

# A NEW MEDICAID

New federal law gives state officials greater latitude in shaping Medicaid reforms.

By Carl Tubbesing and Joy Johnson Wilson

The long-term spending bill that Congress approved earlier this year left the state-federal landscape marred by fiscal craters and public policy debris. The new law "unreforms" the 1996 landmark welfare reform law and shifts several billion dollars in child care, child support enforcement and child welfare costs to the states. It reduces federal funding for Medicaid by \$4.8 billion. But there is a bright spot on the horizon. The law includes the most significant legislative reforms in the Medicaid program since 1997.

Medicaid, the nation's health care program for low income individuals and families, is funded jointly by the states and the federal government. The federal government sets the Medicaid ground rules. The states administer the program and have certain latitude to determine who is eligible and what services they offer. Spending on Medicaid is second only to education in state budgets. The federal government spent \$315.2 billion in fiscal year 2005—7.6 percent of its total budget. State and federal spending on Medicaid currently is growing by 7.7 percent per year. It's no wonder that state legislators, governors and federal officials are so anxious to control Medicaid costs and to execute substantive reforms to the program.

Congress' budget reconciliation bill for 2005 was a vehicle for both. Changes in the new law, now known as the Deficit Reduction Act of 2005, will save the federal government nearly \$1 billion a year over the next five years. It also creates several new programs and alters some older ones. There are four common threads to the reforms. They afford state officials greater latitude in shaping the Medicaid program, at least in certain areas. They attempt a new direction in the country's approach to funding for long-term care. They encourage moving people from institutions, such as nursing

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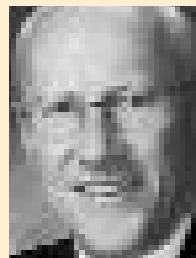


**This is the first in a series on the health care issues faced by state lawmakers. Next month the magazine looks at the uninsured and medical savings accounts.**

homes, to care that takes place in their homes and communities. And they seek efficiencies to control Medicaid spending.

## MORE FLEXIBILITY

"The new law is encouraging for state officials because it recognizes that Medicaid really is a partnership between the federal government and the states," says North Dakota Representative Ken Svedjan. "It offers us greater flexibility and emphasizes experi-



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mentation and innovation in several important areas."

North Carolina Representative Beverly Earle, who, along with Representative Svedjan, co-chairs NCSL's Medicaid task force, points out that the new law shows greater deference to the states than its predecessor. "There seem to be fewer hoops to jump through," she says. "For example, many legislators find the Medicaid waiver process to be unwieldy and wonder why a successful waiver program simply can't become permanent. In several areas, the new law dispenses with waivers and, instead, allows states to choose from among various optional approaches."

One particularly important new avenue for experimentation is in cost-sharing and benefit design. Many state officials believe that one way to control Medicaid spending is to encourage cost-sharing between the states and recipients with higher incomes. "I feel strongly," says Kansas Representative Melvin Neufeld, "that a legislature should be able to impose deductibles, co-payments or premiums on certain populations as a way of reducing the state's costs, but also to influence the kinds of health care decisions that people make." The new law grants state officials some limited authority to do that. Legislatures now can impose premiums and other cost-sharing arrangements on certain groups by simply amending their state Medicaid plan—without, that is, going through the cumbersome waiver process. They can, for example, require a payment before medical assistance is offered and they can permit providers to withhold care if the recipient does not pay the co-payment.

Under the new law, state officials also have greater flexibility in designing benefit packages for Medicaid recipients. They'll be able to tailor benefit plans to different groups—to make sure chronically ill patients have the care they need, but to provide a less costly plan for recipients who only need routine care. Borrowing a concept from the State Children's Health Insurance program, the Medicaid law lets states choose from four so-called benchmark packages—the standard Blue Cross/Blue Shield preferred provider plan for federal employees; a health benefits plan that the state offers to its employees; a plan offered by the largest health maintenance organization in the state; or coverage approved by the secretary of Health and Human Services.

## LONG TERM CARE PARTNERSHIPS

Over its 40-year history, Medicaid has become the long-term care plan for a large proportion of the country's population, and not just for those with low incomes. Because nursing home and other long-term care expenses contribute so significantly to the overall growth in Medicaid costs, the writers of the deficit reduction act singled out long-term care reforms for special attention, using a stick in one place and a carrot in another.

Their stick is to require greater scrutiny of applicants' income and assets. Their carrot is to encourage the purchase of long-term care insurance. The new law renews a long-term care partnership program, once in place but dropped in 1993, that applies different income and asset transfer rules to people who have private long-term care insurance. The partnership saves both the states and the federal government money by substituting private insurance for Medicaid. Because a key to the eventual success of the partnerships is making sure that long-term care insurance policies are portable, the act instructs the secretary of Health and Human Services to develop standards for reciprocal recognition of the policies from state to state.

## GETTING CARE AT HOME

A hallmark of the 2005 Medicaid reforms is the law's emphasis on home- and community-based care for the elderly and people with disabilities. "The law takes a rather big step toward 're-balancing' the country's approach to long-term care," says Nebraska Senator Dennis Byars. "It recognizes that nursing home care may be right for some

people, while care that takes place in the home is desirable for others."

One thing that Byars and other legislators like about the reforms is that they are options for states—that is, they can be done without waivers from the U.S. Department of Health and Human Services. Beginning next January, when this element of the law goes into effect, state legislatures will have the option of offering home and community-based services to certain people with incomes below 150 percent of the federal poverty level. The state will not have to determine that the person requires institutional care to be eligible for the services.

"This is huge," Byars says. "We'll actually be able to provide long term care to a larger number of people—in settings that are more compatible with their situations."

The new law authorizes three state demonstration programs also intended to increase the use of home and community-based care. One lets states set up a kind of voucher program for personal care services, such as assistance with bathing and dressing. Another will give states 90 percent of the first year's costs of moving someone from an institution into the community. The third, championed by U.S. Senator Charles Grassley of Iowa, will allow 10 states to develop home- and community-based services as an alternative to psychiatric residential treatment facilities for children.

## FINDING EFFICIENCIES

Because Medicaid is so costly and so complex, both its friends and critics are always on the lookout for new ways to make it more effective and less expensive. The deficit reduction act includes several innovative mechanisms for achieving efficiencies. For example, it encourages states to adopt false claims acts. Currently, when states recover funds related to Medicaid fraud, they split the recovery with the federal government at the same level as their Medicaid matching rate. (If a state's Medicaid matching rate is 52 percent, that's the percentage it gets to keep of money it recovers from Medicaid fraud.) Beginning January 2007, when this provision takes effect, a state's share of the recoveries would be 10 percentage points higher if it adopts the elements of a false claims act specified in the federal law.

The new law creates Medicaid transformation grants, which encourage states to

develop ways to improve the quality and efficiency of medical care. States will be able to use the grants in several ways. They could, for example, reduce patient error rates through the use of electronic health records or e-prescribing programs. They could improve the rates of collection from estates that owe Medicaid or start a medication risk management program. The law assigns the secretary of Health and Human Services the task of developing a mechanism for allocating the grants, giving some preference to states with the highest Medicaid growth.

Medicaid Health Opportunity Accounts, which the law creates as another demonstration program, are health savings accounts for Medicaid beneficiaries. North Dakota Representative Svedjan calls this demonstration program "truly state-friendly." The law lets the secretary of Health and Human Services approve up to 10 state demonstration programs. If the program runs successfully for five years, the state can extend it or make it permanent. In addition, other states are free to adopt any of the successful demonstration programs without going through an HHS approval process.

## A CHANCE FOR REAL REFORM

There are many state and federal officials—at all points along the political spectrum—who argue that the Medicaid program is in need of fundamental reform. The reforms set in motion by the 2005 federal deficit reduction act are not the sweeping changes for which most of them would hope. The new law addresses important issues, such as cost-sharing and long-term care, but in somewhat limited ways. It demonstrates a refreshing deference toward state experimentation and loosens some of the federal bureaucratic controls that historically have characterized the Medicaid program. It will test a number of Medicaid reform precepts and answer questions raised by numerous reform proposals offered over the past several years.

Will these reforms entice people to purchase long-term care insurance? Will the law provide a firm foundation for greater use of home- and community-based care? Will the state demonstration projects lead to ways to improve health and contain costs?

How the states' experience with the new law answers these questions almost certainly will determine the likelihood and direction of future Medicaid reforms.



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