid maximization" is not new, but over the years billions of federal funds have been claimed by states in what the Inspector General of HHS and the Government Accountability Office (GAO) say undermines the federal-state Medicaid partnership and the program's fiscal integrity.²²

Two of the mechanisms states have used in the past to maximize federal reimbursements in questionable ways have involved making excess Medicaid payments to certain providers and requiring those providers to return some or all of the state and/or federal share of those payments back to the state. Payments made under the Medicaid upper payment limit rules and disproportionate share payments to hospitals are described further in two CRS reports.²³ Medicaid reforms could involve re-structuring the federal/state funding relationship of Medicaid entirely, or targeting only those questionable funding mechanisms. As described below, the President's Budget proposal for FY2006 includes several provisions targeting these particular funding approaches. The targeted approach may be less controversial than a complete overhaul of Medicaid's financing rules, but such targeted reforms are still controversial. While these funds are viewed by the federal government as leaving the federal treasury under questionable circumstances, they are often perceived by states as essential to maintaining medical benefits and access to providers for residents.

²¹ U.S. Congress, Senate Committee on Finance, *Medicaid Waste, Fraud and Abuse*, June 29, 2005; U.S. Congress, House Energy and Commerce Committee, Oversight and Investigations Subcommittee, *Medicaid Drugs Reimbursement*, Dec. 7, 2004; U.S. Congress, House Energy and Commerce Committee, Health Subcommittee, *Inter-governmental Transfers: Violations of the Federal-State Medicaid Partnership or Legitimate State Budget Tool?*, March 18, 2004; U.S. Congress, House Committee on Commerce, Subcommittee on Oversight and Investigations, Nov. 9, 1999.

²² Statement of Kathryn G. Allen, U.S. Government Accountability Office, provided before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, on Mar. 18, 2004, GAO-04-574T; U.S. Department of Health and Human Services Office of Inspector General (U.S. DHHS OIG), *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers*, Sept. 2001.

²³ CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia Herz; and CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jeane Hearne.

Unresolved Mission

Not all of those wishing to reform Medicaid are interested in making Medicaid a smaller program. Some propose extending Medicaid to provide health care coverage to more individuals, building on Medicaid's traditional role as the comprehensive insurer of last resort.

What is Medicaid's role today? Under current law, the nation's health care insurer of last resort was built piecemeal over time to meet a number of special needs left unmet by the nation's ad-hoc system of private, job-based coverage. As a result, Medicaid's enrollees, their medical needs, and the services used to meet those needs range widely across states. Medicaid's coverage of low-income families, children and pregnant women reflects consensus that the health care of our children and prenatal care are essential and worthy of government funding. But Medicaid also plays a critical role in providing health care to individuals with chronic physical and mental disabilities. Long term care for the physically frail and elderly and prescription drug coverage for all Medicaid's beneficiaries have become essential to many. The program also covers many items and services that private insurance tends not to cover, such as eyeglasses, dentures, transportation, and nursing home services.

In addition to its role as insurer of last resort, Medicaid also plays a major role in keeping certain kinds of health care providers available to the nation's low-income and uninsured populations.²⁴ Medicaid compensates hospital providers for treating large numbers of people without health insurance and pays relatively higher rates to safety net providers of primary care (e.g., federally qualified health centers and rural health centers.) In many communities where the local hospital or nursing home is the largest employer, Medicaid plays a critical role in helping to maintain the local economy.

Some reformers see Medicaid as doing too little, while others see it as having grown too large. These divergent views of the program reflect a lack of consensus about Medicaid's past success and its future mission. Is Medicaid, as some say, the nation's largest and successful medical safety net that can be relied upon to meet the ever changing and possibly expanding medical needs of the nation's poor? Or is Medicaid, as say others, an incompetent bureaucratic behemoth, greedily swallowing up federal, state and other local government revenues?

Indeed, the clashing assessments of today's Medicaid program and its future mission may reflect a larger lack of consensus on the nation's health care system, as well. Is there a public duty for government to pay for medical care for to those who cannot afford to pay for it? No clear consensus has emerged to resolve this question, and therefore, Medicaid continues to serve as the default solution.

²⁴ For more information on Medicaid payments to safety net providers, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jeane Hearne; and CRS Report RL32644, *Medicaid Reimbursement Policy*, by Mark Merlis.

Proposals for Reform

If Medicaid is to undergo fundamental reform, what would the changes look like? Most agree that program's role as safety-net program should be protected. But should that role be expanded, or should a leaner version of Medicaid be made available to more individuals? Should the focus of reform be on making the program a smaller budget item? Fundamental reforms could include changing the federal/state relationship for funding the program, removing the categorical eligibility requirements, or changing the way that the state and federal governments jointly regulate and administer the programs.

Other reforms could focus on targeted needs or issues. For example, reforms could address those questionable financing mechanisms that inflate federal reimbursements, or could change certain program features to reduce future program costs. The following section summarizes current proposals put forth by some of Medicaid's major stakeholders.

President's Budget. The President's budget for FY2006 contains a number of proposals that would impact the Medicaid program. Some of the proposals would expand Medicaid, others would reduce current or future federal spending for the program.²⁵ The Medicaid proposals include provisions in four broad categories:

- Medicaid and SCHIP Modernization — would provide more flexibility for states to expand Medicaid coverage for low-income families and individuals without creating additional cost to the federal government.
- New Freedom Initiative Proposals — would 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 — would expand the Vaccines for Children program, temporary medical assistance and Medicare premium assistance. In addition there are other proposals designed to reduce federal spending on Medicaid.
- Other Legislative Proposals with a Medicaid Impact — would 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.

The details of the Medicaid modernization proposal are not specified, but its description uses such terms as increasing "flexibility" and increasing the use of SCHIP principles in Medicaid. Both of these ideas are consistent with the NGA proposal for Medicaid reform (see description below.) In addition, the budget plan includes several proposals intended to specifically target Medicaid maximization.

²⁵ For more detail on the Medicaid Proposals in the President's Budget for FY2006, see CRS Report RL32771, *Medicaid and SCHIP: The President's FY2006 Budget Proposals*, by April Grady, et al.

The budget proposes to restrict the use of certain intergovernmental transfers that allow providers to “pay back” the states’ share and sometimes federal share of program reimbursements to the states. Second, the budget proposes to cap Medicaid payments to individual state and local government providers to no more than the cost of providing services to Medicaid beneficiaries.

Congressional Budget Reconciliation. The House and Senate are both working toward a budget reconciliation bill for FY2006 that would reduce Medicaid spending in a number of significant ways. The House and the Senate have conferenced on a bill, S. 1932, The Deficit Reduction Act of 2005. The House passed one version of the conference report on November 18, 2005. The Senate later passed a slightly modified version (on December 19, 2005.) The bill awaits final House action. S. 1932 would achieve Medicaid savings by modifying the federal upper limit for reimbursement of certain Medicaid outpatient prescription drugs, would make improvements in the prescription drug rebate system to achieve rebates on drugs formerly left out of the rebate system, and would further limit the ability of individuals in need of nursing home care to transfer assets to qualify for Medicaid coverage. The bill also would establish greater cost-sharing options and allow greater flexibility on Medicaid benefits for states to enact.²⁶

Medicaid Commission. The Medicaid Commission provided its first report to the Secretary of Health and Human Services (HHS) on September 1, 2005. In the report, the Commission made recommendations to achieve \$10 billion in savings consistent with the budget reconciliation instructions. Recommendations included changes to rules on reimbursement of Medicaid prescription drugs and asset transfers for individuals needing long term care; increasing copayments for Medicaid prescription drugs and expanding the Medicaid drug rebate program. The Commission is required to submit a second report by December 31, 2006 that will include recommendations intended to ensure the long-term sustainability of the program. The recommendations are expected to include proposals relating to eligibility, benefits design and delivery, expanding coverage in a constrained budgetary environment, long term care, quality, and administration.²⁷

State Actions. In the absence of federal reforms, a number of states have moved ahead with plans to restructure their Medicaid programs. Under the authority provided in Section 1115 of the Social Security Act, the Secretary of DHHS can allow states to conduct research and demonstration projects under the Medicaid program. Under the provisions of Section 1115, states can waive many of Medicaid’s rules to conduct a demonstration as long as the demonstration promotes the purposes of the Medicaid program — providing medical assistance to low-

²⁶ For more detail on the Medicaid provisions in the House and Senate reconciliation bills, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz, et. al, and CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children’s Health Insurance Program (SCHIP) Provisions*, by Evelyne Baumrucker, et al. For more information on the FY2006 budget reconciliation process, see CRS Report RL33132, *Report Budget Reconciliation Legislation in 2005*, by Robert Keith.

²⁷ [<http://www.cms.hhs.gov/FACA/>].

income families, blind and disabled individuals. A number of the waivers have extended coverage to people who would not otherwise be eligible for Medicaid under federal rules.²⁸ Some demonstrations, however, have been structured so that program costs are more controllable. Most waivers are subject to federal funding ceilings and many impose higher cost sharing for beneficiaries than allowed under Medicaid rules. Other waivers include benefit packages that can be adjusted annually to keep costs below a pre-determined target, enrollment waiting lists, or reduced benefit packages.

During 2000-2003, many states faced budget shortfalls and state-level policy makers were required to make trade-offs between program costs and coverage of populations and services. Some examples include tightening of program eligibility rules — coverage for low-income working parents was deeply reduced in several states including California and Georgia; Colorado and Maryland reduced coverage for legal immigrants; and Mississippi significantly reduced coverage for the elderly and persons with disabilities. A number of states also implemented or raised beneficiary cost sharing — some of those states include Oregon, Vermont, Rhode Island, and Utah. Covered services were reduced in Michigan. Missouri's governor has threatened to drop the state's Medicaid program altogether. Georgia restricted access to nursing home coverage for the elderly.

While program changes were made to limit the program, a number of other states expanded parts of their Medicaid programs during this period as well. Coverage for children, especially, continued to be expanded in many states despite the budget troubles.

National Governors Association (NGA) Proposal. The NGA has developed a set of guiding principles for Medicaid reform, a Medicaid long term restructuring strategy, and a set of proposals for the short-run that are consistent with the reform principles and the long term strategy. The principles, strategy and proposals are available in more detail on the NGA website.²⁹

NGA's principles for Medicaid reform include:

- The federal government should assume full responsibility for the acute, primary, long-term, and pharmaceutical care of the dual eligibles (i.e., individuals who are eligible for both Medicare and Medicaid services);
- Alternative sources of long-term care coverage should be developed;
- States should have greater ability to manage the Medicaid program with respect to eligibility, benefits, cost-sharing, and coordination with private sector insurance;

²⁸ [<http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage>].

²⁹ NGA Principles for Medicaid Reform at [<http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a278110501010a0/?vgnnextoid=e5ff0640e8e34010VgnVCM1000001a01010aRCRD>]; Medicaid Reform at [<http://www.nga.org/Files/pdf/0506medicaid.pdf>], Short-run Medicaid Reform at [<http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF>].

- Medicaid reform proposals that provide states broader Medicaid program authority should weigh fiscal and health policy implications of the current financing structure;
- Efforts to reduce fraud and abuse by Medicaid beneficiaries and providers are essential but any effort to develop error rates to measure state performance should be strongly opposed;
- To the extent possible, all current waivers should be replaced with clear statutory authority;
- The federal government should pay 100% of the cost of any new Medicaid mandates; and
- The federal contribution for commonwealths and territories should be modified.

Those principles are translated into proposals that include a greater reliance on wellness and health promotion via care management and coordination; more consumer choice; changes to federal rules for reimbursement of Medicaid prescription drugs and asset transfers for individuals needing long term care; greater discretion for states to establish premiums, deductibles and copayments for all Medicaid populations; more flexibility on benefits; and greater ease in the demonstration waiver approval process.

National Academy for State Health Policy (NASHP) Proposal. The NASHP is a non-profit, non-partisan organization whose mission is to help states achieve excellence in health policy and practice. NASHP brought together a working group comprised of state officials and national experts representing a broad range of stakeholder interests in Medicaid to develop recommendations regarding reform. One of the group's recommendations is to replace the current system of categorical eligibility, and expand Medicaid eligibility to all individuals with incomes at or below the federal poverty level. The proposal would maintain the current comprehensive package of benefits for those beneficiaries with income below the federal poverty level, but allow states the flexibility to offer a reduced set of benefits to those with income above those amounts. The group also recommends that revisions be made in the FMAP formula so that each annual update better reflects recent changes in the states' economies and fiscal capacity.³⁰

Other Congressional Proposals. A number of bills have been introduced in the 109th Congress that would expand eligibility for a single group or category of individuals; add a new eligibility pathway to Medicaid; change eligibility documentation requirements; enhance outreach; provide temporary fiscal relief, or provide for a special federal matching percentage for a particular group or service. All of these bills essentially retain the existing structure of the Medicaid program and are too numerous to describe each in detail here.

Few bills have been introduced that would fundamentally reform Medicaid and the plans of the Senate Finance and House Energy and Commerce Committees to meet the reconciliation budgets have not yet been made public. The only bill that would provide an entirely new direction for the Medicaid program is H.R. 3757.

³⁰ [http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf].

H.R. 3757 would amend the Medicaid program to provide states with an option to establish “health opportunity accounts” for selected beneficiaries enrolled in Medicaid. During the first five years after enactment, the “health opportunity accounts” would be established under demonstration projects in no more than 10 states. After five years, if the Secretary finds that the demonstrations were successful, “health opportunity accounts” would become an option for all states. Under the bill, certain Medicaid beneficiaries would be provided with Medicaid coverage for medical expenses after a deductible has been met. The state would fund an “health opportunity account” in an amount (including both state and federal shares) that does not exceed, on an annual basis, \$2,500 for each individual (or family member) who is an adult and \$1,000 for each individual (or family member) who is a child. Deductibles may be set at an amount that is equal to the amount in the health opportunity account or no more than 110% of that amount. The health opportunity funds in the account would be available for each beneficiary to pay for medical items and services obtained before the Medicaid program deductible has been met. Funds remaining in the account after the annual funding period ends roll over to the next year, and after that time, may become available for other uses as described in the bill and specified by states.

Two other bills would extend Medicaid’s provision of health care to children and modify the usual combined federal/state financing arrangement for those benefits. S. 114, the Kids Come First Act of 2005, would give states the option to receive a 100% FMAP for all medical assistance provided to children in families with income below the federal poverty level in exchange for expanding coverage for children in working poor families under Medicaid or SCHIP. The bill would also provide for a refundable tax credit for health insurance coverage of children and the forfeiture of the personal tax exemption for any child not covered by health insurance. A similar bill, H.R. 1668, the Kids First Act of 2005, was introduced in the House of Representatives.