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THE ADMINISTRATION'S MEDICAID PROPOSALS WOULD SHIFT FEDERAL COSTS TO STATES

By Andy Schneider, Leighton Ku, and Judith Solomon

In its new budget, the Administration proposes net federal Medicaid funding cuts equal to $14 billion over the next five years and $35.5 billion over ten years through a combination of legislative changes and regulatory action.[1] These reductions follow on the heels of significant federal Medicaid cuts ($4.9 billion over five years and $26.5 billion over ten years) enacted as part of the budget reconciliation bill signed into law on February 8.

More than four-fifths of the Medicaid savings proposals in the Administration's new budget would reduce federal Medicaid expenditures by shifting costs directly from the federal government to the states. These cost shifts are consistent with a broader theme in the new budget of squeezing grants in aid to states.[2] If implemented, the Administration's Medicaid proposals would leave states the option of cutting back their Medicaid programs (by reducing eligibility, benefits, or provider payments), cutting back other state programs, or increasing taxes to make up for the loss of federal funds. In states that opt to cut back on their Medicaid programs, low-income families, individuals with disabilities, and seniors would be at risk.

How Would the Administration's Proposals Reduce Net Federal Expenditures by $35 Billion Over Ten Years?

The budget contains both legislative and regulatory proposals affecting Medicaid. The budget shows that its proposed legislative changes include both federal spending reductions ($11.9 billion over ten years) and federal spending increases ($6.8 billion). Overall, the legislative proposals would reduce net federal Medicaid expenditures by $5.1 billion over the next ten years (Figure 1). These proposals would require Congressional approval. (More detailed listings of all the budget proposals and the Administration's estimates of their budget effects over both five years and ten years are presented in Table 1 on page 6.)

The Administration's budget also includes proposals for regulatory actions that would reduce federal Medicaid expenditures by $30.4 billion over the next ten years, about six times the net federal

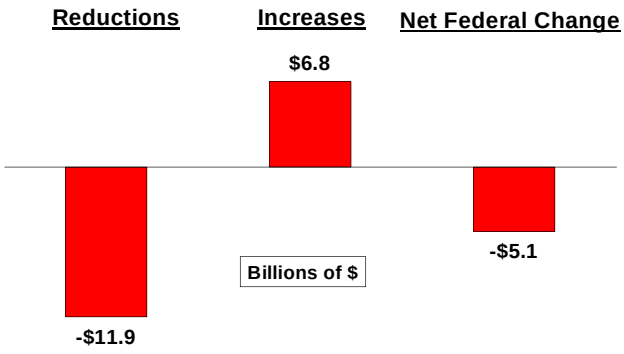
[1] The Administration's budget also proposes changes to the SCHIP program, which are not discussed in this analysis.

[2] Iris Lav, "Federal Grants to States and Localities Cut Deeply in Fiscal Year 2007 Federal Budget," Center on Budget and Policy Priorities, February 7, 2006.

savings proposed through legislation (Figure 2). Although the Administration in last year's budget advanced without success several similar proposals as legislative initiatives, it appears to believe that it has sufficient statutory authority to take these actions administratively. Regulatory proposals do not require Congressional approval.

FIGURE 1

President's Medicaid Proposals FY 2007-16: Legislative Increases and Reductions



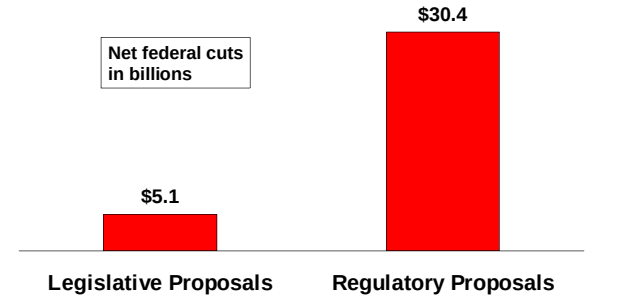
Source: CMS Briefing Document on President's FY 2007 Medicaid Proposals

The Administration's $5.1 billion in net legislative savings, coupled with the $30.4 billion in regulatory reductions, would achieve a total reduction in federal Medicaid expenditures of $35.5 billion over the next ten years. This is about one-third larger than the amount of net federal Medicaid reductions included in the just-enacted budget reconciliation law.

Medicaid is administered and financed jointly by the federal government and the states, with the federal government matching from 50 percent to 76 percent (depending on the state) of the costs that states incur in purchasing health and long-term care services for eligible low-income people. Under this federal-state matching arrangement, there are two ways that the federal government can reduce its Medicaid expenditures. It can achieve efficiencies in the purchasing of needed services for Medicaid beneficiaries. An example of this approach — which reduces *both* federal and state costs — is to increase the rebates that drug manufacturers are required to pay Medicaid for the prescriptions that Medicaid covers, a measure the Senate included in its version of the budget reconciliation bill last fall but that was largely removed in conference. The federal government also can reduce its expenditures by limiting the state Medicaid expenditures that it is willing to match, thereby shifting costs to state budgets (rather than reducing those costs). At least four-fifths of the Administration's new Medicaid budget-reduction proposals would achieve federal savings by shifting costs directly from the federal government to the states.

FIGURE 2

President's Medicaid Proposals FY 2007-16: Legislative vs. Regulatory Proposals



Source: CMS Briefing Document on President's FY 2007 Medicaid Proposals

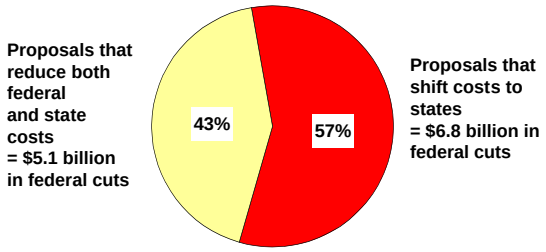
What Legislative Reductions Does the Administration's Medicaid Budget Propose?

The Administration proposes five Medicaid legislative changes that would produce federal savings. (This analysis discusses only those legislative proposals that have a budgetary effect; it does not address proposals with no budget impact.) Two of the proposed changes, which account for more than $6.8 billion in federal savings (or 57 percent of the total legislative savings), represent pure cost shifts (see Figure 3). Under these proposals, the federal government would bear a smaller share of

certain costs that states incur in operating their Medicaid programs. Both have been advanced in recent years without success.

FIGURE 3

President's Medicaid Proposals FY 2007-16: Legislative Proposals Shift Federal Costs to States



Source: CMS Briefing Document on President's FY 2007 Medicaid Proposals

- The Administration proposes to reduce the federal matching rate for the cost of targeted case management services, from the current matching rate that applies to each state — and exceeds 50 percent in 39 states — to a flat 50 percent. Targeted case management services help specific groups of Medicaid beneficiaries, such as low-income pregnant women, access health care and other needed services. This proposal would affect all states with federal matching rates above 50 percent that have opted to cover targeted case management services. The federal savings are estimated at $3.7 billion over ten years.

- The Administration also would reduce federal Medicaid matching payments to 46 states [3] that have historically pooled the administrative costs of making eligibility determinations for families and children receiving Medicaid, AFDC, and Food Stamps. This proposal, technically known as "cost allocation," effectively reduces the federal matching rate for state administrative costs related to Medicaid eligibility determinations. The federal savings from this proposal, too are estimated at $3.1 billion over ten years.

The remaining 43 percent of the Administration's legislative savings, or $5.1 billion over ten years, are from proposals that would reduce Medicaid spending in such a way that the savings would accrue to both the federal and state governments.

- The Administration proposes to limit Medicaid payments to pharmacists for multiple source drugs (those with three or more manufacturers) to 150 percent of the "average manufacturer price" of the drug. Under the recently enacted budget reconciliation law, the reimbursement limit for such drugs is 250 percent of the average manufacturer price. Federal savings from lowered spending on prescription drugs are estimated at $3.4 billion over ten years; corresponding state savings would be about $2.6 billion.

- Under current law, states must pay provider claims for furnishing prenatal or pediatric care when a third party (e.g., a private insurer) is responsible, then recover the amount paid from the liable party. The Administration would require that states first have providers seek payment directly from the third parties before billing Medicaid. The budget also would lengthen the time period that providers must wait for payment after billing for health care costs from coverage that a non-custodial parent is required to provide for a Medicaid beneficiary, before seeking payment from Medicaid. Federal savings from this proposal, which would result from increased payments from responsible third parties, are estimated at $1.2 billion over ten years.

[3] Vic Miller, "House TANF Bill Includes Possible Medicaid Cost Allocation Offset," Federal Funds Information for States, Issue Brief 05-13, March 24, 2005.

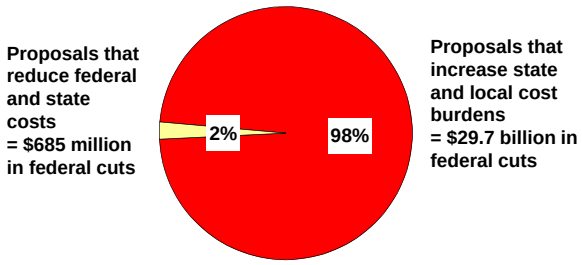
Corresponding state savings would be a little less than $900 million.

- The Administration would give states new authority to establish more restrictive formularies for prescription drugs. According to the Administration, this authority will enable states to use "private sector management techniques to leverage greater discounts through negotiations with drug manufacturers." Federal savings from reduced spending on prescription drugs are estimated at $469 million; corresponding state savings would be $354 million.

What Regulatory Reductions Does the Administration's Medicaid Budget Propose?

FIGURE 4

President's Medicaid Proposals FY 2007-16: Regulatory Proposals Shift Federal Costs to States



Source: CMS Briefing Document on President's FY 2007 Medicaid Proposals

The Administration's budget proposes to reduce federal Medicaid spending by an additional $30.4 billion over the next ten years through administrative action, including issuance of regulations. That is more than double the gross federal savings that the Administration has proposed that the Congress enact over the same period ($11.9 billion). As in the case of its proposed legislative savings, most of the Administration's regulatory changes — some 98 percent of them — represent shifts of costs from the federal government to the states. (Figure 4). Last year's Administration budget advanced as legislative proposals policy changes that are similar to several of the proposals that this year's budget defines as administrative (e.g., capping payments to government providers, limiting provider taxes).

Like the legislative proposals relating to payment for prescription drugs, the proposed regulatory change related to prescription drugs prices would yield savings to both the federal government and states. Under the Administration's regulatory proposal, if a third party (e.g., an insurer) is liable for the cost of a prescription furnished to a Medicaid beneficiary, states would be prohibited from paying the pharmacist and then seeking recovery from the third party. Instead, the pharmacist would be expected to bill the third party. Because the third parties would be more likely to pay the cost of the prescriptions, Medicaid spending would decline, generating savings estimated at $685 million for the federal government and $517 million for states. These federal savings, however, represent only 2 percent of the estimated $30.4 billion in federal savings over ten years that the Administration proposes to achieve through regulatory actions.

The remaining 98 percent of the Administration's federal regulatory savings would come from four proposed changes:

- The Administration's budget proposes to limit Medicaid payments to hospitals (and some other health care institutions that are operated by local or state governments. Medicaid payments to these institutions) would be strictly limited to the cost of furnishing services to Medicaid

beneficiaries; the costs of serving uninsured patients would be excluded. The federal government would "recover" any federal Medicaid funds provided to states for costs incurred by such hospitals or other institutions for expenses other than the costs of providing Medicaid-covered services to Medicaid patients. This would reduce federal Medicaid payments to state and local hospitals and other state and local providers. The Administration estimates the federal savings at $9 billion over ten years. State and local governments generally would continue to incur these costs but would no longer receive the federal matching funds.

- Under current law, Medicaid pays for the cost of covered services for eligible children with disabilities that are part of a child's special education plan under the Individuals with Disabilities Education Act (IDEA). State and local school districts also can be reimbursed by Medicaid for administrative and transportation costs they incur in providing these services. The Administration's budget would prohibit Medicaid reimbursement for these administrative and transportation costs. That would reduce federal Medicaid payments to state and local school districts by an estimated $9.1 billion over ten years, shifting those costs to states and local school authorities.

- The Administration's budget proposes to limit the types of services that states can cover with federal matching funds under the current state Medicaid option to cover rehabilitation services. Under this proposal, states would lose federal matching funds for the costs of certain services for which matching funds are currently allowed, such as special instruction and therapy for Medicaid beneficiaries with mental illness or developmental disabilities. Here, also, there would be no state savings. The federal government would reduce its Medicaid costs by an estimated $6.1 billion over ten years by shifting those costs to states.

- Finally, under current law, states may raise revenues to pay for their share of Medicaid costs by imposing taxes on hospitals, nursing facilities, and other classes of providers. These taxes must meet certain federal requirements, including a limit of 6 percent of gross provider revenues. The Administration proposes to reduce this limit to 3 percent of gross revenues, thereby reducing the amount of revenue a state is able to collect by imposing such a tax. This proposal would reduce the state revenues that qualify for federal Medicaid matching funds, yielding federal savings estimated at $5.5 billion over ten years. It would produce no state savings and represents another shift in costs from the federal government to the states.

What Legislative Initiatives Does the Administration's Medicaid Budget Propose?

The Administration's Medicaid budget does not contain any regulatory initiatives that would increase federal Medicaid outlays. It does propose four legislative initiatives that would increase federal Medicaid expenditures by an estimated $6.8 billion over ten years (Table 1). Three-fourths of these new costs reflect three proposals. These proposals also would increase state costs, with the added state share expenditures totaling an estimated $4.1 billion over ten years.

- The Administration attributes the largest share of these new expenditures — nearly $5 billion over ten years — to increases in Medicaid enrollment by eligible but unenrolled children, as the result of state and private outreach efforts that would be funded by proposed federal grants of $100 million a year. The Administration's estimate implies, however, that states would spend

TABLE 1

Estimates of FY 2007 Medicaid Budget and Regulatory Proposals on Federal Expenditures
(in millions of dollars)

Budget Proposals Lowering Federal *and* State Expenditures	**FY 2007-11**	**FY 2007-16**
Legislative		
Reduce payments to pharmacists	-$1,285	-$3,415
Increase third party collections	-525	-1,175
More restrictive drug formularies	-177	-469
Subtotal, legislative	*-1,987*	*-5,059*
Regulatory		
Increase third party collections for pharmacy	-430	-685
Subtotal, regulatory	*-430*	*-685*
Subtotal, legislative & regulatory	*-2,417*	*-5,744*
Budget Proposals That Lower Federal Funding to States Without Reducing Medicaid Costs and Thereby Shift Costs to States*		
Legislative		
Reduce funds for administrative expenses	-1,770	-3,720
Lower targeted case management match to 50%	-1,187	-3,079
Subtotal, legislative	*-2,957*	*-6,799*
Regulatory		
Limit payments to government providers to cost	-3,812	-9,006
Reduce payments for school-based services	-3,645	-9,050
Limit payments for rehabilitation services	-2,286	-6,148
Provider tax phase down from 6% to 3%	-2,070	-5,520
Subtotal, regulatory	*-11,813*	*-29,724*
Subtotal, legislative & regulatory	*-14,770*	*-36,523*
Extensions and New Initiatives		
*Legislative***		
Medicaid impact of outreach initiative	1,978	4,903
Vaccines for Children	700	1,400
Extend transitional Medicaid through Sept. 30, 2007.	360	360
Medicaid impact of extending SSI for refugees	134	134
Subtotal, legislative (no regulatory)	*3,172*	*6,797*
Total, legislative	*-1,772*	*-5,061*
Total, regulatory	*-12,243*	*-30,409*
Grand Total, legislative and regulatory	***-14,015***	***-35,470***

* These policies reduce federal payments to states or local governments. State or local governments may respond by reducing Medicaid or state/local expenditures or increasing taxes to compensate.
** This does not include estimates for SCHIP or child outreach grants or for proposals with no budgetary impact.
Source: CMS briefing document, "Medicaid and SCHIP: FY 2007 President's Budget Proposals"

Administration's Budget Would Shift Costs to States at the Same Time Many States Are Bearing Unexpected Costs from Problems in Implementation of the Medicare Prescription Drug Benefit

On January 1, 2006, more than six million low-income Medicaid beneficiaries who also are enrolled in Medicare stopped receiving their prescription drugs through Medicaid. These low-income seniors and people with disabilities, including over 1.6 million who reside in nursing homes, now receive their prescription drugs through private Medicare prescription drug plans.

In a substantial number of cases, Medicare beneficiaries have been unable to obtain needed medications because of widespread problems with implementation of the new Medicare prescription drug program. Over half of the states are using their own funds to ensure that prescriptions are filled for these individuals, at significant cost to these states.* For example, in California, the legislature has allocated $150 million from the state's general fund to provide prescription drugs to seniors and people with disabilities unable to get their drugs through Medicare.

The Centers for Medicare & Medicaid Services (CMS), which is responsible for administering the new Medicare prescription drug benefit as well as Medicaid, has announced a demonstration waiver program to reimburse these states,** but the Administration's budget does not request funding for this initiative. In addition, the waiver initiative lasts only until February 15, 2006. It is unlikely that the Medicare drug program's implementation problems will be resolved by then, leaving states with the costs of filling prescriptions for dually eligible Medicare beneficiaries who continue to fall through the cracks.

* "State Medicare Part D Transitional and Emergency Coverage," National Council of State Legislatures, updated February 2, 2006, www.ncsl.org/programs/health/PartDPatch.htm.

** Centers for Medicare and Medicaid Services, State Medicaid Letter #006-001, February 2, 2006.

$3.7 billion of their own funds over this period to finance their share of the costs of covering the newly enrolled children in Medicaid. Given the various cost-shifting proposals the Administration is making, it is questionable whether states would agree to mount outreach efforts that would cause them to incur these added costs.

- Under current law, families leaving welfare for work retain Medicaid eligibility for up to 12 months. This transitional medical assistance (TMA), which was enacted under President Ronald Reagan and is designed to provide an essential work support as families leave welfare for employment, is slated to expire on December 31, 2006. The Administration proposes to extend this requirement an additional nine months, through September 30, 2007, at a cost to the federal government of $360 million over ten years. The cost to states would be $272 million.

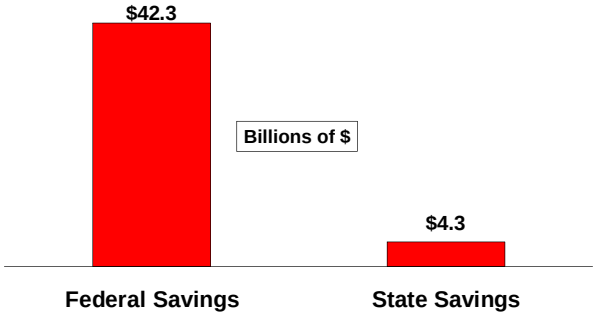
- Under current law, refugees and asylees who are elderly or disabled are permitted to receive Supplemental Security Income (SSI) and the Medicaid benefits that flow from SSI eligibility during their first seven years in the United States. After this point, they lose SSI and Medicaid benefits unless they become citizens. The Administration proposes to allow these individuals to remain eligible for SSI for eight years, a change that would be in effect through fiscal year 2009. The federal Medicaid cost of this proposal would be $134 million; the cost to states would be $101 million.

What Do the Administration's Medicaid Budget Proposals Mean for Beneficiaries?

Although states are no longer in fiscal crisis and revenues have again begun to grow, states with few exceptions are continuing to experience difficulty in financing their share of Medicaid program costs. These cost problems have been exacerbated by the new costs imposed on states by implementation of the Medicare prescription drug benefit, which the Administration's budget does not address (see box on page 7). The Administration's Medicaid budget proposals are structured largely to reduce federal expenditures. As shown in Figure 5, the projected federal savings achieved by the Administration's savings proposals (excluding the new initiatives and extensions) are nearly ten times the estimated state savings from those few proposals that would yield some state savings. Furthermore, the amount of costs shifted to states would swamp the modest savings that states would achieve. As a result, the Administration's proposals would significantly intensify the fiscal pressures on state Medicaid programs.

FIGURE 5

President's Medicaid Proposals FY 2007-16: Impact of Savings Proposals on Federal and State Spending



Source: CBPP analysis of CMS Briefing Document on President's FY 2007 Medicaid Proposals

Large federal cost shifts of the magnitude that the Administration's proposals entail cannot be addressed by states through greater program efficiencies such as reducing fraud and abuse; the amounts involved are much too large. Instead, states would have three basic options for reducing their Medicaid costs by substantial amounts: limit eligibility (thereby denying insurance coverage to various people who are both low-income and uninsured), reduce benefits (thereby denying coverage to low-income beneficiaries for certain health care services, or requiring the beneficiaries to pay more themselves for the services), or reduce payment rates to providers. Faced with fiscal pressure from federal cost-shifting, many states would likely turn to the new flexibility they have just been accorded in the recently-enacted budget reconciliation law to scale back benefits and increase copayments and premium charges imposed on beneficiaries.[4] States that take this route would, in turn, effectively shift costs from their budgets to low-income beneficiaries and their families.

[4] Georgetown University Center for Children and Families, "Children's Health on the Line: Major Child Health Issues in the Budget Conference Agreement," Jan. 30, 2006. http://ccf.georgetown.edu/pdfs/reconbrief013006.pdf