Other workgroup members were extremely concerned that allowing states to cap access to a Medicaid service included in the state plan sets a dangerous precedent that undermines the individual entitlement to services that is a fundamental feature of the Medicaid program. Ultimately, the group concluded that keeping the current Medicaid waiver program but also allowing states to implement home and community-based services as a distinct optional *program*, like the Program for All-Inclusive Care for the Elderly (PACE), rather than as an optional *service* best balanced these multiple concerns.

The workgroup recommended that states be able to continue to cap enrollment for home and community services under a new separate state program. The group also believed that capping enrollment would be a temporary step necessary to allow the system to evolve, to encourage innovations, and to allow states time to put care-management and managed care systems in place in order to better manage program expenditures.

Therefore, the workgroup further recommended that limits on the number of clients in target population programs be phased out over time.

Some workgroup members also voiced a concern that allowing states to cap access to home and community-based services but not institutional services would reinforce Medicaid's current institutional bias. However, the group concluded that the ability to use different functional criteria for nursing homes and for community-based services, as recommended in the eligibility section of this report, would adequately address this issue.

Improving states' ability to manage access to long-term care services

As previously discussed, the majority of the workgroup believed that states would not avail themselves of the benefits of a new home and community-based services program without the ability to contain costs by limiting beneficiary participation in the program. But the workgroup also believed that states would ultimately prefer to contain long-term care costs by helping beneficiaries access the least costly long-term care services that meet their needs. Further, the group concluded that many states do not currently possess the infrastructure they need to effectively manage beneficiaries' access to services. Beneficiaries may access long-term care services from multiple points while, in general, acute care services are accessed through physicians or hospitals. Thus, workgroup members decided that they needed to develop recommendations to improve the organization and coordination of long-term care services even though they did not address delivery system issues for the acute care benefit.

The workgroup recommended that states be able to choose to implement one or more of the following delivery system options to provide them with more effective tools to manage access to long-term care services. [25]

[25] Specific workgroup recommendations for the delivery of long-term care services and supports through these options are described later in this section.

- **An unmanaged fee-for-service delivery system:** States would be required to ensure that applicants received an assessment and a plan of services. This delivery system would consist mainly of nursing home and home health services, services which are mandatory under current federal Medicaid rules. Home and community-based care services would not be included in this option, because they are only available in conjunction with case management.

- **A care managed fee-for-service delivery system:** States choosing this option would be required to ensure that clients receive an assessment, a plan of services, and other care management services. The care management, or comprehensive entry point system, would include providing information and assistance about long-term care services to the general public, screening and assessment, care plan development, service authorization, service monitoring, reassessment, and coordination with other programs and funding sources that may be outside the control of the organization. Services available would include those that states must offer under current Medicaid rules (nursing home and home health) and those that they can offer without a waiver (ICF-MR and personal care), as well as those that can only now be offered under a waiver (long-term services and supports and HCBS for selected populations). Medicare would reimburse states (or providers) for medical or interdisciplinary care coordination for dual eligibles. It is assumed that Medicare remains fee-for-service or with a managed care option.

- **A risk-based, capitated managed care delivery system for long-term care services:** States would be required to ensure that clients receive an assessment, a plan of services, and other care management services. This system provides a capitated payment for enrolled individuals, and the managed care organization is at financial risk. Services include both those that can now be offered without a waiver and those home and community-based services for selected populations that can now only be offered under a waiver. Medicare would reimburse states (or providers) for medical and/or interdisciplinary care coordination for dual eligibles. Acute Medicare services would be available through the fee-for-service or managed care systems.

- **An integrated acute and long-term care service system**: Acute and long-term care services with both Medicaid and Medicare financing would be provided through one managed care organization. The risk-based managed care plan would provide all benefits with some negotiated carve-outs. Any savings would be shared by Medicaid and Medicare.

The workgroup recommended that under the new HCBS program, states be allowed to choose to provide optional populations (those with incomes above the minimum national eligibility threshold) more restrictive choices of delivery systems than they provide to the mandatory population.

The workgroup envisioned that:

States should be allowed to control optional populations' access to long-term care services more strictly than they control the mandatory population's access.

- Mandatory eligible groups would have the full range of delivery system options that a state chooses to implement. Home and community-based services and supports would be available, however, only through a care management or managed care system.

- For optional eligibility groups, the states could choose to:
  - limit beneficiary choices to managed delivery systems such as those described above;
  - enroll beneficiaries into a single (delivery system) plan, rather than being required to provide choices of two or more delivery systems (plans) as they are now under current CMS policy interpretation;
  - only offer access to long-term care benefits through a care management or managed care system; or
  - only offer long-term care services based on an individual assessment of care needs and a determination of what is adequate to meet the client's needs (that is, clients might not have a choice of nursing facility care if a home care or alternative residential care option is available and appropriate).

States choosing to implement any of these delivery system options would be required to provide nursing facility services to members of mandatory and optional groups if the person had sufficient functional impairments to qualify for nursing facility care and the community services program was not available to the individual.

Allowing states to offer consumers greater ability to manage their own care

The workgroup recommended that states be allowed to expand their use of consumer-directed care.

Consumer-directed care offers consumers the ability to choose and direct some or all of the Medicaid-financed community-based services for which they qualify. The workgroup believed that expanding consumer-directed care would provide states an important tool for achieving their goal of allowing "for the design of benefit packages that ensure access to health and support services in order to meet the health care needs of covered populations." Consumer-directed care (or self-determination) provides for consumer autonomy and reduces dependence on agency-provided services; provides consumer control over attendant hiring, supervision, and firing; gives consumers choices over who provides very personal services; improves consumer satisfaction and quality of service; addresses the workforce shortage problem; and may control costs.

The workgroup was particularly interested in the extension of two existing demonstration programs.

- **The group recommended extending the Cash and Counseling Demonstration.** This program is a consumer-directed model of care that provides beneficiaries a flexible allowance, or budget, to purchase and manage their own care services.[26] This method of obtaining benefits can be applied to both the state plan personal care services and to personal care/homemaker services in home and community-based services. Based on an assessment of functional capacity (conducted by a care coordinator) and unmet needs, an "independence budget" or "consumer care account" is established. Consumers are able to receive services that meet defined unmet needs rather than choosing only from a menu of defined services. The consumer account gives beneficiaries the flexibility to purchase services that meet a need identified in the assessment and may be more cost-effective than menu-based service arrangements.

- **The workgroup recommended extending the "money follows the person" concept beyond residents of nursing homes to include residents of ICF-MRs and for individuals with long-term mental illness.** This concept refers to a system of flexible financing for long-term care services that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change."[27] Beginning in Texas, several states have implemented such programs to overcome barriers in their home and community-based services waiver program operations.[28] The programs give HCBS waiver program slots to individuals being discharged from nursing facilities and allow some of the Medicaid funding stream to follow the client to community living. This mechanism can be used to prioritize HCBS program slots in state programs that are closed to new admissions. This prioritization process allows states to give priority for community services to nursing home residents.

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[26] Stacy Dalem et al., "The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas." *Health Affairs Web*, Nov. 19, 2003. Retrieved 17 April 2004. http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.566v1.pdf. See also Robin Stone, "Providing Long-Term Care Benefits in Cash: Moving to a Disability Model,"*Health Affairs* 20(6) (Nov/Dec, 2001): 96-108.

[27] Suzanne Crisp, Steve Eiken, Kerstin Gerst, and Diane Justice, "Money Follows the Person and Balancing Long-Term Care Systems: State Examples." September 2003. Centers for Medicare & Medicaid Services. Retrieved 17 April 2004. http://www.cms.hhs.gov/promisingpractices.

[28] "Texas—Appropriations Rider: Promoting Independence 'Money Follows the Person;' Shifting Funds from Nursing Facility to Community-Based Services Budgets When People Leave Nursing Facilities." Centers for Medicare & Medicaid Services. Retrieved 1 April 2004. http://www.cms.hhs.gov/promisingpractices/moving.asp.

Improving Coordination between Medicaid and Medicare

Approximately six million Americans are full benefit dual eligibles, eligible for the benefits conferred by both the Medicaid and Medicare programs.[29] Since Medicaid is a secondary payer to Medicare, dual eligibles have their inpatient and physician services paid for by Medicare, while long-term care and pharmacy services are paid by Medicaid (until the new Medicare pharmacy benefit commences in January 2006). Medicaid also pays the out-of-pocket expenses related to Medicare (premiums, deductibles, and copayments).

Full benefit dual eligibles are the most expensive members of *both* the Medicaid and Medicare programs.[30] Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, and more likely to have chronic health conditions and to need institutional care. For instance,

- Dual eligibles are more than four times more likely than other Medicare beneficiaries to have a cognitive or mental impairment (40 percent of dual eligibles compared to 9 percent of non-dually eligible Medicare beneficiaries);

- Dual eligibles are more than twice as likely as other Medicare beneficiaries to be members of minority populations (42 percent of dual eligibles compared to 16 percent of non-dually eligible Medicare beneficiaries);

- Dual eligibles are more likely then other Medicare beneficiaries to suffer from a chronic and serious health condition such as diabetes, pulmonary disease, or stroke;

- Over 60 percent of dual eligibles have a limitation in at least one activity of daily living (such as eating, dressing, or bathing) that would require attendant care, a benefit available in most Medicaid programs but unavailable in Medicare; and

- Medicaid pays nursing homes for serving many more Medicare beneficiaries than does Medicare.[31]

Current policies provide dual eligibles with a full range of health care benefits, at no or low cost to the individual (depending on the state). However, the current situation also creates challenges in care coordination, quality oversight, program administration, and coordination of benefits.

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[29] Kaiser Commission on Medicaid and the Uninsured, *Dual Enrollees: Medicaid's Role for Low-Income Medicare Beneficiaries* (Washington, DC: The Commission, February 2003).
[30] Unless otherwise indicated, the remainder of this section will focus on "full benefit" dual eligibles.
[31] Jennifer Ryan and Nora Super, "Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?" National Health Policy Forum Issue Brief No. 794, September 30, 2003: 3.

The workgroup recommended that the federal government and the states embark on a new conversation about how to finance and deliver long-term care services provided by state Medicaid programs to dual eligibles.

Due to the aging of the population, federal civil rights policy enacted through the Americans with Disabilities Act and interpreted through the Olmstead decision,[32] and Medicare's limited long-term care benefit design, the financing of long-term care is a matter of national significance. A federal/state dialogue on the issue should seek to advance four key goals:

- Simplicity;
- Administrative ease;
- Delivery of long-term care services (where, when, and how duals want to receive these services); and
- Coordination of care across settings, benefits, and payers.

Recognizing that fundamental changes in the nation's approach to long-term care needs will take time, the workgroup recommended the following specific steps that should be taken to improve the functioning of existing programs.

Care coordination

Medicare should pay for care coordination as a covered benefit.

Care coordination between Medicare and Medicaid, administered by different government entities, is lacking but could benefit dual eligibles and both programs. For example, Medicaid pays the nursing home costs for just under 70 percent of the nation's nursing facility residents. For more than half of these individuals, the nursing facility stay began as a post-acute admission following a hospital stay, which was covered by Medicare. The hospital stay led to a nursing facility admission for short-term rehabilitation services (again covered by Medicare) but, after a time, the Medicare coverage ended, the resident was not discharged, and she then spent down her assets until Medicaid became the individual's insurer.[33] In this all-too-common situation, Medicare served as the gateway to the nursing facility admission.

In turn, Medicare inpatient services can be avoided if dual-eligibles receive effective Medicaid long-term care services. For instance, the quality of care rendered by Medicaid-paid nursing homes is related to the utilization of Medicare-paid inpatient hospital care: avoidance of falls and bedsores during a Medicaid nursing home stay helps the Medicare program to avoid unnecessary hospitalizations. But coordination of care across these long-term care and inpatient settings is extremely uncommon.

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[32] Olmstead v. L.C., 527 U.S. 581 (1999). Retrieved 16 April 2004. http://www.cms.hhs.gov/olmstead

[33] Jennifer Ryan and Nora Super, "Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?" National Health Policy Forum Issue Brief No. 794, September 30, 2003.

The workgroup recommended that Medicare pay for care coordination as a covered benefit.

Care coordination is a benefit to assist patients in navigating and coordinating the services they receive from direct care providers such as physicians, and it has proved to be an effective clinical practice for persons with chronic conditions.[34] Care coordination can prevent acute exacerbations of chronic conditions, reduce the use of multiple prescription medications, and provide information about alternatives to nursing facility care.

The workgroup also recommended that Medicare and state Medicaid programs share data on service utilization by dual eligibles in order to improve care coordination.

This might involve developing data sharing arrangements (including confidentiality protocols, common files and interfaces, and common fields) in order to transmit information on a regular and timely basis from Medicare to state Medicaid agencies.

Quality oversight and program administration

Apart from care coordination challenges, the administration and policies of the Medicare and Medicaid programs make it difficult for the programs to achieve quality outcomes. The two programs:

- Do not coordinate quality initiatives or outcome measures in such areas as hospital admissions from Medicaid-funded nursing facility stays (to identify preventable hospitalizations related to poor quality in Medicaid-paid nursing home care);
- Do not coordinate delivery system models (such as managed care initiatives); and
- Do not coordinate provider participation standards, to make it simpler for providers to comply with a uniform set of expectations.

These gaps in policy and administrative coordination compound the challenges of service/care coordination and may hinder quality oversight and care coordination for dual eligibles.

[34] Arnold Chen, Randall Brown, Nancy Archibald, et al. "Best Practices in Coordinated Care." Mathematica Policy Research, Inc., 2000. Retrieved 15 January 2005. http://www.mathematica-mpr.com/publications/PDFs/bestpractices.pdf

The workgroup recommended that the Medicare program mandate that Medicare quality improvement organizations (QIOs) identify dual eligibles as a subsample in quality reviews.

This would improve monitoring of the quality of care rendered to dual eligibles, a benefit to both programs given the previously discussed difficulties in coordinating care.

The Medicare Modernization Act will attempt to revive Medicare managed care. Because states also operate managed care programs that affect dual eligibles, a number of policies could be improved to coordinate managed care across the two programs.

Specifically, f**or Medicare Advantage health plans to receive Medicaid-financed premiums, copayments, and other forms of cost sharing, the workgroup recommended that the state have the option to require the Medicare Advantage health plan to contract with the state**. This could help to facilitate coordination with the Medicaid program.

The group also recommended that Medicare ensure that its risk adjustment methodology adequately address enrollment of dual eligibles in managed care plans. Historically, the Medicare program has not adequately considered the financial risk associated with placing dual eligibles in Medicare managed care. In terms of Medicare costs alone, dual eligibles are more expensive than non-dual Medicare beneficiaries. Without the use of adequate measurement or risk adjustment to calculate Medicare managed care payments, Medicare has underfunded managed Medicare health plans for dual eligibles and created an enrollment barrier. Recent changes in Medicare that are designed to better incorporate risk adjustment into managed Medicare are welcome ones. Nevertheless, Medicare should ensure that its risk adjustment methodology adequately address enrollment of dual eligibles in order to assure better access to managed Medicare programs.

Workgroup members believed that improved data sharing between Medicare and Medicaid would provide several important benefits for both programs. Shared data could be used to improve care coordination. It could also be used to improve program integrity. Accordingly, the group developed two recommendations.

- **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.**

- **All Medicare claims data should be matched with state Medicaid data to improve fraud detection.**

Overlapping benefits

Challenges arise when the benefit design of the two programs covers certain benefits simultaneously, yet in a fragmented way. When this occurs, Medicaid may pay for a service even though Medicare, as primary insurer, should bear the responsibility. For example, Medicare commonly only covers home health care for homebound Medicare beneficiaries. When Medicare incorrectly denies home health care for a dually eligible person, improperly asserting he/she is not homebound, Medicaid often ends up providing the home health benefits.[35]

For benefits offered by both programs, Medicare should review its policies governing payment adequacy, benefit design, and medical necessity.

Access to the Medicare benefit depends not only on the coverage criteria for the benefit (for example, being homebound); it also depends on other factors, such as whether Medicare pays its providers adequately and timely. When the Medicare program incorrectly denies access to its benefits, or fails to ease delivery of the benefit based on other factors (payment rates, medical necessity criteria), and Medicaid also offers that benefit, then Medicaid pays when it should not.

To address these issues the workgroup recommended that, for benefits offered by both programs, the Medicare program 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. Further, the workgroup recommended that, in the future, when Medicare takes an action that financially affects a state Medicaid program, the federal government should confer with the affected state before approval.

[35] The Lewin Group. *Medicaid Cost Containment: Report No. 3*. Prepared for the Washington State Legislature. January 2003: 48.

FINANCING

This section focuses on recommendations to improve and restructure Medicaid financing, to align Medicaid funding requirements with state and federal financing capacities, to make the funding formula work in times of economic downturn, and to ensure fiscal integrity in Medicaid financing.

Financing Recommendations

Overall approach: The workgroup recommended against the use of block grant approaches for financing Medicaid. It recommended improving on the federal-state partnership by adjusting the federal matching approach.

FMAP formula: The formula for determining the federal medical assistance percentage (FMAP) should be adjusted so federal Medicaid matching funds are more counter-cyclical and sensitive to downturns in the economy and employment.

Federal-state roles in financing: The federal government should play a larger role in financing care for those dually eligible for Medicaid and Medicare. The federal Medicare program should bear a greater burden for the cost of long-term care services and also for acute care services for dual eligibles. A mechanism should be established so services provided by Medicaid could be coordinated with Medicare.

Enhanced match for new mandatory populations: The federal government should match state spending at the higher SCHIP rate for people with incomes below the federal poverty line who the workgroup recommends be made eligible for Medicaid without regard to age or family structure.

Defining qualifying Medicaid expenditures: Federal definitions of expenditures that qualify for federal Medicaid matching funds should be reviewed to ensure the fact and perception of fiscal integrity in every aspect of Medicaid spending.

Clarifying rules: Federal rules should be clarified and revised relating to federal funding for legal immigrants and Native Americans and for services provided in certain institutions.

Premium Assistance: Federal rules should be changed to facilitate states' use of premium assistance programs by, among other things, allowing states to implement some policies under a state plan amendment that they can now only implement under a Section 1115 waiver.

Long-term care insurance: To increase third-party payment for nursing homes and community-based services, states should encourage private long-term care insurance, while recognizing the limitations of this approach.

Introduction

Early in its deliberations, the workgroup established several goals related to the financing of the Medicaid program. Among them:

- *Structure state and federal financing so that benefits are stable and the integrity and balance of the state-federal relationship is maintained, particularly during economic downturns.* The group believed that it is important for Medicaid financing to support the ability of states to maintain benefit coverage when the economy is poor and enrollment in the program increases.

- *Divide program costs fairly between federal and state governments so states are able to continue to afford their share into the future.* The workgroup believed that clarification of program rules would help to avoid many of the controversies that currently arise between states and the federal government around Medicaid financing.

- *Coordinate resources and financing at the community level and with SCHIP and Medicare.* The workgroup believed that any restructuring of the program must consider Medicaid's interaction with other sources of health care funding.

- *Allow for effective cost controls without sacrificing access to care or quality.* The group believed that states must be given the tools to manage Medicaid programs efficiently and in a manner that assures the integrity of the program.

Current policies governing Medicaid financing

Medicaid is a state/federal partnership in which states receive federal matching funds, known as federal financial participation (FFP), based on their actual expenditures on medical services and related administrative costs. Medicaid is currently financed as an open-ended entitlement to individuals and to states.[36] For an enrolled individual, this means that Medicaid must pay for the provision of any medically needed service included in the state's Medicaid plan, regardless of the state's financial situation. For states, the entitlement means that for every dollar spent on Medicaid-covered services to Medicaid-eligible individuals, the federal government must reimburse the state for the federal portion of the cost with no aggregate limit on the amount that can be reimbursed.

State Medicaid expenditures are matched according to the federal medical assistance percentage (FMAP) formula established in Title XIX of the Social Security Act. The FMAP formula is intended to adjust for differences in state fiscal capacity and reduce program benefit disparities across states by providing proportionately more federal funds

[36] For additional information about how Medicaid is currently financed, see Andy Schneider, Risa Elias, Rachel Garfield, David Rousseau, and Victoria Wachino, *The Medicaid Resource Book* (Washington, DC: Kaiser Commission for Medicaid and the Uninsured, July 2002).

to states with weaker tax bases and larger low-income populations. The FFP currently ranges from 50 percent to 77 percent. On average, the federal government pays 57 percent of the cost of Medicaid programs in the nation, and states finance the remaining 43 percent.

The current financing system has several benefits for both individuals and states.

- As the costs of providing health care increase, the federal government's commitment to providing matching funds means that states can count on the federal government as a partner in financing so that states do not bear more than their share of both planned and unanticipated growth in spending. This feature is particularly beneficial in times of economic downturn (when Medicaid rolls tend to increase because of unemployment) and unanticipated public health needs (such as when AIDS became a major health cost driver in the 1980s), and as expensive new medical treatments and technologies become available.

- Eligible individuals are assured coverage because funding for covered services is not capped and must be offered on a statewide basis in a comparable manner for all who are eligible, and in sufficient amount, duration, and scope to meet the needs of the population.

- The current system motivates states to extend health coverage to their low-income residents because the federal government pays for at least 50 percent of the cost. It also encourages states to maximize federal revenue by structuring health-related services delivered by other state agencies, such as mental health agencies, so that they qualify for Medicaid reimbursement.

- States share in the cost of providing Medicaid services. This creates an incentive for states to control costs.

States and the federal government also have several reasons to want to change the current open-ended entitlement structure.

- Medicaid growth rates can vary significantly from year-to-year making costs for both states and the federal government unpredictable.

- Rapid and sustained growth in program costs is a major challenge for state and federal budgets. Rising Medicaid costs make it more difficult to fund other priorities.

- States, seeking to control their costs, have an incentive to maximize federal revenue. As a result, they have often sought ways to claim federal matching funds for expenditures of state or local funds that cover services that qualify for Medicaid reimbursement. This, of course, increases federal costs.

The workgroup considered alternative financing approaches for Medicaid that included block grants, capped allotments, and per capita caps. **The group determined that the**

current financing structure generally has served the Medicaid program well over its history and should be retained to support current and future goals for the program. The group considered and recommended against fundamental change in the financing structure for Medicaid. Nonetheless, it concluded that it was important to address specific problems with the current financing system.

The workgroup identified three key concerns with the current financing structure.

- *The current FMAP formula does not respond quickly to changes in the economy.* This problem has been highlighted during the recent economic downturn when decreases in state revenue forced most states to take steps to contain costs, such as reducing reimbursement to providers and program eligibility. The group recommends making the FMAP formula more responsive to changes in state economies and the national economy.[37]

- *The balance between federal and state fiscal responsibility is not always clear and does not reflect Medicaid's role in the 21st Century.* This has created tension between the states and the federal government in two specific areas:
    - The perceived "gaming" of the system by states seeking to maximize federal revenue has made some federal officials distrustful of the state role.
    - The cost of serving certain groups of people (e.g., legal immigrants, Native Americans, and those eligible for both Medicaid and Medicare) and providing some services (e.g., long-term care services and services provide to residents of certain institutions) are viewed by some states as appropriately a federal responsibility.

- *As they are in the private sector, costs are increasing.* The growth in health care costs is a source of concern on a national level for both public and private programs. The Medicaid program alone cannot solve the problem of ever-increasing costs; however, the workgroup examined several areas that may strengthen the ability of states to contain costs. It recommends changes to:
    - facilitate the use of premium assistance programs,
    - improve program integrity activities, and
    - improve coordination with private long-term care insurance.

[37] To assist the MMW workgroup in its examination of the current FMAP formula, project staff commissioned a paper to examine three alternatives for amending the present FMAP structure. The paper, "Analyzing the Impact of Adjusting the Federal Medical Assistance Percentage to Improve the Countercyclical Impact," written by Vic Miller of Economic and Management Consulting, is available on the NASHP website. To access the document, go to Making Medicaid Work for the 21st Century at www.nashp.org.

Improving the FMAP Formula

The federal government reimburses states for Medicaid expenditures according to the FMAP formula established in Title XIX. The current FMAP formula is intended to adjust for differences in state fiscal capacity and reduce program benefit disparities across states by providing proportionally more federal funds to states with weaker tax bases and larger low-income populations. A recent study found that the formula narrows the average difference in states' funding ability by 20 percent. It moves 30 states closer to the national average funding ability after they receive their federal funding; however, it also moves 20 states further away from the national average.[38]

Using the FMAP formula, state-specific FMAPs are calculated each year based on per capita income (PCI) data. Each state's FMAP is published in the *Federal Register.* The formula adjusts for a state's ability to pay based on its per capita personal income. States with lower per capita incomes receive higher matching rates and vice versa. The formula is:

$$\textbf{FMAP} = 1.00 - .45 \times [(\text{State PCI})/(\text{U.S. PCI})]^2$$

State PCI in this formula is a three-year moving average of data from the National Income and Product Accounts (NIPA), published by the Department of Commerce. The three-year average is intended to assure stability in each state's FMAP from year to year. The .45 multiplier, established statutorily, determines the average state share of total Medicaid expenses; a smaller multiplier would increase federal outlays and a larger one would reduce them.

The statute also stipulates that no state should bear more than 50 percent of total costs, regardless of FMAP calculated through the formula. The minimum 50 percent federal matching rate assures states a minimum level of federal participation in (and commitment to) the program. Thirteen states benefited from this provision in 2002.

Because of the recent nationwide recession, Congress acted in May 2003 to provide temporary fiscal relief to state Medicaid programs. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (TRRA) provided state Medicaid programs with a temporary increase in FMAP of 2.95 percentage points for the last two quarters of FFY 2003 and the first three quarters of FFY 2004. The fiscal downturn highlighted one shortfall of the FMAP formula: it does not adjust quickly to changes in states' economic conditions. This limitation has led analysts to raise the option of adjusting Medicaid financing for cyclical fluctuations.

[38] U.S. General Accounting Office, *Medicaid Formula: Differences in Funding Ability Among States are Often Widened* (Washington, DC: GAO, July 10, 2003), Report #GAO-03-620.

While the existing FMAP formula works fairly well for the majority of states, several concerns have been raised about it over the years.[39] They include:

- Changes in a state's FMAP will lag changes in economic conditions by several years. For example, a state facing a recession in 2003 may have a relatively low FMAP because the calculation is based on data from 1998-2000 when the state's economy was better. Conversely, states may get a higher FMAP during better economic times because the data being used is from a period when the state economy was in recession.

- The NIPA income measure is not a good measure of state tax capacity. One of the key sources of state revenue, severance taxes that are levied on minerals taken from the ground, is not reflected in the NIPA measure. NIPA includes income that is non-taxable, such as the income of private non-profit organizations and private trust funds, and also excludes significant sources of state revenue, such as residents' realized capital gains. Therefore it does not adequately represent the states' tax base and ability to contribute to the program. In addition, it does not capture differences in the cost of living among states.

- The formula does not take beneficiary need into account. For example, a state with a high per capita income may also have a large population of people living below the poverty level. Such a state could argue that it should receive a higher FMAP to account for the disproportionate size of its poor population which tends to have proportionately higher health care needs.

Many options have been presented in the past to change the basic FMAP formula to better reflect a state's tax base, cost of living, or measures of need. These options have included using alternative measures to the PCI to calculate FMAP and lowering the minimum federal participation from 50 percent to 40 percent. However, these efforts have not succeeded because changes to the formula create winners and losers. In the past, Congress has opted to retain the existing formula rather than harm some states by drastically lowering the FFP they receive. The workgroup, therefore, focused specifically on changes that would make the formula more responsive to cyclical fluctuations in the economy. (NASHP contracted with Vic Miller, a recognized expert in this area, to prepare a background and options paper on this topic. The complete text of that paper is available on NASHP's website at www.nashp.org.)

[39] For a comprehensive discussion of the FMAP matching formula and its weaknesses see Linda Blumberg, et al., *Options for Reforming the Medicaid Matching Formula* (Washington, DC: The Urban Institute, February 18, 1993), and Vic Miller, "Fiscal Federalism and Medicaid," *Spectrum: The Journal of State Government*, Spring 2003.

Making the FMAP formula more responsive to economic downturns by using more current data

As previously noted, the three-year average of state per capita income used in the FMAP formula ensures stability in the matching rates from year to year; however, it is unable to offset state revenue shortfalls during difficult economic times because of time lags in the data.

The workgroup analyzed two alternatives to address the time lag issue.

1. Calculate FMAPs using the current formula, except use only the latest *two years* (instead of the latest three years) of per capita income data. This would eliminate data that is almost five years old when the FMAP rate is effective and help to ensure that the rate more closely reflects current economic conditions.

2. Calculate FMAPs using the current formula. But, in addition to reducing the number of years included in the calculation to two, also use the *preliminary* (instead of final) state personal income data published by the Bureau of Economic Analysis each April. Using the preliminary data would reduce the lag between the personal income data and the year to which the FMAP applies by one year. For example, under the current methodology, the most recent data included in the FY 2005 FMAP calculation would be 2002 data. Just changing the formula to use the preliminary data would allow the calculation to include 2003 data. Further, changing the formula to both use the preliminary data and reduce the number of years considered in the calculation from three to two would result in the 2005 FMAP being calculated based on calendar year 2002 and 2003 data rather than calendar year 2000, 2001, and, 2002 data. Due to the timing in the release of the data, this option would delay the publication of the FMAP by six months.

Analysis of these two methods both showed that states with the lowest economic momentum would have received a larger share of Medicaid dollars. However, the second alternative creates a concern because of the delay in publication. This structure would make a final FMAP unavailable to governors preparing their budgets and to some state legislatures before enacting a budget.

Therefore, the workgroup recommended that the FMAP formula be revised to calculate the FMAP based on a two-year average of PCI data.

Increasing individual states' FMAP during times of statewide high unemployment

Personal income changes alone inadequately capture the needs of fiscally distressed states, and some argue that using unemployment data to supplement the personal income information would direct additional funds to states most in need during an economic downturn. (Unemployment rates are readily available and are well accepted as an indicator of economic conditions.)

While a wide variety of structures could be used, the workgroup considered two options designed to target states most in need. These options would use average unemployment rates for a calendar year (e.g., 2003) to provide additional assistance to states for the then current fiscal year (e.g., 2004). The adjustments would be made every year and would only apply to states with the most need. The two alternatives analyzed were:

1. Increasing FMAPs to states with global unemployment rates exceeding 120 percent of the national average.

2. Increasing FMAPs for one fiscal quarter for states with high or increasing insured unemployment[40] rates. This option would provide additional FMAP for the final quarter of a fiscal year only. The approach would add 0.10 of a percentage point to a state's FMAP rate when that state's insured unemployment rate exceeded 3 percent and an additional 1.0 percentage point if the rate had increased more than 50 percent above the previous year.[41]

The workgroup agreed in principle that federal statute should include an annual adjustment to the FMAP that is designed to help a limited number of states with the most need.

The federal government should pay a higher percentage of Medicaid costs during economic downturns.

However, the group did not reach consensus on a specific method. The second option is preferred by the majority of the workgroup because it would help a larger number of states. These members also believed that unemployment rates are the most reliable and available data for use as an adjuster. A few members expressed concern that 1) unemployment may not be the best adjuster because it does not reflect a high number of senior citizens in the state or Medicaid enrollment, and 2) there

[40] The insured unemployed are those unemployed who are receiving unemployment insurance benefits.

[41] As noted previously, MMW project staff commissioned a paper to examine three alternatives for amending the present FMAP structure. The paper, "Analyzing the Impact of Adjusting the Federal Medical Assistance Percentage to Improve the Countercyclical Impact,"written by Vic Miller of Economic and Management Consulting, is available on the NASHP website. To access the document, go to Making Medicaid Work for the 21st Century at www.nashp.org.

was no clear rationale for selected levels at which the adjustment would be made. Therefore, the group suggested closer examination of the specific method to be used.

Increasing FMAPs for all or many states during periods of nationwide high unemployment

The workgroup also examined a set of options that would increase the FMAP to many or all states during periods of high unemployment.

The federal government's tax and spending structures automatically respond to changes in the economy, providing fiscal stimulus during downturns and fiscal restraint during boom periods. As tax receipts decline, spending for programs such as unemployment insurance and Food Stamps expands. While the federal government has responded in a limited way to states' fiscal needs in most recessions, it has no formal mechanism for doing so. In some years, new programs are created to assist states or provide fiscal stimulus; at times, additional funds are added to current programs; at times, nothing is done.

The workgroup considered mechanisms to permanently amend Medicaid financing so that it increases automatically all or most states' FMAPs during periods when the national (not an individual state's) average global unemployment rate equals or exceeds a specified level. For this discussion, the workgroup looked at a threshold level of 6 percent unemployment—exceeded in calendar year 2003—which would have adjusted the FMAP for the then current fiscal year (FY 2004). Two alternatives were considered:

1. Automatically add 0.10 percentage point to the FMAP for each 0.10 that a state's global unemployment rate exceeds the national average when the national level exceeds 6 percent. This option would help many, but not all, states.

2. Automatically provide one additional percentage point in FMAP to all states when the national average unemployment rate equals or exceeds 6 percent. Similar to the fiscal relief provided in TRRA, this approach acknowledges that all states faced severe budget constraints during the most recent economic downturn.

These options establish a formal mechanism for the federal government to respond to states' fiscal needs during a recession by permanently amending Medicaid, rather than relying on Congressional action in each specific instance. The workgroup agreed in principle on a permanent approach that would increase FMAP when a national trigger is reached. Most members also agreed that all states should receive additional FMAP when this occurs. A few members with dissenting views expressed concern that 1) not all states should receive the additional FMAP and 2) the trigger (a global unemployment rate equal to or greater than 6 percent) may not be set at the appropriate point.

Therefore, the workgroup recommended that the FMAP formula be changed by adding an adjustment into the formula to increase FMAP for most or all states when

unemployment exceeds a national trigger and suggests closer examination of the specific method to be used.

Recommendations to Guide Federal Policy on Matchable Expenditures

The workgroup recommended that federal rules and definitions of expenditures that qualify for federal Medicaid matching funds be reviewed to ensure the fact and perception of fiscal integrity in every aspect of Medicaid spending.

Rules governing the provision of federal matching funds for state Medicaid expenditures should be reviewed and clarified.

Medicaid law and rules define the conditions under which a state can claim federal matching funds for expenditures made in its Medicaid program. Few issues are more fundamentally important to Medicaid than the definition of what does and does not qualify for federal matching funds. Decisions about who to cover, what benefits to cover, and how much to pay for services often hinge on how the federal government provides matching funds for Medicaid expenditures.

Recently, the federal government has raised concerns about how states have used current rules such as the upper payment limit (UPL) and intergovernmental transfer (IGT) arrangements to claim federal matching funds.[42] These concerns have centered on whether these arrangements conform with Congressional intent that federal Medicaid matching funds, with few exceptions, be limited to Medicaid expenditures for specific medical services provided to enrolled beneficiaries. One of these exceptions relates to disproportionate share hospital (DSH) payments. DSH payments are not specifically associated with a medical service for an enrolled beneficiary, but instead provide funds to hospitals to help support their costs for uncompensated care. Another currently approved exception relates to UPL arrangements, these expenditures are associated with covered services, but may be paid outside the claims processing system. Many of these arrangements are funded through provider taxes or limited to public providers and involve intergovernmental transfers.

In some cases, the state acquires the funds that support these Medicaid payments from specific providers or provider groups, through provider taxes or IGTs. Federal proposals have been offered to limit or eliminate these arrangements as a source of the non-federal

[42] The upper payment limit is an aggregate ceiling on the total payment to a class of providers based on the amount that would have been paid under Medicare payment principles. Separate UPLs apply to state-owned, county- or locally-owned, and privately-owned hospitals and nursing homes. IGTs are the transfer of local public funds to the state Medicaid program for use as the state share for purposes of claiming federal matching funds. For more information, see David Rousseau and Andy Schnieder, *Current Issues in Medicaid Financing—An Overview of IGTs, UPLs and DSH* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2004).

share of Medicaid expenditures. States are concerned that these arrangements are fundamental to the way their Medicaid programs are financed. Proceeds from provider taxes, for example, often are used to finance provider payment increases or program expansions. IGTs have been used for many years in several states to help finance Medicaid.

The workgroup believed that it is necessary to address these issues as part of any recommendations for Medicaid reform and recommended the following principles to guide matching funds:

Matching of state expenditures for medical services

- Federal reimbursement for services should be paid only when state (or qualifying local) funds have been paid for Medicaid eligible services provided to Medicaid eligible consumers by a qualified provider at what the MMW workgroup defined as a "real" price.

- Federal standards regarding match should be clearly articulated in statute and formally promulgated in rules. Changes in statute or rules should be effective prospectively and provide reasonable transition time for states affected by a change.

- States should be able to use any legitimate source of state (and/or local) match pursuant to statute and promulgated rules.

- States should have full discretion in the use of earned federal revenue received as reimbursement for legitimate Medicaid claims.

Principles on uncompensated care

- A specific federal program (which could be part of Title XIX) should reimburse states for the federal share of state expenditures to cover the costs of uncompensated care. States could determine which types of facilities and providers are eligible to receive uncompensated care reimbursement.

- A pool of funds devoted to uncompensated care should be created using Disproportionate Share Hospital (DSH) funding and should be distributed to states based on the number of Medicaid beneficiaries and uninsured in each state. There should be a transition period from the current funding mechanism to the new funding mechanism.

Other recommended principles

- Federal statutes and rules should be explicit regarding how Medicaid interacts with other federal programs, especially regarding which program is the payer of last resort.

- Reimbursement standards should not undermine the principles of managed care, including the incentives inherent in prospective payment arrangements which allow health plans and their providers to substitute actuarially equivalent services for contracted services to better serve the specific needs of the enrollees. These alternative services need to be recognized in calculating the actuarial value of future contracts. To do otherwise unintentionally punishes the most creative and responsive health delivery systems.

Recommendations on Federal Financing of Certain Populations and Services

The Medicaid statute identifies populations that can be covered under the program and authorizes the federal government to make matching payments for expenditures relating to those populations and services. In some cases, these populations are mandatory, i.e., states are required to cover them. In other cases they are covered at state option. The statute also excludes certain groups from coverage. Some states have chosen to cover excluded individuals in their Medicaid programs, even though no federal matching funds are available for those individuals.

The workgroup examined federal rules governing which populations and services are eligible for federal matching funds and developed recommendations related to the federal funding of:

- Services provided to optional children, legal immigrants, Native Americans, and dual eligibles; and

- Services provided in acute psychiatric hospitals now classified as Institutions for Mental Disease (IMDs) and long-term care services.

Services provided to children in optional Medicaid groups and SCHIP[43]

The workgroup recommended that states should receive the enhanced SCHIP match[44] 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.[45]

Currently, SCHIP maintenance of effort (MOE) rules preclude states from receiving enhanced federal matching funds for services provided to children covered by Medicaid expansions that were implemented before SCHIP was enacted in 1997. As a result, the states that expanded Medicaid beyond the mandatory level prior to the enactment of SCHIP have felt penalized for their early and innovative work in expanding coverage for children. On the other hand, the federal government matches state Medicaid spending on an open-ended basis, while the SCHIP program is a block grant to states.

The workgroup agreed that the SCHIP MOE rules penalize the 33 states that enacted Medicaid expansions prior to the creation of SCHIP.[46] Most workgroup members believed that it was more equitable to provide the SCHIP enhanced match for expansions above a certain income level rather than for Medicaid expansions after a certain date in time. This change would ensure that states that cover children above mandatory levels are treated consistently. A few workgroup members raised concerns that this policy shift would increase federal costs and not increase the number of covered children (since they are already covered under SCHIP), although these members understood the importance of equity among states.

Services provided to legal immigrants

The federal government does not provide matching funds for some populations. One group that is excluded from coverage for five years is legal immigrants who enter the country after August 22, 1996. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 only allows states to claim federal matching funds for Medicaid services provided to legal immigrants after an individual accumulates five years of continuous residence in the U.S. Many states, nonetheless, cover legal immigrants in their Medicaid programs even before they have five years of residence.

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[43] See Appendix C for a summary of a discussion among SCHIP directors regarding these and other recommendations.

[44] Each state's enhanced SCHIP matching rate is equal to 70 percent of its Medicaid FMAP for the fiscal year plus 30-percentage points, not to exceed 85 percent—this rate is always higher than the Medicaid rate. (Source: CMS, *SCHIP Summary*, http://www.cms.hhs.gov/schip/about-SCHIP.asp. Retrieved 15 November 2004.)

[45] This is a different issue than the recommendation to offer enhanced match for all new eligibles (see the eligibility section of this report) because these children would not be considered new eligibles.

[46] Significant variations exist in the degree of expansion undertaken by these states. Some states undertook a very large pre-SCHIP expansion and others a very narrow one.

States argue that these individuals are in this country legally and should be treated the same as any other U.S. resident.

The workgroup recommended that 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.

Services provided to American Indians and Alaskan Natives

Services provided to American Indian and Alaska Native (AI/AN) beneficiaries in facilities run by the Indian Health Service (IHS) or a tribe are matched at 100 percent.[47] Some states, as well as tribes, have argued that the federal government should pay for all service costs for this population because of the unique federal trust relationship that the federal government has with AI/AN beneficiaries. In addition, the current system results in inequitable treatment of the cost of serving AI/AN depending on where they live, e.g., some may live where there is no access to IHS facilities or where the IHS system is less well developed. Since state Medicaid programs pay a large portion of the cost of serving those AI/AN who receive services outside of IHS or tribal facilities, many states feel that this is an example of how the federal government has shifted some of its responsibility to the states.

The workgroup recommended that the federal government pay for the full cost of services provided to AI/AN beneficiaries regardless of where they receive services.

Services provided to dual eligibles

The workgroup considered a proposed recommendation that the federal government provide additional financial support for long-term care services delivered by state Medicaid programs to dual eligibles. Consensus was not reached on this proposed recommendation. Proponents of the recommendation asserted that this reform would lead to more uniformity in long-term care benefits across states, and it would reflect the federal government's primary role as the insurer for benefits provided to dual eligibles. Those who opposed this recommendation asserted that the Medicare program never was intended to fulfill the role of long-term care insurer and that the recommendation is not politically feasible given the current financial picture at the federal level. This issue requires further discussion.

[47] State Medicaid costs for providing services to AI/AN at urban Indian programs are reimbursed at the regular matching rate for that state. (IHS provides funding to three types of Indian health care facilities: those operated directly by the federal government (IHS facilities), those operated by tribal governments under an agreement with the federal government (Tribal facilities), and non-profit organizations established in urban areas to serve American Indians (urban Indian programs).

Services provided in Institutions for Mental Diseases

Under current federal law, federal matching funds are not available for individuals ages 21 through 64 in an Institution for Mental Disease (IMD). While these individuals may retain their Medicaid eligibility, federal Medicaid matching funds are not available for services while they are residents of an IMD. The federal government has traditionally viewed long-term inpatient psychiatric services as a state responsibility, and the law reflects that position. States argue, however, that most hospitalizations today are of short duration and should be reimbursed like any other hospitalization. Reimbursing acute psychiatric hospitalizations (perhaps up to a limit of 21 days) is consistent with the original intent of the IMD exclusion, i.e., long-term hospitalizations would remain the responsibility of states.

The workgroup recommended that short-term acute psychiatric hospitalizations be covered at the state's usual Medicaid FMAP rate, regardless of whether those services are received in an IMD or not.

Incentives for states to offer home and community-based services.

States already have financial incentives to rebalance their long-term care service delivery systems (services in the community are generally less expensive and are preferred by beneficiaries).[48] The U.S. Supreme Court ruling (Olmstead v L.C., July 1999) and subsequent lawsuits in many states have lent further momentum and urgency to this effort.[49] But many states lag behind the leaders in developing community care systems and providing consumers with community care alternatives. Nine states currently allocate less than 20 percent of their Medicaid long-term care expenditures to home and community-based services.[50] The workgroup supported additional incentives to support further shifts to home and community-based services.

The workgroup recommended providing additional incentives to states to balance their systems and expand home and community-based services. They believed that a temporary, higher match on community-based care services, combined with grants to support infrastructure development, is needed.

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[48] Lisa Alecxih, Steven Lutzky, John Corea, and Barbara Coleman, *Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States* (Washington, DC: AARP Public Policy Institute, November 1996).

[49] Sara Rosenbaum, Joel Teitelbaum, and Alexandra Stewart, "An Analysis of Olmstead Complaints: Implications for Policy and Long-Term Planning," Center for Health Care Strategies, December 2001. Retrieved 16 April 2004. http://ww.chcs.org. See also Wendy Fox Grange, Barbara Coleman, and Donna Folkemer, *The States Response to the Olmstead Decision: A 2003 Update* (Denver, CO, National Conference of State Legislatures, February 2004).

[50] Steven Gregory and Mary Jo Gibson, *Across the States: Profiles of Long-Term Care, 2002, Fifth Edition* (Washington, DC: AARP Public Policy Institute, 2003).

The workgroup discussed ways to use enhanced matching rates to provide states with various incentives to expand and strengthen home and community-based services. For instance, a higher temporary federal match for these services could be targeted to Medicare/Medicaid (dual) eligibles. Or, in order to create incentives for states to implement system level changes, an enhanced match for the home and community-based services program could be tied to desired outcomes. The enhanced match could be conditional; to obtain the match, a state would, for instance, need to demonstrate progress toward serving more people in the community measured as a percentage of the total number of beneficiaries receiving long-term care or as a decline in Medicaid paid nursing home bed days.

Incentives to strengthen management and access to long-term care services

The workgroup also discussed additional incentives that could be created to strengthen management of the long-term care system. State initiatives to rebalance their long-term care systems often have common components that include a comprehensive planning process involving consumers and other stakeholders; an organized single entry point system at the local level providing access to a comprehensive spectrum of long-term care services; a comprehensive client assessment process; the development of a person-centered, comprehensive services plan; a process for monitoring and adjusting care plans as participant conditions change; and a quality assurance/quality improvement system.[51] States often have difficulty obtaining funding for the planning, policy development, and infrastructure development that are needed to shift utilization from nursing facilities to community services.

Premium Assistance

Premium assistance is a strategy in which a state uses public funds (e.g., Medicaid dollars) to pay for a portion of the cost of private coverage (usually employer-sponsored insurance, but sometimes coverage purchased in the individual market). Current use of premium assistance by states is minimal; only about one-third operate such programs, and enrollment ranges from less than 1 percent to about 4 percent of Medicaid enrollment. [52] Nonetheless, state interest in operating premium assistance programs remains high due to the potential benefits of such programs, among them:

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[51] Barbara Coleman, *New Directions for State Long-Term Care Systems: Second Edition* (Washington, D.C., AARP Public Policy Institute, October 1998).

[52] Claudia Williams, *A Snapshot of State Experience: Implementing Premium Assistance Programs* (Portland, ME: National Academy for State Health Policy, 2003). Retrieved 7 October 2004. http://www.nashp.org/Files/snapshot.pdf. See also Ed Neuschler and Rick Curtis, *Premium Assistance: What works? What doesn't?* (Washington, DC: Institute for Health Policy Solutions, 2003). Retrieved 7 October 2004. http://www.ihps.org/Prem%20Asst-What%20Works%20IHPs%20April2003.pdf. And Joan C. Alker, et al. *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity* (Washington, DC: Kaiser

- Premium assistance programs may strengthen the private insurance market and prevent substitution of private coverage by public coverage by encouraging (or requiring) Medicaid beneficiaries to participate in the health insurance plan offered by their employer.

- Premium assistance programs allow Medicaid agencies to capture employer contributions to the cost of delivering health care to Medicaid beneficiaries who qualify for employer coverage. This may lower the Medicaid agency's costs and allow the state to maintain or expand coverage.

- Such programs may ease the transition from public to private coverage since the beneficiary enrolled in a premium assistance program accesses much of his or her care through private insurance.

- Allowing children to enroll with their parents in a single health plan may increase the likelihood that children will be covered and will use preventive and other necessary medical services.

A report by the Kaiser Commission on Medicaid and the Uninsured suggests one reason for low enrollment in premium assistance programs. The report cites research showing that a major structural obstacle to implementing premium assistance in Medicaid is the limited extent to which low-wage workers have access to employer-sponsored health insurance.[53] In addition, policymakers report that some private plans in states with premium assistance programs have only allowed Medicaid beneficiaries who qualify for premium assistance to enroll in the private plan during the plan's open enrollment period. (They have done so using the authority of the Employee Retirement Income Security Act (ERISA.)) This further limits the share of Medicaid enrollees who can participate in such a program. Finally, there have been many reports that the administrative cost of starting a premium assistance program is high and represents a barrier to state implementation.[54] However, many workgroup members felt that premium assistance programs would be more widely used and serve more people if changes to Medicaid and ERISA law were made.

Commission on Medicaid and the Uninsured, October 2003). Retrieved 07 October 2004. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22138

[53] This paper cites a study that shows only 41 percent of workers with income below the poverty level were eligible for employer-sponsored insurance (ESI). Even among workers with family income between 100 and 199 percent FPL, only 62 percent were eligible for ESI. Source: Joan Alker, *Serving Low-Income Families Through Premium Assistance: A Look at Recent Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2003).

[54] *Maryland Children's Health Program (MCHP) Premium Private Option: The Employer Sponsored Premium Assistance Program* (Center for Program Development and Management, University of Maryland, November 2003). See also Sarah Schulte et al. *Final Report of the Child Health Plan Plus Employer Buy-In Feasibility Study*, December 2001. Retrieved 9 November 2004. http://www.rcfdenver.org/Imports/Reports/CHPEmployerBuyIn.pdf.

Expanding premium assistance programs

Currently, states may implement premium assistance programs in Medicaid under Section 1906 or through a Section 1115 waiver.

Section 1906 authority allows Medicaid agencies to subsidize the cost of employer-sponsored insurance (ESI) when a Medicaid beneficiary has access to such coverage and the cost of that coverage is cost-effective for the Medicaid agency.[55] It also allows states to require Medicaid beneficiaries who have access to qualified private coverage to join the private plan. States can establish and modify programs operated under §1906 simply by amending their Medicaid state plans. States, however, must ensure that beneficiaries who participate in the premium assistance program receive the same benefits as other Medicaid beneficiaries and pay no more for the services they receive than other Medicaid beneficiaries.

Section 1115 waiver authority offers more flexibility than §1906 authority. Under the conditions approved by the U.S. Department of Health and Human Services (HHS), states need not ensure that beneficiaries who receive premium assistance receive all Medicaid-covered services and pay no more than other Medicaid beneficiaries. In addition, HHS can waive the previously described cost-effectiveness requirement, although §1115 waivers must be budget neutral.[56] Also, states must obtain approval of a waiver request before implementing the program and meet the often extensive terms and conditions specified by HHS. Finally, states must periodically seek a waiver renewal in order to continue operating the program. Section 1115 waivers usually require renewals every five years. The 2001 Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, which allows for the expedited review of certain §1115 waiver requests, partially addresses state concerns about the length of time needed to obtain a waiver, but it does not address reporting or renewal concerns.

Workgroup members supported the goal of expanding the use of premium assistance programs. Some members believed that premium assistance programs would be more widely used and have greater enrollments if states could implement some of the features tested under the §1115 waivers through the §1906 authority. These members supported modifying §1906 requirements. However, other members wanted to ensure that the policies did not change the nature of the Medicaid program from one of using state and federal funds to provide health care coverage to one of helping those with access to coverage pay for their insurance. The workgroup agreed that program requirements should be designed to avoid this outcome.

[55] Cost-effective means that the cost to the Medicaid program of subsidizing the private coverage is less than the cost of providing direct public coverage.
[56] Budget neutrality means that a Medicaid agency cannot spend more federal funds to provide coverage under a waiver than it would have spent to provide coverage without the waiver.

Accordingly, the group's members recommended that states not be allowed to establish Medicaid programs in which the only coverage offered is premium support, programs that are by definition only available to people who have access to private insurance.

Using the state plan amendment process for premium assistance

The workgroup recommended that states be allowed the option to implement certain policies under §1906 authority (as a state plan amendment) that may now be implemented only under a §1115 waiver, including those related to wrap-around benefit coverage, wrap-around cost sharing, and crowd-out prevention.

Benefits

The workgroup recommended that states be required to provide wrap-around coverage to members of the mandatory population, but that states only be required to provide wrap-around coverage to a member of an optional population when the individual's private insurance coverage would not meet any of the coverage benchmarks that a state could choose to establish for optional adults

The majority of the workgroup supported this recommendation because they believed it balanced the opposing positions expressed by various group members:

- Some workgroup members argued that states electing to subsidize employer-sponsored insurance should be required to "wrap around" other insurance coverage and provide all Medicaid benefits that are not offered under the employer's plan to ensure that the most vulnerable and least able to pay for care have comprehensive, affordable coverage.

- Other members argued that states should be able to subsidize employer-sponsored insurance without wrap-around coverage and thus relieve states of the considerable burden of establishing wrap-around programs.

Further the workgroup recommended that states be able to use a checklist to determine whether the employer plan included the required benefits rather than using a side-by-side, benefit-by-benefit detailed comparison.

Cost sharing (e.g., premiums, deductibles, copayments)

The arguments for and against modifying §1906 authority to allow states to avoid cost-sharing wrap arounds were very similar to those regarding benefit wrap arounds. The workgroup was concerned both that Medicaid continue to ensure that vulnerable low-income people have access to health care they can afford and that the administrative burden (and cost) of operating wrap arounds be minimized.

Therefore, the workgroup recommended that

States should offer wrap-around coverage to the mandatory population but should not be required to do so for an optional population.

- **For mandatory populations, Medicaid would wrap around and cover any cost sharing beyond standard Medicaid limits.**

- **For optional populations, the group believed that some cost sharing would be appropriate as long as there were limits to protect enrollees from incurring excessive amounts of cost sharing.** Group members recommended that the employer's cost sharing would apply until an enrollee had exceeded a specified percent of the family's annual income. The enrollee would not be responsible for any additional cost sharing once this cap was reached. The group thought it was critical for simplicity's sake to allow the employer cost sharing without a wrap around until the cap was reached. While tracking the cap on cost sharing presents operational challenges, group members thought it would be even more cumbersome if the federal government specified the allowable premium and cost sharing amounts.

Cost-effectiveness test

The workgroup recommended that the existing Medicaid standard for cost effectiveness be maintained.

That is, states may enroll eligible individuals (and families) in employer-sponsored insurance as long as the cost to Medicaid of enrolling the individual or family is not greater than the cost of providing direct coverage to the Medicaid-eligible individuals or members of the group. There also was some discussion within the workgroup about whether states should be required to identify a minimum employer contribution level as a part of the cost-effectiveness test. A state may want to include a minimum employer contribution requirement in order to prevent employers from lowering their contribution level. However, the group ultimately decided that a significant employer contribution would be necessary to make the coverage cost effective so a minimum employer contribution requirement was not necessary.

Crowd-out prevention

The workgroup supported allowing states to impose crowd-out prevention measures (such as a waiting period for Medicaid coverage for those who dropped commercial coverage) on optional adults in Medicaid. The group felt strongly that states that choose to impose waiting periods must establish an exceptions process (e.g., for individuals with extremely high medical costs or those who recently became unemployed). In lieu of a waiting period, a state might want to evaluate the extent of crowd out for a period of time before adopting a waiting period given the impact on coverage.

The option to establish an anti-crowd-out measure would apply to optional adults in both premium assistance and in direct coverage. Group members agreed that it would be illogical to only apply waiting periods, for example, to individuals in premium assistance since excluding individuals from premium assistance but covering them in the direct coverage program would result in higher costs for the government.

Facilitating the use of premium assistance programs

Choice of program

Currently, Medicaid programs can require beneficiaries to enroll in their employer's plan if it is cost-effective**.**

The workgroup recommended

- **Retaining the current law for the mandatory population that allows states to require beneficiaries to enroll in qualified private coverage.**

- **Amending existing Medicaid law for optional adults and children.**
  - **If a state chooses to offer wrap-around benefits or cost sharing to optional populations, then the state may require beneficiaries to enroll in the private coverage.**
  - **If a state chooses not to offer wrap-around benefits or cost sharing to optional populations, then the state must offer beneficiaries a choice between the private coverage and direct Medicaid coverage at their initial enrollment and at every periodic eligibility determination**.

Workgroup members made this recommendation because most supported the concept that Medicaid beneficiaries with access to private coverage should not be *required* to accept potentially lesser coverage or pay more for services than those beneficiaries without access to employer coverage.

Qualifying Event

The workgroup recommended that the federal ERISA statute be modified so that states could require self-insured employers to consider Medicaid eligibility determination or the identification of qualified private coverage for a Medicaid beneficiary as a qualifying event. This proposal was in the Bush Administration's proposed budgets for federal fiscal years 2004 and again in 2005.

Self-insured employers should recognize Medicaid eligibility determination and Medicaid's identification of available, qualified private coverage as a qualifying event.

As previously mentioned, states report that private plans often do not treat qualifying for Medicaid or for participation in a premium assistance program as a qualifying event in the same manner as marriage or the birth of a child. Some states (among them Massachusetts, Maryland, and Rhode Island) have amended insurance law to require insurance companies to consider these events as qualifying events. This enables the individual to enroll immediately in the employer plan and not have to wait until an open-enrollment period. Because self-insured employers are not required to adhere to these state laws, due to ERISA provisions, workgroup members supported modifications to ERISA that would allow states to require employers to consider Medicaid determination a qualifying event.

Recommendations to Improve Program Integrity

States are interested in using the best possible approaches to ensuring program and fiscal integrity. Every action must be taken to prevent improper Medicaid payments, whether they result from inadvertent errors or from intentional fraud or abuse. Improper payments can include those for treatments and services not covered by program rules, those that are not medically necessary, or those that were billed but never actually provided. Due to the size and the nature of the program, Medicaid is at risk for billions of dollars in improper payments. The exact amount lost is not known because few states measure the overall accuracy of their payments.[57] Two states developed estimates that 5 to 7 percent of the Medicaid payments in their states were improper.[58]

The workgroup believes that changes in current federal rules relating to the recovery of overpayments identified by the states could provide better incentives for states to pursue erroneous payments and fraud.

[57] General Accounting Office, *Medicaid: State Efforts to Control Improper Payments Varies* (Washington, DC: GAO, January 2001), Report No. GAO-01-662.
[58] Illinois Department of Public Aid, *Payment Accuracy Review of the Illinois Medicaid Program*, 1998, and Texas Office of the Comptroller, *Texas Health Care Claims Study*, 2001.

Federal recovery rule for state identified overpayments

Medicaid rules (§1903(d)(2)(A)) reduce the amount of federal reimbursement to a state in each quarter by the amount of the federal share of any identified overpayments. This means a state loses federal matching funds as soon as it finds a problem, regardless of whether the state has recovered the overpayment from the provider. Many repayments have to be structured over time. States end up financing all of this. As a result, the current rules create an incentive not to identify overpayments.

The workgroup recommended that federal law be amended so states remit identified overpayments to the federal government when recovery of the overpayment is received by the state.

States should not be required to remit overpayments to the federal government before the overpayment is recovered by the state.

The law should include an end date (e.g., 24 months from date of discovery) by which states would be required to remit the federal share regardless of whether recovery had occurred. A state could still file an affidavit of uncollectibility (e.g., in the case of bankruptcy) as is permitted under current law.

Federal reimbursement for state program integrity activities

States are required to operate a Medicaid Fraud and Abuse Control Unit (MFCU) (separate and distinct from the state Medicaid agency) to investigate and prosecute violations of state fraud and abuse laws. MFCU activities are reimbursed at a 75 percent matching rate. In addition, states are responsible for minimizing improper payments due to fraud or to inadvertent billing errors and to ensure collection of all third-party payments where other health insurance coverage is primary to Medicaid. These program integrity activities are reimbursed at the 50 percent matching rate for administrative costs.

The number of improper payments that are actually recovered by states is difficult to measure; however, one state report indicates that only about 2.3 percent to 4.5 percent of the money likely lost to fraud and abuse was recovered over a six-year period.[59] Increasing reimbursement for these activities to 75 percent would be a strong incentive to states to enhance cost avoidance and recovery activities.

The workgroup recommended that federal law be amended to increase the matching rate for qualifying state program integrity activities to 75 percent.

[59] (Florida) Office of Program Policy Analysis and Government Accountability, *Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed*, Report No. 01-39, September 2001.

Data sharing for program integrity purposes

State program integrity activity depends on information and access to large data bases. Currently, the federal government requires a fee for state use of the federal database that lists all national sanctions against providers. The Healthcare Integrity and Protection Database (HIPDB) provides data about adverse actions against providers, suppliers, and practitioners. It is free to Medicare carriers and fiscal intermediaries. The fee for all others (including states) is based on the cost of processing requests and providing information to eligible entities. Applying the fee ($4.25 per name searched) to Medicaid-related activities discourages state use of this resource.

The federal government has an interest in ensuring that state investigation and enforcement efforts are as effective as possible. Eliminating the HIPDB fee would encourage the use of the database in investigations and in the enrollment process**.**

Therefore, the workgroup recommended that the fee required for use of the federal Healthcare Integrity and Protection Database (HIPDB) be eliminated.

Other laws

States have suggested two other areas where room exists to improve program integrity activities.

- **Bankruptcy:** Currently, in filing for bankruptcy, Medicaid (and Medicare) providers can avoid repaying overpayments they have received from Medicaid. As a result, states are unable to recover these overpayments. A change in this area would help states to recover overpayments. In the past, CMS has strongly supported such a law for both Medicare and Medicaid.[60] As a CMS official has noted in testimony to Congress: "Fraudulent providers use bankruptcy protection as a way to dodge responsibility for repaying overpayments, fines or penalties….There are instances where providers owing millions of dollars in overpayments declare bankruptcy as soon as corrective actions are taken against them."

  The workgroup recommended that federal bankruptcy law be amended to prohibit Medicaid providers from discharging overpayments during bankruptcy proceedings when the declaration of bankruptcy is precipitated by the Medicaid agency's attempt to recover the overpayments.

- **Tax intercept:** Another suggested improvement would allow states to intercept federal tax refunds issued to providers who owe federal and state overpayments. The workgroup did not reach consensus on this issue. However, **the majority of workgroup members supported a recommendation to amend federal law to**

[60] Testimony of Penny Thompson, HCFA program integrity director, on preventing Medicare fraud before the House Government Reform Subcommittee on Government Management, Information and Technology, July 25, 2000.

permit the interception of federal tax refunds to Medicaid providers who owe federal or state government money for overpayments. Precedent for such a measure exists. Overpayment of food stamp benefits and non-payment of child support are both areas in which intercept of federal tax refunds are permitted. However, a small minority of members expressed the view that the tax department should not be used as an enforcement vehicle.

Coordination with Private Long-Term Care Insurance

Medicaid is the primary source of funding for long-term care. Some observers fear that middle- and upper-income individuals will use estate planning techniques to shelter assets in order to qualify for Medicaid when they could pay for the long-term care services they need. If more persons had long-term care insurance, a considerable burden could be lifted from Medicaid. However, even though it has been available for many years and its products are improving, long-term care insurance coverage has not yet proved to be an adequate public policy solution for the vast majority of Americans. Even with public subsidies, long-term care insurance has not been widely purchased. For people with limited income and resources, the cost of coverage is high in relation to the assets protected. Very wealthy people can self-insure to cover the costs of care. The Health Insurance Association of America (HIAA) reported that by the end of 2001, 8.3 million long-term care insurance policies had been sold and 70 percent remain in force.[61] One study states that private long-term care insurance plays only a small role in financing long-term care for the older population, accounting for only about 2.5 percent of national long-term care expenditures for the elderly population in 2000.[62] Only a small fraction of older Americans has private insurance to guard against the high costs of long-term care.

Wiener reports that low market penetration may be due to misinformation about long-term care coverage under Medicare, lack of knowledge about the spend-down requirements of Medicaid, company underwriting practices, and the high cost of good quality policies. The average annual premium for quality, individual policies purchased at age sixty-five was $2,346 in 2002, rising to $7,572 if purchased at age seventy-nine.[63] Despite the marked improvement in the financial position of the elderly over the past thirty years, most studies estimate that only 10 to 20 percent of the older population can afford good quality private long-term care insurance policies. Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have assumed purchase of policies with more limited coverage, that the elderly would use a high percentage of their income and assets to pay premiums, or that

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[61] Enid Kassner, "Long-Term Care Insurance, Fact Sheet" (Washington, DC: AARP Public Policy Institute, 2003). Retrieved 18 June 2004. http://research.aarp.org/health/fs7r_ltc.html

[62] Joshua Wiener, Jane Tilly, and Susan Goldenson, "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance," *Elder Law Journal* (June 2000), 57-99.

[63] Kassner, "Long-Term Care Insurance, Fact Sheet." Average premiums for a policy providing a $150 daily benefit with a 90-day elimination period and four years of coverage and with 5 percent compounded inflation protection. Source: American's Health Insurance Plans, 2004.

purchasers would not be required to have a minimum level of assets. For example, by assuming that the older population is able to spend 10 percent of its income on private long-term care insurance, Mulvey and Stucki estimate that 31 percent of people age sixty-five and older can afford a private long-term care insurance policy that covers two or five years of nursing home or home care coverage.[64]

Given the limitations of the current market for private long-term care insurance, policymakers have considered or enacted three strategies:

- Provide individuals with tax incentives that encourage purchase of long-term insurance policies by reducing the net price of such policies.

- Encourage employer-based, private long-term care insurance through tax incentives and by having federal and state governments serve as role models to private employers by providing governmental employees, retirees, and their dependents the opportunity to purchase long-term care insurance.

- Waive some or all of the Medicaid asset depletion requirements for purchasers of qualified private long-term care insurance policies, thus allowing individuals who purchase a qualified plan to qualify for Medicaid without depleting their assets when they exhaust private insurance coverage.[65]

While long-term care insurance is an option for upper-middle income people, especially younger adults, public policy must also recognize that the majority of older persons cannot afford to purchase or maintain coverage and do not have substantial assets to protect.[66] This population and younger adults with modest resources will continue to rely on government programs (Medicaid) for coverage.

This led the workgroup to a two-fold strategy:

The workgroup recommended policy changes that would encourage individuals to take responsibility for their own long-term care coverage and that would help make purchase of long-term care insurance more affordable. This approach would apply to the 10 to 20 percent of individuals who can afford such policies.

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[64]Janemarie Mulvey and Barbara Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?* American Council of Life Insurance, 1998.
[65] Mark Meiners, Hunter McKay, and Kevin Mahoney, "Partnership Insurance: An Innovation to Meet Long-Term Care Financing Needs in an Era of Federal Minimalism," *Journal of Aging and Social Policy*, Volume 14, Number 3/4, (2002), pp.75-93.
[66] Enid Kassner, *Private Long-Term Care Insurance: The Medicaid Interaction* (Washington, DC: AARP Public Policy Institute, 2004). Issue Brief, Number 68.

The group also recommended that public policy support the development of an efficient and effective long-term care delivery system for the 80 to 90 percent of individuals who cannot afford such policies and rely upon the social safety net. This would include the sharpening and enforcement of asset transfer rules to make sure that individuals who do have assets that could be used to pay for long-term care do not divest them in order to qualify for Medicaid.

WAIVERS

This section focuses on recommendations to improve the waiver process:

Waiver Recommendations

Section 1115 and Section 1915(b) waivers: Requirements for managed care and Medicaid restructuring waivers would be simplified and burdensome requirements dropped.

Section 1915(c) waivers: States would have the option of converting home and community-based waivers to "program status." Limits on the numbers of clients in programs would be permitted. States would be able to set functional criteria that differ from the nursing home level of care criteria. The program would not be subject to renewal or cost neutrality requirements. Cost sharing would be allowed.

States would not be able to implement different policies for different geographic areas within a state without a waiver.

Section 1115 Medicaid Research and Demonstration Waivers and Section 1915(b) Freedom of Choice Waivers

One of the great strengths of the Medicaid program has been its ability to support state efforts at innovation. The waiver process has allowed states to develop significant public policy innovations that have expanded access and offered important lessons and served as valuable models for other states.

- Section 1115 Research and Demonstration Waivers offer the most flexibility to states. Under these waivers states may request a waiver of almost any federal Medicaid law. §1115 waivers must generally be renewed every five years and must feature an independent evaluation. In 2001, the federal government announced a new approval process for §1115 waivers that meet certain requirements. The Health Insurance Flexibility and Accountability (HIFA) initiative provides for an expedited review of §1115 waivers that expand coverage, are statewide, and coordinate with private sector coverage.

- Section 1915(b) authority allows states to adopt managed care programs that otherwise do not conform to Medicaid statutory requirements for statewideness, comparability, or freedom of choice. These waivers must generally be renewed every three years. In recent years, CMS has streamlined the process of obtaining a §1915(b) waiver—for example, by creating a template for state use.

Under the auspices of these sections, CMS can waive requirements that otherwise would have to be met in order for a state Medicaid program to qualify for federal matching funds. Although these waivers have proved highly valuable, states frequently report that the process of obtaining waivers is unnecessarily obtuse and difficult and subject to varying federal interpretations.

With the adoption of other recommendations in this report on eligibility and benefit flexibility, it is possible that the need for waivers in the future would lessen. However, it is not possible to anticipate fully future public policy needs in a medical marketplace that is constantly changing. Thus, the workgroup agreed that it would be useful for the waiver authority to continue.

The workgroup recommended that the Section 1115 waiver process be retained in order to allow for future innovations in Medicaid structures, financing, and delivery systems.

A waiver might assist a Medicaid program when it seeks:

- To improve service delivery, expand coverage, or reduce overall costs in order to fulfill an objective related to Medicaid;

- To provide a medical or health service under Medicaid that is normally outside Medicaid coverage (e.g., lead abatement); or

- To serve an eligibility group that otherwise would not be eligible for Medicaid coverage (e.g., non-disabled adults without children).

The Section 1915(b) waiver requirements were amended in 1997 and, for purposes of operating managed care programs, were replaced with a state plan process that was intended to simplify the process.[67] However, state experience suggests that the requirements of the new state plan process are no less burdensome than the waiver process.

The workgroup recommended that the state plan process for managed care be simplified to recognize that managed care is now a mainstream feature of the health care delivery system.

The workgroup also recommended that the process for obtaining both §1115 and §1915(b) waivers be simplified and burdensome requirements dropped. Specifically, the workgroup recommended the following enhancements:

- Redefine the budget neutrality requirement for waivers in order to consider savings achieved in other federal programs through changes in Medicaid (e.g., Medicare

[67] The §1915(b) waivers are still in use for programs such as selective contracting.

savings attributable to avoided hospitalizations; Social Security Administration savings attributable to foregone SSI when someone returns to work).

- Establish a time period by which waivers must be approved or denied.

- Encourage CMS to develop waiver templates (for those types of waivers for which templates do not yet exist). When states follow these templates, the waivers should be approved under an expedited timeframe.

- Treat waiver renewals like state plan amendments to speed the renewal process.

Selective contracting

The workgroup also considered the potential use of selective contracting to increase the ability of states to control costs and assure quality. Under selective contracting, a state selects a limited number of providers to deliver specified services. These providers are usually selected based on service excellence and cost. California uses selective contracting for hospital services. Arkansas and other states have selectively contracted for non-emergency transportation. These selective contracting arrangements are accomplished through the use of Section 1915(b) waivers.

In addition the workgroup discussed the idea of using selective contracting for nursing home services as a vehicle to put greater emphasis on community-based services, reduce beds, and improve quality.

In the context of long-term care, the workgroup identified concerns about the potential negative impacts on current providers who might be excluded from Medicaid participation under selective contracting. For example, many nursing homes receive as much as two-thirds or more of their revenue from Medicaid. If they failed to get a contract with Medicaid, they could be driven out of business. If enough providers are not available, selective contracting might limit access to services to the point where beneficiaries do not have adequate access to care.

Other members pointed out that states that use selective contracting often contract for capacity that exceeds the actual amount needed by some percentage. This helps to assure beneficiaries have choice. While some providers may not receive contracts, it can be argued that the system should not be required or expected to support excess capacity that is not needed. Selective contracting also has the potential for positive impacts, including increasing the ability of a state to develop and enforce specific quality criteria and access standards. These standards might take time to develop but could improve the availability and quality of services.

Based on these considerations, the workgroup recommended that Medicaid law and rules be changed to allow the use of selective contracting without a waiver, when a state chooses to use this approach to control costs and assure quality.

States should not need to obtain a waiver to implement selective contracting to control costs and assure quality.

They further recommended that selective contracting be tied to access and quality standards that could be developed by individual states or nationally through a joint state/federal process with broad stakeholder input.

Home and Community-Based Services as a Separate Program Rather than a Waiver Service.

As discussed in the benefits section, many states have developed extensive Medicaid-based, long-term care delivery systems. These systems of care coordinate home and community-based services waiver programs, personal care, home health services, supportive housing (assisted living), and institutional care for persons with physical disabilities of all ages. Other systems coordinate the range of supportive housing, habilitation, and employment services for persons with developmental disabilities. Many states view HCBS waiver programs as the preferred and core component of their long-term care system.

Therefore, the workgroup recommended that states be able to choose to replace Section 1915(c) waivers with a home and community-based care program that has 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 threshold for admission to an institution (nursing home or ICF-MR) and a lower threshold for the home and community-based services program.

3. The program would not require the burdensome administrative requirements (cost neutrality, three- and five-year approvals, and linkage to nursing home level of care).

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 appropriate service options for sub-populations.

6. Cost sharing for the optional eligibility group (above 100 percent FPL) would be allowed.

Statewideness

The workgroup also considered whether states should be permitted to offer different coverage and eligibility policies in different geographic areas of a state. Currently, federal statewideness requirements prevent states from doing so absent a §1115, §1915(b), or §1915(c) waiver. The workgroup considered that eliminating this requirement would allow states to permit local governments to choose to invest their own funds to provide their residents with coverage above levels chosen by the state Medicaid program. Eliminating this requirement would also allow states to experiment with new initiatives in discrete regions (such as near a medical school, or where a local employer is willing to collaborate). On the other hand, the workgroup was concerned that eliminating statewideness could perpetuate inequities if wealthier local governments develop expansions for their proportionately smaller poverty populations that other less affluent local governments could not match. To partially address these concerns the workgroup considered two potential modifications to statewideness:

- Require uniform benefits for a "large geographical area." This term would need to be defined but workgroup members considered it as smaller than statewide, but larger than a county;

- Permit exceptions to statewideness, but on a time-limited basis.

In workgroup discussions it became clear that each of these modifications would address some, but not all, of the group's concerns about eliminating statewideness and that each would raise other concerns. In addition, both modifications beg the fundamental question of whether and when a non-statewide program is appropriate.

As a result, the workgroup recommended that the current federal requirements for statewideness absent a waiver be continued.

TRANSITIONING TO THE NEW RULES

Whenever changes are recommended to the Medicaid program, questions invariably arise about how the changes will apply to states that have already expanded coverage. Typically, the most fundamental of these questions is this: can states apply the new rules to a currently covered population or must they abide by the Medicaid rules that previously covered the population? Not surprisingly, this proved a critical question for the workgroup because several of its recommendations (for new optional groups under Medicaid) would create a different acute and long-term care benefit package than the one currently in place and could mean that benefits important to affected individuals could be restricted or even lost.

On this issue the discussion focused on how to minimize adverse consequences to affected individuals while also addressing the overall goal of minimizing complexity in the program. The workgroup was concerned that if states were required to keep current beneficiaries at the same level of benefits they would need to have a separate tracking system which would, once again, result in complex eligibility rules for the program. In addition, group members agreed that the states that already covered optional populations should be able to get the enhanced federal matching funds for those populations.

Therefore, the workgroup recommended that states have the option to provide "out-of-plan" benefits (some or all benefits that are currently Medicaid covered but would not be in the new package) to current beneficiaries. This situation could continue, at state option, either for some state-established transitional period or permanently.

SUMMARY AND CONCLUSION

The *Making Medicaid Work for the 21st Century* project was a year-long effort by a workgroup of state officials and national experts representing the broad range of stakeholder interests in Medicaid. The group's objective was to identify the important changes in the program that would make it more effective and successful as the program nears its 40th birthday and enters the new century.

The workgroup made recommendations for important changes in Medicaid eligibility, benefits and flexibility, and financing and in the Medicaid waiver rules and process. These recommendations are interrelated and must be viewed as a whole. They often reflected a balance of competing interests, and highlighting one recommendation, separate from the context of the others, would not honor the deliberative process of the workgroup.

The most significant recommendation is based on the premise that Medicaid is a key vehicle for addressing the issue of the uninsured: Medicaid should assure coverage for all Americans in households with incomes below the federal poverty level. Children up to age six and pregnant women would continue to be covered up to a minimum of 133 percent of the federal poverty level. The current system of categorical eligibility would be ended. This would simplify the eligibility system and its administration. It would create a national Medicaid minimum eligibility level that would provide full or supplemental coverage to an estimated additional 5.3 million individuals. This would reduce the number of uninsured individuals by about four million, or ten percent. Among proposals for reducing the number of uninsured in America, this proposal would be one of the more efficient in terms of increases in the number of insured compared to the cost of that coverage. In 2005 dollars, the total annual cost would be an estimated $16.6 billion. If an enhanced federal match for new eligibles were offered, the federal share of that amount would be $11.2 billion and the state share would be $5.3 billion. This means that state Medicaid costs would increase by about 4.1 percent.

All individuals covered under the new national minimum eligibility level would be regarded as mandatory eligibles. The workgroup recommended that these individuals would be entitled to the same set of benefits provided under current Medicaid law. States would have the option to cover individuals at incomes above the minimum. These would be optional eligibles. States would have the option to offer the same benefit package for optional eligibles as for mandatory eligibles. At state option, the set of benefits for optional eligibles could be less extensive than for mandatory eligibles, but no less comprehensive than a benchmark plan such as a commercial insurance plan approved by the state, a state employee plan, or similar alternative benchmark.

The workgroup also recommended changes in the waiver process. Specifically, states should have the option to implement an on-going program for some policies and initiatives that now require a waiver. Waiver authority should be maintained, but the waiver approval and renewal process should be streamlined.

Significant recommendations were made for Medicaid financing. The formula and process for establishing the federal matching percentage (FMAP) needs review and revision. The FMAP needs to be set in a way that reflects changes in the economy and in the fiscal capacity of states to support Medicaid.

The workgroup does not regard its recommendations as an exhaustive list of all the ways Medicaid could or should be changed. However, the group acted on a belief that the current program is a central and critical component of today's health care system and that, to the over 52 million individuals the program serves, it is essential that improvements be made so that Medicaid can continue to be successful in the years ahead.

Appendices

Appendix A: Medicaid Goals and Problems

Appendix B: Cost Estimates for Major Eligibility Recommendations Contained in the Report

Appendix C: Summary of SCHIP Director Feedback

A. MEDICAID GOALS AND PROBLEMS

The Making Medicaid Work for the 21st Century workgroup met on July 14, 2004, to develop a common set of goals and to identify major issues and problems that confront the Medicaid program. The discussion was intended to provide the workgroup with a common starting point and guide as its members began its work. This document is a synthesis of the discussions that occurred on July 14th.

The group organized goals for the Medicaid program into five categories:

- eligibility,
- benefits and cost-sharing,
- delivery system,
- quality of care, and
- financing and controlling costs.

For each category, the group articulated a goal and identified issues and problems that currently stand in the way of achieving the goal. The group also developed an overall vision/role statement for the Medicaid program, and this document begins with that statement.

Vision and Role for Medicaid

To support the health and well-being of low-income populations by prudently managing programs that ensure access to quality health care and support services through a federal-state financial partnership.

Eligibility

Goal

To serve eligible populations through policies and enrollment processes that maximize coverage and simplify administration.

Problems and Issues

Current eligibility policies are complex and inequitable and sometimes prevent eligible individuals from enrolling.

Current rules exclude certain populations from coverage (e.g., non-pregnant, childless adults aged 21-64 who are neither blind nor disabled and certain legal immigrants).

There is little consistency among states in how they calculate whether an applicant meets the financial eligibility criteria (i.e., income and assets).

Existing rules favor the provision of long-term care in institutions rather than in the community.

Benefits

Goals

Allow for the design of benefit packages that ensure access to health and support services (community-based and institutional, chronic, long-term, and acute care) in order to meet the health care needs of covered populations.

Ensure access to primary care, including preventive care, screenings, early diagnosis, and public health services.

Promote integration of services and care coordination.

Problems and Issues

Current benefits need updating to allow for the most appropriate and cost-effective setting for meeting consumer needs.

Current rules do not allow for enough flexibility to meet the needs of specific populations or allow for different packages of services for different groups of people.

Cost-sharing rules need updating.

Financing and Controlling Costs

Goals

Structure state and federal financing so that benefits can be stable during times of economic downturn and state budget shortfalls, and the integrity and balance of the state-federal relationship is maintained.

Divide program costs fairly between federal and state governments so states are able to continue to afford their share of Medicaid costs into the future and the federal government has assurance of funding integrity.

Coordinate resources and financing with SCHIP and Medicare.

Allow for effective cost controls without sacrificing access to care or quality.

Coordinate with the private sector and other public programs (e.g., SCHIP and Medicare) to allow a smooth transition between public and private coverage to enable use of premium assistance programs, support the private insurance market, and prevent the replacement of private funding with public funding.

Create systems of care and payment for dual eligibles that facilitate treating the person as a whole, prevents cost-shifting between Medicare and Medicaid, and divides costs fairly between federal and state governments.

Problems and Issues

State funding has not been adequate to assure stability of eligibility and benefit levels.

Policies governing which state expenditures are eligible for federal reimbursement and how much federal reimbursement those services are eligible for need to be re-examined to make sure that they fairly represent state and federal governments' relative responsibilities and capabilities and recognize the need for state and federal fiscal accountability.

Medicaid costs, like private sector health care costs, are growing.

Coordination between the Medicare and Medicaid programs is largely absent resulting in poorer care for beneficiaries who qualify for both programs and higher costs to state and federal governments who pay for that care.

Delivery Systems

Goals

Create community-based systems that allow for a full range of services, organized around the consumer's needs.

Obtain sufficient provider participation.

Provide services to consumers in a user-friendly manner.

Problems and Issues

The provider reimbursement system is outdated and may not assure the availability of the most effective delivery system of community-based services.

The delivery system does not encourage use of home based care.

Medicaid is expected to play a dual role of both providing coverage to certain low-income populations and subsidizing safety net providers for the uninsured.

Quality of Care

Goals

Design quality into service delivery with a focus on health, recovery, and function. Encourage measurement and improvement of quality.

Use purchasing power to foster excellence in health care quality, efficiency, and service.

Issue

Quality of care is not a focus.

B. COST ESTIMATES FOR MAJOR ELIGIBILITY RECOMMENDATIONS CONTAINED IN THIS REPORT

The workgroup believed it could not develop responsible recommendations about a national minimum eligibility level without a good sense of the cost implications of such a recommendation. As a result, the group identified four specific options for expanding Medicaid coverage and then obtained estimates of the costs associated with each one.[1] A cost-estimate also was obtained for a fifth option to require Medicaid coverage of all children up to 133 percent FPL, due to the interest among some workgroup members in establishing a uniform minimum income eligibility level at 133 percent FPL for all children, regardless of age.

The workgroup concluded from the cost estimates that the cost of extending eligibility was not unrealistic. Workgroup members noted that the "target efficiency" of establishing a national minimum eligibility level was relatively high when compared to other proposed strategies for reducing the number of Americans without health insurance coverage.

It should be noted that the first four options assume that the existing mandatory minimum eligibility level would remain at 133 percent for children up to age six and for pregnant women. It should also be noted that the cost estimates do not include long-term care services. All estimates are expressed in 2005 dollars.

- **Option #1**: Mandatory Medicaid coverage for all Americans in households with incomes at or below 100 percent FPL, with coverage phased in incrementally by income level over four years.

- **Option #2**: Mandatory Medicaid coverage for all Americans at or below 75 percent FPL, phased in incrementally by income level over four years.

- **Option #3**: Mandatory Medicaid coverage for all Americans at or below 100 percent of the FPL, phased in incrementally over four years by age group (i.e., parents with children age 18 or younger, adults age 55-64; adults age 35-54, and all remaining adults).

- **Option #4**: Voluntary expansions, with enhanced match to any state that extended eligibility for acute care to all individuals at or below 100 percent FPL.

- **Option #5**: Mandatory Medicaid coverage for children 100-133 percent FPL. (That is, transfer children in separate SCHIP programs who are 100-133 percent FPL to Medicaid.)

The annual estimated cost of each option is below.

[1] Cost estimates of eligibility options were prepared by John Holahan of the Urban Institute.

Option #1: Coverage would be required for all individuals at or below 100 percent FPL, phased in incrementally by income level over four years. Coverage would continue for children and pregnant women at 133 percent FPL

This option would add coverage for 5.3 million individuals, including 4.0 million previously uninsured individuals. The estimated cost would be $16.6 billion per year, including $9.6 billion in federal funds and $7.0 billion in state funds. On a base of approximately $130 billion in state funds, this would represent an increase in state spending of 5.4 percent. Phasing in this option over 4 years would increase the annual rate of growth in Medicaid spending by approximately 1.4 percent each of the four years.

(numbers in thousands, dollars in billions)	**Option 1** Mandatory to 100%	
	Regular Match	SCHIP Match for Newly Eligibles
	Assumptions about State Response	
	Group 1: No Change Group 2: Expand to 100% Group 3: Expand to 100%	Group 1: No Change Group 2: Expand to 100% Group 3: Expand to 100%
Take-Up of Coverage	**5,297**	**5,297**
Previously Employer	529	529
Previously Non-group	764	764
Previously Uninsured	4,004	4,004
Net Cost to Government	**$16.6**	**$16.6**
Federal Share	$9.6	$11.2
State Share	$7.0	$5.3

Note: Because the proposals being analyzed contained several options as well as mandates, it was necessary to make assumptions about state behavior. The underlying assumption is that past behavior is the best guide to the future. Therefore, states were divided into three groups according to their previous expansion levels and potential to expand coverage in the future. In states that already expanded to 100 percent for certain groups of adults, there was no change modeled.

Group 1: All states cover parents and nonparents to 100 percent
Group 2: Most states cover parents to 100 percent
Group 3: Rest of states

The annual cost of achieving coverage at 100 percent of the FPL in four phases, by mandatory level, is shown in the following table:

	Year 1 *Option 1 and Option 4*	**Year 2** *Option 1*	**Year 3** *Option 1 and Option 2*	**Year 4** *Option 1*
Mandatory level	NA	50% FPL	75% FPL	100% FPL
Optional level	100% FPL	100% FPL	100% FPL	NA
Take-up (millions of people)	1.2	3.3	4.1	5.3
Previous coverage:				
--employer	0.1	0.3	0.4	0.5
--non-group	0.2	0.5	0.6	0.8
--uninsured	0.9	2.5	3.1	4.0
Net cost ($ billions)	$3.8	$10.2	$12.8	$16.6
--federal	$2.1	$5.8	$7.3	$9.6
--state	$1.7	$4.3	$5.4	$7.0

Option #2: Mandatory Medicaid coverage for all Americans at or below 75 percent FPL, phased in incrementally by income level over four years.

As shown in the above table, this option would add 4.1 million individuals to Medicaid coverage, at a net cost to government of $12.8 billion per year, including $7.3 billion federal and $5.4 billion state. This would represent an increase in state expenditures of approximately 4 percent. When phased in over four years, this option would increase the annual rate of growth by about 1 percent for each of the four years.

Option #3: Mandatory Medicaid coverage for all Americans at or below 100 percent of the FPL, phased in incrementally over four years by age group (i.e., parents with children age 18 or younger, adults age 55-64; adults age 35-54, and all remaining adults).

Phasing in to 100 percent of the FPL by age group achieves the same result as Option 1, in a slightly different manner, as shown below:

(numbers in thousands, dollars in billions)	Mandatory to 100% Assumptions about State Response Group 1: No Change Group 2: Expand to 100% Group 3: Expand to 100% **Phase 1** Parents	**Phase 2** Parents and Adults 55-64	**Phase 3** Parents and Adults 35-64	**Phase 4** All Adults
Take-Up of Coverage	**1,818**	**2,409**	**3,387**	**5,297**
Previously Employer	232	309	372	529
Previously Non-group	153	289	395	764
Previously Uninsured	1,434	1,811	2,620	4,004
Net Cost to Government	**$5.0**	**$7.0**	**$10.3**	**$16.6**
Regular Match				
Federal Share	**$3.0**	**$4.1**	**$6.0**	**$9.6**
State Share	**$2.1**	**$2.9**	**$4.3**	**$7.0**
SCHIP Match, Newly Eligible				
Federal Share	**$3.3**	**$4.6**	**$6.9**	**$11.2**
State Share	**$1.7**	**$2.4**	**$3.4**	**$5.3**

Option #4: Voluntary expansions, with enhanced match to any state that extended eligibility for acute care to all individuals at or below 100 percent FPL.

Based on assumed take-up rates, and an assumed enhanced match that was the same as the SCHIP matching rate, the simulation indicated that this option would result in a total of 1.5 million individuals added to Medicaid coverage, including 1.1 previously uninsured individuals. The total net annual cost was estimated to be $4.8 billion, including $3.2 billion federal and $1.5 billion state.

Option #5: Mandatory Medicaid coverage for children between 100-133 percent FPL. (That is, transfer children in separate SCHIP programs between 100-133 percent FPL to Medicaid.)

This option would smooth the eligibility level so children would remain on Medicaid at age six instead of being transferred to a separate SCHIP program in some states. Children of different ages in the same families would be in the same program. It would cost states $128 million due to services being matched at the Medicaid matching rate instead of the higher rate for SCHIP.

C. SUMMARY OF SCHIP DIRECTOR FEEDBACK

NASHP convened a conference call of state SCHIP directors on August 31, 2004, to obtain their feedback on options and recommendations developed by the Making Medicaid Work for the 21st Century workgroup that relate to children. SCHIP directors and/or their representatives from 12 states participated in the conference call. The states represented included: Alabama, Colorado, Iowa, Illinois, Massachusetts, Mississippi, Missouri, North Carolina, Pennsylvania, Rhode Island, Vermont, and Wisconsin. Background materials were provided prior to the call and laid out a series of options considered by the workgroup as well as the group's final recommendations. Call participants were asked to comment on these options and recommendations.

Debbie Chang provided some context for the discussion. She noted that the workgroup had made a conscious decision early on in the project that it would not focus its efforts on improvements to SCHIP itself. She noted that group members felt that there was a huge array of issues to tackle in Medicaid and that providing recommendations on restructuring SCHIP was not within the scope of the project. Instead, the workgroup decided it would address issues where the Medicaid and SCHIP programs intersect. In particular, the group focused on whether it makes sense to apply the SCHIP rules to children in Medicaid who are above the current mandatory levels.

General Feedback

Some SCHIP directors supported the creation of a single health insurance program for children so families with children of different ages would not have to participate in two public programs (Medicaid and SCHIP) with different rules and different provider networks. Another participant added: "children need their own program, with a heavy emphasis on preventive care."

Some participants supported raising the mandatory Medicaid eligibility level to 133 percent of the FPL for all children in order to eliminate the current "stair step" where the mandatory Medicaid income eligibility level decreases from 133 percent FPL to 100 percent FPL for children age six and older. Another pointed out that the change would result in higher costs for states as some states currently are receiving enhanced match for a portion of that population.

One SCHIP director stated that there are features of the Medicaid program that SCHIP could benefit from as well as the features from SCHIP that might be imported into Medicaid. Two areas where Medicaid rules might improve the SCHIP program are:

- Adding the Medicaid EPSDT requirement to separate SCHIP programs so children would be "better served."
- Adding the Medicaid requirement to "wrap around" coverage in premium assistance programs in order to ensure better coverage for children in separate SCHIP programs.

Another member observed that the group's final report will be designed to be one that people can reflect on in future years. It should not just be considered in the context of the current fiscal crises that states are facing. If the fiscal situation turns around, the SCHIP directors might have a different perspective on these recommendations.

Finally, one participant added that "the challenge seems to be how to bring into Medicaid certain aspects of SCHIP that would improve care for Medicaid beneficiaries without losing critical aspects of the Medicaid program."

Medicaid Coverage for All Americans Below Poverty

MMW recommendation:

All Americans with income at or below the federal poverty level would be eligible for Medicaid coverage. (Categorical eligibility would be eliminated.) Coverage would be phased-in, and states would receive enhanced match. The existing mandatory eligibility levels for pregnant women and children would be unchanged. For adults above the poverty level, states could continue to apply the existing Medicaid rules or they could offer a less comprehensive benefit package and impose higher cost sharing.

It was clear from the discussion around this recommendation that the overriding issue of the fiscal crises facing states was foremost on the minds of many of the participants. It is important to note that this context overshadowed the discussion and thoughts of the participants on the call.

A number of participants on the call stated that this recommendation would have a significant negative financial impact on states. While it is an admirable goal to cover adults up to the federal poverty level, some states may have to reduce eligibility in optional groups such as SCHIP in order to expand coverage to these adults. One person raised concerns that adults are more expensive than children and noted: "There are just not enough providers to serve all these people who now have coverage."

Although all participants agreed that this recommendation would have a significant financial impact on states, not all thought it would result in eligibility reductions. Some said it would have no impact on children in their state. One participant remarked that since one-third of her state's population is under the poverty level, this recommendation would have a significant impact on the uninsured. "It would be a huge financial burden for the state, but by the same token it would be one of the best bangs for the buck in terms of addressing the uninsured."

One of the SCHIP directors suggested that a "middle ground option" would be to create a new optional Medicaid eligibility category of childless adults. This would allow individual states to have a policy debate about the merits of covering adults versus children given limited funding.

Financing

MMW recommendation:

States should receive the SCHIP enhanced match for all children in the optional Medicaid groups. The funding of the enhanced match should come out of each state's existing yearly SCHIP allotment.

The participants on the call were concerned that the existing SCHIP allotments would not be sufficient to provide enhanced match to all children in optional Medicaid groups.

Some participants argued that this requirement should be more permissive. States should have the option of receiving the SCHIP enhanced match for children in optional Medicaid groups regardless of their allotment. Many states have insufficient SCHIP allotments to fund their SCHIP populations with enhanced match and could not cover any additional groups. Since states have a capped SCHIP allotment, they should not be required to use these funds to provide enhanced match to Medicaid populations. Another participant noted that the MMW proposal does not improve access since the enhanced match will be applied to individuals who already are covered.

Two participants proposed modifications to the workgroup recommendation:

- Federal law should assure that annual federal SCHIP allotments to each state are minimally adequate to cover all SCHIP-eligible and optional children in Medicaid.
- Federal law should provide states the regular Medicaid match rate for all children, including SCHIP enrollees. This change would simplify administration of the two programs and would eliminate the current inequities across states.

MMW recommendation:

States with pre-SCHIP Medicaid expansions would be allowed to move these children into separate SCHIP programs at their option.

The participants agreed with this recommendation, although it did not elicit much discussion. They supported the fact that it allowed state flexibility to make a decision that was best for the state.

Programmatic Flexibility

Benefits

MMW recommendation:

The workgroup did not reach consensus on whether states should have flexibility in the design of benefit packages for children in the Medicaid optional groups.

Like the MMW workgroup, the SCHIP directors participating on the conference call were not in agreement over whether there should be flexibility in benefits for Medicaid children in optional groups.

A number of the SCHIP directors supported a new option that would require the benefit package for children in the optional Medicaid groups to cover the same services as recommended in the American Academy of Pediatrics periodicity schedule. This would ensure that children would have access to the wellness visits that they need and would address the fear among some participants that the benchmark the state selected might have substandard benefits for children.

Some members, however, supported maintaining the EPSDT requirement for optional Medicaid groups. One person raised a concern that if economic conditions worsen, it is conceivable that states would reduce benefits for children in optional groups if more flexibility were allowed. Furthermore, if you erode the Medicaid standard for this optional group, it could happen "up and down the line." Some erosion is already occurring in the commercial markets given the current economic climate.

One SCHIP director suggested that the vast majority of "income-eligible" children don't need EPSDT: "Kids are not extremely sick because they are poor." Another argued that EPSDT was designed to cover the "worst case scenario" since there are no defined limits in EPSDT.

One member had available a summary of expenditures from her state's SCHIP population which showed that the bulk of the "per member per month" (PMPM) expenditure was for basic services. A second SCHIP director echoed her comments and stated that EPSDT was "not that big of a burden" in her state either.

The discussion about EPSDT evolved into whether the SCHIP benchmarks provided a reasonable standard of care for children. One participant observed that the benefit package in SCHIP seems to be appropriate for about 98 percent or even 99 percent of SCHIP enrollees.

A suggestion was made to separate out the optional Medicaid children with very high expenses and ensure that they get the full Medicaid benefit package. The remaining children in optional Medicaid groups would receive a reduced benefit package. The advantage is that you "would not be providing an open-ended door to services for every

child in an optional Medicaid group." This is essentially a reinsurance design where a small percentage of enrollees who require a much higher level of care than average would be eligible for the full slate of services, including EPSDT, that is provided to the children in mandatory Medicaid.

One participant argued that the discussion of flexibility in the draft report focused on reducing benefits, reducing eligibility, and saving money. He suggested that we should look outside our country to see how other countries achieve similar outcomes for less expense.

Cost sharing

MMW recommendation:

Workgroup members did not reach consensus on whether additional flexibility in cost sharing could be provided for children in the optional Medicaid groups. They were more comfortable with imposing cost sharing on children than in reducing benefits. They felt that premiums were much easier to handle administratively than copayments. They raised concerns about the tracking of copayments and in setting cost sharing at an appropriate level for the particular income level.

The SCHIP directors were not in consensus on the issue of whether states should be allowed to impose cost sharing on Medicaid optional groups.

The SCHIP directors focused on the merits of imposing premiums compared to copayments and had differing opinions based on how their programs were designed. Some believed that instituting premiums was a complex endeavor because it requires the state to set up completely new systems to bill all enrollees, collect payments, and figure out whether enrollees need to be reinstated when they do not pay. One participant said it would "cost a fortune to bring a system on line to impose premiums."

Others suggested that the most difficult aspect of administering copayments was tracking the amount paid by the enrollee in order to determine when a family has reached the 5 percent of family income out-of-pocket limit. Health insurers usually track cost sharing on an individual basis but not on a family basis. Since premiums are paid on a regular basis, it is much simpler to keep track of how much enrollees have paid in premiums. States with experience imposing premiums generally prefer premiums as a cost-sharing option.

Another participant whose state has had experience with both premiums and copayments said that there was no real financial gain from collecting copayments. Cost sharing is, however, a political statement. Most families in this person's state agree that they should contribute to the cost of participating in the public program.

One of the SCHIP directors proposed a principle that "states should have the option to provide coverage to children in Medicaid optional groups using either SCHIP or

Medicaid rules, including for policies relating to benefits, cost-sharing, delivery system and enrollment caps." In other words, states should be given the flexibility of SCHIP in the optional Medicaid groups while maintaining the ability to claim Medicaid match.

Some SCHIP directors took issue with this statement, especially with respect to allowing states to cap enrollment in Medicaid optional groups. Some felt that children needed to be protected from the "winds of the political world." One said: "We need to think long and hard about whether we would be willing to sacrifice this protection for the poorest of the poor in order to obtain freedom to do certain things." Another participant observed that SCHIP was intended to be an expansion of coverage, and the SCHIP rules are not appropriate for children who are already covered in Medicaid. Although he is somewhat less concerned about the optional Medicaid groups, he argued it would be too easy to extend more flexible rules to mandatory groups once they have been imposed on the optional groups.

Parental Choice of Program

MMW recommendation:

States could allow parental choice if states met certain conditions. They would have to: adopt a joint application for Medicaid and SCHIP; children would receive the Medicaid match rate for Medicaid eligibles who opted into SCHIP; the child's entitlement to Medicaid coverage and the state's entitlement to federal matching funds would remain unchanged; and the parents would have the opportunity to re-enroll their children in Medicaid at least once a year.

Most of the participants supported this recommendation.

One of the SCHIP directors said she agreed with the recommendation but didn't understand why the requirement for a joint application was needed. If people don't want Medicaid, they are likely to not want to use a joint application for Medicaid and SCHIP. NASHP staff responded that MMW members thought it was important that the application and enrollment processes are simplified for both programs. If it is the same application for both programs, then individuals are not simply applying for SCHIP because it is an easier process but because they prefer SCHIP. A joint application also provides the added security that individuals who are Medicaid eligible will be identified as such.

Most of the SCHIP directors indicated that they were in favor of this recommendation. One stated that parents prefer SCHIP over Medicaid because of the providers, some of which are the same providers as in their family's insurance plan. Another said that this recommendation would address the concern about the limited SCHIP allotment since the Medicaid-eligible child would receive the Medicaid match rate. While it is important to fix the underlying problems in Medicaid, they have to deal with 35 years of Medicaid stigma, which will not change overnight.

One participant opposed this MMW recommendation because her state can't enroll all the SCHIP-eligible children. She wasn't sure what would be accomplished by allowing people to choose to go into a program that freezes periodically. Another noted that his preference was for the option requiring states to conduct satisfaction surveys of Medicaid beneficiaries and then to develop customer improvement plans.

Finally, one of the participants advocated for allowing family members in a mixed SCHIP/Medicaid family to enroll in SCHIP. One of the other SCHIP directors responded that she was concerned about this proposal because the Medicaid income eligibility limits for infants are so high in many states.