Medicaid Reform Proposal Summaries

Compiled by
The Medicaid Commission Staff

April 2006

Reform Area: Eligibility
Theme: State Flexibility
***** Impacted by the DRA – See Below*****

There has been considerable debate over the level of flexibility that states should be allowed with regard to who they cover, at what income levels, and for what services. Currently there are federal statutory requirements for states to cover certain populations in order for them to receive federal matching funds, and generally they must cover all required populations with the same benefit package.

Some groups have proposed lessening or eliminating the federal coverage requirements, allowing states the flexibility to chose what populations to cover and what services to offer different populations.

SPECIFIC PROPOSAL(S)

- Target benefits to targeted populations through the use of tailoring benefits to "optional populations", or providing benchmark coverage, benchmark equivalent coverage, existing state-based comprehensive coverage requirements, or Secretary approved coverage. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Allow Medicaid eligible children to enroll in SCHIP if the parent chooses.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 allows states to provide benchmark or benchmark equivalent benefits to certain Medicaid populations, **NOT** including: mandatory pregnant women; blind and disabled individuals; dual eligibles; terminally ill hospice patients; inpatients in medical institutions required to spend all income but a minimal amount for personal needs; medically frail and special medical needs individuals; beneficiaries qualifying for long-term care services; children in foster care receiving child welfare services or receiving foster care or adoption assistance; Temporary Assistance for Needy Families (TANF) and section 1931 parents; women in the breast or cervical cancer program; and limited services beneficiaries.
- Benchmark coverage is one of four types of coverage: Blue Cross/ Blue Shield standard FEHBP coverage; state employee coverage; coverage of the largest commercial HMO in the state; and Secretary-approved coverage. Children under age 19 enrolled in a benchmark plan will continue to receive EPSDT benefits through wrap-around coverage.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme:[1] National Governor's Association, The President's Budget Fiscal Year 2004, and Health Management Associates.

[1] While the groups listed in the "Proposing Organizations/Authors" sections throughout the summaries have developed and published reform proposals on the relevant subject area, not every group endorses each of the elements outlined in the 'Specific Proposal(s)" section.

Reform Area: Eligibility
Theme: Simplifying Eligibility

Under the current Medicaid program, eligibility is based on income, resources (assets), and categorical assignment. An individual is not eligible based solely on their financial circumstances; they must also be a member of a statutorily defined coverage group. These groups fall into five broad categories: children, pregnant women, adults in families with dependent children, individuals with disabilities, and the elderly. In total, under federal statute there are 28 mandatory populations that states must cover and 21 optional populations that states may cover, and in determining eligibility for each of these populations there are minimum income and resource thresholds that must be met and can be exceeded at State option.

In light of this complexity, Medicaid reform discussions often include the need for simplifying Medicaid eligibility.

SPECIFIC PROPOSAL(S)

- Eligibility reform should simplify and improve American Indian/Alaskan Native outreach, eligibility and enrollment (allow for self-declaration).
- Base eligibility solely on income, and extend coverage to everyone below a certain poverty level (e.g. 100 or 150 % FPL).

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 established documentation requirements for eligibility without exceptions for certain populations.
- While there are few published estimates of the impact of converting Medicaid eligibility to a solely income-based program, according to a June 2006 Health Affairs article,[2] the Lewin Group estimated that if eligibility were extended to childless adults (a population currently not eligible), 4.7 million previously uninsured adults would become Medicaid eligible. This estimate was made in the context of other targeted expansions for parents.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Roundtable on Indian Health; National Conference of State Legislatures; Health Management Associates; National Academy for State health Policy; and Lambrew, Podesta & Shaw.

[2] Sherry Glied and Douglas Gould, Variations In The Impact Of Health Coverage Expansion Proposals Across States, Health Affairs, June 2005, accessed online at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.259/DC1?ijkey=XJQSX/G7qBsmM&keytype=ref&siteid=healthaff&eaf

Reform Area: Eligibility
Theme: Federal "Coverage Expansion" Within Medicaid
***** Impacted by the DRA – See Below*****

Because the Medicaid program currently only covers categorically eligible populations under certain income levels, there are proposals to reform the program to expand coverage to new populations that currently aren't allowed (by federal law) to be covered under Medicaid.

SPECIFIC PROPOSAL(S)

- States should be allowed to expand eligibility levels as high above the federal floor as they desire as a state plan option.
- States should be allowed the option to extend Medicaid coverage for spouses of disabled individuals who return to work and are themselves eligible for supplemental security benefits.
- Allow states to test innovative approaches within Medicaid that incorporate health savings accounts or tax credits as strategies to increase coverage for the uninsured. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Legal immigrants should be eligible for Medicaid on the same terms as U.S. citizens regardless of their date of entry into the country or length of residence.

KEY POINTS/FINDINGS

- Currently, there are maximum income thresholds for eligibility that states are not allowed to exceed within their state plan (they can currently use a waiver to cover populations above or below the federal mandates).
- The Deficit Reduction Act of 2005 established a demonstration program under which states may provide alternative benefit packages to certain Medicaid populations. These alternative benefits packages would consist of a high deductible health plan and a Health Opportunity Account (HOA), which would function similarly to a high deductible health plan and an HSA in the private market.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Academy for State Health Policy, The President's Budget Fiscal Year 2004, Health Management Associates, and the National Academy for State Health Policy.

Reform Area: Eligibility
Theme: Federal "Coverage Reductions" Within Medicaid

Due to the increasing demand that the Medicaid program is placing on federal and state budgets, some organizations have proposed ways to reduce Medicaid enrollment.

SPECIFIC PROPOSAL(S)

- Repeal the entitlement of services to beneficiaries.
- Discourage program expansions by freezing payments at the 2005 level.

KEY POINTS/FINDINGS

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: The Cato Institute and The United Hospital Fund.

Reform Area: Eligibility
Theme: Federal "Coverage Expansion" Outside Medicaid

Given the growing budget of Medicaid, and the growing number of uninsured Americans, many groups/individuals have proposed methods for expanding coverage for uninsured Americans without using Medicaid as the coverage mechanism.

SPECIFIC PROPOSAL(S)

- Provide tax incentives for individuals to purchase private insurance.
- Supplement ESI market with an insurance pool modeled after the Federal Employee Health Benefit Program (FEHBP) for those without an ESI offer.
- Strengthen the employer-based health insurance system.
- Provide incentives to employers to offer and for individuals to establish health savings accounts and other innovative financing options to provide support for long-term care services.
- Provide tax incentives and programs that provide support services, such as respite care, for family caregivers.
- Provide premium assistance for Medicaid beneficiaries to purchase private insurance.

KEY POINTS/FINDINGS

- While these reforms proposals are not necessarily within the scope of Medicaid reform, they provide opportunities for the Commission to consider and endorse health care reforms that could take fiscal pressures off the Medicaid program.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Conference of State Legislatures; National Governor's Association; AcademyHealth; The Heritage Foundation; Center for Health Transformation; National Center for Policy Analysis; GWU and Center for American Progress; Medicaid Policy LLC; and Lambrew, Podesta & Shaw.

Reform Area: Long-Term Care
Theme: Benefit Flexibility

Medicaid is the largest source of financing for long-term care, accounting for forty-nine percent of all long-term care financing.[3] The need for long-term care is projected to increase due to the growth in the under-65 disabled population as well as from the increasing demand of an aging population.

Medicaid services fall into mandatory and optional services with over half of the spending on optional services going to nursing home facility and other long-term care.

Some authors of reform proposals have suggested that Medicaid savings can be achieved through changing benefit packages as well as criteria for establishing long-term care eligibility.

SPECIFIC PROPOSAL(S)

- Benefit design packages: allow states to design benefits packages for higher income groups that are not as comprehensive as those provided to lower income groups.
- States should be allowed to have flexibility to establish different criteria for institutional and community long-term care as well as medical/functional/cognitive eligibility.

KEY POINTS/FINDINGS

- Flexibility in benefit packages may allow for greater efficiencies without compromising quality of care for appropriate Medicaid populations.
- This flexibility could allow Medicaid to focus more on improving health outcomes.
- Some advocacy groups are concerned about exclusion of benefits such as mental health.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: The Heritage Foundation, George Washington University & the Center for American Progress, CATO Institute, Health Management Associates, and the National Academy for State Health Policy.

[3] Source: GAO Analysis of 2004 data from the Centers for Medicare and Medicaid Services.

Reform Area: Long-Term Care
Theme: Improving Access to Home and Community Based Services
***** Impacted by the DRA – See Below*****

The HCBS waiver program is the major funding program to improve access to community-based care for Medicaid beneficiaries who are elderly and disabled. Authorized under section 1915(c) of the Social Security Act, states have used HCBS waiver programs to serve a wide variety of populations, including seniors; people with physical disabilities, HIV/AIDS, mental retardation and developmental disabilities MR/DD), and traumatic brain injury (TBI); and children who are medically fragile and/or technology-dependent (such as ventilator dependent due to paralysis). Authors of reform proposals have suggested that Medicaid savings can be achieved through increasing access to home and community-based services for the elderly and disabled, and shifting away from the more expensive institutional care such as in nursing homes.

SPECIFIC PROPOSAL(S)

- Allow states to provide HCBS under regular Medicaid, set size of programs and provide service without providing full range of additional Medicaid Services. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Allow states to modify income and asset tests to allow certain applicants still within the community seeking community care to qualify for Medicaid financed acute and community care. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Allow states to replace Section 1915(c) waivers with a home and community-based care program with the following components:
    1) States would submit a plan to CMS describing the services covered. Once approved, the program would continue without renewal requirements.
    2) States could set a higher functional threshold for admission to an institution (nursing home or ICF-MR) and a lower functional threshold for the home and community-based services program.
    3) The program would not be subject to existing waiver requirements.
    4) States would be able to set caps on participation in the home and community services program.
    5) The program could serve multiple populations with different service options for subpopulations.
    6) Cost sharing would be allowed for the optional eligibility group (above 100 percent FPL).
    7) Limits on the number of clients in target population programs should be phased out over time.

Key elements of this reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 addresses the points suggested in reform proposals and expands access to home and community-based services for the elderly and disabled by making home and community based services (HCBS) for the elderly and disabled an optional benefit for states under their state plan without a waiver. The provision takes a step towards removing the long-term care institutional bias and sets a number of new requirements for states; including needs based criteria, individualized care plans, and establishing projections of the number of eligible individuals.
- Some enrollment caps are allowed in the new law established by the Deficit Reduction Act.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme:
National Association of State Health Policy and Health Management Associates.

Reform Area: Long-Term Care
Theme: Promoting Consumer Direction
***** Impacted by the DRA – See Below*****

Authors of reform proposals have suggested that Medicaid saving can be achieved through expanding the role of an individual in health care choice as well as in managing budgets. Additionally consumer direction may lead to improvements in care quality and beneficiary satisfaction. The premise is that program costs can be controlled if Medicaid beneficiaries are active participants in the program and can make informed choices, directing their own care, and understanding the cost of their care.

SPECIFIC PROPOSAL(S)

- Promote consumer-directed models of care such as Cash and Counseling Programs whereby developmentally disabled adults, children, chronically ill and frail elderly opt for a budget to pay for their home and personal care services. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Establish the Money Follows the Person Demonstration program. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Provide Medicaid beneficiaries and their families' access to the information they need to navigate the health care system and to make informed decisions about their care. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Promote consumer-directed models of care. Build on the Independence Plus waiver to expand consumer directed care to the broader Medicaid population. This waiver allows certain disabled Medicaid persons the power to manage their own care.
- Create a Medical Assistance Account at the beginning of each year to cover all Medicaid expenses, rather than the current "pay-as-you-go" system.

KEY POINTS/FINDINGS

- Bullets one through three have been addressed by the Deficit Reduction Act of 2005:
  - The Cash and Counseling program is extended to all states, allowing them to cover the costs of self-directed personal care services for individuals who would be eligible for personal care services or enrollment in a HCBS waiver program;
  - The Money Follows the Person (MFP) demonstration program is authorized as a demonstration program; and
  - Family-to-Family Health information Centers are established and funded.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Center for Health Transformation, National Center for Policy Analysis, George Washington University, National Academy of State Health Policy, Health Management Associates, ADAPT, and the American Legislative Exchange Council.

Reform Area: Long-Term Care
Theme: Improving Care of Dual Eligibles

There are approximately 6.2 million individuals who receive full Medicaid benefits and are considered dually eligible for Medicaid and Medicare coverage. They tend to be poor and report lower health status than other beneficiaries, and have greater costs than non-dual eligibles. Dual eligibles comprise a large share (40%) of total Medicaid spending. The majority of Medicaid expenditures for dual eligibles are for long-term care services (66%).[4] Most proposals address the simplification of administration as well as designing unique programs and benefit design for these individuals.

SPECIFIC PROPOSAL(S)

- Simplify the relationship between Medicare and Medicaid.
- Amend federal Medicare law so the federal government assumes specific responsibility for low income Medicare/Medicaid dual eligibles, including full payment of premiums, coinsurance and deductibles.
- Promote innovative care management models with information and fund sharing between Medicaid and Medicare.
- For benefits offered by both programs, the Medicare program should review its policies in the areas of payment adequacy, benefit design, and medical necessity to ensure that its beneficiaries have appropriate access to these benefits through Medicare, rather than initially seeking those benefits from Medicaid.
- Case-specific management: for high-cost beneficiaries as dual eligibles.

KEY POINTS/FINDINGS

- Medicare Advantage special needs plans (SNPs) were established by the Medicare Prescription Drug, Improvement and Modernization Act (MMA). SNPs were created to encourage greater access to Medicare managed care for certain special needs populations: the institutionalized, persons dually eligible for Medicare and Medicaid, and the chronically ill. SNPs may provide an opportunity to integrate acute and long-term care services as well as Medicare and Medicaid financing.
- The DRA authorizes a rural PACE provider grant program, which expands (in a limited fashion) this care coordination model:
  - Provides for $7,500,000 for rural pace projects, available through FY08.
  - No more that 15 grants will be awarded and they are capped at $750,000 per award.
- See also the *Program Administration* section on *Coordination with Medicare* for further information on the PACE program.

[4] Kaiser Commission on the Uninsured, Dual Eligibles: Medicaid's Role for Low Income Medicare Beneficiaries, 2005.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Conference of State Legislators, National Academy of State Health Policy, and Health Management Associates.

Reform Area: Long-Term Care
Theme: Other Models of Care

Some have argued that LTC should be approached differently than acute care and focus away from institutional settings for care. Every state that receives Medicaid must provide nursing home services, but community based services are optional.

SPECIFIC PROPOSAL(S)

- Financing of long-term care: separate the delivery of social services from the delivery of medical services.
- Allow states to partner with cities and counties in providing health care through locally designed networks.
- MiCASSA (Medicaid Attendant Services and Supports Act) establishes a national program of community-based attendant services and supports for people with disabilities, regardless of their age or disability. The bill would allow the dollars to follow the personal and allow eligible individuals, or their representatives to choose where they would receive services and supports. Any individual who is entitled to nursing home or other institutional services would have the choices where and how services would be provided. This would not be a new entitlement, but would make the existing entitlement more flexible.

KEY POINTS/FINDINGS

- The Congressional Budget Office (CBO) has previously estimated that 8 million people may be eligible if the MiCASSA legislation is passed. Assuming that only 2 million would actually request the benefit, CBO estimated an annual federal cost of $10-20 billion.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: The Heritage Foundation, National Academy for State Health Policy, Health Management Associates, and ADAPT.

Reform Area: Long-Term Care
Theme: LTC Insurance
***** Impacted by the DRA – See Below*****

Some authors of reform proposals have suggested that there should be greater incentive to purchase long-term care insurance in the earlier part of an individual's life to cover the expenses associated with care once elderly or disabled. Long-term care insurance can help pay for many types of long-term care, including both skilled and non-skilled care. The coverage can vary widely. Some policies may cover only nursing home care. Others may include coverage for a whole range of services like care in an adult day care center, assisted living, medical equipment, and formal and informal home care.

SPECIFIC PROPOSAL(S)

- Promote LTC planning, education, and awareness so that consumers know the importance of preparing for their own LTC needs. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Provide incentives for states to adopt policies that ensure those who can afford to pay for long-term care do so, including policies that advantage individuals with long-term care insurance.
- Give preferential tax treatment such as tax credits and deductions for those who purchase long-term care insurance and incentives to offer long-term care insurance.
- Expand options for private long-term care insurance, flexible life insurance products, and home equity sharing programs, such as reverse annuity mortgages.
- Promote programs such as the Medicaid Long-Term Living Flexibility Option/Demonstration program.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 establishes a national clearinghouse for education of beneficiaries on all types of long-term care insurance.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Academy of State Health Policy and Health Management Associates.

Reform Area: Long-Term Care
Theme: LTC Insurance "Partnership" Programs
***** Impacted by the DRA – See Below*****

The Partnership for Long-Term Care, a partnership between Medicaid and long-term care insurers, is currently available in the states of four states (IN, NY, CA, and CT) to provide an alternative to spending down or transferring assets. The four Partnership states have focused on creating affordable products that encourage people to self-insure, enable purchasers to provide better protection against impoverishment, and reduce long-term care costs for the Medicaid program.

Reform proposals have suggested that this program be made available nationwide in order to give many people who do not now purchase long-term care insurance an incentive to do so while saving money for both the federal and state governments.

SPECIFIC PROPOSAL(S)

- To help the aging population plan for future long-term care needs all states should be allowed to participate and provide for the availability of the Long-Term Care Partnership program. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Congress should repeal the provision in the Omnibus Budget Reconciliation Act of 1993 that restricts the ability of the states to develop programs that provide limited asset protection within the Medicaid program to individuals who purchase long-term care insurance.

KEY POINTS/FINDINGS

- The expansion of the Long-Term Care Partnership Program has been addressed by the Deficit Reduction Act of 2005. The provision establishes authority for all states (outside of original 4 state demonstrations) to implement LTC partnership plans.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Governors Association, Health Management Associates, and the National Conference of State Legislators.

Reform Area: Long-Term Care
Theme: Estate Recovery, Reverse Mortgages, and Asset Tests
***** Impacted by the DRA – See Below*****

Medicaid imposes stringent limits on income and assets of recipients, consistent with its mission to provide a health care safety net for the poor and for those whose personal resources are insufficient to pay the full cost of care. In order to fulfill this mission, Medicaid also recovers expenses paid on behalf of recipients from their estates under certain circumstances. In addition Medicaid eligibility criteria require that individuals must first deplete or "spend down" their assets. Historically, Medicaid rules typically ignore the applicant's home, regardless of its value.

Some authors of reform proposals have suggested that asset transfer loopholes lead to a number of individuals qualifying for Medicaid who may actually have substantial asset holdings.

SPECIFIC PROPOSAL(S)

- Eliminate asset transfer loopholes:
  1) The look-back period should be increased from 3 to 5 years;
  2) Penalty periods should begin at the time of application;
  3) The sheltering of excess resources in annuities, trusts or promissory notes must be prevented; and
  4) Home equity should be considered a countable asset in order to require individuals to use home equity to off-set long-term and other medical expenses that would otherwise be paid by Medicaid. Reverse mortgage loans are available to allow seniors (age 62 or older) to convert home equity into cash; and insure that coverage is reserved for low-income persons and not as an asset protection program. One option to consider is placing restrictions on, or imposing penalties for, asset transfers used to render people eligible for Medicaid coverage.

  This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.
- Create new options for setting financial and functional criteria to qualify for LTC services.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 addresses issues regarding asset treatment and eligibility for long-term care coverage. The start date for the period of ineligibility has been changed. The DRA also lengthens the look-back period to 60 months, requires states to use the income-first rule in applying the community spouses' income before assets when calculating the community spouse resource allowance; disqualifies individuals from receiving Medicaid long-term care services if the

equity in the individual's home exceeds $500,000; requires states to impose partial months of ineligibility; allows states to accumulate multiple transfers into one penalty period and requiring states to spend down resources declared for admission into continuing care retirement communities before applying for Medicaid.

- Opponents of Medicaid recoveries argue that the practice is unfair in that it mainly affects people of very modest means, while sparing those who are able to access advice on estate planning techniques.
- Some advocates have proposed that reform should include exemption for American Indian /Alaska Native populations from estate recovery rules.
- While generally asset recovery is not enforced by States, there are legal and historic precedents for looking to home equity to recoup Medicaid spending on behalf of the recipient at some future date when the home is no longer needed by the recipient or certain close relatives.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Roundtable on Indian Health, Center Health Transformation, Heritage Foundation, National Conference of State Legislators, National Governors Association, AcademyHealth, and the National Center for Policy Analysis.

Reform Area: Quality and Information Technology
Theme: Innovation Adoption

IT applications can improve the efficiency and potentially the quality of medical care and could reduce the cost of delivering health care. In a 2005 report, GAO estimated that the potential annual cost savings of nationwide adoption of IT was $78 billion for the adoption of electronic health records and $44 billion for ambulatory care computerized record entry.[5] In particular, use of electronic health records adoption of health care technology can decrease duplicative efforts and inefficiencies in coordinating care across multiple providers.

SPECIFIC PROPOSAL(S)

- Provide an upfront investment in technology.
- Provide states incentives to adopt private sector technologies.
- Accelerate the adaptation of health innovations leading to improvement in quality of life.
- Increase the use of health information technology in the Medicaid program to: (1) monitor and improve safety and quality; (2) control costs, (3) simplify program administration, (4) improve efforts to collect data to evaluate program effectiveness, and (5) improve patient coordination among multiple providers.
- Provide an enhanced administrative match for information technology services.
- Electronic health records should be linked to systems to prevent medical errors.

KEY POINTS/FINDINGS

- Many in health policy support adoption of innovative technologies based on the success of similar models in the private sector.
- Information technology is transforming the practice of medicine. Cost effectiveness of the use of technologies like telemedicine is well documented. This is especially true for delivery of care to individuals with limited access to specialty and subspecialty services. The impact of the increasing use of telephonic technology as well as use of electronic health records continues to be studied.
- While most advocate the adoption of new technologies, there is some concern that some innovations should be adopted in a way that unintended harm could be minimized. Privacy and security laws need to be protected and maintained. Interoperability with different State Medicaid systems is critical for this effort to be successful.
- Proposals to increase information technology in the healthcare field are typically scored as a "coster", and often don't show a return on investment until beyond 5 or

[5] Government Accountability Office, HHS's Estimate of Savings from Health IT, February 2005, GAO-05-309R

even 10 years. As a result, investments in technology are often controversial due to the high up front costs.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Academy Health, Center for Health Transformation, United Hospital Fund, National Conference on State Legislatures 2005, George Washington University and Center for American Progress, and Health Management Associates.

Reform Area: Quality and Information Technology
Theme: Prevention and Disease Management

Prevention and disease management programs can prevent or delay the onset of the more severe stages of a disease. Studies indicate that closely managing patients with chronic diseases can reduce the higher cost services these patients often require. At the same time, these programs can improve quality of life for the patient. In addition, prevention and disease management (based on evidence-based guidelines and used in conjunction with appropriate information technology) can help manage and improve the health status of a defined patient population over the entire course of a disease.

SPECIFIC PROPOSAL(S)

- Focus on an integrated delivery method for active, healthy aging, such as with the Silver Sneakers Fitness Program to increase physical activity in elderly or strength training for seniors.
- Allow states to promote preventive care using enhanced reimbursement strategies with providers and care managers, and cost sharing strategies with beneficiaries.
- Increase the focus on preventive versus reactive medicine to avoid lowering short-term costs at the expense of increasing long-term costs, and simultaneously improve quality of care.
- Promote disease-specific management (e.g. for asthma, diabetes).
- The Medicare program should mandate that Medicare quality improvement organizations (QIOs) identify dual eligibles as a subsample in quality reviews. Specifically, for Medicare Advantage health plans to receive Medicaid-financed premiums, co-payments, and other forms of cost sharing, the state should have the option to require the Medicare Advantage health plan to contract with the state. Medicare should ensure that its risk adjustment methodology adequately address enrollment of dual eligibles in managed care plans.
- If a state's Medicaid program meets basic quality and cost standards then in return, a state should have more flexibility with the program.

KEY POINTS/FINDINGS

Examples of prevention and disease management programs and associated success:

- The SilverSneakers Fitness Program is an exercise- and socially-oriented program designed to encourage older adults to increase their levels of physical activity and motivate them to continue to exercise. The program is responsible for reducing members' high-risk, sedentary behavior by 70%. 44% of enrollees report increasing their frequency of physical activity by an average of two days per week. Members experience lower utilization of high-cost healthcare services over time resulting in the avoidance of preventable costs. Claims costs for participating members decreased 66%. Depression in beneficiaries who participated dropped by over 60%.

- Since 1999, Florida's Medicaid program has included disease management programs for individuals who are enrolled in MediPass, the Medicaid managed care program that utilizes a primary care case management mechanism. The disease management program targets MediPass patients with HIV/AIDS, hemophilia, diabetes, asthma, cancer, congestive heart failure, kidney disease, hypertension, and several other chronic conditions. The state estimates that approximately 19 percent of the MediPass population qualifies for disease management services.
- The state contracts with eight disease management organizations to implement management strategies for each high-cost chronic disease. In 2001, an independent evaluation of the asthma program found a decline in inpatient hospital costs of $70.86 per month; asthma-related outpatient costs decreased $38.06 per month; and total Medicaid expenditures for program participants decreased by 33 percent (approximately $3,525). Another study found that the program reduced medical claims costs by 38 percent for patients with hemophilia, and 39.7 percent for HIV/AIDS patients, versus previous years' expenditures.[6]
- Over 30 states in the US have or are developing Medicaid disease management programs and have already gained much insight.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Center for Health Transformation, Health Management Associates, AcademyHealth, George Washington University and Center for American Progress, and The Commonwealth Fund.

[6] The Commonwealth Fund, Florida's Medipass Program, October 2004

Reform Area: Quality and Information Technology
Theme: Pay for Performance

Pay for performance links actual activities and efforts of providers using evidence-based practices and systems (in the form of structural measures that will be collected at the agency level) to promote use of practices that show improvement in populations with chronic diseases.

SPECIFIC PROPOSAL(S)

- Medicaid should be a system that is more results-oriented than process-oriented.
- Promote pay-for-performance quality incentives.
- Grants to the states and/or an increased matching rate should be provided for quality improvement efforts in Medicaid, such as those being considered for Medicare.
- Payment and coverage should be based on outcomes and evidence, using comparative effectiveness research to guide benefit and cost sharing policies. Medicaid should also use performance as a basis for payment.

KEY POINTS/FINDINGS

- There is evidence that tying a portion of reimbursement to delivery of care has been proven to be effective in closely managing patients with chronic diseases and leads to reduction in higher cost services.
- Example of a pay-for-performance program:
  - New York State's Medicaid incentive program offers financial and other incentives to Medicaid managed care programs that perform well on a number of measures. As part of its commitment to quality, the Monroe County Plan for Medical Care initiated programs to improve prenatal care, asthma care, and rates of cancer screening. The success of these initiatives has earned Monroe quality rewards from the state, which the plan is reinvesting in further quality improvement efforts.
  - Monroe Plan's NICU admission rates have progressively decreased from a 1998 baseline rate of 107.6 per 1,000 live births to 56.7 per 1,000 live births in 2003. By comparison, NICU admission rates for the general Upstate New York Medicaid population remained in the range of 110 to 115 per 1,000 live births from 1998 to 2002.
  - In addition, Monroe Plan's rate of births at a gestational age below 32 weeks decreased from 2.9 percent in 2001 to 0.9 percent in 2003, and the rate of births with a birth weight less than 1,900 grams decreased from 6.1 percent in 2001 to 1.6 percent in 2003. The number of women beginning prenatal care during their third trimester decreased from 13.0 percent in 2001 to 7.7 percent in 2003. Initial data indicate that the percentage of women beginning prenatal care during their

first trimester has increased from approximately 13 percent in 2001 to 21 percent in 2004 and 24 percent so far in 2005.

- Since the Monroe Plan pilot project was implemented in the winter of 2003, five aspects of health and quality of life for children with asthma have been measured every six months using the Integrated Therapeutics Group (ITG) Asthma for Children Survey. Based on the ITG survey scale from 1 to 100, with the higher score indicating higher quality of life and functionality, the Monroe Plan found that statistically significant improvements have occurred in five domains from winter 2003 to summer 2003:
  - daytime symptoms improved from 62 to 66;
  - nighttime symptoms improved from 59 to 68;
  - functional limitations improved from 73 to 78;
  - inhaler interference improved from 77 to 79; and
  - family-life adjustment improved from 66 to 71.[7]

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Center for Health Transformation, National Governor's Association, National Center for Policy Analysis, and George Washington University and Center for American Progress.

[7] Commonwealth Fund A Case Study of Quality Improvement in Medicaid: New York's Monroe Plan for Medical Care, April 2005.

Reform Area: Quality and Information Technology
Theme: Health Disparities

Racially and ethnically diverse populations experience more barriers to care, lower quality, and a disproportionate burden of illness from chronic diseases. The Centers for Medicare and Medicaid Services indicate that in 2001, nearly half of the 31 million beneficiaries of Medicaid were culturally diverse Americans.[8]

SPECIFIC PROPOSAL(S)

- Minorities are disproportionately represented in the Medicaid population; therefore, creating a better Medicaid system with a focus on this issue offers an opportunity to improve and narrow racial health disparities.
- Establish Quality Assessment and Performance Improvement (QAPI) initiatives in the Medicaid program that require Medicaid providers and Managed Care Organizations (MCOs) to collect performance data with quality-of-care indicators that are stratified by race and ethnicity, enabling them to measure racial and ethnic disparities.

KEY POINTS/FINDINGS

HHS has selected six focus areas in which racial and ethnic minorities experience serious disparities in health access and outcomes. The leadership and resource of the Department will be committed to achieving significant reductions in these disparities by the year 2010:

- *Infant Mortality* - African-American, American Indian, and Puerto Rican infants have higher death rates than white infants. In 2000, the black-to-white ratio in infant mortality was 2.5 (up from 2.4 in 1998). This widening disparity between black and white infants is a trend that has persisted over the last two decades.
- *Cancer Screening and Management* - African-American women are more than twice as likely to die of cervical cancer than are white women and are more likely to die of breast cancer than are women of any other racial or ethnic group.
- *Cardiovascular Disease (CVD)* - Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. In 2000, rates of death from diseases of the heart were 29 percent higher among African-American adults than among white adults, and death rates from stroke were 40 percent higher.
- *Diabetes* - In 2000, American Indians and Alaska Natives were 2.6 times more likely to have diagnosed diabetes compared with non-Hispanic Whites, African Americans were 2.0 times more likely, and Hispanics were 1.9 times more likely.
- *HIV Infection/AIDS* - Although African Americans and Hispanics represented only 26 percent of the U.S. population in 2001, they accounted for 66 percent of adult

[8] Center for Health Care Strategies.

AIDS cases and 82 percent of pediatric AIDS cases reported in the first half of that year.

- *Immunizations* - In 2001, Hispanics and African Americans aged 65 and older were less likely than Non-Hispanic whites to report having received influenza and pneumococcal vaccines.[9]

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Center for Health Transformation and Center for Health Law Studies.

[9] National Center for Health Statistics (NCHS), 2002, National Center for Health Statistics (NCHS), Health, United States, 2002, Table 30, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), 2000, NCHS, Health, United States, 2002, Table 54, Table 55, Morbidity and Mortality Weekly Report (MMWR), 2002, p.1020.

Reform Area: Program Administration
Theme: Coordination with Medicare
***** Impacted by the DRA – See Below*****

Approximately 7.5 million elderly and disabled individuals are enrolled in both the Medicaid and Medicare programs. The Medicare program was designed to provide acute care to the elderly and disabled, while Medicaid was designed to provide acute and long-term care services to vulnerable populations. For individuals who are eligible for and enrolled in both programs, there is coverage overlap.

There are several reform proposals aimed at improving coordination between the Medicaid and Medicare programs in order to reduce redundancies and improve health outcomes.

SPECIFIC PROPOSAL(S)

- Support the development of new and innovative models of care that would combine Medicaid and Medicare funding and incorporate care management, managed care, disease management and quality improvement programs. ***This reform has been put into effect, with limited scope, by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Increase information sharing between the Medicare and Medicaid programs.
- Support investments in long-term strategies that promote better management of chronic illness, disease prevention, and coordination with Medicare to more effectively address the needs of the high costs enrollees who rely on both programs.

KEY POINTS/FINDINGS

- While both programs provide health care services to enrollees, there is considerable evidence that the programs are not sufficiently coordinating care and as a result may be providing services in duplicate. Lack of care coordination could mean that enrollees are not experiencing the best health outcomes that can be achieved through coordination of services.
- The Deficit Reduction Act of 2005 authorizes and funds an expansion of the current Program for All Inclusive Care for the Elderly (PACE) to include up to 15 new rural PACE sites. The PACE program provides comprehensive Medicaid and Medicare services the elderly over 55 who are nursing home eligible, and the service packages offered must include all Medicaid and Medicare services. According to the CMS website, there are currently 35 organizations functioning as PACE providers across nineteen states.
- See also the *Long-term Care* section on *Improving Care of Dual Eligibles* for further information on the PACE program.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Conference of State Legislatures and Kaiser Family Foundation.

Reform Area: Program Administration
Theme: State Plan/Waiver Modifications

States must run their Medicaid program according to the laws set in the Social Security Act (Title XIX) and the regulations that the Centers for Medicare and Medicaid Services (CMS) promulgates in order to receive their federal matching dollars. The basic Medicaid program is referred to in each state as the Medicaid state plan, and changes to the plan must be submitted to and approved by CMS. If a state wishes to administer medical assistance services that would not meet the statutory requirements for the program, they must obtain a waiver from CMS to do so. When this occurs these programs are referred to as "waiver" programs, and they function outside of the Medicaid laws and regulations because CMS "waives" certain elements of the law (e.g., statewideness or comparability). Medicaid waiver programs must be submitted to CMS for approval, and their approval is generally at the discretion of the Secretary of HHS.

In addition to these complexities, over the 40 year life of the program modifications to the law and subsequent regulatory changes have resulted in a multifaceted set of administrative rules. In light of this, many organizations have proposed simplifying the administrative requirements of the Medicaid program for both state plans and waiver programs.

SPECIFIC PROPOSAL(S)

State Plans

- Simplify state plan processing requirements, including the process for implementing managed care.
- Allow maximum program flexibility by reducing federal requirements to a few broad goals for states to meet.
- CMS should be required to promulgate regulations on a timelier basis and states should not be required to comply with new regulations until after CMS has published final regulations.
- Where possible, CMS should publish proposed regulations rather than promulgating interim final regulations, because the publication of proposed regulations provides states with more time for consultation with CMS and provides states with an opportunity to identify problem areas before program implementation.
- Once a portion of the Medicaid statue is waived on a consistent and regular basis, a process should be established (i.e. through regulations) that allows for the waived element to become allowable as a state plan amendment option.

Waivers

- Simplify and ease the waiver application/processing requirements.
- Remove the requirement for waivers to be budget neutral.

KEY POINTS/FINDINGS

- The requirement for waivers to be budget neutral was established as policy by the Department of Health and Human Services, in conjunction with the Departmental agencies that participate in the federal waiver review process and the Office of Management and Budget. "Budget neutrality" is not codified in law or regulations.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Governor's Association, National Conference of State Legislatures, Health Management Associates, CATO Institute, and National Academy for State Health Policy.

Reform Area: Program Administration
Theme: Fraud and Abuse
***** Impacted by the DRA – See Below*****

Responsibility for preventing and detecting fraud and abuse in Medicaid lies primarily with the states. CMS provides technical assistance, guidance, and oversight, but the states are charged with ensuring program integrity. Fraud and abuse can be perpetrated by both providers and beneficiaries, requiring states to monitor and investigate both those receiving services and those providing them.

SPECIFIC PROPOSAL(S)

- Amend Section 1903(a)(6) of the Social Security Act to provide the same federal match for all costs associated with fraud and abuse and Surveillance and Utilization Review Services (SURS) activities conducted by the state Medicaid agency as currently received by the Medicaid fraud control units (75 percent). This enhanced funding would apply to direct fraud and abuse and SURS functions that include, but are not limited to, identification, investigation, and administrative actions (e.g. recoveries and provider exclusions).
- CMS should audit states' fraud and abuse activities.
- Permit states the same opportunities as are currently afforded the federal government to limit, restrict, or suspend the eligibility of beneficiaries and providers, subject to due process, who have been determined in state proceedings to have engaged in fraud or abuse involving the Medicaid program, even if they have not been convicted in federal court of the listed federal crimes.
- Provide that when a state discovers an overpayment and determines it to be attributable to fraud or abuse, the state should refund the federal overpayment in the quarter in which the recovery is made, regardless of when the overpayment is discovered.
- All Medicare claims data should be matched with state Medicaid data to improve fraud detection. For example, when Medicaid is expected to provide cost sharing to providers who render services for dual eligible clients, the Medicare program and its vendors should provide Medicaid agencies with the data needed to verify that the encounters actually occurred. ***This reform has been put into effect, as a national data match program, by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Amend federal law to permit the interception of federal tax refunds to Medicaid providers who owe money to the federal and/or state government as a result of overpayments made to the provider.
- The fee required ($4.25 per name searched) for use of the federal Healthcare Integrity and Protection Database (HIPDB) should be eliminated.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 established new laws governing prevention and detection of fraud and abuse in the Medicaid program:
  - Encouragement of the State False Claims Act – should a state establish a law relating to false or fraudulent claims that meets certain criteria, the repayable FMAP to the federal government will be reduced by 10 percent.
  - Employee Education About False Claims Recovery – any entity receiving at least $5 million annually in Medicaid payments will be required to train their employees in the elements of the federal False Claims Act and include information in their employee policy and training manuals.
  - Prohibition on Restocking Drugs – pharmacies will no longer be allowed to receive federal payment for the ingredient costs of drugs for which they have previously received payment.
  - Medicaid Integrity Program – this newly established program will authorize the federal government to perform Medicaid program payment reviews and audits, identify overpayments, perform educational activities with providers and beneficiaries, and expand the Medicare-Medicaid data match pilot project to a national program.
  - Enhancing Third Party Identification and Payment – now included among liable third party payers are self-insured plans, pharmacy benefit managers, and other entities that are responsible or payment of health care related services and items. In addition, states will be required to ensure that they have laws in effect that enable the Medicaid program to ensure that third party payers are fulfilling their payment obligations for services received by individuals who are simultaneously covered by private insurance and Medicaid.
  - Enforcement of Documentation Requirements – states will not be eligible to receive federal matching payments for medical assistance provided to an individual who has not provided satisfactory evidence of legal residency in the US.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Governor's Association, National Conference of State Legislatures, and National Academy for State Health Policy.

Reform Area: Program Administration
Theme: Financial Reform – General
***** Impacted by the DRA – See Below*****

The Medicaid program is jointly financed by the federal and state governments. The financing structure of the program is an area that is frequently included in reform proposals, as both a necessity to improving efficiency and a means to ensuring program integrity.

This section includes proposals for financing reform that address rules and regulations about the state portion of the funding, program integrity, how payments for certain providers/services are split between the federal government and states, and the entitlement component of the program. Later sections address financial reform proposals specific to the territories, cost sharing, and the Federal Medical Assistance Percentage (FMAP).

SPECIFIC PROPOSAL(S)

Increased Federal Responsibility

- States should be authorized by statute to use provider-specific taxes, voluntary donations, and intergovernmental transfers.
- Realign fiscal responsibility for persons covered by Medicare and Medicaid, so the federal government pays a more appropriate share of the costs for low income Medicare beneficiaries.
- Federal matching funds should be available on a time-limited basis for services provided after presumptive eligibility is determined even if the applicant does not ultimately qualify for Medicaid.

Increased State Responsibility

- End financing mechanisms that inappropriately boost the federal share of Medicaid financing, including prohibiting states from using Intergovernmental Transfers (IGTs) and obtaining federal matching funds for any "upper payment limit" (UPL) arrangements. Should such reforms be implemented, these restrictions should be prospective and not retroactive. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Repeal the entitlement of federal funding for states and implement capped annual allotments instead.

General Enhancements

- Promote the fiscal integrity of the Medicaid program by ensuring that Medicaid reimbursement methodologies encourage prudent payment for Medicaid covered services, and review federal rules and definitions of expenditures that qualify for federal Medicaid matching funds.

- Repeal the federal law that requires states to reimburse Federally Qualified Health Centers and Rural Health Centers at 100% of cost rather than negotiated or capitated rates, and permit states to negotiate or set rates for these entities.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 authorizes reform of the Managed Care organization (MCO) provider tax laws, expanding the MCO class to include both Medicaid and non-Medicaid MCOs.
- The Deficit Reduction Act of 2005 provides clarification on the use of IGTs from publicly owned regional medical centers in another state; use of these funds is permitted on a case-by-case basis at the discretion of the Secretary of HHS.
- In addition, the Deficit Reduction Act of 2005 clarifies what is reimbursable under the Medicaid case management and targeted case management (TCM) benefit. The provision defines the activities that are Medicaid reimbursable and excludes federal Medicaid reimbursement for the "direct delivery" of any underlying medical, educational, social or other service to which an eligible individual has been referred.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: The Heritage Foundation, Health Management Associates, National Conference of State Legislatures, Partnership for Medicaid, National Academy for State Health Policy, United Hospital Fund, and The President's Budget Fiscal Year 2004.

Reform Area: Program Administration
Theme: Financial Reform - Territories

Unlike within the states, in which the Medicaid program is an individual entitlement program and there is no spending cap, the territories are subjected to an annual spending allotment. Once they have reached their capped allotment, any expenditures incurred during the duration of that fiscal year are the full responsibility of the territory.

SPECIFIC PROPOSAL(S)

- Reform the Medicaid program in the territories so that the financing arrangements are similar to those in states, eliminating the spending caps and establishing the same individual entitlement.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 increased the allotments to the territories beginning in FY 2006, but they are still under a capped allotment arrangement.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Governor's Association, National Conference of State Legislatures, and Health Management Associates.

Reform Area: Program Administration
Theme: Financial Reform – Cost Sharing
***** Impacted by the DRA – See Below*****

Traditionally, cost sharing in the form of premiums and co-payments is either prohibited or allowable only at nominal levels (up to $19, depending on family income) in the Medicaid program. Where cost sharing is allowable in the form of a co-payment it is not "enforceable"; a provider is not allowed to deny services or items if a beneficiary is unable to pay the co-payment.

Allowing increases in beneficiary cost sharing has been proposed by many groups as a way to: ensure the most appropriate utilization of services, encourage beneficiaries to take personal responsibility for their health care needs and decisions, and/or incorporate a new funding stream into the program and thereby mitigate some of the costs incurred by the states and federal government.

SPECIFIC PROPOSAL(S)

- Impose higher cost sharing for higher income individuals by allowing states to increase cost sharing beyond nominal levels for beneficiaries above the federal poverty level (FPL) and make cost sharing enforceable. ***This reform has been put into effect by the Deficit Reduction Act of 2005 – see details below in the 'KEY POINTS/FINDINGS' section.***
- Implement sliding fee scales based on Medicaid eligibility tests.
- Allow states to adopt beneficiary cost sharing consistent with cost sharing in employer-sponsored health insurance plans.

KEY POINTS/FINDINGS

- The Deficit Reduction Act of 2005 modified the restrictions on cost sharing for beneficiaries, allowing states to impose premiums and co-payments for any type of services other than drugs as follows:
  - No premiums may be imposed on beneficiaries with family incomes between 100 and 150% FPL, and cost sharing must not exceed 10% of the cost of the item and the total aggregate cost sharing must not exceed 5% of family income.
  - For families with incomes above 150% FPL, premiums can be assessed and cost sharing must not exceed 20% of the cost of the item and the total aggregate cost sharing must not exceed 5% of family income.
  - Premiums cannot be charged for foster care or adoption assistance children, pregnant women, terminally ill persons in hospice care, and persons in inpatient settings, and women in the breast or cervical cancer program.
  - The following types of Medicaid services are excluded from cost sharing: services furnished to foster care or adoption assistance children, prevention services for children, services furnished to pregnant women, services furnished

to terminally ill persons in hospice care and persons in inpatient settings, emergency services, family planning services, and services furnished to women in the breast or cervical cancer program.
  - A state may at its option condition medical services for an individual upon prepayment or terminate eligibility for failure to pay for 60 days or greater.
  - A state may permit providers to require the payment as a condition of service and a provider may reduce or waive the application of such cost sharing.
- The Deficit Reduction Act of 2005 modified the restrictions on cost sharing for prescription drugs as follows:
  - States are permitted to increase cost sharing over current nominal levels for non-preferred drugs, or waive or reduce cost sharing otherwise applicable for preferred drugs.
  - Cost sharing must be nominal for beneficiaries with family incomes at or below 150 percent of the federal poverty line (FPL).
  - Cost sharing for beneficiaries with family incomes above 150 percent FPL cannot exceed 20% of the drug's cost.
  - The aggregate limits on all cost sharing (see information above) apply to cost sharing for prescription drugs.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: National Governor's Association, AcademyHealth, Health Management Associates, and National Academy for State Health Policy.

Reform Area: Program Administration
Theme: FMAP Reform

The Medicaid program is financed with funds from the federal government and the states. The Federal Medical Assistance Percentage is used in determining the amount of federal matching funds for State expenditures for assistance payments for certain social services, including State Medicaid expenditures. Each fall the FMAP is calculated by the Secretary of the US Department of Health & Human Services, and is published in the Federal Register on or before November 30th. The formula and data source for the calculation of the FMAP is set in statute (The Social Security Act, § 1101(a)(8)(B)) , and any changes made to the FMAP would require changes in the law.

Many organizations have proposed reforms to the formula and/or application of the FMAP.

SPECIFIC PROPOSAL(S)

- Congress should update the FMAP to more adequately account for Medicaid's counter-cyclical nature. The formula for calculating the FMAP should be revised so that it reflects the fact that during economic downturns, increased unemployment, public health emergencies, or other unexpected events (such as a hurricane or terrorist attack) more people rely on Medicaid and therefore states' need additional financial assistance.
- The FMAP formula be revised to calculate the FMAP based on a two-year average of per-capita income (PCI) data (instead of a three-year average as is required by law now).
- The FMAP formula should be changed by adding an adjustment into the formula to increase FMAP for most or all states when unemployment exceeds a national trigger.
- States should receive the enhanced SCHIP match for services provided to children above the mandatory Medicaid level and that the enhanced match should come out of each state's existing yearly SCHIP allotment.
- Modify the statue to allow states to provide the same federal support for all children and families covered by Medicaid and the State Children's Health Insurance Program (SCHIP) by applying the current federal matching rate for SCHIP to all Medicaid services provided to children, adults and families who are not also enrolled in Medicare.
- Increase the federal Medicaid matching rate to 90% for Medicaid payments for persons who are enrolled in both Medicare and Medicaid ("dual eligibles").
- One-hundred percent FMAP should be applied for all services provided through Indian health programs.
- Reductions in the FMAP should be phased in over a five year period.
- Federal law should be amended to increase the matching rate for qualifying state program integrity activities to 75 percent.

KEY POINTS/FINDINGS

- ***The Charter of the Medicaid Commission states that, "[t]he Commission shall assume that the basic matching relationship between the federal government and the states will be continued." As such, recommendations for reforming the formula and/or application of the FMAP are outside the purview of the Commission.***
- The Deficit Reduction Act of 2005 modified the Alaska FMAP for Fiscal Years 2006 and 2007 to prevent the state from experiencing a reduced FMAP.
- The Deficit Reduction Act of 2005 established a provision that affects states impacted by Hurricane Katrina such that for any state that the Secretary of HHS determines has a significant number of evacuees from Hurricane Katrina as of October 1, 2005, such evacuees and their incomes will not be included in the data used for the calculation of the FMAP.

PROPOSING ORGANIZATIONS/AUTHORS

The following groups/individuals have developed proposals on this theme: Partnership for Medicaid , National Academy for State Health Policy, National Conference of State Legislatures, Health Management Associates, and Roundtable on Indian Health.