

HealthAffairs

Robert Wood Johnson Foundation



# Health Policy Brief

JANUARY 12, 2012

## **Medicaid Reform.** Many states want greater flexibility, and there is pressure to limit federal spending. Critics fear serious damage to the social safety net.

### WHAT'S THE ISSUE?

Medicaid is the nation's largest public health insurance program for low-income Americans, and is financed jointly by the federal and state governments. The majority of Medicaid spending goes to the elderly and disabled, and the weak economy has boosted enrollment among low-income families with children. In addition to providing health insurance coverage to nearly 20 percent of the US population, Medicaid accounts for about one-sixth of total spending on personal health care and covers 40 percent of births.

Recent concerns about ballooning federal budget deficits, the pressure on states to balance their budgets, and the growth of entitlement spending have fueled new interest in revamping Medicaid. Some proposals would end Medicaid as an entitlement program and turn it into a system of federal block grants to states. Other proposals would preserve Medicaid's basic mission and structure but change the way that states can make innovations, organize care, or pay providers.

This policy brief explores some of the major ideas being discussed to restructure Medicaid and the competing arguments.

### WHAT'S THE BACKGROUND?

Medicaid provides health insurance coverage to more than 60 million people. Low-income

families with dependent children constitute more than two-thirds of Medicaid enrollees but account for about one-third of spending. The elderly and disabled account for the remainder, primarily because of use of long-term care services; 70 percent of those in nursing homes are covered by Medicaid. Because Medicaid is an individual entitlement, anyone meeting income and eligibility requirements can enroll.

**REQUIREMENT AND FLEXIBILITY:** The federal statute authorizing Medicaid requires states to offer a basic set of benefits, such as physician and hospital services. It also requires coverage to certain groups of people, such as pregnant women and children in households below specific income levels. Elderly and disabled people receiving cash assistance are also covered under Medicaid. Under the Affordable Care Act, as of 2014 Medicaid coverage will be expanded to include nearly all adults under age 65 with incomes below 138 percent of the federal poverty level (\$22,350 for a family of four in 2011).

Medicaid programs differ significantly from one state to another. States determine how much providers will be paid. They may expand Medicaid eligibility beyond the required federal levels. States can also offer certain "optional" benefits, such as personal care, rehabilitation services, and prescription drug coverage.

# 57%

## Federal Medicaid portion

The federal government pays about 57 percent of Medicaid costs on average.

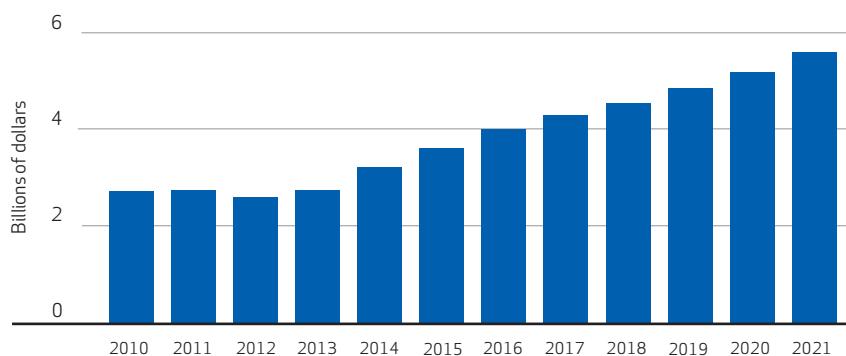
In 1966, the first year of its operation, Medicaid cost \$400 million, but today combined federal and state spending is approaching \$400 billion annually. The Congressional Budget Office (CBO) estimates that the federal portion of Medicaid spending will grow by 7 percent annually from \$275 billion in fiscal year 2011 to nearly \$560 billion in 2021 (Exhibit 1). Estimates of the number of additional people enrolling in Medicaid vary widely, from 8.5 million to 22.4 million. The federal government will pay 100 percent of the cost for these new enrollees from 2014 through 2017 and then gradually reduce its contribution to 90 percent by 2020 and thereafter.

On average, the federal government pays about 57 percent of Medicaid costs, representing approximately 8 percent of total federal government spending. Federal payments, made under a formula called the federal medical assistance percentage (FMAP), vary according to each state's per capita income level. States and some local governments pay the remainder. (See the [Health Policy Brief](#) published on July 14, 2011, for more information on FMAP.)

On average, states spend about 16 cents of every general revenue dollar on Medicaid, according to a recent estimate from the National Association of State Budget Officers. That makes state spending on Medicaid the second most costly category of state spending after elementary and secondary education (35 percent). Despite the high demand for Medicaid, many states are seeking ways to trim costs as the economy remains weak.

## EXHIBIT 1

### Federal Medicaid Spending Projections, Fiscal Years 2010-21



**SOURCE** Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid," March 18, 2011.

## WHAT ARE THE PROPOSALS?

Medicaid is poised to play an even larger role in coverage when health reform is implemented in 2014. Considerable efforts are being made to improve eligibility systems and enrollment procedures, assess payment and health delivery reforms, and expand capacity. At the same time, pressures on state budgets and federal spending are leading to calls to change Medicaid's structure and operations.

Most notably, congressional Republicans and many state governors have called for imposing limits on Medicaid spending and for freeing states from what they see as unnecessary federal restrictions. Acting on their own, they say, states would do a better job of delivering high-quality care to vulnerable populations. They also maintain that states would oversee their programs more efficiently and effectively if they had greater flexibility and authority.

On the other side, Medicaid advocates fear that dramatic changes to the program could compromise the health care safety net, hamper states' abilities to meet increased demand for coverage during periods of economic downturns and implementation of health reform, and weaken accountability for how federal dollars are spent.

**TWO APPROACHES TO CHANGE:** Proposed reforms to Medicaid fall into two general categories. The first would end the program as an "open-ended" entitlement, under which program costs automatically increase as more people become eligible. The second category of reforms would preserve Medicaid as an entitlement program and expand coverage with health reform but make certain targeted changes to achieve savings.

- **Block grants.** The leading proposal to end Medicaid as an entitlement would convert the program into a system of federal block grants to states, along the lines of hundreds of smaller programs that channel federal money to the states for such activities as community development and child care. The idea of converting Medicaid to a block grant was included in the House Republican budget for 2011 and has been considered at least as far back as the Reagan presidency. Under this approach, the federal government would send states specific amounts tied to a particular spending formula. With fewer federal standards, states would have even greater flexibility than they

now have to design and manage their Medicaid programs.

Advocates of block grants, including many Republican governors, argue that this approach would allow the federal government to cap and limit the growth in Medicaid spending while giving states more control over how they spend federal dollars. Opponents maintain that block grants with reduced levels of federal support would ultimately lead to reductions in eligibility and benefits and require cuts in payments to providers. If federal allocations were fixed too low, Medicaid costs could be shifted to states. States would have to choose between making up the difference and spending more, or cutting the program to spend less. If they chose the latter course, many people who previously would have been covered by Medicaid could end up uninsured.

- **Swapping federal eligibility and benefit rules for state-specific goals.** Under an approach advanced by the Republican Governors Association, the current entitlement would be abolished along with federal benefit and eligibility requirements. Instead, states would negotiate broad program operating agreements with the Centers for Medicare and Medicaid Services (CMS). Under those agreements, states would pledge to meet specific goals for their Medicaid programs in terms of quality, cost, access, and customer satisfaction and to assess program performance over time. The federal government would step in to oversee a state's program only if there was a significant difference between the state's performance on an outcome measure compared to what it had committed to deliver.

The Republican Governors Association says such an approach would be preferable to the “onerous” federal review process now in place. Critics maintain that retaining strong federal oversight is necessary to ensure Medicaid is administered consistently and appropriately by all the states. They also question the standards of data that might be used to measure performance.

- **Eliminating the waiver process.** A related proposal, also advanced by the Republican Governors Association, would target the federal review process that requires states to obtain waivers to test certain innovations, such as changes in benefits and services or in provider payments. Currently, waivers issued by the Department of Health and Human Services remain in effect for five years and may be renewed for three more, but they cannot be

issued permanently. The waiver process has long been criticized for making it difficult for states to innovate. Others counter that federal review and waiver authority is appropriate given the federal government's large share of total program costs.

- **Streamlining eligibility and enforcing reasonable cost sharing.** Eligibility for Medicaid coverage is currently determined under a complex set of requirements. These include various limits on income and assets, such as home ownership. In addition, there are varying requirements for cost sharing, or required deductibles and copayments, that must be paid by beneficiaries. Under the Affordable Care Act, for example, asset tests will be disallowed for certain enrollees starting in 2013 but can remain in place for others, such as the elderly. Furthermore, almost all states have eliminated asset tests for enrolling children in Medicaid or the Children's Health Insurance Program (CHIP). The Republican Governors Association, by contrast, has called for making asset tests more “reasonable, rational, and consistent” across all types of enrollees. For example, it says child support payments should be included as income when determining eligibility of mothers applying for Medicaid.

There are also differences of opinion over how much cost sharing should be allowed within the Medicaid program. Current federal law exempts children from most copayments; it also forbids people with incomes at or below the federal poverty level from being forced to make copayments at the point of service. However, the Deficit Reduction Act of 2005 gives states more flexibility to impose cost sharing on people with incomes above 150 percent of the federal poverty levels. Over the past two years, 19 states either have planned to increase or have increased existing copayments or have imposed new copayments, mainly for pharmacy and emergency department visits.

The Republican Governors Association has called for giving states even greater leeway to require cost sharing for Medicaid beneficiaries on grounds that more people should contribute to the cost of their care. The group contends that modest cost sharing may discourage unnecessary or inappropriate care. Critics of this proposal, meanwhile, say that states already have a significant amount of flexibility with respect to determining eligibility and cost sharing. Moreover, there is a wide body of evidence demonstrating that cost sharing greatly limits access to care.

# 7%

## Annual growth rate

Federal Medicaid spending is expected to grow by 7 percent annually from 2011 to 2021.

**“Because Medicaid is an individual entitlement, anyone meeting income and eligibility requirements can enroll.”**

# 8%

## Portion of federal budget

Medicaid represents about 8 percent of total federal government spending.

**“The leading proposal to end Medicaid as an entitlement would convert the program into a system of federal block grants to states.”**

- **Repealing “maintenance of effort” provisions.** Under the Affordable Care Act, states may not reduce Medicaid eligibility requirements until 2014, when the federal government will begin to pay for expanded coverage. Repealing this requirement is a short-term proposal that would cut states’ financial liability and reduce federal spending by \$2.8 billion over five years, according to a preliminary estimate from the Congressional Budget Office. But the CBO also estimates that this change would result in half of the states eliminating their CHIP programs. Enrollment in private coverage and Medicaid would increase—but 300,000 children would become uninsured in 2016.

**OBAMA ADMINISTRATION PROPOSALS:** Despite the expansion of Medicaid as a key strategy for expanding insurance coverage under the Affordable Care Act, pressure to reduce the federal deficit has prompted the Obama administration to propose several changes to the program. These include the following:

- **Reducing the Medicaid provider tax starting in 2015.** Some states employ a complicated system that taxes providers and then uses those funds to increase the federal match by counting them as part of the state share of contributions to funding Medicaid. Currently, these taxes cannot exceed 5.5 percent of a health care organization’s revenues. The Obama administration has proposed gradually reducing that ceiling to 3.5 percent over a 10-year period starting in 2014. This measure would save \$26.3 billion over 10 years, according to the White House.

- **Establishing a single “blended rate” for federal matching funds.** Federal payments to states for Medicaid and CHIP are based on a patchwork set of calculations, with different formulas used to calculate payments for different populations. The Obama administration has proposed to create a single “blended rate” for all populations and services and then make across-the-board cuts to the overall rate. At the same time, the administration has proposed that each state’s matching rate would automatically increase if a recession forced enrollment and state costs to rise. The White House estimates that this package of changes would save \$14.9 billion over 10 years starting in 2017.

- **Identifying other savings.** In response to demands from governors for greater control over Medicaid spending, in February 2011 the Department of Health and Human Services

offered to provide experts known as Medicaid State Technical Assistance Teams to help states identify areas of savings within current federal rules. About half of the states have accepted the offer, including some whose governors have been critical of the administration’s Medicaid policies. For example, Arkansas asked for assistance in revamping its system in order to pay groups of providers lump sums when they agree to work together. Louisiana Medicaid officials also requested support to help with planning, contracts, and quality assurance issues needed to create coordinated care networks.

**OTHER APPROACHES:** Nearly everyone supports efforts to maintain what’s termed “program integrity” and reduce waste, fraud, and abuse in the Medicaid program—although not necessarily by the same means. Vice President Joseph Biden announced a new initiative in September 2011 intended to save \$2.1 billion in improper Medicaid spending over five years. Modeled on a successful Medicare initiative, the program would require states to contract with independent auditors to review Medicaid claims for improper payments.

However, the Republican Governors Association says that states should take full responsibility for “program integrity” and draw on federal funding to take proactive steps to reduce fraud and abuse. The governors argue that they shouldn’t have to use contractors who may not be familiar with individual state programs and may simply pay all claims first, and then try to track down instances of fraud and abuse after the fact.

There is also emerging agreement on new approaches to caring for people with chronic diseases or complex conditions, particularly the growing number of so-called dual eligibles. These are primarily low-income, elderly people who receive coverage under both Medicare and Medicaid. In particular, their out-of-pocket expenses under Medicare (for Part B premiums and cost sharing) are covered by Medicaid, as are other services that Medicare doesn’t cover, specifically long-term care. Although the dual eligibles constitute about 15 percent of Medicaid enrollees, they account for approximately 40 percent of Medicaid spending.

A new CMS office mandated by the Affordable Care Act is examining the needs of the dual eligibles and is seeking ways to align federal and state incentives to meet them. The office is also developing new models of care

# 16¢

## State Medicaid spending

On average, states spend about 16 cents of every general revenue dollar on Medicaid.

### About Health Policy Briefs

Written by  
**Joanne Kenen**

Editorial review by  
**Raymond Scheppach**  
Professor of Practice  
Frank Batten School of Leadership  
and Public Policy  
University of Virginia

**Ted Agres**  
Senior Editor for Special Content  
*Health Affairs*

**Anne Schwartz**  
Deputy Editor  
*Health Affairs*

**Susan Dentzer**  
Editor-in-Chief  
*Health Affairs*

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:  
"Health Policy Brief: Medicaid Reform," *Health Affairs*, January 12, 2012.

Sign up for free policy briefs at:  
[www.healthaffairs.org/healthpolicybriefs](http://www.healthaffairs.org/healthpolicybriefs)

to better meet their needs. Fifteen states have been given demonstration grants to coordinate care across primary, acute, and behavioral health care and long-term services and supports.

The CMS office is also seeking ways to reduce cost shifting between states and the federal government when payments for patients go back and forth between Medicare and Medicaid—a complicated process to manage with respect to both patient care and federal-state relations. For example, it is not unusual for a patient in a Medicaid-paid nursing home to be transferred to a Medicare-paid hospital when he or she becomes sicker. Once discharged from the hospital, the patient returns to the nursing home, at which point Medicare may initially pay for skilled care before Medicaid resumes payment for long-term care. Such care transitions are not always smooth and may result in higher costs over the long run. There is also concern that providers involved in transferring patients back and forth do so in ways that maximize their reimbursements.

### WHAT'S NEXT?

The debate over federal and state roles in administering Medicaid could be redefined by cases now before the US Supreme Court. *Douglas v. Independent Living Center of Southern California* as well as two related cases brought against the State of California by Medicaid patients and health care providers focus on whether that state had the authority to cut

Medicaid payments to certain providers by as much as 10 percent in 2008. The plaintiffs argue that the state violated a federal law requiring that payments to providers be sufficient to ensure access to care. The immediate question before the court is whether beneficiaries and providers have legal standing to challenge California's actions. Such a determination could limit the ability of states to set payment rates to providers.

The Supreme Court has also agreed to rule on the constitutionality of Medicaid coverage provisions of the Affordable Care Act. A ruling is expected by June 2012 as to whether the law's requirement that states expand Medicaid coverage to low-income adults starting in 2014 or face the possibility of forfeiting all federal Medicaid funding is unduly coercive. (See the [Health Policy Brief](#) published on November 30, 2011, for more information on legal challenges to the health care law.)

Finally, amid ongoing federal budget pressures, Medicaid is likely to remain a target for budget savings going forward. Medicaid was one of the few programs exempted from automatic cuts to the federal budget that are now scheduled to begin in January 2013. However, it seems unlikely that the program will continue to be off limits for budget cuts. Very different scenarios with respect to Medicaid are possible depending on the outcome of the 2012 presidential and congressional elections as well as the trajectory of the national economy. ■

### RESOURCES

Blase, Brian, "[How States Can Survive the Medicaid Crisis](#)," WebMemo on Health Care, Heritage Foundation, February 28, 2011.

Flowers, Lynda, "[The High Cost of Capping Federal Medicaid Funding](#)," AARP Public Policy Institute, April 2011.

Holahan, John, Matthew Buettgens, Vicki Chen, Caitlin Carroll, and Emily Lawton, "[House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing](#)," Kaiser Commission on Medicaid and the Uninsured, May 2011.

Office of Management and Budget, "[Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction](#)," September 2011.

Republican Governors Association, "[A New Medicaid: A Flexible, Innovative, and Accountable Future](#)," August 30, 2011.

Smith, Vernon K., Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, "[Moving Ahead amid Fiscal Challenges: A Look at Medicaid Spending, Coverage, and Policy Trends](#)," Kaiser Commission on Medicaid and the Uninsured, October 2011.

Sommers, Benjamin D., Katherine Swartz, and Arnold Epstein, "[Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians under Health Reform](#)," *Health Affairs* 30, no. 11 (2011): 2186–93.