Option #	Short Title	General Approach	Fiscal Impact (Federal)	Scored By	Options Author
Administrative Claiming					
1	Administrative claiming allotment reform	Establishes individual State allotments for Medicaid administrative costs to encourage States to use more cost-effective methods in administering the program.	$1.1 Billion over 5 years (2006-2010)	CMS Office of the Actuary	President's Budget FY 2006
2	Equalization of the Medicaid administrative match.	This option would set all federal administrative match rates at 50%.	$7.14 Billion over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, *2005 Budget Options*
3	Limit Medicaid administrative costs to a cap on a per-enrollee basis.	This option would cap the per-enrollee administrative cost at the 2004 level, and this cap would grow by 5% per year. States would not be reimbursed for any administrative costs in excess of this cap.	$4.23 Billion over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, *2005 Budget Options*
4	Elimination of the "double" administrative payment to states.	States incur administrative costs that are common to Medicaid, TANF, and Food Stamps. However, states are now required to charge the Medicaid share of these common costs to the Medicaid program. This proposal would eliminate this double payment by restricting the Medicaid reimbursement to only that part of the common administrative costs that is not included in the TANF block grant.	$1.77 Billion over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, *2005 Budget Options*
Asset Transfer					
5	Change the start date of penalty period for persons transferring assets for Medicaid eligibility.	This option proposes to move the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date whichever is later. Changing this date extends the time during which Medicaid applicants who made transfers are financially responsible for the cost of their care.	$1.5 Billion over 5 Years (2006-2010)/$1.4 Billion over 5 years (2006-2010)	CMS Office of the Actuary and Congressional Budget Office	President's Budget FY 2006
6	Change the start date of penalty period for persons transferring assets for Medicaid eligibility.	This option proposes to move the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date whichever is later. Changing this date extends the time during which Medicaid applicants who made transfers are financially responsible for the cost of their care.	$1.5 Billion over 5 Years (2006-2010)/$1.4 Billion over 5 years (2006-2010)	CMS Office of the Actuary and Congressional Budget Office	National Governors Association -Draft working paper
7	Increase "look-back" period from 3 to 5 years	Financial eligibility screeners look for transfers from personal assets of Medicaid applicants made during a period of time prior to application (this is referred to as the "look-back" period) that appear to have been made for the purpose of obtaining Medicaid eligibility. Applicants are prohibited from transferring resources during the look back period for less than fair market value. This option would increase the "look-back" period from 36 months to 5 years.	Small impact, less than $100 million over 5 years (2006-2010)	CMS Office of the Actuary	National Governors Association -Draft working paper

Cost Sharing					
8	Increase co-pays for certain Medicaid services.	This option would increase the allowable co-pay limit from $3 to $5 for adults and from $0 to $3 for children. These co-pays would apply to outpatient hospital visits, prescription drugs, non-emergency ER visits, and physician and dental visits. Co-pays would continue to be prohibited for some services, including emergency care and family planning.	$1.97 Billion over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, 2005 Budget Options
9	Providing states flexibility in defining cost sharing requirements for health care services	In this option, states would be given the ability to implement enforceable cost-sharing throughout the Medicaid program. This new flexibility would be completely at state option, and states could choose to further restrict the types of cost-sharing in the program by income level, beneficiary category, or service type. States would be able to increase cost-sharing beyond nominal levels for all beneficiaries above the federal poverty level and be given the authority to make cost-sharing enforceable. For beneficiaries above the federal poverty level, premiums may be appropriate as a cost-sharing option for states and states would be given flexibility to experiment with mechanisms to collect these premiums. Beneficiaries will be protected by a 5% cap on the total amount of cost-sharing they would be responsible for (5% of total family income). This would increase to 7.5% for those higher income households (defined as above 150% FPL).	$1.2 Billion over 5 years (2006-2010)	CMS Office of the Actuary	National Governors Association -Draft working paper
10	Tiered co-payments for prescription drugs	Under this option states would be able to increase co-pays on non preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. For beneficiaries at or below the federal poverty line, co-pays for preferred drugs would remain nominal. All co pays on drugs would become enforceable. States would be given broad authority to waive co-pays in cases of true hardship or where failure to take a preferred drug might create serious adverse health effects	$2 Billion over 5 years (2006-2010)	CMS Office of the Actuary	National Governors Association -Draft working paper
Disproportionate Share Hospital Program					
11	Convert Medicaid disproportionate share hospital payments into a block grant.	This option would convert the current Medicaid Disproportionate Share Hospital (DSH) program into a block grant to the states. In addition, states would be given greater flexibility to use the funds.	$180 Million over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, *2005 Budget Options*

Payment Reform					
12	Restrict Intergovernmental Transfers (IGTs)	This option restricts intergovernmental transfers (IGTs) by requiring CMS to recover Federal funds inappropriately retained by or returned from providers to the State. The proposal would base Federal match to States on net expenditures, and would provide federal matching funds to states only for payments retained by Medicaid providers.	$4.6 Billion over 5 years (2006-2010)	CMS Office of the Actuary	President's Budget FY 2006
13	Upper Payment Limit (UPL) reform for government providers	This option would change the permissible upper payment limit (UPL) for government providers from the Medicare payment rate to the cost of providing services.	$1.2 Billion over 5 years (2006-2010)	CMS Office of the Actuary	President's Budget FY 2006
14	Require all states to comply with current UPL regulations by 2006	HHS instituted regulations in 2001 that created separate UPLs for facilities run by local governments. However, some states are not subject to this rule until September 30, 2008. This proposal would require all states to adhere to the new UPL rules starting in 2006.	$1.97 Billion over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, *2005 Budget Options*
Prescription Drug Costs					
15	Prescription drug reimbursement formula reform	This option would require States to reimburse the Average Sales Price (ASP) of a drug to pharmacies for Medicaid drugs, plus a 6 percent fee for storage, dispensing, and counseling.	$5.4 Billion over 5 Years (2006-2010)/ $5.2 Billion over 5 Years (2006-2010)	CMS Office of the Actuary and Congressional Budget Office	President's Budget FY 2006
16	Prescription drug reimbursement formula reform	This option would allow states to negotiate pharmaceutical prices based on the Average Manufacturer Price (AMP) rather than the published average wholesale price (AWP) as is done today. There is widespread acceptance that the AWP is inflated and does not reflect a valid benchmark for pricing. Additionally, reforms would be implemented to ensure that manufacturers are appropriately reporting data.	$4.3 Billion over 5 Years (2006-2010)	CMS Office of the Actuary	National Governors Association -Draft working paper
17	Prescription drug reimbursement formula reform	This option would require States to reimburse the Average Sales Price (ASP) of a drug to pharmacies for Medicaid drugs, plus a $9 flat fee for storage, dispensing, and counseling.	$2.2 Billion over 5 Years (2006-2010)	CMS Office of the Actuary	Governor Angus King
18	Increase the flat rebate paid by brand-name drug manufacturers by increasing the minimum rebate percentage	In return for their drugs being covered by Medicaid, drug manufacturers must enter into an agreement with Medicaid to refund a portion of their payments back to the Medicaid program. This proposal would change the minimum percentage of the rebate from 15.1% to 20%. It is estimated that this would increase the average rebate percentage received from manufacturers from 20% to 23%.	$3.22 Billion over 5 years (2006-2010)	Congressional Budget Office	Congressional Budget Office, *2005 Budget Options*

19	Increase the flat rebate paid by brand-name drug manufacturers by increasing the minimum rebate percentage	In return for their drugs being covered by Medicaid, drug manufacturers must enter into an agreement with Medicaid to refund a portion of their payments back to the Medicaid program. This proposal would change the minimum percentage of the rebate from 15.1% to 20%. It is estimated that this would increase the average rebate percentage received from manufacturers from 20% to 23%.	$3.22 Billion over 5 years (2006-2010)	Congressional Budget Office	National Governors Association -Draft working paper
20	Extension of the Medicaid drug rebate program to Medicaid managed care	This option would give Medicaid managed care health plans access to the existing pharmaceutical manufacturer rebate program. Currently, the Medicaid Drug Rebate Program requires drug manufacturers to have rebate agreements for outpatient drugs dispensed to Medicaid patients as part of their fee-for-service programs. Currently, Medicaid managed care plans end up paying higher prices for the drugs even though they are also serving Medicaid beneficiaries.	$2 Billion over 5 years (2006-2010)	CMS Office of the Actuary	National Governors Association -Draft working paper
21	Extension of the Medicaid drug rebate program to Medicaid managed care	This option would give Medicaid managed care health plans access to the existing pharmaceutical manufacturer rebate program. Currently, the Medicaid Drug Rebate Program requires drug manufacturers to have rebate agreements for outpatient drugs dispensed to Medicaid patients as part of their fee-for-service programs. Currently, Medicaid managed care plans end up paying higher prices for the drugs even though they are also serving Medicaid beneficiaries.	$2 Billion over 5 years (2006-2010)	CMS Office of the Actuary	Association for Community Affiliated Plans (formerly Association for Health Center Affiliated Health Plans)
~~22~~	~~Inclusion of "authorized generics" in calculation of "best drug price"~~	In this option “Authorized generics” would be included in calculations of best price for the brand name drug. In addition, an “authorized generic” would qualify a particular drug for having a CMS set Federal Upper Limit (FUL). Currently, if at least three versions of the drug are rated as therapeutically equivalent by the FDA and the drug has at least three suppliers listed in current editions of national compendia, an FUL should be set by CMS.	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See “Criteria for Considering Submissions” in Tab 4.*		National Governors Association -Draft working paper
23	Modification of the Federal Upper Limit (FUL) calculation and use	A new federal reimbursement ceiling for all drugs would be established based on the Average Manufacturer Price (AMP). The current Federal Upper Limit (FUL) practice would be maintained, but instead of using the AWP (Average Wholesale Price) the AMP (Average Manufacturer Price) would be used in the calculation.	$3 Billion over 5 years (2006-2010)	CMS Office of the Actuary	National Governors Association -Draft working paper
~~24~~	~~Increase generic utilization~~	Require greater use of generic drugs where therapeutically equivalent generics are available, and standardizing rules governing generic substitution to eliminate conflicting state and Federal requirements.	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See “Criteria for Considering Submissions” in Tab 4.*		National Association of Chain Drug Stores (NACDS)

~~25 Encouraging the implementation of step therapy programs and approved therapeutic interchanges~~	This option enhances the use of lower cost drugs by encouraging the implementation of step therapy programs and approved therapeutic interchanges. This would require the use of lower-cost treatments that would be expected to work before using more expensive products.	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*	National Association of Chain Drug Stores (NACDS)
~~26 Expansion of preferred drug lists and prior authorization~~	This option includes 1. Requiring that state Medicaid programs develop and implement preferred drug lists (PDL); 2. Encouraging and approving multi-state purchasing or negotiating pools among states and 3. Considering all drug categories, including mental health/central nervous system classes, when developing these PDLs.	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*	National Association of Chain Drug Stores (NACDS)
~~27 Improve drug utilization review~~	This option would provide greater resources to states to improve their drug utilization review (DUR) procedures, and making utilization review more effective through such follow-up measures as prescriber profiling and counter-detailing.	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See*	National Association of Chain Drug Stores (NACDS)
~~28 Expansion of electronic prescribing~~	This option would provide grants or enhanced Medicaid match for the adoption of expansion of electronic prescribing (e-prescribing) and related technologies. This would include supplying handheld, wireless devices, containing the Medicaid preferred drug list, 60-day patient specific prescription history, and drug utilization reports, to 1,000 high-volume prescribers.	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*	National Association of Chain Drug Stores (NACDS)

Provider Taxes					
29	Reduce the allowable Medicaid provider tax	This option proposes to phase down the allowable tax rate States can charge providers from six percent to three percent. (Provider taxes are a financing mechanism states have used to generate state funds needed to obtain federal Medicaid matching payments.)	$2.8 Billion over 5 years (2006-2010)/ $4.5 Billion over 5 years (2006-2010)	CMS Office of the Actuary and Congressional Budget Office	President's Budget FY 2006
30	Reform of the Medicaid Managed Care Organization (MCO) provider tax requirement	This option would require that managed care organizations (MCOs) be treated the same as other classes of health care providers with respect to uniformity requirements. Under this proposal, states would be prevented from guaranteeing that tax revenues paid to states by MCOs would be returned. (Provider taxes are a financing mechanism states have used to generate state funds needed to obtain federal Medicaid matching payments.)	$399 Million over 5 years (2006-2010)/ $1.2 Billion over 5 years (2006-2010)	CMS Office of the Actuary and Congressional Budget Office	President's Budget FY 2006
Targeted Case Management					
31	Reduce Targeted Case Management (TCM) reimbursement matching rate to 50 percent	This option would reduce the Federal matching rate for targeted case management services to 50% from the State-specific Federal medical assistance percentages (FMAP). (FMAP currently averages 57 percent).	$1 billion over 5 years (2006-2010)/ $1.5 billion over 5 years (2006-2010)	CMS Office of the Actuary and Congressional Budget Office	President's Budget FY 2006
32	Clarification of reimbursement policies for targeted case management and rehabilitation services	This option clarifies reimbursement policies for targeted case management (TCM) services, rehabilitation services, and "free care" principles. The Federal Government would continue to pay for TCM and rehabilitation services, but this proposal tightens the definitions of what would be reimbursable under these services.	$2 Billion over 5 years (2006-2010)	CMS Office of the Actuary	President's Budget FY 2006
Benefits					
~~33~~	~~Increased Flexibility to Tailor Benefits to Beneficiary Health Care Needs.~~	This option would provide flexibility as is afforded states in the State Children's Health Insurance Program and would allow states to design an appropriate benefit package for relatively healthy individuals. This flexibility includes the ability to choose to provide the set Medicaid benefit package or to provide a tailored benefit package with four options for coverage: 1. Benchmark coverage, 2. Benchmark equivalent coverage, 3. Existing state-based comprehensive coverage, or 4. Secretary approved coverage. (See summary for further description).	*The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*		National Governors Association -Draft working paper