

Medicaid in 2006: A Trip Down the Yellow Brick Road?

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OVERVIEW — *This issue brief explores the continuing evolution of the Medicaid program on several fronts. It discusses the benefits and cost-sharing flexibility that is included in the Deficit Reduction Act of 2005 (DRA) and examines the implications of these provisions for states, beneficiaries, and providers. The paper also explores recent trends in section 1115 waiver development and considers the use of waivers as a vehicle for restructuring Medicaid financing systems and for testing completely new approaches to health care delivery. The role of section 1115 waivers in the context of the DRA and as a mechanism for continued state innovation is also discussed.*

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The Medicaid program is at a turning point. The policy and programmatic changes that were debated and resolved during 2005 will undoubtedly have far-reaching effects on the program and its stakeholders, and the implications are only beginning to be understood.

While champions and critics alike have come to acknowledge that the growth in Medicaid expenditures over the past decade is unsustainable, mutually agreeable solutions to the problem continue to elude policymakers. As a result, the Medicaid program may become even more complex as some states try out the new flexibility provided by the Deficit Reduction Act of 2005 (DRA), while others continue to look to section 1115 waivers as a means of program innovation and preservation of federal funding levels. The coming year could represent the beginning of a trip down the “yellow brick road”—a long and winding path of innovative ideas—that in the end could turn out to be full of surprises and with no clear answers to be found behind the curtain.

The provisions included in the DRA were not intended to represent comprehensive Medicaid reform. Rather, they were designed to provide the nation’s governors additional flexibility to contain Medicaid costs. Indeed, the DRA adopts many of the recommendations set forth in the National Governors Association’s reform proposals during 2005. However, although the DRA does include provisions that take steps to improve the health and social circumstances for elderly and disabled individuals, the legislation does not offer a comprehensive solution to the unsustainable cost growth in the area of long-term care. In fact, the Center for American Progress found that the significant health needs of just 10 percent of Medicaid enrollees account for 72 percent of all Medicaid expenditures. And the group known as the “dual eligibles”—those eligible for both Medicare and Medicaid benefits—accounts for over half of total state Medicaid spending. The DRA does not include provisions that will change these imbalanced proportions, and it has been argued that it will take nothing short of a major overhaul of the federal-state financing system to do so.

BACKGROUND

The Medicaid program serves an estimated 52 million individuals (39 million people in low-income families and 13 million elderly and disabled individuals) with a combined state and federal price tag of over

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\$320 billion in fiscal year (FY) 2005. Medicaid comprises 17 percent of the average state’s budget, second only to education.¹ The Medicaid program also makes coverage available to individuals who would otherwise have difficulty obtaining coverage. For example, Medicaid finances care for half of children under age four who have severe disabilities and is the largest source of health insurance coverage for individuals living with HIV/AIDS. It has been argued that the availability of publicly financed coverage for these groups effectively lowers the cost of private coverage.²

Medicaid spending increased by over 50 percent between 2001 and 2004, driven primarily by significant growth in enrollment (due in large part to the economic downturn in the country) and by rapidly rising health care costs, for prescription drugs and hospital care in particular. Although spending growth has slowed to a rate of 7.5 percent from a peak of 12.7 percent in 2002, Medicaid program growth still outpaces state revenues. The growth in Medicaid enrollment has also slowed to a more comfortable 3.1 percent, down from a nearly 10 percent increase in 2002. (It should be noted that some of the slowing in enrollment is due to state restrictions on program eligibility.) And despite some positive indicators of economic recovery, 26 states expect to face budget shortfalls in FY 2006.³ Not

MEDICAID'S VITAL ROLES

Health coverage for 52.7 million individuals

Low-Income Families	Elderly	People with Disabilities
25 million children 14 million adults <i>Provides coverage for 50 percent of all births to low-income families.</i>	5.1 million people age 65 and older <i>Helps finance care for 65 percent of all nursing facility patients.</i> <i>Covers 18 percent of all Medicare beneficiaries.</i>	8.6 million disabled persons <i>Pays for 43.5 percent of all long-term care services.</i>

Safety net financing

Medicaid represents:

- 17 percent of national health spending
- The largest single source of federal funds to states
- 40 percent of funding for public hospitals

surprisingly, Medicaid sustainability is a concern at both the federal and state levels. The ongoing expenditure and enrollment increases have prompted widespread discussion about the problems and, less often, about potential solutions.

Among other things, the changes in the DRA provide states additional flexibility to design alternate Medicaid benefit packages for targeted populations and to increase cost-sharing requirements. While these changes partly reflect Congress's and the Bush administration's philosophical approach to publicly financed health care programs, the primary purpose is to enable states (and the federal government) to better control Medicaid spending. Toward that end, the Congressional Budget Office (CBO) estimates that the DRA will generate \$39 billion in federal entitlement savings across the board, with \$4.8 billion in net reductions in federal Medicaid spending over five years.⁴ (The CBO does not provide estimates of state Medicaid savings.) These estimates are based on a series of assumptions about how many and to what extent states will elect to use the new flexibility; however, the DRA's role in reshaping the Medicaid program remains to be seen.

Meanwhile, the administration has been proactively using the section 1115 waiver authority to permit states to make fundamental changes in the way Medicaid services are delivered and financed. In general, section 1115 permits the Secretary of Health and Human Services (HHS) to "waive" certain provisions of the statute to enable states to apply savings generated by a demonstration initiative toward activities that are not otherwise permitted. In 2001, the Centers for Medicare & Medicaid Services (CMS) announced the Health Insurance Flexibility and Accountability (HIFA) initiative, which originally offered states additional benefits and cost-sharing flexibility in exchange for coverage expansions. (However, in some of the recent waivers that included a coverage component, the expansions have not been implemented.)⁵ Since then, CMS has approved 25 section 1115 waivers that range from modest new benefits and cost-sharing flexibility to refinancing the states' hospital payment systems to completely transforming the way Medicaid benefits are delivered and paid for. These more recent approvals, such as those in Florida and Vermont, could be considered in line with the truer "demonstration" nature of section 1115 because they are testing completely new strategies for health care delivery and financing.

While innovation is a desirable goal, some have raised concerns about the appropriateness of some of these new approaches for low-income and medically fragile populations. In addition, these waiver approvals have raised red flags over the past few years in Congress prompting a series of ongoing Government Accountability Office (GAO) studies.⁶ Critics have

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challenged the lack of transparency of the waiver review process and questioned whether the flexibility permitted could be in conflict with the intent of the Medicaid statute. In fact, the DRA included a provision that prohibits the use of State Children’s Health Insurance Program (SCHIP) funds for new coverage of adults without children—a waiver approach that has been approved in several states in the past five years. Further, the enactment of the DRA begs the question of whether states now have sufficient flexibility to improve the efficiency and cost-effectiveness of their Medicaid programs. Some in Congress have even suggested the possibility that new waiver approvals should be put on hold in favor of giving states the opportunity to test the new options provided in the legislation.

“SCHIP”PING AWAY AT MEDICAID

Medicaid “reform” has been a highly charged topic for many years. One solution that has repeatedly surfaced is to change the program’s financing structure by placing a cap on the amount of federal Medicaid program spending that would be available. President Reagan first proposed this “block grant” concept in 1981 and Congress passed a similar cap on program funding in 1995, but the legislation was vetoed by President Clinton. The Bush administration has suggested the block grant concept at various points over the past several years, but Congress has not considered legislation toward that end recently.⁷ Instead, in 2005 Congress took a different approach, giving states the ability to control Medicaid costs by providing more limited benefit packages and by increasing cost sharing for beneficiaries.

The Deficit Reduction Act of 2005

After months of controversy and heated debate, President Bush signed the DRA (P.L. 109-362) on February 8, 2006. According to the CBO, more than half of the estimated \$4.8 billion net Medicaid program savings (\$3.2 billion) will be generated by new flexibility that will enable states to design more limited benefit packages and to require higher levels of cost sharing and premiums for certain beneficiaries. (The legislation also includes provisions that account for the rest of the estimated savings, such as lowering payments for outpatient prescription drugs and further limiting the circumstances under which individuals can transfer assets in order to qualify for Medicaid-financed nursing home care.)⁸

The benefits and cost-sharing provisions in the DRA are clearly modeled after the structure of SCHIP. Enacted in the Balanced Budget Act (BBA) of 1997, SCHIP was designed to offer health insurance coverage to low-income children in families with incomes too high to qualify for Medicaid in most states but too low to afford private health insurance coverage. The new program also gave states the option of using SCHIP funds to expand Medicaid coverage to higher-income children.

The enactment of SCHIP was, in some ways, a response to ongoing dissatisfaction with certain aspects of the Medicaid program. In order to achieve passage, the SCHIP legislation included, among other things, new flexibility for states to provide alternate benefit packages and to impose additional cost sharing on beneficiaries. These variations from the Medicaid standards acknowledged, in part, the higher incomes of the families that would be targeted by the new program—those with incomes up to 200 percent of the federal poverty level (FPL), which amounts to \$33,200 for a family of three in 2006. However, the changes were also an attempt to make the new SCHIP program appear more like a commercial insurance product and less like a “welfare” program, a connotation that had deterred Medicaid enrollment and program credibility in some states.

SCHIP has been considered a successful program, credited with significantly expanding access to children’s coverage through both Medicaid and SCHIP. States have been credited with designing comprehensive benefit packages and provider participation has been more enthusiastic, in part as a result of better payment rates than Medicaid generally offers. Enrollees report high satisfaction with their coverage, and research has indicated that more children have a usual source of care and have access to a comprehensive set of benefits that meet their medical needs.⁹ To date, 33 states are operating Medicaid expansion SCHIP programs (using the Medicaid benefit package) and fewer than half of the states with separate SCHIP programs have used the benefits flexibility to design coverage packages that are less comprehensive than those provided under Medicaid.¹⁰

However, what seems like a logical conclusion—to apply the elements of this successful program to Medicaid—could have significant health consequences for beneficiaries. Medicaid was designed as a safety net for low-income individuals and those with acute and long-term health needs, not as a risk insurer. In fact, it has been noted that the hallmark of Medicaid is coverage of populations, services, and benefits that lie well outside of actuarial coverage norms.¹¹ The financial and health status of the Medicaid population does not mirror those of the SCHIP and commercial populations. SCHIP generally serves healthy children who are relatively inexpensive to insure. In contrast, children with disabilities and those who develop significant medical needs generally end up becoming eligible for Medicaid either as a disabled child (receiving Supplemental Security Income benefits) or through “spending down” to Medicaid eligibility.¹² The low-income families that are served by Medicaid have higher rates of asthma, allergies, and other chronic illnesses, and the children are more likely to have developmental disabilities and delays.¹³ Consequently, analysts have raised concerns about the implications of the new flexibility that is provided by the DRA.

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“Benchmark” Benefits

While states had a certain amount of flexibility to design benefit packages under the original Medicaid statute, the Deficit Reduction Act of 2005 permits states to further define the services that will be available to beneficiaries. Like SCHIP, states will now be able to design benefit packages (for certain populations) that differ from the standard Medicaid package. To use as a model in creating a new benefit design, states will have a set of “benchmark” benefit package options:

- The standard Blue Cross/Blue Shield plan offered under the Federal Employees Health Benefits Program
- The health benefit plan that is offered and generally available to state employees
- The health coverage package offered by the health maintenance organization with the largest commercial enrollment in the state
- Any coverage determined by the Secretary of HHS to be “appropriate” for the population

All state-designed benefit packages must include certain basic services, such as physician visits and hospital coverage, and must be at least “actuarially equivalent” to one of the benchmark options.¹⁴ In addition, states will be permitted to provide Medicaid-financed wrap-around benefits to supplement other forms of health insurance, including employer-sponsored insurance.

To address concerns about how these new benefit options could adversely affect the most medically vulnerable beneficiaries, the statute prohibits states from offering reduced benefits to mandatory eligibility groups of pregnant women, certain low-income parents, individuals with disabilities, dual eligibles, and certain other aged and disabled individuals who are medically frail, need long-term care, and/or have special medical needs. In effect, the new benefit packages can only be offered to adults not covered by Temporary Assistance for Needy Families (TANF) and to nondisabled children. States will be permitted to enroll children in a benchmark benefit plan, but they are required to ensure coverage of all other Medicaid services (that is, those currently guaranteed through early, periodic, screening, diagnosis and treatment, or EPSDT, for children) in the form of wrap-around benefits. (See next page, “EPSDT: In or Out?”)

States must also ensure that beneficiaries continue to have access to rural health clinic and federally qualified health center services. Finally, the benefit package options apply only to eligibility groups currently defined under the state’s Medicaid plan, meaning the state cannot use the provision to design more limited benefit packages for new or modified eligibility groups. From the state perspective, because the benchmark options can be applied only to low-income adults and children

EPSDT: In or Out?

One of the main points of contention and concern during the debate over the budget reconciliation bills was whether Congress was attempting to discontinue the Medicaid entitlement to early, periodic, screening, diagnosis and treatment (EPSDT) services for children. This fundamental element of the Medicaid program has been credited with ensuring comprehensive and generally uniform coverage for children in all states and is often used as a catch-all when questions are raised about what children's benefits must be covered. The legislation does not specifically note that the new benchmark options must include EPSDT in its current form. However, senior congressional committee staff and CMS officials have said informally that EPSDT will remain intact for children, and the DRA does include a provision that directs states to provide wrap-around coverage for any services that are not included in a benchmark benefit package. It remains to be seen whether access to these often critical services can be guaranteed for the 25 million children enrolled in Medicaid nationwide.

EPSDT has always been somewhat ambiguous in the real world, and this provision may further erode the

continuum of primary and preventive care that is critical for optimal child development. Access to the range of EPSDT-required benefits has been tenuous at best. For example, a study by the GAO found that only 21 percent of children aged two through five had received the EPSDT-required dental screening visit in 2001.* In addition, concerns have been raised regarding fragmented and delayed access to EPSDT benefits through managed care. The practical implications in states that expand their Medicaid markets to include new plans—plans without existing contractual relationships with the state—could be challenging. Ensuring the wrap-around benefits and continuity of care will be one of the many issues that need attention.†

* *Government Accountability Office, Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services, GAO-01-749, July 2001, 3-4; available at www.gao.gov/new.items/d01749.pdf.*

† *Jocelyn Guyer, Cindy Mann, and Joan Alker, "The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families," Center for Children and Families, Georgetown University Health Policy Institute, March 2006; available at <http://jonesd.ihcrp.georgetown.edu/~jonesd3/reconbrief013006.pdf>*

and perhaps some groups of elderly individuals residing in the community, the opportunity for real program savings generated by the new flexibility is actually quite limited to relatively healthy (low-cost) populations. And because states have worked for many years to find ways to better meet the needs of these vulnerable populations, the philosophical desire to cut benefits may not materialize.

Implications for Beneficiaries — While the DRA contains protections for many of the most vulnerable Medicaid beneficiaries, some analysts have raised concerns about the overall negative effect the benefits provisions could have on access to care in an already fragile delivery system. The CBO estimates that the new benefits flexibility will reduce federal spending by \$1.3 billion over five years, primarily from reduced utilization of services, and further predicts that most of the reductions will be in the coverage for dental, vision, mental health, rehabilitation, and other therapies. Reductions in the amount, duration, and scope of services will also be permitted under the new law, resulting in further savings.¹⁵ Removing this requirement for "comparability" among Medicaid populations means that states will be able to place limits, for

example, on numbers of physician visits or the length of hospital stays and constrain what is covered within a particular benefit category.¹⁶ In addition, states will be able to provide certain benefits for certain populations.

Concerns have been raised that the benchmark benefits standards are missing a “bottom line” in that the statutory language is quite open-ended. For example, under the state employee plan option, states can choose to offer any plan that is generally available to state employees, with no more specific parameters. This could conceivably be a plan that provides extremely limited or only catastrophic coverage, or a plan in which only a few state employees are enrolled.¹⁷ In addition, the fourth option for “Secretary-approved coverage” leaves the determination of an acceptable benefit standard completely to the discretion of the Secretary, with no apparent checks, balances, or limitations.

Although the Blue Cross/Blue Shield option in the Federal Employees Health Benefits plan is widely available and generally considered to be comprehensive, there are limitations that differ from Medicaid benefits guarantees. For example, home health care is covered for two hours per day, 25 visits per year, when furnished by a nurse and under a doctor’s orders, whereas Medicaid coverage of home health services is unlimited, subject to medical necessity. Therapy services are also more limited, with exclusions for maintenance, recreational, or educational therapies. In addition, all services billed by schools or by school staff members are excluded from coverage.¹⁸

Table 1 (next page) provides an illustration of the possible benefit package options that could be available in South Carolina and Kansas. While it is difficult to select a state that can be considered “typical” or representative of other states, South Carolina and Kansas offer examples of two states that are not currently operating section 1115 waivers and, therefore, have not made significant changes to their Medicaid benefit packages or delivery systems to date. South Carolina provides a particularly interesting example because the state recently withdrew its section 1115 waiver proposal from consideration at CMS, citing plans to pursue the desired program changes through the flexibility provided by the DRA.

The real implications for the new benefits flexibility are not yet known. The CBO noted in its cost estimates that it expected that the alternative benefits packages developed by states would reduce per capita spending by about 30 percent for the affected populations. However, the CBO also expressed its uncertainty about the actual extent to which states will take steps to restrict benefits, saying that some states will likely pursue far-reaching changes whereas others will not use the flexibility at all.¹⁹ If the experience with SCHIP is any indication, it is likely that states may look to other channels for program savings. It is also possible that states might use the new flexibility to offer expanded benefits to certain populations. For example, states now have the ability to offer personal care services tailored for groups of individuals with disabilities.

TABLE 1
Comparison of Selected Benefits for South Carolina and Kansas

South Carolina			
Benefit	Medicaid/SCHIP*	State Employee Health Plan (State Health Plan)	FEHBP Option (BCBS PPO Standard Option)†
Dental	\$3 per visit. Limited to trauma care and emergency treatments.	Not covered (exceptions in certain circumstances).	Preventive care covered (2 visits/year), no copay or deductible. Sealants covered up to age 16.
Vision	\$1 per visit refractive exams only. Eyeglasses covered for post-cataract surgery only.	Not covered.	Coverage limited to accidental injury or related to a specific medical condition.
Mental Health/ Substance Abuse	Fee-for-service coverage at state-approved facilities. Psychologist services not covered.	Covered as medically necessary.	\$20 copay per office visit; \$100 to \$500 per hospitalization. Limited to 25 visits or treatment sessions/year.
Rehabilitation Services	Physical therapy (PT), occupational therapy (OT), speech therapy not covered.	Covered only for short-term needs; behavioral therapies not covered.	Subject to copays/deductibles. PT limited to 50 visits/year; OT, speech therapy limited to 25 visits/ year.
Kansas			
Benefit	Medicaid/SCHIP*	State Employee Health Plan (Preferred Plus/Premier Blue Coventry)	FEHBP Option (BCBS PPO Standard Option)†
Dental	\$3 per visit. Limited to procedures associated with medically necessary extractions.	Not covered. (State has a separate contract with Delta Dental.)	Same as above.
Vision	1 exam and 1 pair of glasses every 4 years; exceptions for certain medical conditions.	Covered; subject to copays and deductibles.	Same as above.
Mental Health/ Substance Abuse	4 hours of psychiatric testing and evaluation every 2 years. 32 hours of psychotherapy per year covered.	Inpatient limited to 60 days per year; outpatient covered but subject to increasing copays and coinsurance.	Same as above.
Rehabilitation Services	PT, OT, and speech therapy limited to post-trauma/illness. Rehabilitation potential required.	Limited to medically necessary services. Medical records must show continued improvement in condition.	Same as above.

* South Carolina is operating a Medicaid expansion SCHIP program. Kansas elected to create a separate SCHIP program, but did not place limitations on the program's benefit package. The benefit limitations listed would not apply to children because they are covered under the early, periodic, screening, diagnosis, and treatment (EPSDT) benefit (subject to medical necessity).

† Includes a \$250 per person (\$500 per family) annual deductible.

Sources: Author's compilation of: benefit description plans from the South Carolina State Health Plan insurance benefits guide (www.eip.sc.gov/publications/catman/insbeneguide/02shp.pdf) and the Kansas State Employee Health Plan benefits comparison chart for 2005 (<http://da.state.ks.us/ps/documents/oecomp05.pdf>); Kaiser Family Foundation state-by-state Medicaid benefits listing (www.kff.org/medicaid/benefits/index.jsp); Federal Employees Health Benefits Plan nationwide fee-for-service option, Blue Cross/Blue Shield Standard Option (www.opm.gov/insure/06/brochures/pdf/71-005.pdf); and the benefits design sections of the SCHIP FY2001 Report to Congress, Mathematica Policy Research, Inc. (www.cms.hhs.gov/NationalSCHIPPolicy/07_EvaluationsAndReports.asp#TopOfPage).

Cost-Sharing Increases

The DRA also included provisions to provide states additional flexibility to require beneficiaries to make contributions toward the cost of Medicaid coverage. These provisions permit states to impose premiums and cost sharing on any group of enrollees within certain parameters:²⁰

- “Nominal” copayment amounts may be increased according to medical inflation beginning in 2006 (current nominal amounts range from \$0.50 to \$3.00 per visit or prescription).
- Aggregate cost sharing and premiums for all family members combined may not exceed 5 percent of family income (applied on either a quarterly or monthly basis).
- The statute is silent regarding premiums for families with incomes below 100 percent of the FPL (\$16,600 for a family of three in 2006). However, the DRA explicitly prohibits premiums for families with incomes between 100 and 150 percent of the FPL. For individuals with incomes above 150 percent of the FPL (\$24,900 for a family of three in 2006), premiums may be imposed and there are no specific limitations on premium amounts as long as total spending remains within the 5 percent cap.
- For individuals with incomes between 100 and 150 percent of the FPL, states may require individuals to pay cost sharing at the point of service (coinsurance) that amounts to 10 percent of the cost of an item or service. For enrollees with incomes above 150 percent of the FPL, cost-sharing charges may total up to 20 percent of the cost of an item or service.
- States have the option to allow providers to deny care at the point of service if the individual cannot pay the required copayments (and states may require prepayment of premiums as a condition of Medicaid enrollment).

In addition, states will now be permitted to charge higher cost sharing for nonpreferred prescription drugs and for nonemergency use of the emergency room for all Medicaid populations.

The DRA includes exemptions from increased cost sharing for certain populations and services. Cost-sharing levels may not be increased beyond the nominal amounts for mandatory eligibility categories of children, pregnant women, and disabled and elderly individuals living in institutions. In addition, cost sharing will not be permitted for preventive services for children, for prenatal care and other pregnancy-related services, and for services exempted under current law, including emergency room visits, family planning services, and hospice care.

Issues and Concerns: Difficult Choices for New “Consumers” — Many of the individuals (including low-income parents, seniors, and individuals with disabilities) who will be subject to new cost-sharing charges have

incomes below the poverty line or just above it.²¹ While analysts have long argued that cost-sharing amounts should be adjusted to reflect inflation (indeed, the nominal cost-sharing levels had not been increased since 1982), these provisions are more far-reaching than anything previously enacted, including the SCHIP program.

The CBO cost estimate associated with these provisions was based on an analysis of existing state cost-sharing policies and income and administrative data. The agency predicts that the cost-sharing increases will result in a \$1.9 billion reduction in Medicaid spending over five years. According to the CBO, savings will result from reduced utilization of services and decreased Medicaid enrollment in states that elect to impose premiums. Recent research on cost-sharing policies in SCHIP and Medicaid confirms that enrollment declines as premiums increase as a proportion of income. An Urban Institute analysis of state Medicaid waivers that include increased levels of cost sharing found that only 18 percent of individuals enroll in health coverage when premiums reach 5 percent of income.²²

For example, in 2002 when Rhode Island began charging premiums (ranging from \$43 to \$58 per month) for families with incomes above 150 percent of the FPL, 20 percent of them were disenrolled after failing to pay their premiums during the following three months. A follow-up survey found that half of those families indicated they could not afford the premium and had become uninsured upon leaving Medicaid. When Oregon increased premiums for low-income adults in 2003, nearly 50,000 people (half of the group affected by the new premiums) were disenrolled; 67 percent of these individuals reported becoming uninsured. Finally, Maryland reported a 28 percent disenrollment rate when the state implemented SCHIP premiums of \$37 per month for children with family incomes between 185 and 200 percent of the FPL. The state legislature subsequently eliminated the premiums.²³

Survey results from the state of Utah provide an interesting example of individuals' reactions to cost sharing. Nearly 75 percent of survey participants said that it "feels good to pay a little bit" but nearly 40 percent of respondents also said that the copayments caused serious financial difficulties for them. Focus groups conducted by the National Academy for State Health Policy similarly found that individuals were willing to contribute toward the cost of their health care, as long as the amounts were affordable to them.²⁴

Finally, concerns have been raised that, as with SCHIP, there is no prescribed method for tracking copayments to ensure that the family does not exceed the 5 percent cap, and anecdotal experiences have shown that families often do not realize when they have reached their cap and therefore continue paying copayments at the point of service.

Missing the Big Picture

Although the changes to the structure of the Medicaid program are significant and could have far-reaching effects, they do not address the perennial issue of the program's main cost drivers. Long-term care services and expenditures for the elderly and disabled will not be significantly limited through the legislation, due in part to the exceptions in the legislative language protecting the frailest populations. While the asset transfer limitations were expected to generate some program savings through delayed access to Medicaid-financed nursing home care, they are not likely to stem the demand for long-term care services as the nation's population ages and life expectancy increases. In fact, the DRA contains provisions that will actually increase Medicaid spending on the elderly and disabled. States will have new options for expanding the use of home and community-based services, facilitating the availability of consumer-directed care, and enabling families of disabled children to buy into Medicaid. The provisions are estimated to increase Medicaid spending by more than \$2.5 billion over five years.²⁵ Finally, the DRA does not address the ongoing challenge of serving the population of dual eligibles. There is a need for improved administrative and care coordination between Medicare and Medicaid both at the federal and state level. While the new option for enrolling dual eligibles in Medicare Advantage Special Needs Plans offers a potential for improvement, it is very early in the implementation process and too soon to be able to measure the effectiveness of these plans.

THE NEW WORLD OF WAIVERS, AGAIN?

Section 1115 of the Social Security Act was designed to give the Secretary of Health and Human Services an opportunity to permit states to approve and test new approaches to the delivery and financing of health and social services programs. Originally designed as a "research and demonstration" authority, the purpose was to provide a testing ground for policies that might eventually be codified through legislation. The cost-sharing and benefit changes included in the DRA are not inconsistent with policies that have been approved by the current administration and tested by states through Medicaid section 1115 waiver demonstrations over the past several years. However, the changes in the DRA represent a significant departure from earlier statutory modifications; this is the first time since the creation of the Medicaid program in 1965 that Congress

The State Plan Amendment Process

The DRA effectively expanded the list of program changes that can be made through the Medicaid "state plan amendment" process. Although this process is considerably less complicated than applying for and negotiating a section 1115 waiver, it does not give states carte blanche to change their Medicaid programs. When proposing to make "traditional" changes to Medicaid policies, states submit requests to amend the approved state Medicaid plan. State plan amendments (SPAs) are subject to review and approval (or disapproval) by CMS. The process consists of a 90-day review period at CMS, with the possibility of requests for additional information, which stop the 90-day "clock" until the state responds. If the state's response is not sufficient, CMS may make additional requests, stopping and resetting the review clock until the federal officials are satisfied that the SPA is consistent with the intent of the statute.

has passed a major legislative package that is expected to explicitly reduce access to care for beneficiaries.

An example of state innovation first tested under waivers and ultimately translated into a new statutory Medicaid program option was in the Balanced Budget Act (BBA) of 1997. In this case, Congress took steps to make it easier for states to enact mandatory enrollment in Medicaid managed care plans. The BBA codified this approach, which had been tested as a source of savings throughout the late 1980s and early 1990s through section 1115 demonstrations and section 1915(b) (“freedom of choice of provider”) waivers; managed care has since become the primary delivery system for low-income families enrolled in Medicaid. In fact, between 1991 and 1999, the proportion of all Medicaid beneficiaries enrolled in some form of managed care grew from about 10 percent to about 56 percent, generating significant and ongoing program savings.²⁶ As these savings were realized and the economic boom of the 1990s took hold, states used section 1115 demonstrations to implement Medicaid coverage expansions that—in states like Minnesota, Rhode Island, Oregon, Tennessee, and Massachusetts—translated into single-digit rates of uninsurance.

More recently, waivers have provided the opportunity for CMS and states to renegotiate and refinance the Medicaid payment structure. For example, four of the six most recent section 1115 waiver approvals have focused primarily on restructuring states’ hospital financing systems in exchange for a phase-out of states’ use of “creative financing strategies.” Beginning in the 1990s, states, sometimes with federal encouragement, identified several new ways to leverage federal Medicaid matching funds without increasing state outlays. In light of the constitutional requirement to balance budgets each year, states have reason to search for mechanisms that “maximize” federal Medicaid funding, at times, beyond what is appropriate. The nature of the federal-state Medicaid matching structure both hinders and helps these efforts. The statute is relatively vague in some areas, particularly around permissible sources of the state share of matching funds. In addition, the entitlement nature of the program means that there is no statutory cap on the amount of federal funds that can be made available, as long as the state puts up its share of matching dollars.

States have developed a variety of creative strategies—imposing taxes on providers, overpaying public hospitals and nursing facilities (the upper payment limit, or UPL, strategy), and using a circular system of intergovernmental transfers (IGTs)—to generate the nonfederal share of Medicaid matching funds. In some cases, states have been able to find ways to avoid using state general funds altogether, a practice known as “recycling.”²⁷ This practice increases the “effective federal Medicaid matching rate” to a

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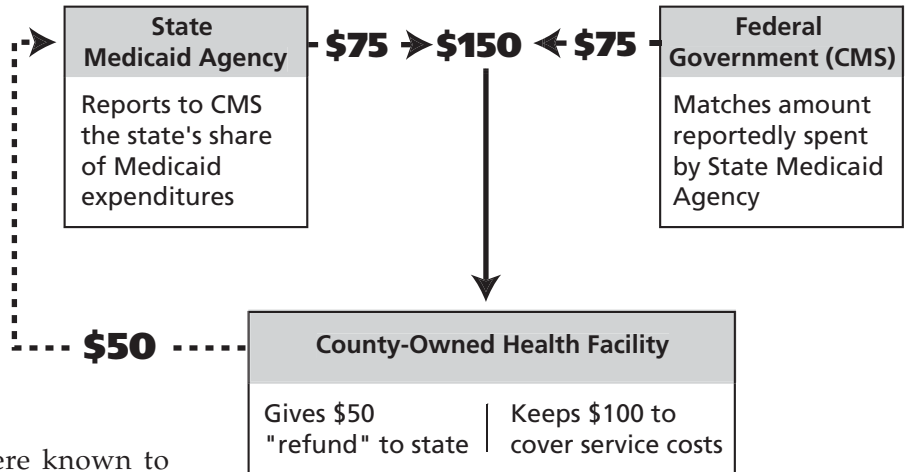
higher level than is provided for in the statute. For example, if a state Medicaid agency makes a Medicaid payment to a county hospital and then requires the county hospital to return some or all of the payment to the state Medicaid agency through an IGT to be used as the source of the nonfederal (state) share of matching funds, this would be considered recycling of funds (see illustration, "Intergovernmental Transfers and 'Recycling'"). The practice of transferring money between state agencies is not illegal, and states' claiming practices were known to CMS. However, over the years these financing strategies have disturbed the balance of the Medicaid financing structure and taken a toll on the federal bank account.

In 1999 the Health Care Financing Administration (now CMS) took stock of the existing Medicaid regulations and began to reconsider what financing practices were actually appropriate and in keeping with the intent of the statute. It was determined that the practice of manipulating UPLs and IGTs to generate matching funds should be phased out over time (these practices have generated such a large amount of revenue for states that to cut them off would have threatened to bankrupt the safety net system). In the Benefits Improvement and Protection Act of 2000, Congress did try to limit states' ability to claim excessive amounts of federal matching funds through UPL- and IGT-related schemes; however, as is the nature of state-federal relations, some states got better deals than others and the practices continue.

The Bush administration has continued the phase-out policy, but has taken a slightly different approach in the past five years. CMS has begun requiring that states interested in pursuing Medicaid program changes through 1115 waivers include a phase-out of their questionable accounting practices.²⁸ In fact, the focus of many state waiver proposals has shifted to containing Medicaid costs, rather than expanding coverage. The majority of recent waiver approvals have focused primarily on refinancing, with program changes more subtly woven into the "special terms and conditions" of the waiver package.²⁹ Few of the waiver proposals include

Intergovernmental Transfers and "Recycling"

In this example of a state with a 50-50 matching arrangement, the use of an IGT effectively increases the federal match to 75 percent.



BALANCE SHEET			
Federal Government	-\$75	- \$0	= -\$75
State Medicaid Agency	-\$75	+ \$50	= -\$25
County-Owned Facility	\$150	- \$50	= \$100

Expenditures are shown as negative values; gains are shown as positive values. Numbers are simplified for illustrative purposes.

The Realities of Budget Neutrality

Ensuring the budget neutrality of section 1115 waivers has often been the largest point of contention between CMS and the states. The concept is that federal spending over the life of the waiver must be no greater than federal spending would have been in absence of the waiver. However, in reality, the series of special assumptions that CMS uses in predicting what program spending would have been without the waiver make the likelihood of a state ever reaching or exceeding the budget neutrality caps very small. For example, states are typically given credit for eligibility expansions that could have been accomplished under the regular state plan (without a waiver) and can be “held harmless” for costs associated with caseload growth within the expansion populations. In addition, in some cases states are able to count unspent disproportionate share hospital funds toward meeting budget neutrality, even though these funds

are provided through a federal allotment.* These factors, combined with the policy allowing budget neutrality to be calculated over the five-year period of the waiver rather than on an annual basis, have made the overall concept a little less daunting for states hoping to enact significant program expansions. †

* Theresa Laper Sachs and Jenna Walls, “Uncharted Territory: Current Trends in Section 1115 Demonstrations,” Health Management Associates, prepared for State Coverage Initiatives, Issue Brief, March 2006; available at www.statecoverage.net/pdf/issuebrief306.pdf.

† The Government Accountability Office has raised concerns about the budget neutrality process, noting that HHS’ review of section 1115 waivers does not adequately ensure that all waivers are budget neutral. See GAO, Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns, GAO-02-817, July 2002, 29–32; available at www.gao.gov/new.items/d02817.pdf.

concepts that are now permitted under the DRA, so it seems unlikely that the new legislation has obviated states’ perceived need for the flexibility provided through section 1115 waivers. The budget neutrality agreements in these newer waivers introduce some new financing concepts that will likely have far-reaching effects on state-federal and state-provider relations alike.

New Waiver Buzz Words: Certified Public Expenditures, Uncompensated Care Pools, and Milestones

Several of the recently approved waivers enable states to receive guaranteed amounts of federal funds previously furnished to public hospitals through creative financing arrangements in exchange for certain forms of limited coverage expansions. These agreements enable states to be assured of continued receipt of federal funding levels in exchange for dedicating these funds toward newly permitted purposes. There are a few common elements worth noting that reflect CMS’s new approach to waivers:

Certified Public Expenditures (CPEs) — As part of its requirement that states nearly eliminate the use of IGTs as a means of generating the nonfederal share of Medicaid matching funds, CMS has indicated that it will accept documentation of certified public expenditures as the source of the state match. CPEs are funds certified by counties, state university teaching hospitals, or other public entities within a state as having been

spent on the provision of covered services to Medicaid beneficiaries and the uninsured. The use of CPEs is not limited to waivers and is not a new concept. CPEs are discussed in federal regulations as a permissible source of matching funds but have been overshadowed by other mechanisms in recent years. As an example of CPE documentation, a county could—instead of actually transferring public funds to the state Medicaid agency (through an IGT)—certify that the hospital it operates has incurred specified costs for treating Medicaid patients. The state Medicaid agency can then use the amount of costs certified by the county hospital as the nonfederal share for purposes of claiming federal matching funds.³⁰ This new system of documenting CPEs in order to qualify for federal Medicaid reimbursement is an indication of CMS's policy that all future Medicaid expenditures will be subject to more rigorous federal review and approval.

Uncompensated Care Pools — The second common element of the group of recently approved financing waivers is the creation of a dedicated fund to be used for improving and expanding care for the uninsured. These pools appear to be in exchange for the phase-out of UPLs and IGTs as financing mechanisms, recognizing the vulnerability of state-provider relations and the need to continue support for the public hospital system. These new financing provisions allow states to shift resources currently funneled through hospitals (through the disproportionate share hospital allotments) to provide free care to individuals or develop programs aimed at reducing the number of uninsured. The recent waivers all include such pools, albeit with different names and in different amounts.

- California's Safety Net Care Pool (SNCP) makes \$766 million in federal funds available in each year of the waiver, subject to demonstrating legitimate sources of the state match. However, \$180 million of the SNCP is subject to the state's meeting certain milestones related to transitioning elderly and disabled beneficiaries into Medicaid managed care. Another portion is designated for use in developing initiatives to reach out to the uninsured.
- Similarly, Florida's Low-Income Pool reserves up to \$1 billion per year for safety net providers, but \$300 million of the total amount is contingent on meeting milestones related to evaluation and improvement of the state's health care delivery system and serving the uninsured.³¹ (See "Florida and Beyond," next page.)
- Massachusetts' waiver renewal included an SNCP containing up to \$1.2 billion per year in federal funds. The SNCP funds are capped at the same amount for each year of the waiver, regardless of increases (or decreases) in the number of uninsured. In this case, 10 percent of the SCNP funds may be used to improve delivery of care to the uninsured in Massachusetts, and both the governor and the state legislature have aggressive proposals to provide universal coverage to all of the state's residents, presumably using the SNCP as a starting point.

- The IowaCare pool redirects IGT and UPL funds that had previously gone to two of the state's public hospitals to a limited benefit and limited provider network expansion for adults aged 19 to 64. These individuals then receive services from the two expanded hospital-based provider networks.

Milestones — In some but not all cases, CMS has made access to portions of the pooled funds contingent on the states' meeting certain programmatic milestones. If the milestones are not met or are delayed, states stand to lose access to large amounts of federal funds. These milestones reflect the administration's priorities, which are at times at odds with those of the state. For example, California's waiver approval includes a specific progression of steps leading the state to transition its elderly and disabled Medi-Cal beneficiaries into a managed care delivery system. Under the waiver agreement, \$360 million of federal SNCP funding in the first two years of the demonstration (\$180 million per year) is available to the state, assuming implementation of the mandatory managed care enrollment for the new populations beginning in January 2007.³²

If legislation authorizing a transition to a mandatory managed care delivery system is not enacted by August 31, 2006, none of the \$180 million of the SNCP funds will be available to California in the first year. If there is no such legislation by August 31, 2007, none of the full \$360 million will be available to the state. The state legislature's opposition to the waiver agreement is so vehement that it appears willing to forego the funds in order to prevent the managed care transition.³³

Florida's Low-Income Pool also has milestone requirements, although they are less specific than those in other states. The milestones for Florida are related to the evaluation and improvement of the health care delivery system, serving the uninsured, and adhering to various other time frames for the waiver's terms and conditions.³⁴

Florida and Beyond: Transforming Medicaid?

A second category of recent waiver approvals has been the focus of a great deal of interest and controversy. In addition to modifying some of the questionable financing practices, this group of waivers seeks to fundamentally transform the way Medicaid services are delivered and financed. These new waivers are coming to be known as "mega-waivers" or super waivers, because of the magnitude of the changes that are being proposed.

Florida has received approval from CMS to pursue a "defined contribution" model of providing health care services. The state will pay premiums to managed care plans that are to be risk-adjusted based on assumptions about the health needs of specific individuals. Medicaid beneficiaries will be required to review the list of state-approved managed care plan options and determine which plan will best suit their health care needs.

The benefit plans will be required to include all mandatory Medicaid benefits and most optional benefits, but services can vary in amount, duration, and scope. Enrollees will be subject to the service limitations and cost-sharing requirements of the particular plan they choose. (The state has indicated that all medically necessary services for children and pregnant women will be guaranteed and that it will not raise associated cost-sharing requirements.) It is likely that there will be variation among the plan options for different eligibility groups, and plans may also vary by geographic areas. Beneficiaries will have the ability to opt out of the new Medicaid structure and use their risk-adjusted premium amount toward the purchase of employer-sponsored insurance (assuming it is available). In this case, the state Medicaid agency will pay the employee share of the premium on behalf of the individual up to the determined premium amount.

The Florida demonstration will begin in 2006 as a two-county pilot program with mandatory participation for TANF-related eligibility groups (low-income parents and children) and for disabled persons eligible for Medicaid but not Medicare. The pilot is expected to expand to three additional counties by 2007 and be implemented statewide within the five-year term of the waiver.³⁵ The first phase will begin in Broward (Ft. Lauderdale) and Duval (Jacksonville) counties and include approximately 220,000 individuals, about 9 percent of the state's Medicaid population.³⁶

The Florida model has been hailed by the Bush administration as an unprecedented step toward introducing competition and consumer choice to improve quality of care in Medicaid.³⁷ The state has asserted that giving individuals the ability to decide how they receive care and to choose a health plan that reflects their individual health needs and preferences will make them better health care consumers. Incorporating free market strategies of choice and competition by encouraging private plans to compete for Medicaid enrollees is expected to stabilize and improve the program.³⁸ In addition, these new consumers will be more likely to use health care services appropriately. As a result, program savings might be generated through greater use of low-cost preventive services (to avoid more expensive care later) and through incentives for consumers to choose lower-cost options for equivalent care (such as choosing generic prescription drugs). Provider participation could also improve, given the expectation of higher payment rates that are more like those of "commercial" health insurance. In addition, as the states and health plans develop new benefit designs, new and different providers who were not previously part of the Medicaid delivery system may emerge.³⁹

On the other hand, consumer groups across the country have raised concerns about the Florida waiver approval's major departure from the

The Florida model has been hailed by the Bush administration as an unprecedented step toward introducing competition and consumer choice to improve quality of care in Medicaid.

traditional Medicaid program's defined benefit structure. For example, the new structure includes an annual maximum benefit limit for adults (pregnant women and children are exempt). Although the state has not provided specifics about how it will define the benefit limits, it is possible, even likely, that beneficiaries could be made responsible for health care costs that exceed the limit. This is of particular concern because the disabled eligibility groups are more likely to have significant and high-cost health care needs. In addition, those beneficiaries that opt out of the Medicaid plans will be in the position of having to comparison shop among the employer-sponsored insurance plans available in the private market, within the constraints of their Medicaid risk-adjusted premium amounts. This raises the additional concern that beneficiaries cannot access services until they have selected a plan, which compels them to make a choice quickly. Although the state will have enrollment counselors on hand to help beneficiaries choose among the various plans, navigating health plan options can be extremely complicated and confusing even in the best of circumstances.

THE CHANGING FACE OF MEDICAID

The state budget crisis that began in 2000 was driven in part by rapidly escalating Medicaid costs. The increasing proportion of state budgets devoted to Medicaid has elevated the significance of health and human services agencies in state government. Consequently, the position of state Medicaid director has become a much more demanding and politically significant post. State Medicaid directors have often been career public servants who have risen through the ranks of state government, commonly through the state's budget office. These long-serving state officials have had a unique depth and breadth of knowledge and a personal understanding of the history of the Medicaid program in their states. Although the rate of turnover has been higher in some states than others, there has been a core group of individuals who have participated in and provided leadership for the program's evolution from a relatively small, welfare-related health support program to a major health insurance coverage vehicle that provides vital health care services for many facets of the population.

As the "baby boom" generation ages and retires, so does a generation of state Medicaid directors (SMDs). Today, at least 26 of 56 SMDs have been on the job for two years or less, and many have come from positions outside state government.⁴⁰ In many states, retiring public servants

Promoting Healthy Lifestyles

One interesting element of Florida's waiver agreement is the "enhanced benefits" that will be made available to beneficiaries who demonstrate state-defined healthy behaviors. Individual Medicaid beneficiaries can earn credits for participating in preventive health activities (mammograms, colorectal screenings, childhood immunizations, vision and dental exams) and for keeping appointments. Earned credits may be used to purchase enhanced benefits that are not otherwise covered such as smoking cessation classes, contact lenses, and routine dental care for adults. The credit dollars can also be used for premium costs of private coverage if the individual loses Medicaid eligibility, as long as his or her income remains below 200 percent of the FPL. The state plans to finance these benefits with savings generated by the waiver and will receive federal matching payments for them.

are being replaced by politically appointed individuals chosen personally by the state's governor. This change reflects the Medicaid program's increased significance both as a state budget line item and as a critical part of the safety net. While certainly there is no reason to doubt that these 26 new state leaders are capable and committed to the goals of the Medicaid program, the loss of institutional memory and a more politicized environment have changed the landscape. Governors have to pay much more attention to their Medicaid programs today and therefore are more likely to want someone they know and trust in the job.

As in Washington, political tensions at the state level run high and divisions are wide. There are currently 18 states whose majority party in the legislature is different from the governor's.⁴¹ And although state legislatures continue to have the final say (notwithstanding a veto) in drafting legislation and deciding what programs get cut or expanded, the governors' budget proposals are more likely to include philosophical reflections of his or her approach to health care and the role of publicly financed programs. Therefore, SMDs who serve at the pleasure of the governor are more sensitive to politics than they may have been in the past. And with 36 governors' races scheduled to take place in 2006, the political sands may continue to shift. Some have predicted that Democratic candidates will gain seats in Congress as well as in governors' mansions, which raises the potential for a Democratic majority of governorships for the first time since 1990.⁴² This would also translate into a new dynamic on the national level and change the relationship between the National Governors Association and the administration.

LOOKING TO THE FUTURE

As the Medicaid program continues to evolve and change, the coming years will likely be some of the most interesting and perhaps most challenging for CMS, states, providers, and beneficiaries alike. While there has been speculation about whether the need or desire for section 1115 waivers in Medicaid will continue in light of the DRA, it seems likely the two vehicles will need to continue on separate paths. This seems particularly probable because so many of the recently approved waivers have centered primarily on the state-federal financing relationship. Because the DRA does not address the larger Medicaid financing issues or the real cost drivers—care for the chronically ill—states will continue to pursue negotiations with CMS to preserve federal funding levels as they phase out old financing mechanisms. Many challenges lie ahead in terms of reconciling program changes that states may want to pursue under the new legislation with financing structures that are being negotiated through waivers. The interplay between the two approaches to Medicaid innovation and sustainability is hard to predict, but many watchful eyes will be following the states on their journey down this yellow brick road, wondering whether the quest for answers will be successful.

ENDNOTES

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2. Cindy Mann and Jeanne Lambrew, "The Role of Medicaid in the Context of a Restructured Health Care System," New America Foundation, Working Paper #5, February 2005; available at www.newamerica.net/Download_Docs/pdfs/Doc_File_2206_1.pdf.
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4. Congressional Budget Office (CBO), "Congressional Budget Office Cost Estimate for S.1932, the Deficit Reduction Act of 2005," January 27, 2006, 35–37; available at www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf. See also CBO, "Additional Information on CBO's Estimate for the Medicaid Provisions of the Conference Agreement for S. 1932, the Deficit Reduction Act of 2005," January 27, 2006; available at www.cbo.gov/ftpdocs/70xx/doc7030/s1932updat.pdf.
5. As a result, overall coverage gains through waivers in the past five years have been small, amounting to fewer than 300,000 people nationwide.
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7. The Bush administration has experimented with the concept of block grants through waivers. For example, several states agreed to accept global caps on their overall Medicaid programs in exchange for "Pharmacy+Plus" waivers that enabled states to provide Medicaid-financed prescription drug coverage to individuals not otherwise eligible for Medicaid benefits. CMS negotiated these caps as a means of limiting federal exposure. In addition, the more recently approved Vermont global access waiver appears to include a capped financing structure.
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11. Sara Rosenbaum, "Health Policy Report: Medicaid," *New England Journal of Medicine*, 346, no. 8 (February 21, 2002): 635–640.
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16. The Medicaid statute as originally drafted provided that each service category that a state covers under its Medicaid program must be “sufficient in amount, duration, and scope to reasonably achieve its purpose.” There is no precise federal definition for this concept beyond the statutory language.
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20. For more information, see Karen Tritz *et al.*, “Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005,” Report for Congress, Congressional Research Service, January 30, 2006; available at www.opencrs.cdt.org/rpts/RL33251_20060130.pdf.
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26. GAO, *Medicaid: Stronger Efforts Needed to Ensure Children’s Access to Screening Services*, GAO-01-749, July 2001, 7; available at www.gao.gov/new.items/d01749.pdf.
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28. These phase-outs are also being negotiated through the state plan amendment process and are the subject of an ongoing GAO study.
29. All section 1115 waivers are approved with a set of “special terms and conditions” that lay out the stipulations of CMS approval and provide the real details of the financing and programmatic structure. These documents are often lengthy and complicated and subject to a great deal of negotiation.

Endnotes / continued ►

Endnotes / continued

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