

# **REDESIGNING MEDICAID DURING A TIME OF BUDGET DEFICITS**

**American College of Physicians  
Position Paper  
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A Position Paper of the  
American College of Physicians

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## REDESIGNING MEDICAID DURING A TIME OF BUDGET DEFICITS

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### Executive Summary

This paper examines the merits and faults of the most commonly debated proposals to reform the Medicaid program. For years, the program has consumed both state and federal budgets. What differs this year--and for years to come-- is that the nation faces a massive federal budget deficit. Over the next decade, from 2005 to 2014, the Congressional Budget Office (CBO) estimates that the deficit will total \$2.3 trillion.<sup>1</sup> As the federal government attempts to reduce the size of the deficit, it is almost certain that entitlement programs, such as Medicaid and Medicare, will be the first to be targeted for cuts.

Previous positions taken by the College on the subject of Medicaid were composed under more favorable fiscal circumstances. It is therefore necessary to revisit many of these policies and compare them against the current political environment to determine whether they are still feasible solutions.

In evaluating old policies and formulating new ones, ACP made sure to balance proposed reforms against the critical role Medicaid plays in the nation's increasingly stressed healthcare system. Medicaid now meets the health and long-term care needs of one in ten Americans, including people with low-incomes, children, the elderly, and the disabled.<sup>2</sup> This success cannot be ignored when assessing reforms that would force states to drop coverage for the poor or erode coverage to those currently covered by Medicaid.

ACP places incredible value on the safety net function of the Medicaid program and continues to believe that this feature should in no way be compromised by any proposal to reform the program. ACP's proposal to expand health care coverage to all Americans preserves the significant role of Medicaid by enhancing state flexibility over coverage expansions and by giving states the option of using a federal minimum standard for eligibility that would extend the program's benefits to those who now lack health insurance, with the additional coverage being borne by the federal government.<sup>3</sup> Although this proposal would increase federal expenditures on Medicaid, it would provide substantial financial relief to the states.<sup>4</sup> Continued expansions of safety-net programs to all of those who fall below the federal poverty level will assure that our neediest populations can lead healthy, functional lives.

The College's position on Medicaid reform can be summarized as follows:

**Position 1: ACP believes the Medicaid program should be preserved, and to the extent possible, expanded to provide coverage for more uninsured persons. ACP's proposal to expand health insurance coverage to all within seven years (HealthCARE Act) calls for an incremental package of reforms that includes improving and expanding Medicaid and SCHIP without imposing new unfunded mandates on the states. To the extent that federal budget constraints do not allow**

**for Medicaid expansions at this time, then Congress should at least “do no harm” by refraining from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.**

**Position 2: The federal government should recognize the benefit of gradually eliminating the use of categorical eligibility in the Medicaid program so that health coverage eventually could be extended to all low-income populations, including couples without children and single adults. At the same time, states should be given greater flexibility to extend and expand need-based Medicaid coverage to their poorest residents. In making this transition, the federal government must ensure that the safety net function of Medicaid is preserved.**

**Position 3: Medicaid eligibility standards should be uniform on a national basis. The maximum income level for eligibility could be phased-in over several years, as was done to raise coverage of low-income children to the poverty-level. As is currently the case, states would still have the option of expanding eligibility to income levels higher than the federal standard.<sup>5</sup>**

**Position 4: Individuals with long-term care needs should be allowed to supplement Medicaid coverage with private policies. Premium subsidies in the form of refundable tax credits may be available for individuals with long-term care needs to purchase supplemental insurance. This will give beneficiaries in need of special services enhanced choice and flexibility while lessening the burden on the Medicaid program.**

**Position 5: In the case of long-term care, Medicaid beneficiaries should be offered more flexibility to choose among alternatives to nursing home care, such as community or home health care, since these services can be more cost-effective and more suitable to the individual’s needs.**

**Position 6: ACP stands ready to help the administration and Congress identify structural changes in the Medicaid program that enhance state flexibility without compromising beneficiaries.**

**Position 7: States should be granted more flexibility over how to structure their Medicaid programs to assure effective delivery of services to those in need, but such flexibility must be within a framework consistent with a federal definition of essential benefits and reasonable cost sharing for eligible people.**

**Position 8: Under a system of enhanced state flexibility, states must continue to be subject to federal standards regarding payments to providers to both ensure that enrollees have access to services and protect the program’s fiscal integrity. Medicaid payment rates must be adequate to reimburse physicians and health care facilities for the cost of providing services, to enhance physician and other provider participation in the Medicaid program, and to assure access to Medicaid covered services.**

**Position 9: Giving states flexibility to be creative with their Medicaid programs requires that the program adopt a more organized, systematic process through which all state Medicaid programs - and policymakers - can learn from experience and implement best practices. With more than five times the spending of most domestic cabinet departments, Medicaid is still only a small administrative component of the Centers for Medicare and Medicaid Services.**

**Position 10: While the federal fiscal relief package that ended in June 2004 was a reprieve for states, it was only a temporary fix. Congress should establish a counter-cyclical funding mechanism for Medicaid, similar to the funding mechanism for unemployment insurance, increasing federal dollars during economic downturns.<sup>6</sup> Substantial structural changes to Medicaid are necessary if states are to meet the needs of the nation's most vulnerable populations.**

**Position 11: Medicaid should be held accountable for adopting policies and projects that improve quality of care and health status, including reducing racial and ethnic disparities, promoting prevention, and effectively managing chronic diseases. The program also should promote enhanced administrative efficiency. Public reporting, financial incentives, and other forms of recognition for improved quality performance should also be tested.<sup>7</sup>**

**Position 12: ACP supports strengthening the prevention of fraud, abuse and waste under the Medicaid program as a way to maximize administrative efficiencies. Efforts to eliminate fraud, abuse and waste should not create an unnecessary burden for physicians who do not engage in illegal activities.**

**Position 13: Efforts to limit prescription drug costs under Medicaid should target proven overpayments for prescription drugs rather than limits on beneficiary access to prescription drugs. Medicaid patients should have access to prescription medications based on their individual needs as determined by their physician. States should not limit the number of prescriptions or the number of pills per prescription.**

**Position 14: ACP supports changes in the "clawback" provision of the Medicare Modernization Act to relieve short- and long-term financial pressures under state Medicaid programs that may occur due to the shift in dual-eligible drug coverage from state Medicaid programs to Medicare.**

## **Introduction**

Medicaid, an entitlement program that serves the poor and disabled, currently has more than 50 million beneficiaries and more than \$300 billion a year in combined federal and state outlays.<sup>8</sup> Medicaid spending has shot up 63 percent in the last five years, making the program the nation's largest health insurance program and the second largest item in

most state budgets.<sup>9</sup> The Congressional Budget Office (CBO) projects that Medicaid costs will continue to increase on average 8.5 percent each year over the coming decade.<sup>10</sup> Compared to some other programs, however, Medicaid is not a dominant contributor to the overall deficit projections. Medicaid accounted for only 8 percent of federal outlays in 2004, compared to 12 percent for Medicare and 21 percent for Social Security.<sup>11</sup> Still, the Bush Administration has vowed to cut the federal budget deficit by half in five years, making it unlikely that the Medicaid program will escape cuts.

Medicaid is jointly administered by federal and state agencies. The federal government matches state spending under Medicaid and, depending on the state, the federal government pays 50 percent to 77 percent of Medicaid expenditures.<sup>12</sup> Although the growth of Medicaid expenditures in FY04 averaged 9.5 percent, basically unchanged from FY03, the growth of the program continues to outpace state revenues.<sup>13</sup> Program enrollment grew by an annual rate of about 5.9 percent between 2002 and 2003. While this marked a decline from previous years, it is still relatively high.<sup>14</sup> Also adding to the expense of the program has been reductions in federal Medicaid payments, benefit increases, prescription drug costs, and general health care cost inflation. As of December 2004, Medicaid spending exceeded appropriations in 16 states. In Iowa, for example, Medicaid has an anticipated supplemental need of between \$52 million and \$85 million. Maryland's FY05 spending shortfalls could approach \$200 million, while in Maine Medicaid costs are \$33 million over the state budget.<sup>15</sup> In FY04, for the first time ever, Medicaid became a larger component of total state spending than elementary and secondary education combined.<sup>16</sup>

Although budget pressures have subsided this year, it is forecasted that FY06 will present another round of fiscal challenges for states stemming from Medicaid.<sup>17</sup> States have just about depleted their "rainy day" funds, which accumulated during better economic times, as well as revenue available through the states' legal settlement with tobacco companies.<sup>18</sup> As a result, Medicaid remains a top issue on state legislative agendas. To meet these challenges, states have reduced or frozen Medicaid physician payment rates, scaled back covered benefits, and reduced eligibility. Colorado and Minnesota ended state-funded coverage for immigrants this year; Alaska imposed a freeze on its income-eligibility level for Medicaid so it will no longer rise with inflation; and Texas reduced the amount of assets a family could have and still qualify for Medicaid, while imposing a 90-day waiting period for enrollment.<sup>19</sup> Tennessee recently announced that TennCare, which consumes 26 percent of the state's annual revenue and is one of the most generous Medicaid programs in the country, faces changes that could make it one of the smallest and most restrictive Medicaid programs in the country. Because Tennessee currently receives \$2 from the federal government for every state dollar devoted to the program, any reduction in the state's share of funding means twice the drop in federal aid.<sup>20</sup> The Center on Budget and Policy Priorities predicted that in FY05, cuts adopted in 34 states would cause 1.2 million to 1.6 million low-income people to lose health insurance.<sup>21</sup>

### **Proposals for Reform**

As states continue to do all they can within the confines of Medicaid law to make the program more manageable and affordable, the federal government is looking to broader reforms that would in many respects completely transform the program as we currently know it. A discussion of these reforms follows, along with ACP's position on each of these proposals.

## **Capping Federal Payments**

**Position 1: ACP believes the Medicaid program should be preserved, and to the extent possible, expanded to provide coverage for more uninsured persons. ACP's proposal to expand health insurance coverage to all within seven years (HealthCARE Act) calls for an incremental package of reforms that includes improving and expanding Medicaid and SCHIP without imposing new unfunded mandates on the states. To the extent that federal budget constraints do not allow for Medicaid expansions at this time, then Congress should at least "do no harm" by refraining from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.**

In 1995, Congress passed a bill to end the individual entitlement and let each state devise its own program with a lump sum of federal money, but the measure was eventually vetoed by President Clinton.<sup>22</sup> The Bush Administration offered a similar proposal in 2003, which would have effectively combined Medicaid and SCHIP into a single program and given states a fixed annual allotment for both, instead of basing federal Medicaid payments on enrollment, as is currently the case under the entitlement. In exchange, states would be given much greater latitude to determine which benefits would be covered and which populations would be served.<sup>23</sup> In the 108<sup>th</sup> Congress, Medicaid reform saw no movement, taking a back seat to Medicare reform. In the 109<sup>th</sup> Congress, Medicaid reform proposals are expected to resurface, as the administration seeks to balance the federal budget.

Whether in the form of a state allotment, allocation, or block grant, capped federal payments present challenges for the states. By basing Medicaid payments to states on enrollment, the current structure of the entitlement ensures that these payments reflect, for the most part, actual health care costs. The federal government guarantees that federal matching funds will be available no matter how many people are found to be eligible. But under a system of capped federal payments, where the entitlement is essentially destroyed, critics fear the program would be prevented from doing what it now does best-- offering very comprehensive benefits at nominal cost, in sharp contrast to privately-funded coverage.<sup>24</sup> As a result, states would be forced to shuffle limited funds to best meet the needs of their most vulnerable populations. States that wish to continue offering comprehensive coverage could only do so for a small number of people, while those that opt to maximize eligibility could only do so by offering bare-bones coverage. Either way, states would be forced to make cuts in benefits and caseloads, and further cuts in provider payment rates in order to restrain growth. In the end, access to care would be compromised for those most in need of it. Critics of

capping Medicaid spending also believe it would act as an incentive for states to use questionable creative financing schemes to maximize federal funding (see discussion below).

On the other hand, block grants have proven successful in extending access to health care to vulnerable populations, as is the case with SCHIP. SCHIP, which is funded as a block grant, is currently an important source of coverage for about four million children.<sup>25</sup> Under the program, states receive a fixed annual federal allotment, in contrast to the open-ended entitlement of the Medicaid program, to provide coverage to children in families with incomes up to 200% of the federal poverty line.<sup>26</sup> Still, SCHIP is not without its defects. While SCHIP gives states a higher federal match than Medicaid, the program is still counter-cyclical in the sense that more people become eligible as economic conditions deteriorate. The program also has had difficulty projecting spending needs and appropriately targeting funds to where they are needed most. While federal spending allotments exceeded spending in the early years of the program, many states are now expecting funding shortfalls in SCHIP over the next few years.<sup>27</sup> Furthermore, under current law, states that have unspent SCHIP funds made available through a reallocation process must return those funds to the U.S. Treasury if they do not use them within a limited period of time.<sup>28</sup> \$1.1 billion in unspent SCHIP funds allocated to states from 1998 to 2000 expired in 2004 and were reverted to the Treasury.<sup>29</sup>

Various groups have spoken out against capping federal Medicaid payments. The National Governors Association (NGA) wrote in a bipartisan letter to Congress that it was “unacceptable in any deficit reduction strategy to simply shift federal costs to states, as Medicaid continues to impose severe strains on state budgets.”<sup>30</sup> In a letter to the President, a group of 48 U.S. Senators voiced “opposition to any Medicaid reform proposal that seeks to impose a cap on federal Medicaid spending in any form or eliminates the fundamental guarantee to Medicaid coverage for our nation’s most vulnerable citizens.” According to the letter, “arbitrary limits on federal Medicaid spending fail to automatically adjust for economic recessions, demographic changes, health care inflation, or disasters, including terrorism.” The letter went on to say that capped federal payments profoundly limit a state’s ability to respond and adopt innovative approaches to deal with the uninsured, putting states at too much of a risk, such as unexpected caseload growth.<sup>31</sup>

Alternatively, in a report issued by its Council on Medical Service, the American Medical Association concluded:<sup>32</sup>

The structure and financing of the current Medicaid program is crumbling. States already have and plan to continue to reduce Medicaid benefits; reduce and/or restrict optional Medicaid eligibility categories; increase Medicaid beneficiary cost-sharing; and freeze and/or reduce Medicaid payments to physicians and other health care providers. Medicaid beneficiaries experience decreased access to medical care and diminished choice of physicians and other health care providers....The Council would strongly oppose merely an expansion of eligibility to Medicaid because it would be wrong to make more people dependent upon such a tenuous program, especially when it would be unlikely that increased

spending would be commensurate.

The AMA House of Delegates subsequently adopted policy reflecting the Council's proposal:

That the medical care portion of the Medicaid program should be financed with federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP), with varying cost-sharing obligations based on income and eligibility under the current Medicaid program.<sup>33</sup>

Current ACP policy states that any legislative or budgetary changes affecting the Medicaid program should preserve the safety net function of Medicaid.<sup>34</sup> As a result, ACP specifically opposes proposals that would aim to limit the number of Medicaid recipients and curtail coverage by freezing budgeted amounts to states. Imposing a cap on federal Medicaid spending would undermine the federal commitment to our nation's most vulnerable populations, including low-income children, parents, pregnant women, people with disabilities, and senior citizens. Limits on federal Medicaid spending fail to automatically adjust for economic, demographic, and societal changes, and limit a state's ability to be innovative in responding to the growing number of uninsured individuals. Medicaid costs are affected in different ways across the country, and no one formula can account for all the varying factors.<sup>35</sup>

In a December 16, 2004 letter to the President, ACP, along with 25 other health care organizations, requested that the FY06 budget not include any reductions on the rate of growth or propose caps on Medicaid spending. With many states in fiscal crises, the letter warned that Medicaid reductions at the federal level would drastically unravel an already frail health care safety net.<sup>36</sup>

As stated in previous ACP policy, should limits be placed on federal Medicaid contributions to states, they should take into account changes in the mix and growth of a state's eligible population. A per capita cap would be one such method for restraining growth in spending while recognizing the need to respond to demographic changes in recipient groups.<sup>37</sup>

## **Reforming Eligibility Standards**

**Position 2: The federal government should recognize the benefit of gradually eliminating the use of categorical eligibility in the Medicaid program so that health coverage eventually could be extended to all low-income populations, including couples without children and single adults. At the same time, states should be given greater flexibility to extend and expand need-based Medicaid coverage to their poorest residents. In making this transition, the federal government must ensure that the safety net function of Medicaid is preserved.**

**Position 3: Medicaid eligibility standards should be uniform on a national basis. The maximum income level for eligibility could be phased-in over several years, as was done to raise coverage of low-income children to the poverty-level. As is currently the case, states would still have the option of expanding eligibility to income levels higher than the federal standard.<sup>38</sup>**

A variety of proposals to upgrade current federal standards for Medicaid eligibility, which still frequently lags below the federal poverty level,<sup>39</sup> have been recommended. These include establishing national Medicaid eligibility for all senior citizens below poverty, with higher levels for seniors and younger people with serious long-term disabilities; making “spend-down” eligibility a national standard (it is now only a state option); making the federal poverty level a national standard for adults, as well as for children; and offering buy-in opportunities for those who cannot obtain affordable insurance (also now a state option for some people with disabilities). Some states have already expanded Medicaid to cover families with incomes up to twice the federal poverty level and working adults. These include Washington’s Basic Health Plan, MassHealth, BadgerCare, and MinnesotaCare.<sup>40</sup>

Many of these proposals would make a fundamental change in the program by eliminating the categorical eligibility component of Medicaid. Instead, eligibility would be based primarily on the need for financial assistance to pay for medical care.<sup>41</sup> Medicaid’s categorical eligibility dates back to the public welfare laws of the 1930s, when such programs were limited to people who could not work, such as the aged, blind, or disabled and single mothers with children. As a result, Medicaid law has historically excluded those who were expected to work, such as single adults, couples, and two-parent families, regardless of their incomes or the size of their medical bills.<sup>42</sup> Over the years, Medicaid eligibility categories expanded and income and asset tests were broadened. Welfare reform in 1996 finally broke the eligibility link between welfare and Medicaid for families. Yet despite the fact that the Medicaid statute now mandates eligibility for twenty-eight different categories of people and allows states to cover up to twenty-one optional eligibility groups,<sup>43</sup> eligibility is still based on somewhat restrictive criteria.

Basing eligibility simply on income would allow states to cover certain vulnerable populations that currently do not qualify for coverage. One population that is often neglected by Medicaid and quite vulnerable to uninsurance is working-age adults. Among households with incomes below the federal poverty level, 12 million working-age adults now lack health coverage, comprising 27 percent of the uninsured.<sup>44</sup> Recent increases in uninsurance have been concentrated in this group. Between 2000 and 2003, as the total number of uninsured rose by 5 million, the number of uninsured adults with incomes below 100 percent of the FPL rose by 2.2 million—more than any other group.<sup>45</sup>

Under ACP’s proposal to expand health care coverage to all, states would not have to get a federal waiver to cover childless workers. Without a waiver, current law forbids state Medicaid programs from covering workers who are neither pregnant nor parents. According to ACP, states, not federal authorities, should decide whether to cover

childless workers.<sup>46</sup>

Another way to modify existing eligibility standards would be to replace the current multiple eligibility categories with a basic standard. Under one scenario, income eligibility would be set at 200 percent FPL for children and pregnant women and 100 percent FPL for all other adults. The federal entitlement to benefits would remain, as would the federal definition of comprehensive benefits for eligible people. States would also be subject to federal standards regarding payments to providers to both ensure that enrollees have access to services and protect the program's fiscal integrity.<sup>47</sup>

ACP has recommended in the past that current eligibility standards for Medicaid and SCHIP, based on a variety of demographic and categorical requirements, should be replaced with a federally-mandated standard based solely on income. Under ACP's proposal to expand access to coverage, a uniform national income eligibility for Medicaid would be phased in over several years. States would be given a new Medicaid option that would allow them to cover residents based simply on household income up to 100 percent of the FPL, with an increase in federal matching payments to wholly compensate states for increased program costs.<sup>48</sup>

## **Managing the Cost of Long-term Care**

**Position 4: Individuals with long-term care needs should be allowed to supplement Medicaid coverage with private policies. Premium subsidies in the form of refundable tax credits may be available for individuals with long-term care needs to purchase supplemental insurance. This will give beneficiaries in need of special services enhanced choice and flexibility while lessening the burden on the Medicaid program.**

**Position 5: In the case of long-term care, Medicaid beneficiaries should be offered more flexibility to choose among alternatives to nursing home care, such as community or home health care, since these services can be more cost-effective and more suitable to the individual's needs.**

Medicaid is the primary source of financing for long-term care and accounts for the large majority of public spending on long-term care. In 2003, Medicaid accounted for 43 percent of long-term care spending and financed care for nearly 60 percent of nursing home residents.<sup>49</sup> The long-term care benefit places a serious strain on the Medicaid program. In 2003, long-term care made up 36 percent of total Medicaid spending.<sup>50</sup> This share is expected to heighten as demand for long-term care grows significantly over the next several decades. By 2040, growth in the over 85 population – the population most likely to need long-term care services—is projected to more than triple from about 4 million to about 14 million.<sup>51</sup>

Various options have been proposed to better manage this benefit and the population it serves. One option is to expand eligibility for the long-term care benefit by relaxing Medicaid's financial eligibility requirements, creating a needs-based buy-in option for

individuals with serious disabilities and workers with disabilities, or offering tax credits to people those who are functionally impaired but not financially eligible. Although Medicaid provides long-term care services to both elderly and nonelderly persons with disabilities, Medicaid's protections are limited to the poor or to those who have become poor due to high out-of-pocket spending on medical or long-term care.<sup>52</sup> Given the current budget deficit and fiscal pressures anticipated with the aging of the baby-boom generation, it is unlikely that Congress will expand the program this year.

Proposals to reduce or simply eliminate the long-term care benefit under Medicaid are more likely to arise under the current fiscal climate. Limiting the growth of Medicaid spending on long-term care is an option that can be phased in over an extended period to allow people who face new restrictions on eligibility and benefits ample time to make other financial arrangements. One way to limit growth would be to reduce the number of individuals eligible for Medicaid long-term care coverage. This could be done by tightening existing limits on income and assets or eliminating some of the mechanisms that people currently use to spend down their income. Both options could significantly reduce the number of individuals who became eligible for coverage.<sup>53</sup>

With the long-term care benefit reduced or eliminated under Medicaid, either the Medicare program or the private insurance industry would have to step in to ensure those with long-term care needs can access care. Medicare could provide more comprehensive long-term coverage than it currently does by expanding its benefits for skilled nursing facility and home health care or by covering other types of long-term care-related services. However, this option is unlikely to get much attention this year, given the prescription drug benefit that was recently added to Medicare. A shift to private coverage would mean standardizing private policies or allowing consumers to purchase private policies that supplement Medicaid's coverage.<sup>54</sup> Under current rules, Medicaid beneficiaries are not allowed to hold supplemental private insurance. Applicants for Medicaid must exhaust all other sources of long-term care financing--including benefits offered by any private insurance they might carry.<sup>55</sup>

Another option is to modify the long-term care benefit. The Bush administration has voiced its commitment to "money follows-the-person" legislation, which would make financing for long-term care services more flexible, allowing available Medicaid funding to move with the beneficiaries to appropriate settings as the individual's needs and preferences change.<sup>56</sup> Under the current Medicaid law, home and community-based services are an optional benefit, limited by waiver requirements and budget-neutrality. Nevertheless, states that have been granted home and community-based waivers have realized substantial cost-savings and it has been proposed that these services, as well as other personally-directed services, become a standard Medicaid benefit.<sup>57</sup>

The challenge with giving states more flexibility in dealing with long-term care is the conflict with the Medicaid statute, which accommodates institutionalized long-term populations. The Family Opportunity Act, introduced last year, was linked to money follows-the-person legislation, but failed to gain traction. CMS Administrator Mark McClellan has noted that there are things CMS can do administratively to allow states to

expand coverage to disabled children whose families earn too much to qualify for Medicaid coverage. For instance, many states could use unspent SCHIP allotments to do targeted expansions to families with children with disabilities.<sup>58</sup>

## **Enhancing State Flexibility**

**Position 6: ACP stands ready to help the administration and Congress identify structural changes in the Medicaid program that enhance state flexibility without compromising beneficiaries.**

The current division of responsibility for health care between states and the federal government has been both hailed and criticized. Supporters believe it strengthens our system by allowing the neediest Americans to access health care and by allowing the program to evolve to meet changing needs through experimentation. Opponents feel states are left with too large a responsibility and too little federal funding and that these responsibilities are best left to the federal government.

Since responsibility over the Medicaid program is shared, both levels of government have an incentive to administer the program in a cost-effective way. Proponents of giving states more flexibility point to the fact that the states are particularly well-suited for this task. Although total Medicaid costs are growing at a rate of 12 percent per year, the annual growth in Medicaid per capita spending has not exceeded approximately 4.5 percent per year, substantially below the growth rate of private health insurance premiums, which have averaged 12.5 percent per year for the last three years.<sup>59</sup>

Proposals to enhance state flexibility under the Medicaid program would allow states to make changes to their Medicaid programs, including modifications in copayments, benefits, and eligibility standards. More extreme versions of this proposal include permitting local officials to provide different benefits in different parts of the state. Currently, states must apply for a waiver to make changes to their program. Without a waiver, federal law forbids state Medicaid programs from covering certain populations, such as workers who are neither pregnant nor parents, no matter how low their incomes or how hard they work. While some states appreciate the added flexibility waivers provide, others criticize the application process as slow and arduous.

With Michael Leavitt, former governor of Utah, recently nominated as Secretary of the U.S. Department of Health and Human Services (HHS), federal officials have hinted that Utah's Medicaid program is an example of the kind of changes they would accept in other states.<sup>60</sup> As governor, Mr. Leavitt obtained a federal waiver allowing Utah to provide coverage to more people at no additional cost to the federal government. The state reduced benefits for some people on the rolls and provided a limited set of benefits to new recipients. The new recipients received coverage for primary care doctors and up to four prescriptions a month, but the benefit package did not include hospital care or mental health services.<sup>61</sup>

ACP has stated in the past that it favors alternatives that promote flexibility and

innovation in the Medicaid program while ensuring quality and improving access to health care services.<sup>62</sup> The College has also expressed that states should be given the option and the dedicated federal funding to innovate and develop alternative methods to achieve equal or better coverage outcomes for the uninsured, with measures to protect Medicaid and SCHIP beneficiaries from losing services or eligibility or being subjected to increased costs.<sup>63</sup> One option, which is included in ACP's proposal to expand health coverage, would permit states to use public funds to subsidize low-income families' premium costs for employer-sponsored coverage as a cost-effective way to insure low-income children and their families.<sup>64</sup> In 2003, it was estimated that using Medicaid and SCHIP funds to subsidize families' premium costs for employer-sponsored insurance would cost the government less than providing coverage directly.<sup>65</sup>

**Position 7: States should be granted more flexibility over how to structure their Medicaid programs to assure effective delivery of services to those in need, but such flexibility must be within a framework consistent with a federal definition of essential benefits and reasonable cost sharing for eligible people.**

While states may be in the best position to access their own needs, added flexibility can unintentionally lead to compromised patient care. The Government Accountability Office (GAO) recently found that through Medicaid waivers, states are able to skirt the law by providing less coverage than mandated by law.<sup>66</sup> Attempts to curb expenses through benefit cuts have, in many instances, landed states in federal court. For the most part, the courts have upheld the rights of Medicaid recipients to sue for the denial of benefits, limiting the options of state officials who want to use this technique to cut costs.<sup>67</sup> In a November 2004 case in which the state of Louisiana refused to cover disposable diapers prescribed for a 16 year-old boy with spina bifida who had no control of his bowel or bladder, the U.S. Court of Appeals for the Fifth Circuit ruled that the state had to cover such supplies for children, regardless of whether they were available to adults.<sup>68</sup>

As ACP has stated in previous policy, minimum benefits should be specified in federal law, as under the current program, with states granted the option to cover additional categories of services. Furthermore, reasonable cost sharing should be imposed according to a public schedule of charges and adjusted for family size, income and resources.<sup>69</sup>

**Position 8: Under a system of enhanced state flexibility, states must continue to be subject to federal standards regarding payments to providers to both ensure that enrollees have access to services and protect the program's fiscal integrity. Medicaid payment rates must be adequate to reimburse physicians and health care facilities for the cost of providing services, to enhance physician and other provider participation in the Medicaid program, and to assure access to Medicaid covered services.**

Any reforms made to Medicaid must ensure that reimbursement levels for physicians and other health care professionals are at least adequate to cover the costs of providing

services to the covered population. If reimbursement levels are inadequate, access to care may be seriously compromised. At the same time, ACP continues to believe that states should not be given total authority to set provider and health plan reimbursements free from any federal oversight or to set standards for provider and health plan qualifications.<sup>70</sup>

**Position 9: Giving states flexibility to be creative with their Medicaid programs requires that the program adopt a more organized, systematic process through which all state Medicaid programs- and policymakers- can learn from experience and implement best practices. With more than five times the spending of most domestic cabinet departments, Medicaid is still only a small administrative component of the Centers for Medicare and Medicaid Services.**

ACP currently holds that states should be given greater freedom through changes in the waiver process and other federal regulations to control utilization of services. It is more important than ever that the excessive regulatory burden imposed on states by the existing waiver process be reduced. At the same time, federal accountability should be retained through continued monitoring of changes to states' Medicaid plans.<sup>71</sup>

### **Modifying the Federal Match**

**Position 10: While the federal fiscal relief package that ended in June 2004 was a reprieve for states, it was only a temporary fix. Congress should establish a counter-cyclical funding mechanism for Medicaid and SCHIP, similar to the funding mechanism for unemployment insurance, increasing federal dollars during economic downturns.<sup>72</sup> Substantial structural changes to Medicaid are necessary if states are to meet the needs of the nation's most vulnerable populations.**

Like SCHIP, Medicaid operates countercyclically, which works for and against the population it serves. On one hand, more Americans are eligible for coverage when they need it most. On the other hand, the program becomes more expensive to the federal and state governments exactly when they can least afford it. This is largely due to the fact that states must provide matching dollars to receive federal dollars for their Medicaid program, even when a weak economy and growing state budget deficits make this difficult to do.<sup>73</sup>

The federal government should modify the current funding mechanism to make it easier for states to reduce the number of uninsured in times of greatest need. In 2003, it was estimated that as much as an additional \$6.1 billion in federal money was available to states to cover eligible children who were not yet enrolled, but states had to raise \$3.7 billion in matching funds to access these federal dollars. A counter-cyclical funding mechanism, similar to that used for unemployment insurance, would allow states to access these additional resources when state budgets limit spending.<sup>74</sup>

In the spring of 2004, Congress provided some short-term fiscal assistance to the cash-strapped states as part of the tax-cut legislation. The legislation included \$10 billion for the states in the form of a temporary increase in the proportion of Medicaid costs reimbursed by the federal government.

While recent Congressional proposals have centered on enhancing the federal-state match (FMAP), others claim the entire matching formula is inadequate and should be reformed or replaced. The federal matching rate is adjusted to state per capita income. If a state's per capita income rises, it receives a smaller match rate. Although this results in lower-income states receiving a higher match rate than higher-income states, the formula does not reflect the number of people in need (i.e., low-income) in each state or accurately assess a state's fiscal capacity.<sup>75</sup> States that can afford to spend more of their own dollars receive more federal dollars through the match. Consequently, critics charge that the formula essentially redistributes tax revenues from lower- to higher-income states. For example, 31.5 percent of all health care spending in New York is financed through its Medicaid program, compared with a national average of 15.7 percent and 9.1 percent in the lowest state.

States rely heavily on the Medicaid federal match. A recent study of ten randomly selected states found that most states did not make significant cuts in their Medicaid programs in FY04, despite large budget gaps and spending cuts in other program areas, such as transportation and the environment. According to the study, states are reluctant to make major cuts in Medicaid because the federal match is such a lucrative source of revenue and can be used to develop creative financing mechanisms. Other reasons include political considerations and the fact that the program provides economic development benefits that are broadly dispersed geographically. Medicaid supports jobs and business through support of facilities that are major employers and purchasers in many states, such as nursing homes and hospitals.<sup>76</sup>

## **Enhancing Quality**

**Position 11: Medicaid should be held accountable for adopting policies and projects that improve quality of care and health status, including reducing racial and ethnic disparities, promoting prevention, and effectively managing chronic diseases. The program also should promote enhanced administrative efficiency. Public reporting, financial incentives, and other forms of recognition for improved quality performance should be tested.**<sup>77</sup>

The Medicaid program should be responsible for policies and projects that enhance quality of care and health status, reduce racial disparities in access and treatment, promote prevention, and improve care for patients with chronic disease. Enhanced quality of care will lead to better health outcomes and lower costs in the long-term. Similar to recent reforms made to Medicare, it has been suggested that Medicaid quality care initiatives include disease management demonstrations and public reporting. These initiatives would be particularly effective for the six million high-risk, dual-eligibles, who

use 35 percent of Medicaid funds (\$88 billion), and Medicaid's long-term care population, which significantly adds to the cost of the program.<sup>78</sup>

## **Reducing Fraud and Waste**

**Position 12: ACP supports strengthening the prevention of fraud, abuse and waste under the Medicaid program as a way to maximize administrative efficiencies. Efforts to eliminate fraud, abuse and waste should not create an unnecessary burden for physicians who do not engage in illegal activities.**

Multiple reports have documented that the Medicaid program is rife with fraud, abuse, and waste. Since the states administer their own Medicaid programs, it is more difficult for the federal government to identify fraudulent or improper activities. As a result, recent reform proposals have been aimed at improving the program's overall integrity.

In a July 2004 report, the GAO stated that CMS does not devote a high enough level of resources to fight Medicaid fraud and counter the large financial risks fraudulent activities pose to the program. For example, in 2004, CMS designated \$26,000 and eight staffers nationally to oversee the states' Medicaid program integrity activities. The GAO also found that state fraud-control efforts are limited in scope, with CMS failing to evaluate states' effectiveness in addressing improper payments. Among the numerous incidents cited in the GAO report was a recent Medicaid fraud scheme in California, which involved more than 15 clinical laboratories that illegally billed for more than \$20 million for tests that were not ordered by physicians.<sup>79</sup>

CMS responded to the GAO report stating that its Medicaid anti-fraud efforts should be viewed as part of its broader financial management of state Medicaid programs. Sixty-five financial management staffers in CMS regional offices review Medicaid expenditures, conduct financial management reviews, provide technical assistance to states on financial policy issues, and analyze state cost allocation.<sup>80</sup> The HHS Inspector General recently reported that states' Medicaid Fraud Control Units (MFCUs) recovered \$268 million in court ordered restitutions, fines, civil settlements, and penalties and helped secure 1,096 convictions during fiscal year 2003. In FY04, CMS expects to hire 100 new Medicaid financial management staff and has contracted with the Health and Human Services Office of Inspector General to perform additional auditing.<sup>81</sup>

On August 27, 2004, CMS issued a new proposed rule announcing a new error rate measurement for Medicaid and SCHIP. Under the proposal, states will be required to prepare annual estimates of total improper payments and calculate payment error rates for Medicaid and SCHIP. States will have to identify the cause of each error, address it, and recover any overpayments to health care providers. While proponents see it as a way to make the program more efficient, critics believe the rule creates an unnecessary new bureaucracy that will make running Medicaid even more difficult for states and stifle progress that states have made in simplifying Medicaid and SCHIP.

In the meantime, federal auditors have been reviewing state Medicaid programs to crack down on methods that states have been using to maximize federal dollars. One target of regulation has been the use of creative financing mechanisms that states use to pay for programs that otherwise would be funded solely by the state. States claim the maximum federal Medicaid match and then, through a practice known as intergovernmental transfers, direct the enhanced federal funds (in many instances, payments meant for providers) to programs other than Medicaid, such as county government programs or transportation projects. State and federal officials continue to debate the legality of this and similar practices. CMS claims that these “illegal recycling” practices shift the cost of the Medicaid program from state and local governments to the federal government.<sup>82</sup> The Bush administration recently accused Massachusetts of improperly obtaining more than \$580 million in federal Medicaid money without paying its share. Governor Mitt Romney continues to defend the state’s method of financing, claiming that the practice is approved by the federal government as one of the ways states provide health care to the poor and needy.<sup>83</sup>

Other efforts focus on enhancing administrative efficiencies in the Medicaid program. To combat waste and reign in costs, some states have even turned to the private sector. The state of Illinois is considering involving the private sector more in managing the state’s \$9.9 billion Medicaid program in order to provide more cost-effective care and control spending. Under the plan, disease management firms would help identify wasteful Medicaid spending, determine ways for people with chronic illnesses to avoid more expensive long-term care, and encourage beneficiaries to enroll in HMOs.<sup>84</sup>

In 2005, GAO designated Medicaid a “high-risk” program due to its greater vulnerability to fraud, waste, abuse, and mismanagement. The Medicaid program has been on the GAO’s “high-risk” list since 2003.<sup>85</sup>

## **Limiting Prescription Drug Costs**

**Position 13: Efforts to limit prescription drug costs under Medicaid should target proven overpayments for prescription drugs rather than limits on beneficiary access to prescription drugs. Medicaid patients should have access to prescription medications based on their individual needs as determined by their physician. States should not limit the number of prescriptions or the number of pills per prescription.**

Medicaid’s growth rate is also affected by the rising cost and utilization of prescription drugs. For prescription drugs, alone, Medicaid spending soared to \$34 billion in 2003, from \$23.6 billion in 1998.<sup>86</sup> Prescription drugs now make up ten percent of total Medicaid spending.<sup>87</sup>

Every state’s Medicaid program covers prescription drugs. Although states are not required to offer this benefit, if they do they must comply with federal minimum standards. For instance, the federal limit on copayments is \$3 for a prescription drug, regardless of a family’s income.<sup>88</sup> Federal officials have proposed easing up on these

minimum standards by allowing states to limit the number of prescriptions and the number of pills per prescription for adults as long as such limits keep the drug benefit “sufficient in amount, duration, and scope” to meet the needs of most adults.<sup>89</sup>

Without federal action, states began turning to preferred drug lists and formularies to help manage the high cost and utilization rates of prescription drugs covered by Medicaid. In April 2004, the U.S. Court of Appeals for the District of Columbia Circuit upheld a lower court decision that a Michigan’s Medicaid drug formulary was legal.<sup>90</sup> Assured that these money-saving strategies do not violate federal rules, more than half the states have enacted legislation pertaining to Medicaid preferred drug lists, prior authorization, supplemental rebates, generic drug substitution, co-payments, and prescribing and dispensing limitations. The laws include everything from studying the issues to creating programs.<sup>91</sup> Critics of these alternatives cite the fact that limiting access to prescriptions drugs can be detrimental to patients and costly in the long-run, since patients may seek emergency care as a result of their inability to access necessary drugs.

To reign in the cost of prescription drugs, the Bush Administration has also proposed limiting Medicaid payments for prescription drugs. Federal investigators have reported that Medicaid wastes hundreds of millions of dollars a year by overpaying for prescription drugs. Pharmacies have been accused of receiving Medicaid payments far more expensive than what it cost them to buy the drugs from manufacturers and wholesalers, while manufacturers have reported false and inflated prices to Medicaid. In a recent case in Texas, two companies had to pay the state \$45 million to settle such charges. One of the Administration’s initiatives would link payments to actual market prices, which are often much lower than the list prices reported by drug companies.<sup>92</sup> It is estimated that reforms to ensure that states pay the same low price as pharmacies for prescription drugs under Medicaid would save the federal government \$15 billion over the next ten years and would save state governments \$11 billion.<sup>93</sup>

As stated in previous ACP policy, a method of pricing Medicaid payments for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products.<sup>94</sup>

ACP continues to favor financial incentive arrangements linked to cost-effective practices rather than formulary compliance. Should formularies be used, it is critical that they not operate to the detriment of patient care, such as those developed primarily to control costs. Formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically indicated cause) without cumbersome prior authorization requirements.<sup>95</sup>

## **Modifying Coverage of the Dual Eligible Population**

**Position 14: ACP supports changes in the “clawback” provision of the Medicare Modernization Act to relieve short- and long-term financial pressures under state**

## **Medicaid programs that may occur due to the shift in dual-eligible drug coverage from state Medicaid programs to Medicare.**

Coverage of the dual eligible population is one significant factor that makes Medicaid so expensive for the states. Dual eligibles are low-income elderly or disabled individuals who are enrolled in both Medicare and Medicaid. As enrollees of Medicaid, they are eligible for state coverage of prescription drug benefits. Currently, 42 percent of all Medicaid benefits paid by states are delivered to Medicare beneficiaries, despite the fact that they comprise a small percentage of the Medicaid caseload and are already fully insured by Medicare.<sup>96</sup>

As part of the Medicare prescription drug benefit (Part D) authorized under the Medicare Modernization Act (MMA) of 2003, starting in 2006, Medicare will take over the drug benefit that is currently provided to dual eligibles through Medicaid. Lessening Medicaid's liability for one of its highest expenses could benefit the program and particularly benefit states. If Medicare fully assumed the cost of drug coverage for this population, Medicaid spending for the dually eligible would be reduced by up to \$16 billion, while Medicare coverage of people eligible for Social Security Disability Insurance (SSDI) without a two-year waiting period could save the Medicaid program \$4 billion.<sup>97</sup> However, under the MMA, states are expected to help pay for this reform through a mechanism commonly referred to as the "clawback." The "clawback" is a monthly payment that each state will be required to pay the federal Medicare program beginning in January 2006. The amount of each state's payment will roughly reflect what the state would have spent out of its own funds if it continued to pay for prescription drugs through Medicaid on behalf of dual eligibles. The CBO estimates that over the first five years of the benefit, the states will pay \$48 billion toward Part D drug coverage, representing the largest single flow of funds from states to the federal government from 2006 onward.<sup>98</sup>

The recent ACP policy monograph entitled, "The Effects of the Medicare Modernization Act on Qualified Medicare Beneficiary Drug Benefits: Recommendations for Quality Maintenance,"<sup>99</sup> discusses in further detail changes that will affect states and dually eligible populations as a result of the Medicare Modernization Act of 2003.

## **Conclusion**

The Medicaid program has a proven track record in providing coverage to our most vulnerable populations, but its effectiveness has been limited by eligibility restrictions and funding constraints. To reform the program without disrupting what it already succeeds at doing, it is necessary that the program continue to guarantee that individuals who qualify for the program receive benefits and that states willing to commit resources to provide covered services receive matching federal dollars.<sup>100</sup>

ACP's own proposal to expand health insurance represents a shift to a system of federal funding that requires good coverage outcomes, rather than state compliance with federally-mandated procedures. Rather than imposing new unfunded mandates, states

would be given increased flexibility—and more federal dollars-- to cover the uninsured without cutting current benefits. Medicaid's entitlement to care has been the cornerstone of the program since its inception in the 1960s. The dismantlement of this structure would not only be in direct conflict with ACP's goal of ensuring that all Americans have access to health care, but would pose a serious threat to the health of our neediest patients.

Although reducing growth in the Medicaid program would help shrink future budget deficits, the risks it carries are too significant to be ignored. Through careful planning, an expansion of Medicaid and SCHIP could extend coverage to millions of uninsured Americans and prove to be a worthy investment.

## **Glossary**

|              |                                              |
|--------------|----------------------------------------------|
| <b>CBO</b>   | Congressional Budget Office                  |
| <b>CMS</b>   | Centers for Medicare and Medicaid Services   |
| <b>FEHBP</b> | Federal Employees Health Benefits Plan       |
| <b>FMAP</b>  | Federal Matching Percentages                 |
| <b>FPL</b>   | Federal Poverty Level                        |
| <b>GAO</b>   | Government Accountability Office             |
| <b>HHS</b>   | U.S. Department of Health and Human Services |
| <b>HMO</b>   | Health Maintenance Organization              |
| <b>MFCUs</b> | Medicaid Fraud Control Units                 |
| <b>MMA</b>   | Medicare Modernization Act of 2003           |
| <b>NGA</b>   | National Governors Association               |
| <b>SCHIP</b> | State Children's Health Insurance Program    |
| <b>SSDI</b>  | Social Security Disability Insurance         |

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