

medicaid and the uninsured

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FEDERAL CORE REQUIREMENTS AND STATE OPTIONS IN MEDICAID: CURRENT POLICIES AND KEY ISSUES

OVERVIEW

Medicaid was originally enacted in 1965 to enable states, at their option, to furnish medical assistance, as well as rehabilitative and other services, for certain families and aged, blind, and disabled individuals whose income and resources are insufficient to meet the costs of medically necessary services. The program has evolved over time, and, today, Medicaid serves as the nation's primary health insurance program for low-income and high-need individuals. Under the Affordable Care Act (ACA), Medicaid will expand in 2014 to become the base of coverage for the low-income population. This brief presents an overview of the current Medicaid program framework, with a focus on eligibility, benefits and cost sharing, care delivery and provider payment, long-term services and supports, and dual eligibles.

The Federal-State Financing and Administrative Structure of Medicaid

Medicaid is a jointly financed partnership between the federal government and states. The federal government provides federal matching dollars for allowable state spending on Medicaid on an open-ended basis. States administer the program on a day-to-day basis. Given the substantial investment of federal funds, the federal government provides oversight of state program administration and shares responsibility with states to ensure program integrity.

To participate in Medicaid, states are required to meet federal core requirements, which include covering a specified set of eligibility groups and benefits. At the time Medicaid was enacted, these eligibility groups were tied to welfare, but have since incrementally expanded, mostly for children and pregnant women. Medicaid will expand to a national minimum eligibility floor of 133% of poverty across groups in 2014.

States can choose to cover optional groups and benefits with federal matching funds and have substantial discretion to determine how care is delivered as well as how and what providers are paid. States have responded to program options in different ways, and, as a result, there is significant program variation across states.

Key Issues

There is discussion of program restructuring at the state and federal level to address budget concerns. States continue to face budget shortfalls, due to recession-driven enrollment growth and the loss of temporary fiscal relief at the same time that state revenues are still recovering. Some states are seeking to make cost saving changes beyond those allowed under current options. At the federal level, proposals have emerged to limit federal funding by restructuring Medicaid into a block grant program.

Other efforts are focused on achieving cost efficiencies, while improving care, within the current program framework. The ACA includes provisions to support innovative delivery models to improve care and achieve cost efficiencies, particularly for high-need and high-cost individuals, including dual eligibles.

Looking Ahead

The ACA revises the framework of the Medicaid program with new requirements as well as new options and incentives designed to strengthen Medicaid as the base of coverage for the low-income population. The balance between federal standards and state options and the inherent tensions associated with this balance will likely continue to evolve to reflect changes in health care needs, innovations, and priorities. Looking ahead, the balance between federal standards and state options as well as federal and state financing will have even greater implications as Medicaid expands under health reform and state and federal policymakers contemplate changes to the program.

INTRODUCTION

Medicaid was originally enacted in 1965 to enable states, at their option, to furnish medical assistance, as well as rehabilitative and other services, for certain families and aged, blind, and disabled individuals whose income and resources are insufficient to meet the costs of medically necessary services.¹ The program has evolved over time in many ways and, today, Medicaid serves as the nation's primary health insurance program for low-income and high-need individuals. Under the ACA, Medicaid will expand in 2014 to become the base of coverage for the low-income population.

Medicaid covers low-income families who lack access to other affordable coverage, individuals with disabilities for whom private coverage is often not available or adequate, and low-income Medicare beneficiaries to assist with premiums and gaps in coverage. Medicaid enrollees are sicker, poorer, and more disabled than those with private insurance, and Medicaid covers a wide array of services, including mental health and long-term services and supports, to meet their extensive health needs.²

Medicaid is a jointly financed partnership between the federal government and states. The federal-state financing and administrative structure of Medicaid provides a framework of federal core requirements to support its statutory purpose of providing health services to certain low income individuals, and also provides broad state options for program design and administration. This brief presents an overview of this framework of federal core requirements and state options, with a focus on eligibility, benefits and cost sharing, care delivery and provider payment, long-term care services and supports, and dual eligibles (see also Appendix A).

BACKGROUND: THE FEDERAL-STATE FINANCING AND ADMINISTRATIVE STRUCTURE

Medicaid Financing

The federal government provides federal matching dollars for allowable state spending on individuals eligible for Medicaid on an open-ended basis. States make payments for eligible services for qualified enrollees and then are able to draw down federal matching payments for these services. The federal medical assistance percentage (FMAP) is determined by a statutory formula based on state per capita income, which varies across states and adjusts over time. On average, the federal government pays 57% of program costs, but matching rates across states range from 50% to 75% in 2011 with poorer states receiving more federal assistance.³ The federal government has twice temporarily increased the matching rate to provide fiscal relief to states during economic downturns, when program needs increase at a time when state revenues are depressed. Most recently, under the American Reinvestment and Recovery Act of 2009 (ARRA), states were provided an increase in the FMAP through December 2010, which was later extended through June 2011 but at a lower level.⁴

Program Administration and Accountability

States administer Medicaid on a day-to-day basis. To participate in the program, each state must have a state Medicaid plan on file with CMS, which sets forth how the state will comply with the federal core requirements.⁵ Each state is responsible for setting up eligibility and enrollment processes and systems, determining the scope of benefits that will be covered, processing claims and making payments to providers, and monitoring the quality of the services it purchases.⁶ Moreover, states have shared responsibility with the federal government to ensure that state and federal funds are spent properly and efficiently, and must collect and report information necessary for effective program administration and accountability as well as resolve grievances by applicants, enrollees, providers and plans.⁷

Given the substantial investment of federal funds in the Medicaid program, the federal government has responsibilities and a role in ensuring funds are appropriately used to support the program's purposes and spent efficiently. To this end, the federal government, through the Centers for Medicare and Medicaid Services (CMS), interprets and implements legislation through regulations and guidance, administers federal matching payments to states, and monitors and assures state compliance with federal law.⁸ CMS also is responsible for ensuring the efficient administration of the program by state and local agencies and the proper spending of federal matching funds as well as for collecting accurate data on expenditures of federal funds.⁹ If CMS determines that claims are not allowable, it can defer or disallow quarterly payments to the states.¹⁰ CMS also ensures the quality of institutional care through survey and certification activities.¹¹

States implement Medicaid policy changes by filing a State Plan Amendment (SPA) or requesting a waiver. To implement an allowable program change, a state submits a SPA to CMS, which CMS must act on within a specified timeframe and generally must approve if it complies with federal law.¹² A state may seek a waiver to make program changes not otherwise allowed under program rules. Under Section 1115 of the Social Security Act, the Secretary of HHS can approve waivers that allow states to use federal Medicaid funds in ways not otherwise allowed under federal rules as long as the Secretary determines the initiative is a research and demonstration project that “furthers the objectives” of the program. There also are more narrow waivers that allow states to mandate enrollment in managed care, provide home and community-based services, or provide family planning services (although legislation now allows states to implement these policies without a waiver). States have been seeking less paperwork and faster decisions on SPAs and waivers, and the Secretary has committed to expedite review of state proposals.¹³ Further, forthcoming regulations to address longstanding concerns about the transparency of the Section 1115 waiver approval process, which HHS was directed to issue under the ACA, will include new requirements related to the timing of reviews and approvals of waivers.¹⁴

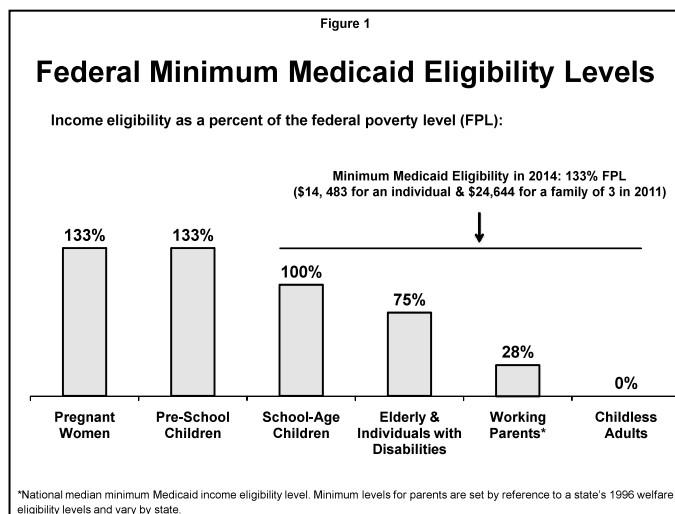
Individual states vary in the extent to which program changes are subject to state legislative review or approval. Some states require legislative approval of SPAs or waivers or legislative notice and review of changes before a state Medicaid agency can move forward with a change.¹⁵ Moreover, some states have specific statutory requirements related to Medicaid cost sharing amounts and/or benefits or a general requirement that mandates state legislative approval before the state Medicaid agency can amend its state plan or make program changes that will have a certain financial impact on state expenditures.¹⁶

The federal government and states have shared responsibility to ensure program integrity. At the federal level, the Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) which is designed to reduce provider fraud, waste, and abuse in Medicaid.¹⁷ MIP interfaces with other federal program integrity efforts, such as the Medicare and Medicaid (Medi-Medi) data matching project and the Medicaid Payment Error Rate Measurement (PERM) program.¹⁸ The ACA also creates new requirements and safeguards against fraud and abuse and the Medicaid Quality Measurement Program to establish quality measures for adults.¹⁹ States have responsibility for program integrity through operation of their Medicaid Fraud Control Units (MFCUs) and efficient administration of their programs.²⁰ Federal law requires states to have MFCUs that generally perform both investigatory and prosecutorial functions and which are required to be separate from the Medicaid agency to ensure independence.²¹ With regard to combating fraud and abuse, some states have independent Inspectors General, others have very active involvement from the Office of the Controller, and others rely heavily on the State Attorney General. Within the Medicaid agency, states use administrative dollars to oversee their programs with regard to payment, quality and enrollment.²² However, oversight policies and efforts vary by state.²³

ELIGIBILITY

Federal Core Requirements

To fulfill Medicaid's statutory purpose of providing medical assistance to certain individuals, to participate in the program, states are required to cover core groups of low-income individuals. At the time Medicaid was enacted, these groups were tied to welfare, and included low-income families and aged, blind, and disabled individuals receiving cash assistance.²⁴ Over time, the minimum eligibility groups incrementally expanded, mostly for children and pregnant women, and increasingly separated from welfare.²⁵ Today, these core groups include pregnant women, children, parents, elderly individuals, and individuals with disabilities up to specified minimum income levels (Figure 1). The minimum income level for parents is set by reference to a state's 1996 welfare eligibility level, which varies across states but is below 50% of the federal poverty level (FPL) in nearly all states (\$9,265 for a family of 3 in 2011).²⁶ For seniors and individuals with disabilities, states generally must cover those receiving Supplemental Security Income (SSI) (up to 75% FPL or \$8,168 for an individual in 2011).²⁷ One group that has historically been excluded from the core federal groups is non-disabled adults without dependent children. This will change in 2014, when, under the ACA, Medicaid eligibility will expand to a national minimum of 133% FPL (\$14,483 for an individual and \$24,645 for a family of 3 in 2011) across all groups, with nearly all expansion costs financed with federal funds.



The ACA includes a “maintenance of effort” (MOE) requirement to keep Medicaid and CHIP coverage stable until coverage expands under reform. To receive federal Medicaid funds, states must maintain eligibility and enrollment policies that are no more restrictive than those in place at the time the ACA was enacted (March 23, 2010) until 2014 for adults and until 2019 for children in Medicaid and CHIP. An exception allows states facing a budget deficit to reduce eligibility for non-disabled adults above 133% FPL.²⁸

State Options

States may choose to extend eligibility to pregnant women, children, parents, seniors, and individuals with disabilities above federal minimum levels and receive federal matching funds. States also have broad discretion to determine enrollment and renewal procedures, which have a substantial impact on enrollment. Just as federal minimum eligibility requirements have evolved over time, so have eligibility options. For example, in the 1990s states were given new options to cover low-income families without regard to receipt of cash assistance.²⁹ The Children's Health Insurance Program (CHIP), enacted in 1997, and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) also provided new options to increase coverage and streamline enrollment for low-income children in Medicaid and CHIP.³⁰

The ACA provides states a new option, effective April 2010, to receive federal funds to cover low-income non-disabled adults without dependent children with incomes up to 133% FPL. Prior to passage of the ACA, these adults were not included in the groups that states could cover through the Medicaid program with federal dollars, and states could only cover them through a waiver or a fully state-funded program.

State Responses to Program Options

All states have expanded coverage for children well above mandatory minimum levels, and most have expanded coverage for other groups, but eligibility limits vary significantly across groups and states:

- **Children and Pregnant Women:** All states have expanded coverage for children through Medicaid and CHIP with 25 states, including DC, extending coverage to children at or above 250% FPL and only 4 states limiting eligibility to less than 200% FPL.³¹ Further, 45 states, including DC, have expanded coverage for pregnant women above the 133% FPL minimum, with 40 states setting eligibility at or above 185% FPL.³² Although states have largely expanded coverage for children and pregnant women, there is still significant variation across states in their eligibility thresholds for these groups.³³
- **Parents and Other Non-Disabled Adults:** The majority of states (38) also have expanded parent eligibility beyond mandatory levels through options or by obtaining a waiver, but, overall, eligibility limits for parents remain low.³⁴ The Medicaid eligibility limit for working parents remains below poverty in 33 states and the national median is 64% FPL (\$11, 859 for a family of three in 2011).³⁵ Eligibility for other non-disabled adults is even more limited with only 8 states, including DC, providing Medicaid or Medicaid-equivalent coverage to these adults.³⁶ A number of states provide coverage that is more limited in scope than Medicaid for parents and other adults up to higher income limits through a waiver.³⁷
- **Seniors and Individuals with Disabilities.** As of 2010, 23 states, including DC, had increased eligibility above the SSI assistance level (75% FPL or \$8,168 for an individual in 2011).³⁸ Medically needy coverage was offered in 32 states, including DC, enabling individuals with high medical bills to spend down to a state-set eligibility standard, and 43 states allowed people in need of nursing home care to qualify with income up to 300% of the SSI assistance level.³⁹ Many states also allow working individuals with disabilities and children with disabilities with family incomes above eligibility limits to buy into Medicaid.⁴⁰

Key Issues

*States have achieved significant progress streamlining enrollment procedures for children, but progress for adults has been more limited.*⁴¹ Health reform provides new opportunities and requirements for states to streamline and modernize their enrollment systems, and there is increasing movement to adopt streamlined procedures, often through technology.⁴² Building on these efforts will be important as states prepare for the coverage expansion and develop integrated Medicaid, CHIP, and Exchange eligibility systems under reform.⁴³

Some states are expanding coverage to adults to obtain federal assistance for previously fully state-funded coverage and prepare for the expansion under reform. The Medicaid expansion in 2014 will increase eligibility for parents and other adults in many states. The extent of the increase in each state will vary depending on current eligibility policies, and initially will be largely financed with federal funds. Several states (CA, CT, DC, MN, NJ, and WA) recently expanded Medicaid to adults through the new ACA option and/or by obtaining a waiver.⁴⁴ These states all previously covered low-income adults with solely state funds and are using the newly available federal funds to strengthen and expand this coverage and prepare for the expansion.

However, other states are seeking authority to reduce eligibility to address state budget shortfalls. Through 2010 and into 2011, states held steady or made targeted improvements in their eligibility and enrollment rules, largely due to the temporary Medicaid fiscal relief and the MOE requirement.⁴⁵ However, states continue to face budget shortfalls, due to recession-driven enrollment growth, the end of fiscal relief on June 30, 2011, and state revenues that remain depressed, and some states have been calling for the authority to reduce eligibility and impose more restrictive enrollment policies.⁴⁶ There is also discussion of legislation to change the MOE requirement. Without the MOE requirement, states could cut back optional coverage for low-income children, families, elderly individuals, and individuals with disabilities and impose more restrictive enrollment policies that affect all enrollees.⁴⁷

BENEFITS AND COST-SHARING

Federal Core Requirements

States are required to provide enrollees a core set of “mandatory” benefits and certain cost sharing protections to participate in the Medicaid program (Figure 2). While physician and hospital services are included as mandatory benefits, other benefits and services that are important for comprehensive coverage and care, such as prescription drugs, are not included. However, the program seeks to ensure children receive all necessary services through the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) benefit, which includes screening, vision, dental, and hearing services and any medically necessary care. The ACA added some new mandatory benefits including smoking cessation services for pregnant women and free-standing birth center services. Given the limited incomes of enrollees, there also are limitations regarding who and what services may be subject to cost sharing and what amounts may be charged.

Figure 2
Medicaid Benefits

<u>“Mandatory” Benefits</u>	<u>“Optional” Benefits</u>
<ul style="list-style-type: none">• Physician services• Laboratory and x-ray services• Inpatient hospital services• Outpatient hospital services• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21• Family planning• Rural and federally-qualified health center (FQHC) services• Nurse midwife services• Nursing facility (NF) services for individuals 21 or over• Home health care services for individuals entitled to nursing facility care• Smoking cessation services for pregnant women• Free-standing birth center services	<ul style="list-style-type: none">• Prescription drugs• Clinic services• Dental services, dentures• Physical therapy and rehab services• Prosthetic devices, eyeglasses• Primary care case management• Intermediate care facilities for the mentally retarded (ICF/MR) services• Inpatient psychiatric care for individuals under 21• Home health care services• Personal care services• Hospice services• Health home services to individuals with chronic conditions

State Program Options

States may choose to cover optional benefits with federal matching funds, and states determine the amount, duration, and scope of covered benefits. Reflecting the diverse health needs of enrollees, there is a broad range of optional benefits states may choose to cover, for which they may receive federal matching funds, including long-term care services and supports that are not typically included in private plans. The ACA created a new optional health home benefit to provide coordinated care to individuals with chronic conditions and states can receive a 90% federal match for two years for this benefit.⁴⁸ For both mandatory and optional benefits, states determine the amount, duration, and scope of covered benefits (e.g., the number of covered visits), subject to the requirement that coverage of the benefit be sufficient to achieve its purpose.

States may provide some groups “benchmark benefit packages” or premium assistance rather than the Medicaid benefit package. The Deficit Reduction Act of 2005 (DRA) gave states a new option to provide a benchmark or benchmark-equivalent benefit package to some groups, and also newly allowed states to vary the benefits provided across groups or areas of the state for groups that may receive benchmark benefits.⁴⁹ These benchmark plans include the standard Blue Cross Blue Shield (BCBS) preferred provider plan under the Federal Employees Health Benefits Plan (FEHBP), a state employee plan, the state’s largest commercial health maintenance organization (HMO), or other Secretary-approved coverage. States also have the option to provide premium assistance to subsidize the cost of purchasing employer-sponsored coverage rather than providing direct coverage, although premium assistance programs operated under the state option must meet certain requirements including providing wraparound coverage to ensure enrollees can still access full Medicaid benefits and cost sharing protections.⁵⁰

States may charge some groups cost sharing within federal limits. The DRA gave states new options to charge premiums and cost sharing, which vary by children and adults and by income.⁵¹ Under these options, mandatory children are largely exempt from cost sharing, optional children with family income at or below 150% FPL can be charged cost sharing up to specified limits but no premiums, and children above 150% FPL

can be charged cost sharing up to specified limits and premiums. Similarly, adults with income at or below 100% may be charged nominal copayments, adults with incomes above 100% FPL may be charged slightly higher cost sharing amounts, and adults above 150% FPL may be charged cost sharing and premiums. Regardless of income, aggregate individual costs must not exceed 5% of family income. The DRA also allowed states to make premiums and cost sharing enforceable, meaning individuals can be disenrolled from coverage due to unpaid premiums and a state can allow providers to deny care (other than emergency services) unless an individual makes a required copayment at the point of service.⁵²

State Responses to Program Options

*All states offer at least some optional benefits, including prescription drugs, but how many and which optional benefits are offered vary across states as do the limits on covered benefits.*⁵³ Specific cost sharing policies also vary across states, but, overall, 36 states charge some premiums and 45 states, including DC, have copayment requirements.⁵⁴ Eleven states provide benchmark coverage for some groups as allowed under the DRA.⁵⁵ These states have generally used the option to provide additional benefits to targeted groups of beneficiaries.⁵⁶ Most states operate a premium assistance program, but, overall, enrollment in these programs is relatively low, reflecting the limited availability of employer-sponsored coverage among the low-income population.⁵⁷

*Under Section 1115 waivers, some states provide more limited benefits and charge higher cost sharing for parents and other adults than otherwise allowed in Medicaid.*⁵⁸ The scope of benefits provided to parents and other adults through waivers varies widely, with some states providing the full Medicaid benefit package and others providing much more limited benefits, such as coverage limited solely to primary care. Moreover, some states charge adults higher costs under waivers than otherwise allowed in Medicaid, including premiums, deductibles, copayments, and coinsurance charges.

Key Issues

*In fiscal year 2010, 20 states eliminated optional benefits and/or tightened restrictions on covered benefits.*⁵⁹ Further, some states have recently expressed interest in reducing benefits and increasing cost sharing and premiums in ways not allowed under current options to address budget shortfalls. While these changes can yield savings, they generally are relatively limited. Further, the changes can increase barriers to care and pressures on community clinics and public hospitals.

States will have increased flexibility to design Medicaid benefits for adults who become newly eligible for Medicaid under the coverage expansion in 2014. Most adults newly eligible for Medicaid will receive benchmark benefits that must, at a minimum provide, “essential health benefits” that will be required to be covered by Exchange plans.⁶⁰ HHS has indicated that it will consider the full Medicaid benefit package to be a benchmark plan under the “Secretary-approved coverage” benchmark option.⁶¹ Many newly eligible adults will have extensive health needs, including mental health needs, which will be important to consider in making benefit decisions.⁶² Moreover, it will be important for states to consider the impact of benefit design on program administration. For example, providing newly eligible adults a benefit package that differs from the state’s regular Medicaid benefit package creates new administrative needs and challenges to assure individuals receive the correct benefits. However, to better understand these issues, more guidance is needed on what will be included in the essential health benefits package for Exchange coverage and how it compares to states’ Medicaid benefit packages.

CARE DELIVERY AND PROVIDER PAYMENT

Federal Core Requirements

States largely determine provider payments within limited federal requirements. Federal law requires that payments be consistent with efficiency, economy, quality and access and safeguard against unnecessary utilization. Additional requirements vary by provider type, as follows:

- **Institutional providers (hospitals) and nursing facilities.** States are required to publish payment methodologies for public review and comment and payments are subject to upper payment limits for these providers based on what Medicare would have paid in aggregate.
- **Physicians, other providers, and managed care organizations.** States are required to pay rates that are sufficient to ensure access equal to the rest of the area population. For managed care organizations, payments must be actuarially sound. The ACA will increase payments for primary care services to 100% of Medicare payment rates for 2013 and 2014 and provide 100% federal financing for the increase.
- **Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).** Under legislation enacted in 2001, states are required to pay these health centers and clinics based on a prospective payment system that relies on costs in a base year and trended forward.
- **Prescription drugs.** Federal law requires that drug manufacturers enter into rebate agreements with HHS to provide their drugs through Medicaid.

Federal requirements related to delivery of care are also limited. Following the Balanced Budget Act of 1997, states can require many groups of Medicaid enrollees to enroll in managed care, as long as certain federal requirements relating to choice of plan and consumer protection are met.⁶³ Certain groups, such as children with special health care needs, Medicare beneficiaries, and Native Americans, are exempt from being required to enroll in managed care.

The extent of federal requirements related to provider payments and delivery of care has fluctuated over time. While currently limited, there at times have been more requirements and standards related to payments of certain providers and use of managed care to address concerns related to access and program integrity.⁶⁴

State Options

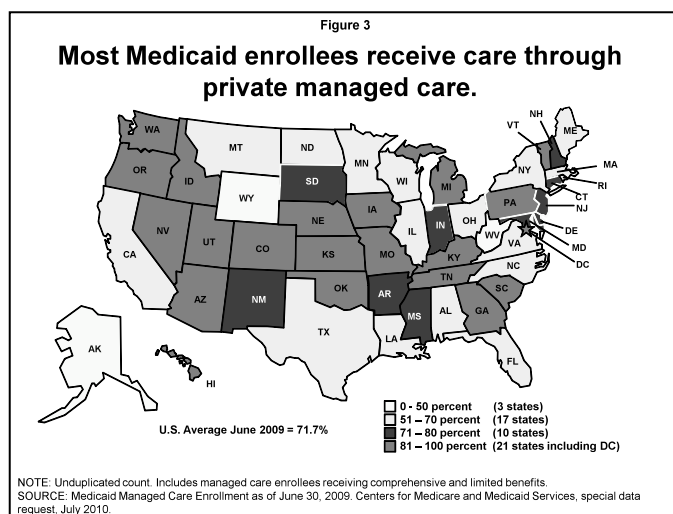
States establish how and what they will pay providers and whether to buy covered services on a fee-for-service or managed care basis. States determine provider payments subject to the provider-specific requirements described above. States may choose to require most Medicaid enrollees to enroll into managed care plans, except for the exempt high-need populations. States also can enroll individuals in managed care on a voluntary basis, including those groups exempt from mandatory enrollment. States determine the structure of their managed care arrangements, including the extent to which they utilize capitated or non-capitated payment arrangements.⁶⁵ Also, under the ACA, states may now choose whether to include prescription drugs in managed care contracts or carve drugs out separately without losing the rebates paid by manufacturers.

The ACA provides new opportunities for states to improve care delivery in Medicaid. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) to test, evaluate, and expand innovative care and payment models to foster patient-centered care, improve quality, and slow cost growth in Medicare, Medicaid and CHIP. The ACA also includes several demonstrations that will enable some states to test new approaches such as bundling payments around hospital care, setting global payments for safety-net hospital systems, allowing pediatric providers to organize as accountable care organizations (ACOs), and encouraging healthy lifestyle changes.

State Responses to Program Options

About 70% of enrollees receive some or all of their services through capitated and non-capitated managed care arrangements.⁶⁶ In 48 states, including DC, more than half of enrollees are in managed care (Figure 3).⁶⁷ As of June 2008, 35 states, including DC, operated 307 full-risk capitated plans with 21.7 million enrollees, and 29 states operated 35 primary care case management programs (PCCMs) with 6.7 million enrollees.⁶⁸

There is significant variation across states in how provider rates are determined as well as in payment levels. States use a variety of payment methodologies for hospitals, including diagnosis related groups (DRGs) similar to Medicare, per diem amounts, or costs. Further, fee-for-service payments for physicians vary significantly across states. For example, rates for office visits in California are 33% below the national Medicaid average while Oklahoma pays 55% above the average.⁶⁹ On average, states pay fee-for-service providers about 72% of what Medicare pays.⁷⁰ For managed care, some states set rates based on fee-for-service claims while others base rates on risk adjustments for different populations. Information is limited regarding the rates paid to providers in managed care.



Key Issues

Due to the recession and state fiscal pressures, nearly all states have restricted provider rates in recent years and states continue to look for ways to reduce payments.⁷¹ Some states have called for more flexibility around payments for FQHCs and RHCs. States also are exploring changes in payments for prescription drugs. Alabama has saved 6% in pharmacy costs by using actual acquisition costs, and the Secretary has indicated that HHS will work to provide states with more accurate data to base payments on actual acquisition costs.⁷²

There are concerns that low Medicaid payment rates depress provider participation and contribute to access problems, particularly for specialty care. Gaps in access are a system-wide concern driven by overall primary care provider shortages and the geographic mal-distribution of providers relative to need.⁷³ These concerns are amplified in Medicaid because of low physician participation, the geographic location of enrollees, and factors related to poverty.⁷⁴ The Medicaid and CHIP Payment and Access Commission was recently established to provide analysis and recommendations related to payment and access issues in Medicaid and CHIP to Congress. Further, the Supreme Court has agreed to hear a case (*Douglas v. Independent Living Center of Southern California*) to decide whether beneficiaries and providers have the right to challenge the sufficiency of Medicaid provider rates in federal court, and federal regulations related to Medicaid payment rate standards are expected in the near-term.⁷⁵ The ACA increases in primary care rates coupled with efforts to reduce administrative burdens and changes in state licensure laws to allow nurse practitioners and physician assistants to practice at the “top of their license” could help increase provider supply and access to care.⁷⁶

There are efforts to implement care delivery and purchasing arrangements that improve care and create cost efficiencies. States are expanding managed care to more service areas and populations, including people with disabilities.⁷⁷ More states are also turning to innovative PCCM and medical home models, similar to Community Care of North Carolina, to support care management outside of fully-capitated arrangements.⁷⁸ In addition, some states are restructuring payment rates based on performance and/or reconfiguring rates to promote more ambulatory care.⁷⁹ At the federal level, the Secretary has highlighted innovative care models to reduce premature births and improve care management for children and adults with asthma.⁸⁰

LONG-TERM SERVICES AND SUPPORTS

Federal Core Requirements

One of the key purposes of Medicaid is to provide support for long-term services and supports to seniors and adults and children with disabilities. As such, nursing facility and home health services for those who qualify for nursing facility services are included in the “mandatory” benefits states are required to cover for individuals who meet financial and level of need eligibility criteria. The inclusion of these benefits provides access to institutional care, but there are no requirements for additional home and community-based care beyond the home health benefit. However, under the 1999 Supreme Court decision (*Olmstead v. L.C.*) the Justices ruled that, under the Americans with Disabilities Act, institutionalizing a person with a disability who can benefit from and wants to live in the community is discrimination.

To ensure assistance goes to individuals who do not have resources or assets to meet their needs, there are specific federal financial requirements that individuals must meet in order to receive Medicaid coverage for long-term care.⁸¹ Individuals with substantial home equity are ineligible, unless there is a spouse or child with a disability residing in the home. Further, individuals are subject to a “look-back” period of five years for asset transfers to prevent individuals from giving away their resources in order to qualify for coverage. However, to prevent impoverishment of the spouses of nursing home residents, states are required to disregard income of a community spouse and a specified level of assets.

There are federal requirements focused on ensuring quality of care in nursing homes. Current nursing home quality standards are predominantly the result of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). OBRA 87 changed the previous federal system of regulating nursing home care by creating new, higher standards that were more resident-focused than previous standards, upgrading staffing requirements for nursing homes, establishing an enforcement system for non-compliant nursing homes, and merging Medicaid and Medicare standards and survey and certification into a single system.⁸²

State Options

States determine the financial and level of need criteria for long-term services and supports within federal requirements and options. As previously noted, states may increase income eligibility limits for groups above the federal mandatory minimums and receive federal matching funds for this coverage as well as offer medically needy coverage and allow children and adults with disabilities with incomes above income eligibility limits to buy into Medicaid. States can also choose to expand Medicaid eligibility income limits specifically for nursing home residents. States’ eligibility policies combined with level of need criteria determine who qualifies for long-term services and supports.

There are optional institutional and home and community based services (HCBS) that states may choose to provide for which they receive federal matching funds. These include the optional personal care benefit as well as HCBS through a 1915(c) waiver or the state option created under the DRA. In addition to creating the HCBS state option, the DRA made other changes to support the provision of services in the community, including allowing for consumer-direction of personal assistance services without a waiver, expanding spousal impoverishment protections to HCBS, and creating the Money Follows the Person (MFP) demonstration, which provides enhanced federal match to help states transition individuals from an institution to the community.⁸³ The ACA further built on these changes by allowing states to expand eligibility under the HCBS option to a higher level, extending MFP for five years, and creating the State Balancing Incentive Payments Program and Community First Choice Option, which provide enhanced federal matching funds for certain state actions to increase HCBS.⁸⁴

State Responses to Options

Most states have broadened coverage for long-term services and supports and increased the availability of HCBS. As noted, most states have taken up options to expand eligibility for elderly individuals and individuals with disabilities, and, in 2010, 43 states had higher Medicaid income limits for nursing home residents, 40 of which were set at 300% of the SSI assistance level.⁸⁵ Further, as a result of state actions to provide HCBS, the national percentage of long-term care spending that goes toward HCBS has more than doubled since 1995.⁸⁶ Overall, HCBS spending represents 43% of long-term care spending, but ranges from less than 30% in 5 states to more than 50% in 12 states (Figure 4).⁸⁷ As of 2007, 49 states, including DC, operated 270 HCBS waivers; four states (IA, CO, NV, and WA) offered HCBS under the state option; and 32 states were actively offering the optional personal care benefit.⁸⁸ However, demand for HCBS remains high with 39 states reporting HCBS waiver waiting lists totaling 365,553 individuals as of 2009.⁸⁹

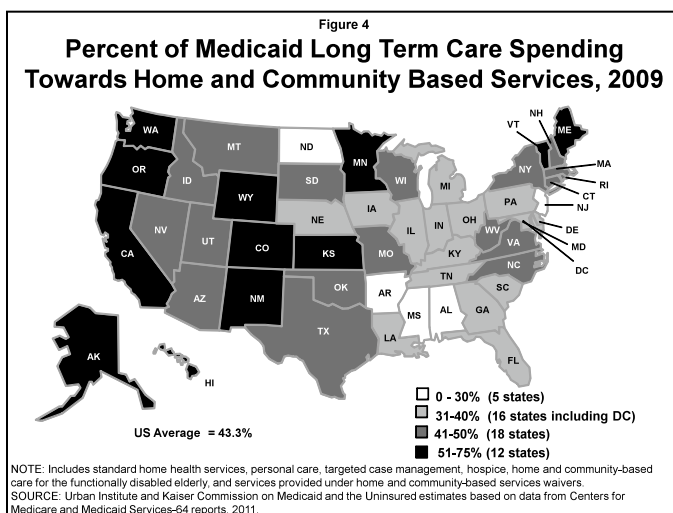
States are using consumer direction within their HCBS programs. Consumer direction refers to various initiatives that give Medicaid beneficiaries control over where, when, and how certain long-term services are provided. As of 2009, 37 of the 49 states with an HCBS waiver allowed or required consumer direction in at least some of their HCBS waivers.⁹⁰

Key Issues

Medicaid is the nation's primary source of support for long-term services and supports for those who are poor or who exhaust their resources. Paying for nursing home care is expensive and can quickly exhaust lifetime savings. Medicaid fills gaps in private coverage and Medicare for these services, financing 43% of all long-term care and paying for 7 in 10 nursing home residents.⁹¹ Medicare accounts for less than a quarter of total long-term care spending, direct out-of-pocket spending accounts for 19%, and private coverage accounts for less than 10%.⁹² There are initiatives to increase private long-term care coverage, including the Long-Term Care Partnership Program, under which a state can allow individuals that purchase qualified long-term care insurance policies to shelter assets when they apply for Medicaid after exhausting their policy benefits, and the national, voluntary insurance program for purchasing Community Living Services and Supports (CLASS), established by the ACA. However, in the absence of major growth in private long-term care coverage, Medicaid will remain the primary source of support for long-term services and supports.

With demand for services in the community remaining high, states continue to be pressed to expand access to HCBS. However, efforts to increase provision of these services often face budgetary challenges. The availability of enhanced federal matching funds through MFP and the new State Balancing Incentive Payments Program and Community First Choice options may help support these efforts. Moreover, recently proposed regulations would newly allow states to serve multiple groups under a single HCBS waiver, potentially creating significant administrative simplifications by allowing states to consolidate some of these waivers.⁹³

While there have been improvements in quality of care, concerns remain. Although there was an initial upgrading of the quality of care following OBRA 87, substantial proportions of nursing homes are still cited for inadequate care and there are still concerns about the adequacy of staffing levels.⁹⁴ Further, while CMS has improved its enforcement system, analysis suggests that long-standing problems with this process remain.⁹⁵ In addition, the quality of HCBS is of growing importance as care is increasingly provided through HCBS.

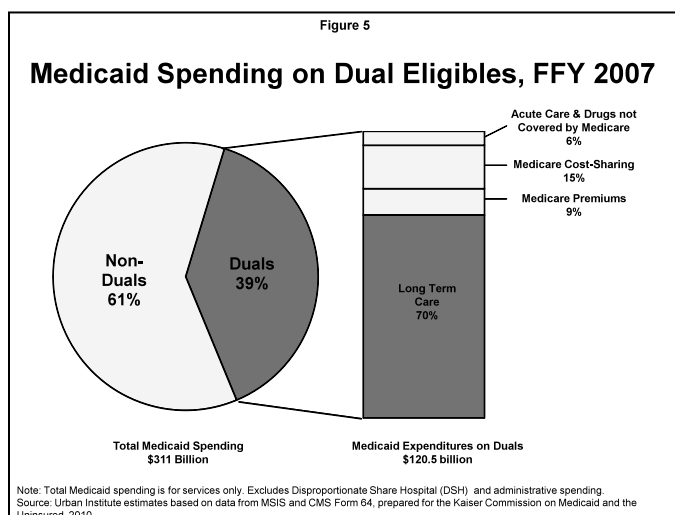


CARE OF DUAL ELIGIBLES

Federal Core Requirements

Under federal requirements, states provide varying levels of assistance to some low-income Medicare enrollees. As noted, to receive federal funds, states are required to extend Medicaid coverage to elderly and disabled individuals who qualify for SSI cash assistance. Many of these elderly and disabled Medicaid enrollees are “dual eligibles” who are also enrolled in Medicare. For these “dual eligibles,” Medicaid helps pay Medicare premiums and cost sharing and covers important benefits not covered by Medicare, such as long-term care. Further, under federal requirements, through Medicare Savings Programs, states pay Medicare premium and cost sharing amounts for low-income Medicare enrollees slightly above SSI assistance levels.

Medicaid coverage of long-term services and supports fills important gaps in Medicare coverage for dual eligibles. Dual eligibles tend to be sicker, poorer, and have more extensive physical and cognitive impairments than other Medicaid or Medicare enrollees.⁹⁶ As such, they often need extensive health services, including long-term services and supports. As noted, under federal Medicaid requirements, states must provide nursing facility and home health care to enrollees. This Medicaid coverage fills key gaps in Medicare coverage, which is largely limited to coverage of acute care services. Overall, 70% of all Medicaid spending for dual eligibles is for long term services and supports (Figure 5).⁹⁷



States are required to continue to make payments related to prescription drug spending for dual eligibles. Nearly all prescription drug spending for dual eligibles was absorbed into Medicare in January 2006 with implementation of Medicare Part D. However, states are required to make a substantial contribution toward this benefit through monthly “clawback” payments to the federal treasury. These payments accounted for about 1% of Medicaid spending for dual eligibles in 2007.⁹⁸

State Options

States can expand eligibility and provide important optional benefits for dual eligibles with federal matching funds. As previously noted, states may increase income eligibility limits for seniors and individuals with disabilities, including dual eligibles, above the federal mandatory minimums and receive federal matching funds for this coverage. States can also choose to expand Medicaid eligibility income limits for nursing home residents and provide coverage to those who become impoverished as a result of a disabling illness or injury through “medically needy” coverage. Moreover, as noted, states have options to increase the availability of HCBS, which are often important for dual eligibles.

In addition to providing care on a fee-for-service basis, states can enroll dual eligibles in managed care on a voluntary basis and utilize other types of care management approaches to serve dual eligibles. The new health home benefit created under the ACA allows states to receive 90% federal match for two years to provide care management and coordination services for individuals with chronic conditions, including dual

eligibles. Also, states have an option to implement the Program of All-Inclusive Care for the Elderly (PACE), which integrates Medicare and Medicaid services and financing for individuals over age 55 who need a nursing home-level of care and pays for care on a capitated basis.⁹⁹ Moreover, beginning in 2010, new Medicare Special Needs Plans (SNPs) for dual eligibles and existing SNPs that want to expand their service area are required to contract with states to provide at least some coordination with Medicaid benefits.¹⁰⁰

State Responses to Program Options

Most states have expanded eligibility in ways that increase coverage options for dual eligibles. As of 2010, 23 states, including DC, had expanded coverage for seniors and individuals with disabilities above the SSI assistance level (75% FPL or \$8,168 for an individual in 2011), with 17 of these states setting eligibility limits to at least 100% FPL (\$10,890 for an individual in 2011).¹⁰¹ In addition, 32 states, including DC, offered “medically needy” coverage, enabling individuals with high medical bills to spend down to a state-set eligibility standard. Further, 43 states have expanded Medicaid income limits for nursing home residents, 40 of which set the limit at 300% of the SSI assistance level.¹⁰² However, even with these eligibility expansions, more than one-third of poor Medicare beneficiaries are not enrolled in Medicaid because they fall above eligibility limits or have not completed the Medicaid enrollment process.¹⁰³

States provide care to dual eligibles through a range of approaches. Although some states provide care on a fee-for-service basis, others enroll dual eligibles into managed care plans on a voluntary basis. Further, a number of states are exploring care management and medical home models for dual eligibles, several have submitted SPAs to offer the new health home benefit, and states continue to pursue options to increase the provision of HCBS to dual eligibles. Moreover, states have utilized a number of integrated models, including Medicare demonstrations, state Medicaid waivers, and Medicare SNPs to better coordinate care for dual eligibles.¹⁰⁴

Key Issues

Dual eligibles are a high-cost, vulnerable population with significant health needs. Nearly 9 million Medicaid beneficiaries are dual eligibles, representing about 15% of Medicaid enrollees but about 40% of Medicaid spending.¹⁰⁵ Dual eligibles are among the sickest and poorest individuals covered by either Medicare or Medicaid. Further, dual eligibles have a heavy reliance on institutional care, particularly among those who are seniors over age 75.¹⁰⁶

There has long been interest in improving the coordination and integration of care for dual eligibles given the high cost of serving these individuals and recognizing the challenges of coordinating Medicare and Medicaid coverage. The ACA creates new opportunities to coordinate care for dual eligibles. It establishes the Federal Coordinated Health Care Office (FCHCO) to align Medicare and Medicaid financing, benefits administration, oversight rules and policies for dual eligibles. FCHCO recently awarded \$1 million contracts to 15 states to design models to improve care for duals.¹⁰⁷ In addition, the new CMMI created under the ACA has explicit authority to allow states to test and evaluate integrated care for duals. However, given the substantial health needs of duals and their entitlement and rights under Medicare, beneficiary safeguards will be an essential component of these efforts.

There are ongoing tensions between Medicare and Medicaid financing of dual eligibles. Initiatives to improve care for dual eligibles raise issues related to the extent to which states share in any cost savings, since improvements often result in savings to Medicare, and how to assure federal accountability for federal Medicare funds. Moreover, there are a number of Medicare costs which states are required to pay, including Medicare premiums and cost sharing through the Medicare Savings Programs and “clawback” payments for prescription drug costs under Medicare Part D, over which states have no control.

CONCLUSION

Medicaid is a jointly financed partnership between the federal government and states. The federal government provides federal matching dollars for allowable state spending on Medicaid on an open-ended basis. States administer the program on a day-to-day basis. To participate in the program, states are required to meet federal core requirements and also have broad program options. Given the substantial investment of federal funds, the federal government provides oversight of state program administration and shares responsibility with states to assure program integrity.

Recently, some states have expressed interest in the authority to make cost saving changes that are not allowed under current requirements and options to address budget shortfalls that largely stem from the end of fiscal relief in July 2011. In particular, some states have noted that they are constrained in the cost saving changes they can make under the MOE requirement to maintain eligibility and enrollment policies. Further, as part of a focus on deficit reduction at the federal level, proposals have emerged to reduce federal costs by fundamentally restructuring Medicaid into a block grant program.

At the same time, other efforts are focused on identifying cost saving opportunities within the current program framework. The Secretary of HHS has focused on helping states identify cost savings and efficiencies available under current options and has recognized the need to streamline processes for states to implement program changes. Moreover, at a broader level, there is growing state and federal interest in innovative care and payment models to improve care and achieve cost efficiencies, particularly for high-need and high-cost individuals, including dual eligibles.

The federal requirements and state options in Medicaid have evolved over time in various ways. The ACA revises the framework with new requirements as well as new options and incentives designed to strengthen Medicaid as the base of coverage for the low-income population. The balance between federal standards and state options and the inherent tensions associated with this balance will likely continue to evolve to reflect changes in health care needs, innovations, and priorities. Looking ahead, the balance between federal standards and state options and federal and state financing will have even greater implications as Medicaid expands under health reform and state and federal policymakers contemplate changes in the program.

Appendix A:

Current Federal Minimum Requirements, State Options, and Waiver Authority in Medicaid: Selected Policy Issues

Policy	Federal Core Requirement	State Option	Core Requirement(s) can be waived under Section 1115?*
Participation in Medicaid			
	Not required	States elect to participate	N/A
Eligibility			
Children Under Age 6	<133% FPL	133% FPL<CHIP eligibility	Yes
Children Ages 6-19	<100% FPL	100% FPL<CHIP eligibility	Yes
Pregnant women	<133% FPL	>133% FPL	Yes
Parents of Dependent Children	<1996 state AFDC levels Welfare to work transition	>1996 state AFDC level Medically needy	Yes
Other Non-Disabled Adults (<age 65)	None	<133% FPL	N/A
Individuals with disabilities	SSI recipients (75% FPL) or 1972 state level	Medically needy Working disabled HCBS eligible	Yes
Seniors	SSI recipients (75% FPL) or 1972 state level	<100% FPL Medically needy Institutionalized <300% SSI level HCBS eligible	Yes
Premiums and Cost Sharing for Medicare	<100% FPL for premiums and cost-sharing <135% FPL for premiums	Working disabled <200% FPL (Part A premium only)	Yes
Maintenance-of-Effort (MOE)	Must maintain eligibility rules no more restrictive than those in effect March 23, 2010, except for non-disabled adults >133% FPL if facing documented budget deficit	May reduce eligibility for non-pregnant non-disabled adults >133% FPL if facing documented budget deficit	Undecided
Acute Care Benefits (Selected)			
EPSDT for children under 21	Required	N/A	Yes
Hospital care (inpatient & outpatient)	Required	Amount, duration, and scope of covered services	Yes
Community health centers (FQHCs, RHCs)	Required	Amount, duration, and scope of covered services	Yes
Outpatient Prescription Drugs	Not Required	Provided at state option Amount, duration, and scope of covered drugs May impose formulary	N/A
Dental and Vision Care for Adults	Not Required	Provided at state option	N/A
Benchmark Benefits	Not Required	May require for non-exempt groups (Some groups exempt, e.g., disabled, Medicare beneficiaries, etc.)	N/A
Cost-sharing			
Premiums	Not allowed <150% FPL	>150% FPL (Some groups exempt, e.g., pregnant women and mandatory children) May enforce by terminating coverage for unpaid amounts	No**
Copayments/Coinsurance	Allowed subject to limits that vary by service, income, and children and adults	May charge for some services and groups up to specified limits (Some services and groups exempt; e.g., preventive services to children, pregnant women, etc.) May charge tiered copayments for drugs based on preferred status May charge higher copayments for non-emergency use of the emergency room May allow providers to deny care for non-payment	No**
Aggregate Cap	Premiums and copayments subject to aggregate cap at 5% of family income		Yes

Policy	Federal Minimum Requirement	State Option	Core Requirement(s) can be waived under Section 1115?*
Delivery System			
Fee-for-Service	Required for children with special health care needs, Medicare beneficiaries, Native Americans	Provided at state option for other groups	No
Managed Care	Not required	May require enrollment in managed care; some groups exempt (i.e., children with special health care needs, Medicare beneficiaries, Native Americans) May offer voluntary enrollment in managed care to exempt groups	N/A
Health Homes for Individuals with Chronic Conditions	Not required	Provided at state option with 90% FMAP for first 8 calendar quarters	N/A
Innovative Delivery Models	Not required	Allowed under section 1115A waiver authority with federal funding	N/A
Provider and Plan Payment			
Hospitals (inpatient and outpatient) and Nursing Facilities	No minimum payment standard other than sufficiency standard*** Subject to Upper Payment Limit Public process required	State establishes subject to Upper Payment Limit	N/A
Physicians	No minimum payment standard other than sufficiency standard*** (In 2013 and 2014, must pay 100% of Medicare rates for primary care services)	State establishes subject to sufficiency standard***	Yes
FQHCs	Must use prospective payment system	May use alternative payment methodology subject to FQHC agreement	Yes
Managed Care Organizations	Capitation rates must be actuarially sound	State establishes subject to actuarially sound requirement	Yes
Innovative Payment Models	Not required	Allowed under section 1115A waiver authority with federal funding	N/A
Long-Term Services and Supports (Selected)			
Nursing Facility services	Yes for > age 21	Amount, duration, and scope of covered Level of need to qualify for services	Yes
ICF/DD Services	Not Required	Provided at state option	N/A
Personal Care Services	Not Required	Provided at state option	N/A
Home and Community-Based Services (HCBS)	Not Required	Provided at state option for elderly or disabled <150% FPL State may obtain 1915(c) waiver to offer to elderly and/or disabled in need of institutional care	N/A
Self-directed Personal Assistance Services	Not Required	Provided at state option to elderly or disabled in need of institutional care State may target by population (e.g., elderly, disabled, etc.)	N/A
Community First Choice Option (Attendant Services and Supports)	Not Required	Effective 10/1/11 may provide at state option to elderly or disabled in need of institutional care with 6 percentage point FMAP increase State may target by population (e.g., elderly, disabled, etc.)	N/A
Rebalancing Incentive Payments for Non-institutional Services and Supports	Not Required	Effective 10/1/11, may provide at state option with 5 or 2 percentage point FMAP increase	N/A
Money Follows the Person Rebalancing Demonstration	Not Required	Provided at state option with 12-month enhanced FMAP for individuals transitioning from institution to community	N/A

*Secretary of HHS authorized to waive specified requirement as part of a demonstration if the Secretary determines the project is "likely to assist in promoting the objectives" of Medicaid.

**Although these requirements have been waived for expansion populations covered under waiver authority.

*** Payments to must be sufficient to ensure equal access by Medicaid beneficiaries to the rest of the area population.

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