

medicaid
and the uninsured

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**The Nuts and Bolts of Making Medicaid Policy Changes:
An Overview and a Look at the Deficit Reduction Act**

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Executive Summary

The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006, contains a large number of changes in Medicaid policy which are expected to affect almost all elements of the Medicaid program—eligibility, benefits and cost-sharing, provider payments, and program integrity. In most instances the policy changes are optional for state Medicaid programs, but in some the changes are mandatory. At the federal level, the interpretation and implementation of these legislative policy changes is primarily the responsibility of the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS). State Medicaid agencies and state legislatures look to CMS for guidance as to what policy changes they must make and what policy changes they are allowed to make.

This Issue Brief outlines the roles of Congress, CMS and the states in implementing Medicaid policy changes and highlights some of the changes included in the DRA. The brief also examines how the forms and timing of guidance can affect the transparency of the public policy process as well as lead time for state implementation of new policies.

The Role of Congress, CMS and the States

Congress may pass legislation to change the Medicaid statute and has program oversight responsibilities. The federal Medicaid statute, found in Title XIX of the Social Security Act, is the foundation for providing health and long-term care coverage to over 55 million low-income Americans. This statute makes federal matching funds available for the costs of benefits and administration that are incurred by states with approved state Medicaid plans. Since Medicaid's enactment in 1965, Congress has made numerous statutory changes to the Medicaid program. The most recent set of Congressional changes is contained in the Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006. The Act contains a large number of changes in Medicaid policy, most of which are intended to reduce federal Medicaid spending. Congress also oversees the executive branch agencies that carry out legislative changes, primarily CMS. The Congress may conduct this oversight through its own staff, or it may direct the Government Accountability Office (GAO) or the Office of Inspector General (OIG) to do so.

CMS is the federal agency responsible for interpreting and implementing the federal Medicaid statute through regulations and other guidance. At the federal level, the implementation of legislative policy changes is primarily the responsibility of the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS). The role of CMS is to issue regulations and other forms of administrative guidance explaining statutory requirements and how to comply with them. CMS also makes the determination as to whether a state’s Medicaid plan complies with the requirements of Title XIX and ensures that federal Medicaid funds spent by state Medicaid programs are being spent in accordance with federal Medicaid law. The Secretary of HHS has legislative authority to waive certain requirements of Title XIX for various purposes.

States implement Medicaid policy changes by filing a State Plan Amendment (SPA) or by applying for a waiver for changes that are not allowed under current law. Within the parameters of federal statutory and regulatory requirements, states develop a state Medicaid plan which serves as the comprehensive written statement explaining how a state operates its Medicaid program—i.e., whom it covers, what services it offers, how much it pays for those services, etc. In general, to change its Medicaid program a state must either amend its state Medicaid plan or obtain a waiver of requirements set forth in Title XIX from the Secretary of HHS. To amend its state Medicaid plan, a state must submit a State Plan Amendment (SPA) to CMS for review and approval. CMS must act on the SPA within a specified timeframe, and it must generally approve any SPA that meets the federal statutory requirements. To obtain a waiver of federal statutory requirements, a state must apply to CMS. In contrast to the SPA process, the Secretary has broad discretion in deciding whether to grant a state’s request for a waiver and, if so, on what terms. Waivers must generally be “budget neutral”—that is, they must not cost the federal government more than what the federal government would spend in the absence of the waiver. This constraint does not apply to SPAs.

Medicaid Policy Changes in the DRA and the Outlook for Implementation

The DRA contains a number of important changes in the Medicaid policy process. The DRA allows states to implement some policies that would have required a waiver from the Secretary before the passage of the DRA. For example, the DRA allows states to limit Medicaid benefits for certain populations or expand home and community based services through the SPA process instead of using a waiver. As of August 1, 2006, the Secretary had approved such “benchmark” benefits SPAs for three states. The ability for states to file SPAs for home and community-based services will be effective in January 2007. The DRA also creates two new waiver authorities for the Secretary that expressly allow states to receive more federal Medicaid matching funds for certain costs than they otherwise would receive. The DRA requires the use of a regulation in only four of its 39 Medicaid provisions. Other provisions are scheduled to take effect with or without formal or informal guidance. Appendix A outlines the provisions in the DRA, whether state compliance is mandatory, the effective date, the CBO cost estimate for federal spending, if regulations are required by the DRA and the status of any CMS guidance issued at the time of this paper.

As implementation of the DRA continues, the timing and form of CMS guidance will have significant implications for states' ability to implement changes and the public's ability to comment on changes. Whether CMS issues guidance on provisions in the DRA and if so, how it does so—through formal regulations or through less formal means such as letters to state Medicaid Directors—have important implications for transparency in Medicaid policymaking. The rulemaking process (the process of issuing formal regulations) is relatively transparent, generally allowing for notice and public comment on proposed policy guidance. Letters to state Medicaid Directors, in contrast, are usually issued without any opportunity for providers, beneficiaries, or the public to comment (state officials are often allowed to review drafts).

The opportunity for beneficiaries and providers to comment on Medicaid policy changes initiated at the state level often depends on state rules. Some states require public notice or legislative action to make significant changes in their state Medicaid plans or to implement a Medicaid waiver, while other states make such changes administratively, without legislative review and approval. All state Medicaid agencies are required by federal regulations to establish an advisory committee with provider and beneficiary representation, but the role of these committees in relation to SPAs and waivers varies. The level of transparency and opportunity for public input in the policymaking process can be critical in understanding changes that could have implications for low-income beneficiaries served by the program.

The timing of CMS guidance is also critical in states' ability to comply with new requirements. For example, guidance on the citizenship documentation requirements were issued close to the effective date of the provision and then final regulations, which included some significant changes to the original guidance, were issued after the effective date. Tight timeframes for legislative effective dates combined with delayed issuance of guidance makes it hard for states to make administrative changes such as necessary training for eligibility workers for implementing new documentation requirements. The timing and form of future guidance on DRA-related provisions could have implications for public understanding of Medicaid changes, for the way states administer their programs and for the ways in which beneficiaries use the Medicaid program.

Introduction

The Deficit Reduction Act of 2005 (DRA), signed into law on February 8, 2006 contains a large number of changes in Medicaid policy which are expected to reduce federal Medicaid spending by \$28.3 billion over the next ten years. The changes affect almost all elements of the Medicaid program—eligibility, benefits and cost-sharing, provider payments, and program integrity.¹ In most instances the policy changes are optional for state Medicaid programs, but in some the changes are mandatory. At the federal level, the interpretation and implementation of these legislative policy changes is primarily the responsibility of the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS). State Medicaid agencies and state legislatures look to CMS for guidance as to what policy changes they must make and what policy changes they are allowed to make.

This Issue Brief explains the legislative and oversight roles of Congress and the responsibilities of CMS relating to issuance of policy guidance to states. The brief reviews the different procedural pathways available to CMS and state Medicaid agencies for implementing policy changes. The brief then describes how states can implement Medicaid policy changes, which in most cases involves submission of a state plan amendment or a waiver application and its approval by CMS. The brief concludes with a discussion of some of the new SPA and waiver authorities contained in the DRA and their implications for the transparency of the Medicaid policy process. (See Appendix A for information on specific DRA provisions).

The Federal Medicaid Statute and the Role of Congress

Federal Medicaid law is found in Title XIX of the Social Security Act. Medicaid is the federal-state program that provides federal funds to enable states to provide health coverage and long-term care assistance to over 39 million people in low-income families and 12 million elderly and disabled people, to fill in gaps in Medicare coverage for low-income Medicare beneficiaries, and to support safety-net providers that serve low-income, uninsured populations. Medicaid policy is governed by the statutory language in Title XIX of the Social Security Act. This statute entitles each state with an approved state Medicaid plan to payment of federal matching funds at a specified rate for all allowable expenditures. States are not required to participate in Medicaid, although all have elected to do so. The statutory responsibility for approving a state’s Medicaid plan and for paying federal matching funds to the state rests with the Secretary of HHS, who has delegated this responsibility to the Administrator of CMS. The responsibility for administering the state Medicaid plan rests with a “single State agency” designated by the state. This agency may delegate the execution of most Medicaid administrative functions to other state or local agencies or private contractors, and many have done so.²

Section 1902(a) of the Social Security Act sets forth approximately 70 requirements (some mandatory and some optional) that each state Medicaid plan must meet in order to qualify for federal Medicaid matching funds. For example, section 1902(a)(1)—the “statewideness” requirement—stipulates that a state’s Medicaid program be in effect

throughout the state. Other requirements for state Medicaid plans are conditional in the sense that they only apply if a state chooses to pursue a particular policy. For example, section 1902(a)(14) specifies the rules states must follow if they wish to impose premiums or cost-sharing requirements on Medicaid beneficiaries. The statute does not require that a state impose premiums or cost-sharing. However, if a state wishes to do so, it must follow the statutory rules as to what services and populations are subject to cost-sharing and in what amounts, or it may be denied federal Medicaid matching funds.

Congress, through legislation, establishes and modifies State Medicaid plan requirements. Over the last 40 years, Congress has made numerous changes in federal Medicaid policy, by modifying existing state plan requirements or adding new ones.³ When Medicaid was first enacted in 1965, Congress specified 22 state Medicaid plan requirements. Through the 1980s and early 1990s Congress acted to expand Medicaid eligibility. Many Medicaid changes over time were enacted through the use of a federal budget procedure known as “reconciliation.”⁴ So-called “budget reconciliation bills” generally are used to make changes to entitlement programs like Medicaid and Medicare. These bills have special rules for debate time and require only a majority vote to pass in the Senate. The DRA was a budget reconciliation bill.

Some of these requirements, such as statewideness, did not change. Others, such as the premium and cost-sharing policies, have been modified several times, most recently in the DRA. In still other cases, Congress has added new requirements, such as the DRA provision that states comply with requirements determined by the Secretary of HHS to be necessary to carry out the new Medicaid Integrity Program.⁵

Congress has granted the Secretary of HHS statutory authority to waive certain federal Medicaid requirements. While the Medicaid statute sets the ground rules for administering the Medicaid program, Congress has given the Secretary various statutory authorities to waive state Medicaid plan requirements so that states do not have to meet them but can still receive federal Medicaid matching funds for allowable expenditures. Prior to the DRA, the three waiver authorities most commonly used by the Secretary and the states were the section 1915(b) “freedom of choice” waivers, the section 1915(c) home and community-based services (HCBS) waivers,⁶ and the section 1115 demonstration waivers.⁷ As discussed below, these waivers may lead to Medicaid policy change without formal congressional action.

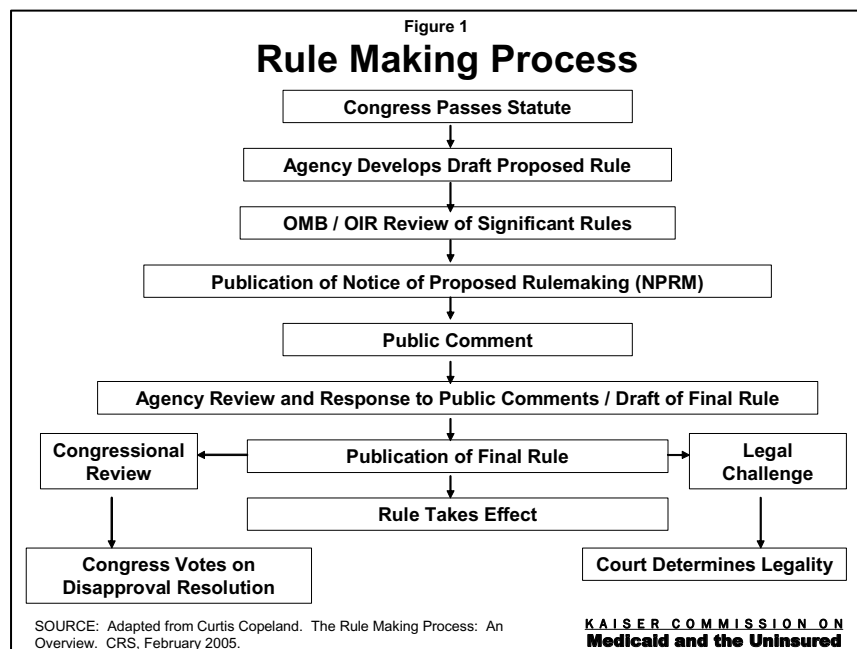
Congress also has oversight responsibilities. The role of Congress is not limited to making changes to the federal Medicaid statute. Congress also oversees the executive branch agencies that carry out these changes, primarily CMS. The Congress may conduct this oversight through its own staff, or it may direct the Government Accountability Office (GAO) or the Office of Inspector General (OIG) to do so. Congressional oversight may lead to changes in federal Medicaid policy, as evidenced by the June 2005 oversight hearings conducted by the Senate Finance Committee that led to the Medicaid Integrity Program provisions in the DRA.⁸ In addition, if Congress does not agree with a “major” (e.g., has a \$100 million impact on the economy) regulation that

HHS (or another federal agency) has issued, Congress has reserved the right to disapprove the regulation prior to it taking effect.⁹

Federal Administrative Guidance and the Role of CMS

CMS is the federal agency responsible for interpreting and implementing the federal Medicaid statute through regulations and other guidance. These interpretations are sometimes set forth in formal regulations found in Title 42 of the Code of Federal Regulations, Parts 430 to 456. Regulations, which are also referred to as “rules,” are one of the means by which federal agencies like DHHS implement federal statutes. There are relatively few provisions of the Medicaid statute that expressly require the Secretary of HHS to issue regulations.¹⁰ The Secretary, however, has general authority to issue regulations “as may be necessary to the efficient administration of” the Medicaid program.¹¹ In issuing regulations, DHHS, like other federal agencies, is subject to the Administrative Procedure Act (APA) of 1946 (5 U.S.C. 551 et seq.).

The rulemaking process—that is, the procedures that DHHS is required to follow in writing regulations—is complex. Not only must the agency satisfy the requirements of the Administrative Procedure Act (APA), it must also comply with the Regulatory Flexibility Act (RFA) of 1980 (P.L. 96-354); section 1102(b) of the Social Security Act (relating to the impact on small rural hospitals); the Unfunded Mandates Reform Act (UMRA) of 1995 (P.L.104-4), and Executive Order 12866 (September 1993). In addition, all DHHS regulations are reviewed prior to issuance in proposed or final form by the Office of Management and Budget Office of Information and Regulatory Affairs (OIRA). Many of these features of the rulemaking process are designed to ensure that those affected by a regulation have an opportunity to submit comments to the administering agency to inform its decisions before the regulation takes effect. (Figure 1)



A recent example of the rulemaking process is CMS's implementation of some of the Medicaid provisions enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), P.L.108-173. While most of the changes made by Congress in the MMA affected Medicare, the legislation contained a number of Medicaid changes, including a new state Medicaid plan requirement that state Medicaid agencies conduct eligibility determinations for the Medicare Part D Low-Income Subsidy (LIS) program. To implement this requirement as well as many other MMA provisions, CMS published a notice of proposed rulemaking (NPRM) in the *Federal Register* in August 2004, eight months after enactment. The agency received nearly 7,700 comments. In January 2005, CMS published the final regulations, making them effective March 22, 2005. In the *Federal Register* preamble to these final regulations, CMS explained its proposed rule, discussed the comments it had received from states, providers, beneficiary advocates, and others, and explained the provisions of the final rule.¹²

The President's FY 2007 Budget includes a number of proposals to reduce federal Medicaid spending by \$30.4 billion over ten years by issuing regulations to change certain federal policies.¹³ While CMS has de-emphasized the rulemaking process in making federal Medicaid policy in recent years, some of these budget proposals represent policy changes of considerable importance to states, to providers, and to beneficiaries. Among the Administration's regulatory proposals are to cap payments to government providers at no more than the costs of providing services; to phase-down the allowable tax rate on providers from 6 to 3 percent of provider revenues; and to prohibit federal matching payments for certain school-based administrative and transportation costs.¹⁴ In issuing these regulations, CMS may decide not to use the "notice and comment" procedure that it used in implementing the MMA, but instead to publish an "interim final" rule—that is, a final rule, issued without an NPRM, that is effective immediately and gives the public an opportunity to comment only after its publication.¹⁵ Without an NPRM to review, Medicaid providers and beneficiaries will not be able to comment on CMS policy decisions before they take effect. Some members of Congress have questioned if it is "appropriate for the Department, under the administrative authority of CMS to make these changes."¹⁶

Many written CMS policy interpretations are found not in regulations, but in other written guidance. A good deal of policy guidance appears in the State Medical Manual (SMM), which contains "instructions" for implementing provisions of Title XIX.¹⁷ CMS policy interpretations also appear in letters to State Medicaid Directors (SMD Letters)¹⁸ and in memoranda from the CMS Central Office to CMS Regional Offices. The de-emphasis of formal rulemaking by CMS means less transparency in the federal Medicaid policy process. CMS is not required to give advance notice of SMM instructions, SMD Letters, or Regional Office memoranda. This can put Medicaid beneficiaries and providers at a particular disadvantage, since they may not have notice of CMS's intention to change federal Medicaid policy and therefore cannot review and comment on the agency's thinking before it acts. In some cases CMS may circulate a draft SMD letter to state officials for review.

CMS determines if states are in compliance with federal law. Among other tasks, CMS reviews state requests for approval of program policy changes to determine whether they comply with the federal Medicaid statute. For example, a state may wish to expand its Medicaid program to cover a service for which it has not previously paid, or it may wish to contract its program by eliminating coverage for a service. In either case, CMS would make the determination as to whether the state’s proposed policy change complies with the federal Medicaid statute. CMS’s determination is subject to review by federal courts.¹⁹ In determining whether a state’s proposed policy change complies with the state Medicaid plan requirements set forth in Title XIX of the Social Security Act, CMS often relies upon its own written interpretation of those requirements.

Implementing Medicaid Policy Changes and the Role of States

Medicaid is administered on a day-to-day basis by the states within the parameters of federal law and regulations. These federal requirements frame the policy choices of state Medicaid programs in the following way: compliance with the requirements ensures the continued availability of federal Medicaid matching funds, while noncompliance risks the loss of some or, in theory, all of those funds. Because many of the parameters are optional, they permit a wide range of policy choices by the states, which in part explains the enormous variation in eligibility, benefits design, provider payments, and program administration from state to state.²⁰

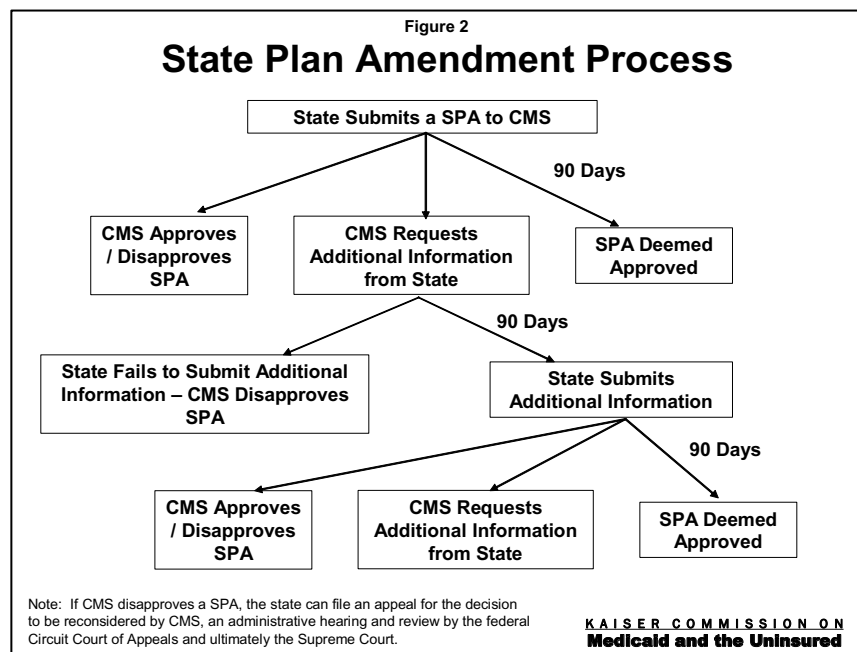
The legal lynchpin of this federal-state transaction is the “state plan for medical assistance,” or state Medicaid plan. A state’s Medicaid plan is the “comprehensive written statement” submitted by the state Medicaid agency to CMS that sets forth how each state will comply with these requirements.²¹ These documents, which are often quite extensive, are posted on the CMS website, although they may not be up to date.²² In order for a state to qualify for federal Medicaid matching funds, it must have a state Medicaid plan that complies with the federal statutory requirements and it must administer its state Medicaid plan in such a way that it is in substantial compliance with all of these requirements. The Secretary of HHS is responsible for approving each state’s Medicaid plan and for determining whether each state’s Medicaid program is in substantial compliance with the state plan requirements.²³

Whatever form CMS guidance takes—regulations, SMM issuances, SMD Letters, or otherwise—states need to secure CMS approval for policy changes they wish to make in their Medicaid programs or risk the loss of federal Medicaid matching funds. There are two formal procedural pathways for states to obtain CMS approval. The first is the State Plan Amendment (SPA). This route is used when a state seeks to make a policy change that is consistent with the federal requirements for state Medicaid plans. The second is a waiver request under one of several statutory authorities. This route is used when a state wants to make a policy change that is not consistent with one or more federal requirements for state Medicaid plans and it therefore seeks to be excused from compliance with the requirement. States have their own rules and procedures as to whether and when Medicaid policy changes require state legislative action or public hearings and notice.²⁴ All state Medicaid agencies are required by CMS regulation to

establish an advisory committee with provider and consumer representation, but the role of these committees in relation to Medicaid policy changes varies.²⁵

States use State Plan Amendments (SPAs) to make program changes that are allowed under current law. States are required to amend their state Medicaid plans whenever they make a “material” change in state law, organization, or policy, or in their “operation” of the Medicaid program.²⁶ For example, if a state wants to expand its program to add a new eligibility group or offer a benefit not previously covered, the state would be required to amend its state Medicaid plan in order to receive federal Medicaid matching funds for expenditures associated with the new group or benefit. States are also required to amend their state Medicaid plans to reflect changes in federal law, regulations, policy interpretations, or court decisions. Thus, if Congress limits the scope of a benefit for which federal Medicaid matching funds are available, states that offer that benefit are required to amend their state Medicaid plans to reflect the more limited scope.²⁷

To amend its state Medicaid plan, a state must submit a state plan amendment (SPA) to the Secretary. In some cases, CMS has developed State plan "preprint" pages on which state Medicaid programs simply check the policy options they have selected. The Secretary must approve any state Medicaid plan (or amendment) that meets the federal state Medicaid plan requirements.²⁸ CMS, in formal regulations, has set forth timelines for review of SPAs under which SPAs are generally considered approved or disapproved within 90 days of receipt unless CMS requests additional information.²⁹ If CMS disapproves a SPA, the state is entitled to a reconsideration by the CMS Administrator, an administrative hearing, and review by the federal Circuit Court of Appeals and ultimately the U.S. Supreme Court.³⁰ Under the federal Administrative Procedures Act, the federal courts are required to uphold the decision of the CMS Administrator to disapprove a SPA unless it is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”³¹ (Figure 2)



In recent years, CMS has used the SPA review process as a tool for gathering information about the financing of state Medicaid programs. More specifically, in August 2003 CMS began requiring any state submitting for approval an SPA relating to payment methodologies to answer “Five Questions” prior to approval of the SPA, even if the SPA requested otherwise complied with federal law. These questions address funding mechanisms such as intergovernmental transfers (IGTs) and certified public expenditures (CPEs) for which CMS has not issued detailed compliance standards.³² As of June 2005, according to CMS, 26 states had revised their financing arrangements.³³

States can implement Medicaid program changes that are not allowed under current law by requesting a waiver from the Secretary of HHS. The other formal procedural pathway for making Medicaid policy changes is the waiver process. As noted above, the Secretary of HHS has different waiver authorities, ranging from the section 1915(b) “freedom of choice” waivers to the 1915(c) home and community-based services (HCBS) waivers to the section 1115 demonstration waivers. Each of these waiver authorities has its own rules and approval procedures. There are two commonalities, however, that distinguish these waiver authorities from SPAs.

First, waivers are, as a legal matter, broadly discretionary with the Secretary. This is in sharp contrast to the Secretary’s statutory responsibility with respect to SPAs, which is to approve them if they comply with the federal Medicaid requirements. While the politics of a particular request for a new waiver, or for the renewal of a waiver, may as a practical matter compel Secretarial approval, approval is not required, even if the waiver request clearly meets the requirements for the particular waiver in question. Of course, as CMS’s use of “Five Questions” suggests, the Secretary as a practical matter has substantial discretion with respect to whether and when to approve SPAs.

Second, longstanding federal policy requires waivers to be “budget neutral” for the federal government meaning that federal costs under a waiver cannot be more than projected federal Medicaid costs in the absence of the waiver. The precise demonstration of budget neutrality may vary from one type of waiver to the next and, within a type of waiver, from one state to the next. There is no comparable requirement for SPAs, some of which by definition will result in additional federal spending. If the SPA is consistent with the federal Medicaid requirements, the Secretary is obligated to approve it, even if it results in additional federal expenditures.

Waivers are a means for CMS to change federal Medicaid policy without obtaining Congressional approval through legislation.³⁴ For example, the Secretary of HHS has used the section 1115 demonstration waiver authority to promote what he calls Health Insurance Flexibility and Accountability (HIFA) demonstrations, “broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200% of the Federal poverty level (FPL).” CMS has posted templates and detailed guidance for interested states to

facilitate submission of HIFA waiver requests and has offered “priority review” for such proposals.³⁵

The DRA and the Federal Medicaid Policy Process

The DRA represents the most significant change in Medicaid policy enacted by the Congress since the Medicare Modernization Act of 2003 (MMA) and the most comprehensive set of changes since the Balanced Budget Act of 1997 (BBA). It contains 39 sections changing a wide range of federal Medicaid policies and procedures that are intended to produce \$11.5 billion in gross savings and \$4.9 billion in net savings to the federal government over the next five years.³⁶

Reflected in these sections are three congressional decisions of particular importance to the federal Medicaid policy process:

- First, in the overwhelming majority of cases, the Congress has not required that CMS implement the statutory change by regulation with notice to the public and opportunity to comment.
- Second, the Congress has opened up the SPA process as a pathway for States seeking to modify their benefits packages or offer home and community-based services.
- Finally, the Congress has added two important demonstration programs to the Secretary’s waiver portfolio that do not require budget neutrality. The DRA also ratifies certain section 1115 waivers that the Secretary granted in connection with Hurricane Katrina by providing \$2 billion in new federal funding to carry out their terms.

The DRA only requires federal regulations in four of the 39 Medicaid sections. As shown in Table 1, the DRA contains 39 sections that CBO estimates have an effect on federal Medicaid spending and that are administered by the Secretary of HHS. In four of the 39 sections, Congress specified that the Secretary is to implement the provisions through regulation: section 6001 (pharmacy payments), 6021 (LTC Partnership Program), 6036 (documentation of citizenship), and 6052 (Targeted Case Management). In all other sections, Congress was silent or indicated that the provision should be implemented by a specific date whether or not the Secretary has issued a regulation.

As of August 1, 2006 CMS had issued only one DRA-related regulation, an interim final regulation for the documentation of citizenship provisions which was released on July 6, 2006 (six days after the effective date of the documentation requirements). The content of the regulation had some significant changes from the original guidance issued in the June 9 SMD letter on this issue, most importantly an exemption for approximately eight million elderly and disabled individuals from complying with the new law. The agency has announced its intention to implement ten sections of the DRA through notice of proposed rulemaking, and two by interim final regulation.³⁷ CMS has also issued letters

to State Medicaid Directors implementing a number of other DRA provisions: section 6002 (physician-administered drugs); sections 6011, 6012, 6013, 6014, 6015, and 6016 (asset transfer provisions); section 6021 (long-term care partnership program)l section 6033 (double payment for prescription drugs); 6036 (documentation of citizenship); 6041-6043 (cost-sharing); 6044 (Benchmark Benefits); 6083 (Non-emergency Medical Transportation); 6081 (Medicaid Transformation Grants), and 6085 (MCO rates to non-contract emergency care providers). The Secretary also issued a white paper on March 31 relating to the new “benchmark” benefits option.³⁸ CMS has also issued a “Comprehensive Medicaid Integrity Plan for the Medicaid Integrity Program” in compliance with section 6034 which created the new Medicaid Integrity Program as well as a grant announcement for section 6071 (Money Follows the Person “Rebalancing” Demonstration”).³⁹

The DRA gives states flexibility to make changes through the SPA process that previously required waiver authority. Prior to the DRA, states participating in Medicaid were generally required to offer all of the services they covered (whether “mandatory,” like hospital and physician care, or “optional,” like prescription drugs for adults) to almost all of the eligibility groups they covered. States had discretion to limit the amount, duration, and scope of these services, but under the state Medicaid plan requirement of “comparability” they could not offer a different benefits package to different groups (e.g., prescription drugs for the low-income elderly but not for low-income parents), and they could not discriminate in designing their benefits package based on diagnosis (e.g., no prescription drug coverage for persons with AIDS).⁴⁰ The only way for a state to vary benefits by group or by health status was to seek a waiver of the comparability requirement, generally under section 1115 of the Social Security Act.

Section 6044 of the DRA gives states the option, through the SPA process, to provide different “benchmark” benefits packages to individuals within one of more groups of individuals (primarily low-income children and parents). The provision took effect March 31, 2006. That same day, CMS issued an SMD Letter setting forth its interpretation of this DRA provision,⁴¹ and the Secretary released a white paper describing the new DRA provision and how states could use it to modify their Medicaid programs.⁴² As of August 1, 2006, CMS had approved “benchmark” benefits SPAs submitted by Idaho, Kentucky, and West Virginia.⁴³ Congress took the same procedural approach in the DRA provision granting states the authority, through a SPA, to increase premiums and cost-sharing for certain low-income children and parents.⁴⁴

The DRA also creates a new SPA procedural pathway for states seeking federal Medicaid matching funds for the costs of home and community-based (HCBS) services for individuals with disabilities or the frail elderly. Since 1981, the Secretary has had the authority, under section 1915(c) of the Social Security Act, to waive various statutory requirements to enable states to cover HCBS services for individuals who would otherwise require nursing home or other institutional care and receive federal matching funds for the costs of these services.⁴⁵ Section 6086 of the DRA gives states the option of covering HCBS services, with federal matching funds, through a SPA, effective January 1, 2007. This new SPA option does not replace the section 1915(c) waiver authority,

which remains available to states, and it differs from the waiver authority in a number of respects, notably that budget neutrality is not required.⁴⁶

The DRA also establishes new waiver authority. Section 6082 of the DRA requires the Secretary to operate a demonstration of an alternative benefits package with a high deductible combined with a “Health Opportunity Account” established for individual Medicaid beneficiaries. This new demonstration authority expressly overrides the statewideness and comparability requirements of the Medicaid statute. The demonstration is limited to low-income children and parents in no more than 10 states; participation by the target population must be voluntary. A demonstration state would contribute funds (up to \$2,500 per adult, \$1,000 per child) to a beneficiary’s Health Opportunity Account; the beneficiary could use these funds to meet the high deductible (which could not exceed 110% of the amount contributed by the state) and other health care costs specified by the state. Under the demonstration, federal Medicaid matching funds would be available for the state contribution to the Health Opportunity Accounts as well as for the costs of the high-deductible alternative benefits package. Participating states are not required to demonstrate budget neutrality (the Congressional Budget Office (CBO) estimates that over the five-year period FY 2007 -2011 this provision will result in a \$56 million increase in federal Medicaid spending).

Section 6071 of the DRA creates a new “Money Follows the Person” (MFP) “Rebalancing” demonstration authority under which the Secretary may give waivers and enhanced federal Medicaid matching funds to states seeking to transition elderly or disabled individuals out of hospitals, nursing facilities or other institutions into the community. The new authority allows the Secretary to waive a number of state Plan requirements, including statewideness and comparability. No showing of budget neutrality is necessary. To the contrary, states that participate will receive an enhanced federal matching rate ranging from 75 to 90 percent for the cost of furnishing home and community-based long-term care services to individuals for the first 12 months after they move out of an institution into a community-based residential setting. The total amount of new federal funds available for the MFP is capped at \$1.75 billion over the five-year period FY 2007 – FY 2011. The MFP demonstration is in addition to the existing section 1915(c) HCBS waiver and the new HCBS option discussed above.

In the months following Hurricane Katrina, the Secretary granted section 1115 waivers to the states directly affected—Alabama, Louisiana, and Mississippi—as well as to 27 other states (and the District of Columbia) where individuals displaced by Katrina relocated.⁴⁷ These waivers authorized the payment of the state share of the costs of providing Medicaid (and SCHIP) services to certain evacuees, and for payment of the costs of uncompensated services furnished to uninsured evacuees not eligible for Medicaid (or SCHIP).⁴⁸ Section 6201 of the DRA directs the Secretary to pay up to a total of \$2.0 billion to states that received such waivers for such costs. On March 24, the Secretary issued a press release announcing the award of \$1.5 billion to 31 states and the District of Columbia.⁴⁹

The states will look to CMS for guidance on how to implement the many Medicaid changes included in the DRA. Implementation of the DRA will bring about far-reaching changes in Medicaid policy intended to reduce federal Medicaid spending by \$28.3 billion over the next 10 years. Many of the DRA provisions require compliance on the part of states in order to achieve these intended savings. Other DRA provisions are optional with the states. In either case, states, providers, and beneficiaries will look to CMS for guidance as to exactly what changes states must make to bring themselves into compliance, as well as what changes they are allowed to make. CMS could choose to implement these DRA changes using the same rulemaking process that it used to implement many of the Medicaid changes in the 2003 Medicare Prescription Drug legislation (MMA), with notice and opportunity to comment for all affected. Even though the DRA requires use of the rulemaking process in only four of its 39 provisions, it does not prohibit CMS from doing so in other cases.

Conclusion

While the Deficit Reduction Act legislation passed in February of 2006, many of the provisions are beginning to take effect. To implement this new legislation, CMS has issued some guidance and will continue to issue additional guidance to help states understand the new options and requirements contained in the new law. In the months to come, CMS will be working to develop guidance on a number of other provisions in the DRA as well as regulatory proposals in the President FY 2007 budget that could have significant consequences for the way states administer their programs and for the ways in which beneficiaries use the Medicaid program. The form and timing of CMS future guidance on DRA-related provisions is important for the public's ability to have input on the guidance and for states' ability to effectively implement changes and comply with new requirements. States can provide opportunities for public or legislative review and comment of proposed Medicaid changes to allow for additional transparency to the policy process and public input before changes are sent to CMS for approval.

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Appendix A
DRA Medicaid Provisions: Status of CMS Administrative Guidance
As of August 1, 2006

Provision	State Compliance Mandatory	Effective Date	CBO Estimate 5-year Federal Funds	Regulation Required by DRA	CMS Guidance Issued
Prescription Drugs					
6001 (Limit pharmacy payments)	Yes	1/1/07 (Secretary to provide states price data starting 7/1/06)	- \$3.6 billion	No for payment limit (effective 1/1/07 w/out regard to regulation) Yes for drug rebate price data (by 7/1/07)	
6002 (Physician –administered drugs)	Not applicable	Enactment (not specified)	- \$70 million	No	SMD Letter 7/11/06 (Intent to publish a rule)
6003 (Authorized generics)	Not applicable	1/1/07	- \$150 million	No	
6004 (Children’s hospitals)	Not applicable	Enactment	- \$50 million	No	
Asset Transfers					
6011 (Penalty period)	Yes	Enactment	- \$1.5 billion	No	SMD Letter 7/27/06
6012 (Annuities)	Yes	Enactment	- \$277 million	No	SMD Letter 7/27/06
6013 (“Income First” rule)	Yes	Enactment	- \$88 million	No	SMD Letter 7/27/06

Provision	State Compliance Mandatory	Effective Date	CBO Estimate 5-year Federal Funds	Regulation Required by DRA	CMS Guidance Issued
6014 (Home Equity)	Yes	1/1/2006	- \$298 million	No	SMD Letter 7/27/06
6015 (CCRC Fees)	Yes	Enactment (not specified)	- \$78 million	No	SMD Letter 7/27/06
6016 (Additional asset transfer rules)	Yes	4/1/06 (except in States requiring legislation)	- \$181 million	No (effective 1/1/07 w/out regard to regulation)	SMD Letter 7/27/06
6021 (LTC Partnership Program)	No (optional)	Enactment	+ \$26 million	Yes (in consultation with NAIC)	SMD Letter 7/27/06
Fraud, Waste, and Abuse					
6031 (State False Claims Acts)	No (optional)	1/1/07	- \$25 million	No	
6032 (False Claims Act education)	Yes	1/1/07 (except in States requiring legislation)	- \$7 million	No	
6033 (Double payments for drugs)	Yes	4/1/06	- \$0.5 million	No	SMD Letter 3/22/06
6034 (Medicaid Integrity Program)	Yes	Enactment (not specified)	+ \$528 million	No	Comprehensive Plan 7/18/06
6035 (Third Party Liability)	Yes	1/1/06 (except in States requiring legislation)	- \$570 million	No	

Provision	State Compliance Mandatory	Effective Date	CBO Estimate 5-year Federal Funds	Regulation Required by DRA	CMS Guidance Issued
6036 (Documentation of citizenship)	Yes	7/1/06	- \$220 million	Yes	SMD Letter 6/9/06 Interim Final Regulations 7/6/06
Cost-Sharing and Benefits					
6041 (Increase premiums and cost-sharing)	No (optional)	3/31/06	- \$960 million	No	SMD Letter 6/16/06
6042 (Cost-sharing for Rx drugs)	No (optional)	3/31/06	- \$960 million	No	Same SMD Letter
6043 (ER co-payments for non-emergency care)	No (optional)	1/1/07	+ \$10 million	No	Same SMD Letter
6044 (Benchmark Benefits)	No (optional)	3/31/06	- \$1.25 billion	No	SMD Letter 3/31/06; Secretary "Roadmap" 3/31/06
State Financing					
6051 (MCO provider tax)	Yes	Enactment (transition for certain states)	- \$435 million	No	

Provision	State Compliance Mandatory	Effective Date	CBO Estimate 5-year Federal Funds	Regulation Required by DRA	CMS Guidance Issued
6052 (Targeted Case Management)	Yes	1/1/06	- \$760 million	Yes (interim final at Secretary option)	
6053 (FMAP adjustments)	Not applicable	Enactment (not specified)	+ \$125 million	No	
6054 (DSH payments for D.C.)	Not applicable	10/1/05	+ \$100 million	No	
6055 (Funding for Territories)	Not applicable	Enactment (not specified)	+ \$140 million	No	
Other Provisions					
6062 (Coverage of Disabled Children)	No (optional)	1/1/07	+ \$1.4 billion	No	
6063 (HCBS demonstration for psychiatric treatment)	No (competitive demonstration)	Enactment (not specified)	+ \$36 million	No	
6064 (Health Information Centers)	Not applicable	Enactment (not specified)	+ \$11 million	No	
6065 (Restoration of Eligibility)	Yes	2/8/07	+ \$105 million	No	
6071 (Money Follows the Person "Rebalancing" Demonstration)	No (competitive demonstration)	1/1/07	+ \$340 million	No	Program Announcement 7/26/06
6081 (Medicaid Transformation Grants)	No (optional)	Enactment (not specified)	+ \$150 million	No	SMD Letter 7/25/06
6082 (Health Opportunity Accounts)	No (competitive demonstration)	1/1/07	+ \$56 million	No	
6083 (Non-emergency medical transportation)	No (optional)	Enactment	- \$55 million	No	SMD Letter 3/31/06
6084 (TMA and abstinence education)	Yes	12/31/05	+ \$761 million	No	
6085 (MCO rates to non-contract providers)	Not applicable	1/1/07	- \$50 million	No	SMD Letter 3/31/06

Provision	State Compliance Mandatory	Effective Date	CBO Estimate 5-year Federal Funds	Regulation Required by DRA	CMS Guidance Issued
6086 (HCBS Services Option)	No (optional)	1/1/07	+ \$766 million	No	
6087 (Cash and Counseling)	No (optional)	1/1/07	+ \$100 million	No	
Katrina Relief					
6201 (Payments under section 1115 waivers)	No (optional)	Enactment (not specified)	+ \$2.0 billion	No	

¹ Kaiser Commission on Medicaid and the Uninsured, *Deficit Reduction Act of 2005: Implications for Medicaid*, February 2006, available at <http://www.kff.org/medicaid/7465.cfm>.

² Andy Schneider and Victoria Wachino, “Chapter IV: Medicaid Administration,” in *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002, available at <http://www.kff.org/medicaid/2236-index.cfm>.

³ Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Timeline of Key Developments*, available at http://www.kff.org/medicaid/medicaid_timeline.cfm

⁴ Martha Coven and Richard Kogan, Center on Budget and Policy Priorities, *Introduction to the Federal Budget Process*, Revised, January 17, 2006, www.cbpp.org/3-7-03bud.pdf.

⁵ Section 1902(a)(69) of the Social Security Act, added by section 6034(b) of the Deficit Reduction Act, P.L. 109-171.

⁶ Martin Kitchener, Terence Ng, Charleen Harrington, and Risa Elias, *Medicaid 1915(c) Home and Community-Based Service Programs: Data Update*, Kaiser Commission on Medicaid and the Uninsured, July 2005, available at <http://www.kff.org/medicaid/7345.cfm>.

⁷ *Medicaid Section 1115 Waivers: Current Issues*, Kaiser Commission on Medicaid and the Uninsured, January 2005, available at <http://www.kff.org/medicaid/7234.cfm>

⁸ Senate Committee on Finance, Medicaid Waste, Fraud and Abuse: Threatening the Health Care Safety Net, June 28 and 29, 2005, at <http://finance.senate.gov/sitepages/2005HearingF.htm/hearings2005.htm>

⁹ Congressional Review Act (CRA) of 1996, 5 U.S.C. 801-808.

¹⁰ For example, of the 70 different state Medicaid plan amendments set forth in section 1902(a) of the Social Security Act, only seven expressly require the issuance of regulations (paragraphs (16), (25)(A)(i), (31), (33)(A), (36), (44), and (65)).

¹¹ Section 1102 of the Social Security Act, 42 USC 1302.

¹² 70 *Fed. Reg.* 4417 – 4421 (January 28, 2005).

¹³ These proposals relate to provider taxes and payments to disproportionate share hospitals. *The Budget of the Department of Health and Human Services*, February 2005, p. 65, available at www.hhs.gov/budget/docbudget.htm.

¹⁴ Henry J. Kaiser Family Foundation, *The President’s FY 2007 Budget Proposal: Overview and Briefing Charts*, March 2006, p. 5 <http://www.kff.org/uninsured/7472.cfm>.

¹⁵ The APA allows an agency to avoid “notice and comment” procedures when the agency finds, for “good cause,” that these procedures are “impracticable, unnecessary, or contrary to the public interest.” A recent example of a CMS interim final rule with comment period is the rule specifying state allotments for payment of Medicare Part B premiums for Qualifying Individuals for FY 2006 and FY 2007. The rule was published on April 28, 2006; it was made effective October 1, 2005; and the 60-day comment period closed June 27, 2006. In explaining why it chose to waive the APA notice and comment requirement, CMS stated: “We are publishing this rule as an interim final rule because of the need to notify individual States of the limitations on Federal funds for their Medicaid expenditures for payment of Medicare Part B premiums for qualifying individuals. Some States have experienced deficits in their current allotments that have caused them to deny benefits to eligible applicants, while other States project a surplus in their allotments. This rule permits redistribution of funds and will allow all eligible applicants to receive QI benefits during this calendar year.” 71 *Fed. Reg.* 25085, 25091 (April 28, 2006).

¹⁶ In a letter dated June 29, 2006, 44 Senators asked Secretary Leavitt to not implement the regulatory proposals that could result in \$12.2 billion in federal Medicaid savings over the next five years from limiting payments to public providers, reducing provider taxes and limiting other Medicaid financing arrangements. Similar letters had been sent from the National Governor’s Association and a group of House Republicans.

¹⁷ In the view of CMS, SMM instructions are “official interpretations of the law and regulations and, as such are binding in state Medicaid agencies.” Forward, B. 1., *State Medicaid Manual*, available at <http://www.cms.hhs.gov/Manuals/PBM/list.asp>, Paper-Based Manual 45.

¹⁸ SMD Letters are available at <http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage>

¹⁹ Any State dissatisfied with the final determination of the CMS Administrator that an SPA is not approvable has a right to judicial review in the U.S. Court of Appeals for the circuit in which the State is located. 42 CFR 430.38(a).

²⁰ State Medicaid Fact Sheets, Kaiser Commission on Medicaid and the Uninsured, available at <http://www.kff.org/mfs/index.jsp>.

²¹ “The State plan is a comprehensive written statement submitted by the [state Medicaid] agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for [CMS] to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the State program.” 42 CFR 430.10.

²² As described by CMS on its website, “The state Medicaid plan for each state is an accumulation of plan pages approved by CMS since the inception of the Medicaid program. State plans often represent over 1,000 pages of material and include many pages that are of poor physical quality.” <http://www.cms.hhs.gov/medicaid/stateplans/>

²³ Section 1904(2) of the Social Security Act, 42 USC 1396c(2).

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- ²⁴ National Health Law Program and National Association of Community Health Centers, *Role of State Law in Limiting Medicaid Changes*, April 2006, www.healthlaw.org.
- ²⁵ 42 CFR 431.12(c) requires that state Medical Care Advisory Committees “must have an opportunity for participation in policy development and program administration.”
- ²⁶ 42 CFR 430.12(c)(ii).
- ²⁷ In the MMA, Congress prohibited the payment of federal Medicaid matching funds after December 31, 2005, for certain outpatient prescription drugs for Medicaid beneficiaries enrolled in Medicare Part D Plans. In the preamble to the final regulations implementing these provisions, CMS wrote that a State “should be aware that any changes it makes to Medicaid payment, eligibility, or coverage because of the impact of the new benefit must be reflected in the State’s plan. A State that does not amend its Medicaid State plan to reflect changes to its Medicaid program risks losing FFP [Federal Financial Participation].” 70 *Fed. Reg.* at 4421 (January 28, 2005).
- ²⁸ Section 1902(b) of the Social Security Act, 42 U.S.C. 1396a(b).
- ²⁹ 42 CFR 430.16.
- ³⁰ 42 CFR 430.38.
- ³¹ 5 U.S.C. 706(2)(A).
- ³² See Penny Thompson, *Medicaid’s Federal-State Partnership: Alternatives for Improving Financial Integrity*, Kaiser Commission on Medicaid and the Uninsured, February 2004, pp. 16-19, <http://www.kff.org/medicaid/7027.cfm>
- ³³ Testimony of Dennis G. Smith, Director, Center for Medicaid and State Operations, on Medicaid Fraud and Abuse before the Senate Committee on Finance, June 28, 2005, p. 3, available at <http://finance.senate.gov/sitepages/2005HearingF.htm/hearings2005.htm>
- ³⁴ For an analysis of the impact of section 1115 waivers on expanding health care coverage, see Samantha Artiga and Cindy Mann, *Coverage Gains Under Recent Section 1115 Waivers: A Data Update*, Kaiser Commission on Medicaid and the Uninsured, August 2005, available at <http://www.kff.org/medicaid/7374.cfm>
- ³⁵ <http://www.cms.hhs.gov/HIFA/>
- ³⁶ Congressional Budget Office, *Cost Estimate S. 1932, Deficit Reduction Act of 2005*, January 27, 2006, available at www.cbo.gov.
- ³⁷ DHHS Semi-Annual Regulatory Agenda, 71 *Fed. Reg.* 22544-22545 (April 24, 2006). The DRA sections that CMS intends to implement through NPRM are 6001-6003 (pharmacy pricing), 6083 (non-emergency medical transportation option), 6041-43 (cost-sharing options), 6044 (benchmark benefits package), 6036 (documentation of citizenship), and 6087 (cash & counseling). The DRA sections that CMS intends to implement through interim final regulation are 6052 (targeted case management) and 6086 (HCBS option).
- ³⁸ State Medicaid Director Letter dated March 22, 2006 relating to DRA section 6033 (redistribution of unused prescription medications). State Medicaid Director Letters dated March 31, 2006 relating to DRA sections 6044 (“benchmark” benefits), 6083 (non-emergency medical transportation brokerage program), and 6085 (limits on payment for non-contracted emergency services).
- ³⁹ http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf
- ⁴⁰ 42 CFR 440.230(c), 42 CFR 440.240.
- ⁴¹ SMDL #06-008, March 31, 2006, available at www.cms.hhs.gov/smdl/downloads/SMD06008.pdf
- ⁴² CMS, *Roadmap to Medicaid Reform: New Options to Improve and Expand Insurance Coverage for Acute Care Needs*, March 31, 2006, available at <http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS061265>.
- ⁴³ For an overview of these “tiered” benefits approaches, see Cindy Mann and Samantha Artiga, *New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility?* Kaiser Commission on Medicaid and the Uninsured, June 2006, pp. 11-12, www.kff.org/medicaid/upload/7507.pdf.
- ⁴⁴ Sections 6041 -6043 of DRA. See Samantha Artiga and Molly O’Malley, *Increasing Premiums and Cost-sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005, available at <http://www.kff.org/medicaid/7322.cfm>.
- ⁴⁵ Kitchener et al., July 2005.
- ⁴⁶ Jeffrey Crowley, *Medicaid Long-Term Services Reforms in the Deficit Reduction Act*, Kaiser Commission on Medicaid and the Uninsured, April 2006, available at <http://www.kff.org/medicaid/7486.cfm>.
- ⁴⁷ Individual Katrina waivers are available at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/07_KatrinaWaivers.asp#TopOfPage.
- ⁴⁸ Kaiser Commission on Medicaid and the Uninsured, *A Comparison of the 17 Approved Katrina Waivers*, January 2006, available at <http://www.kff.org/medicaid/7420.cfm>.
- ⁴⁹ <http://www.hhs.gov/news/press/2006pres/20060324.html>.

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