

Medicaid and Health

Current Program

The Medicaid program, created by Congress in 1965, was designed primarily to provide health care coverage to people who qualified for cash assistance. Over nearly 40 years, Medicaid has grown to cover millions of families and individuals who are elderly and disabled. Today, Medicaid is the country's major public health program for low-income Americans, financing health and long-term care services for more than 50 million people. Specifically, Medicaid is a source of health insurance for 38 million low-income children and parents; it is also an essential source of acute and long-term care coverage for 12 million individuals who are elderly and disabled, including more than 6 million low-income Medicare beneficiaries ("dual eligibles"). The cost to the federal government, states, and territories for Medicaid was more than \$300 billion in fiscal year 2004, making Medicaid the largest funding source for medical and health-related services for America's low-income population.

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In recent years, Medicaid has become the largest and fastest growing component of state spending. In fact, Medicaid expenditures currently represent approximately 22 percent of all state spending nationwide. Although the benefits and eligibility rules vary from state to state, the Medicaid program is vital for children living close to the poverty line and for millions of low-income elderly and individuals with disabilities who need access to long-term care and prescription drugs.

Although Medicare is known as the health insurance program for the elderly and individuals with disabilities, it is actually the Medicaid program that covers the majority of seniors' long-term care costs. Medicaid has become the single largest source of funding for long-term care, including home health and nursing home services. Due to their complex medical conditions and often fragile health, dual eligibles (those individuals eligible for both Medicare and Medicaid) account for a disproportionately large share of all Medicaid costs. A significant portion of these dual-eligible beneficiaries reside in nursing homes. According to the Centers for Medicare and Medicaid Services (CMS), Medicaid pays for 50 percent of all nursing home care costs in the United States, which represents more than \$90 billion in 2004.

The last 25 years have witnessed a tremendous rise in the use of pharmaceuticals for the treatment of a variety of illnesses. When legislation enacting Medicare and Medicaid was first passed in 1965, there was little consideration of the costs of prescription drugs, since at that time they were mostly used on a limited basis for relatively short periods of time—such as antibiotic treatments for bacterial

respiratory infections. Today that has changed. The rate of spending on pharmaceuticals has grown exponentially. In 1990, drug expenditures nationwide were approximately \$45 billion. In 2002, this figure ballooned to \$140.6 billion. According to data from CMS, overall drug spending is expected to reach as high as \$519.8 billion by 2013.¹

In December 2003, the Medicare Modernization Act of 2003 (MMA) was enacted, which added an outpatient prescription drug benefit to the Medicare program. This law will be fully implemented

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with the advent of the new prescription drug program beginning on January 1, 2006. Final MMA regulations, issued on January 21, 2005, require that state Medicaid programs have an independent process in place for determining beneficiary eligibility for the low-income subsidy. Also, states will be required to perform ongoing eligibility and appeals functions for low-income clients who request them to do so. States have been working with CMS and the Social Security Administration (SSA) to determine the scope of the administrative costs and requirements associated with MMA; initial indications are

that the costs will be substantial. Implementation of MMA requires that state Medicaid agencies work closely with CMS and SSA. While federal agencies received \$1.5 billion for the cost associated with implementation, states received no enhanced funding.

States have long argued that the federal government ought to assume responsibility for the costs associated with the dual-eligible population. However, MMA did not contain such a change. Instead, the federal government will assume a share of the pharmaceutical needs of the dual-eligible population in the new Part D drug benefit. States will be required to continue to pay significant costs for pharmacy benefits for dual-eligible beneficiaries under the phased-down state contribution or “clawback.” States will pay 90 percent of adjusted costs for 2006, phasing down to 75 percent in 2014.

The MMA’s phased-down state contribution provision, instead of providing states with expenditure relief, may actually increase states’ prescription drug spending for dual eligibles, particularly in the initial years of the benefit. In CMS’ regulatory analysis in the MMA final rule, CMS estimates (which potentially underestimate states’ obligations) indicate that states will face an additional \$100 million in MMA’s first year—an average of about \$2 million per state. These costs will come at a time when Medicaid spending is already straining state budgets and when proposals have been made to limit states’ flexibility to finance their share of Medicaid spending. CMS’ analysis of the effect on state spending estimated that all states’ calendar year 2006 MMA-related spending, including the phased-down state contribution, will total \$10.7 billion. This spending would rise to \$15.4 billion by 2010, even with state obligations phasing down over this period from 90 percent. By 2010, CMS estimates that states will have repaid aggregate clawback and other MMA costs of \$64.8 billion.² Federal spending for that five-year period is estimated to exceed \$292 billion.

The Balanced Budget Act of 1997 (P.L. 105-33) created the State Children’s Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. This new program enabled states to initiate and expand health insurance coverage for uninsured low-income children. SCHIP benefits became available on October 1, 1997, and provided \$40 billion in federal matching funds over 10

¹ *National Health Expenditures, Aggregate and Per-Capita Amounts for Selected Calendar Years*, Centers for Medicare and Medicaid Services, Office of the Actuary, 2004.

² *Federal Register*, Vol. 70, No. 18, January 28, 2005, Regulatory Impact Statement, Table 4-3. Estimated Net Federal Budgetary Effects of Medicare and Medicaid Benefit Spending, CY 2006–2010.

years. This federal support, at a higher matching rate than for Medicaid, helps states expand health care coverage to children whose family income is less than 200 percent of the federal poverty level (FPL). The SCHIP expansions are financed through the state's traditional Medicaid program or through separate, stand-alone SCHIP plans. The introduction of SCHIP in 1997 presented states with an opportunity to extend health care coverage to greater numbers of low-income children. States welcomed the flexibility that has allowed them to employ a variety of approaches for providing children with health insurance. States that started their state Medicaid program at a higher FPL percentage do not receive an enhanced Title XXI match. The current Title XXI statute effectively bars a significant segment of income-eligible children from SCHIP participation—the children of state and local employees. Title XXI also limits to 10 percent the amount of the state's annual SCHIP spending for administrative expenses, outreach activities, and special health initiatives. SCHIP is widely considered to be a success; since 1998 enrollment has increased rapidly, growing from 898,000 to more than 3.9 million by December 2003.³

The CMS developed special waivers and demonstrations so that more uninsured children and families would be able to obtain health insurance coverage. The Health Insurance Flexibility and Accountability (HIFA) initiative, announced on August 4, 2001, by the U.S. Department of Health and Human Services (HHS), was developed as a Medicaid/SCHIP waiver under Section 1115 of the Social Security Act. The primary goal of the HIFA demonstration initiative is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. Particular emphasis is placed on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with incomes below 200 percent of FPL. Although the HIFA waivers provide some degree of flexibility, states would like more flexibility in using HIFA waivers to allow the uninsured to buy into Medicaid or SCHIP.

Challenges

States report that as their revenue begins to recover from the recent recession, demands for Medicaid spending are outstripping those gains. Over the years, states have implemented a variety of policy and program changes to control the rising costs of the program, such as managed care, preferred drug lists, and pooled purchasing agreements. Also, states have historically administered Medicaid very cost effectively; per-capita Medicaid beneficiary acute care costs have increased between 2000 and 2003 an average of 6.4 percent, a much lower rate of increase than employer-sponsored health insurance, which posted average gains of 12.6 percent. In addition, with administrative costs in the 4 to 6 percent range of paid claims, Medicaid has consistently out-performed the private sector, where administrative costs for indemnity health insurers can be four times higher and health maintenance organizations' costs average 10 to 12 percent higher. Yet, Medicaid finds itself under renewed attack to control spending and growth, and to do it with even fewer federal resources. Over the past several years, the federal government has increased its focus on state administration of the Medicaid program. Approvals of Medicaid State Plan Amendments (SPAs) have been delayed; audits have increased; and new Payment Error Rate Measurement (PERM) systems for state Medicaid and SCHIP programs have been proposed. New unfunded mandates, such as implementation of the Medicare Part D benefit and the Health Insurance Portability and Accountability Act (HIPAA), have also imposed new financial burdens.

³ Vern Smith, David Rousseau, and Molly O'Malley, *SCHIP Program Enrollment: December 2003 Update*, Kaiser Commission on Medicaid and the Uninsured, 2004.

New proposals call for states to receive Medicaid administrative “allotments,” which would replace the current open-ended federal match states receive for administrative expenses. This proposal accompanies new administrative mandates, such as eligibility determination for Part D and the potential for many new Medicaid-eligible beneficiaries being identified by Part D outreach and enrollment. These proposed caps on states’ administrative expenditures could undermine or jeopardize states’ vigorous cost-control initiatives, including Medicaid Management Information Systems (MMIS) investments, disease management, managed care, and an array of home- and community-based service program innovations. Capping states’ administrative expenditures would seriously affect state MMIS expenditures. MMIS costs are currently matched at the 90 percent federal/10 percent state ratio, and many states would be unable to bear increased costs for these longer-term costs. MMIS improvements are important sources of continued administrative savings and innovation. As many as 24 states are actively engaged in MMIS procurements, which may hold the most promise for improved administration, dramatic cost reductions, and better medical care management.

Medicaid administrative caps are only one of the measures proposed to limit states’ ability to fund Medicaid and care for some of the nations’ most needy citizens. Other proposals threaten to further ratchet down state use of legitimate revenue sources, such as the phase-down of the Safe Harbor Tax; reform of the managed care tax; and cost-based reimbursement for public providers. Although states support all federal efforts to address abusive inter-governmental transfers and other illegitimate funding mechanisms to leverage or recycle federal matching funds, they are concerned by what appears to be a concerted effort to pare back legitimate funding mechanisms. For instance, a recent proposal to reduce (phase-down) the Safe Harbor Tax from 6 percent to 3 percent would further reduce states’ legitimate Medicaid matching sources. Under the Safe Harbor Tax, states are permitted to tax health

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care providers up to 6 percent of gross revenue provided the tax is applied uniformly to all providers in the same class. As the name implies, this tax was considered an appropriate and sanctioned Medicaid funding approach. Phasing down this tax while imposing administrative caps will be a double blow to state Medicaid programs that will force states to reduce services for people who already have no alternative sources of care.

Moreover, other proposals further restrict states’ access to Medicaid funding sources, potentially limiting funding for legitimate as well as illegitimate users. One proposal targets the use of a tax on managed care organizations (MCOs) that under current rules can be applied non-uniformly to MCO Medicaid business, excluding non-Medicaid business. The proposal would require that the MCO tax be applied to all providers, effectively eliminating it as a legitimate source of state

matching funds (taxing non-Medicaid MCOs would exacerbate already rapidly rising premiums and likely add to beneficiaries’ cost-sharing obligations, an undesirable outcome). In addition, yet another proposal would restrict state payments to government providers (facilities) to cost-based reimbursement. Upper payment limit (UPL) regulations are in place already to assure that states do not “recycle” provider payments to extract greater federal matching funds. This proposal will further limit states’ ability to provide appropriate matching funds.

States cannot continue to shoulder the annual increases in the Medicaid program. The aging of the U.S. population will exacerbate future fiscal pressures. In six years, the 77 million Americans in the baby boom generation will begin to turn 65. About one in six Americans (17 percent) who reach age

65 will eventually need some type of long-term care service. Fundamental change is necessary and new ways to manage the Medicaid and Medicare programs should be aggressively explored.

Recommendations

MEDICAID FINANCING ISSUES

PROPOSAL

Congress should reject proposals to reduce the federal share of Medicaid funding. Additional state flexibility in administering the program could help alleviate the potential rapid rise in state Medicaid costs.

EXPLANATION

As noted earlier, the majority of Medicaid program costs are spent on a minority of program eligibles—individuals who are elderly and disabled. Given demographic changes, rising pharmacy and long-term care demand and costs, a federal cap on Medicaid expenditures should be rejected.

Congress should work with states to develop program efficiencies and other policies that can save money for both state and federal governments, rather than shifting costs to states through budget cuts, caps, or other mechanisms.

As the National Governors Association has noted, “the Medicaid program is growing rapidly because health care inflation is running two to three times the general inflation rate and the caseload has grown 33 percent over the last four years...Governors have little control over these two cost drivers, and do not want to be in the position of having to choose between funding health care programs for grandparents or programs for their grandchildren. The Medicaid program needs to be rethought and reformed. It needs to redefine the federal-state role in a way that makes the states’ financial commitment sustainable over the long-run.”

Many states are far from able to meet their current Medicaid obligations without additional service demands and rising medical costs. These state programs already face deep service cuts, and further funding restrictions or limits will devastate these programs.

PROPOSAL

Provide states with clear guidance on appropriate Medicaid financing approaches and support states’ existing provider taxing mechanisms at current rates, including the Safe Harbor Tax and managed care provider taxes.

EXPLANATION

Although state economies are recovering, national economic growth is uneven and many states have seen limited revenue growth. Many states are far from able to meet their current Medicaid obligations without additional service demands and rising medical costs. These state programs already face deep service cuts, and further funding restrictions or limits will devastate these programs. Reforming and eliminating states’ Medicaid financing options will handicap states’ means to match federal shares at a time when states are already struggling. Recent proposals to restrict public providers to cost-based

reimbursement would affect states that are compliant with UPL regulations as well as those states that might have “recycling” arrangements in place. CMS has been effective in using the SPA approval and state budget review processes to monitor state UPL approaches without the use of the proposals to limit public facilities to cost-based reimbursement. Similarly, proposals to phase-down over three years the Safe Harbor Tax from the currently allowed 6 percent to 3 percent would further limit the ability of some states to receive Medicaid matching funds from the Safe Harbor Tax.

Proposals to bring MCOs under the same requirements as other providers also would adversely affect some states’ ability to match federal contributions. This proposal also seems to contradict some initiatives to encourage states and Medicare beneficiaries to adopt managed care as a cost-effective service delivery approach. Under the MCO tax, states were granted an exception to the uniformity requirement under provider taxes so that some states with large managed care participation (waivers) could help to raise Medicaid matching funds. The MCO-tax states have been able to expand coverage and eligibility for low-income, but optional, populations. Without the ability to differentially tax MCOs’ Medicaid business units, states will lose this revenue source, thus forcing them to find other revenue sources. In addition, states facing large Medicaid shortfalls and contemplating a MCO tax would have to reconsider their plans. In either case, some of the most aggressive and innovative state Medicaid programs will be forced to reduce coverage or significantly pare eligibility. Now that this funding mechanism has been established to encourage states to accept managed care, it seems contradictory to rescind the exemption and jeopardize managed care states’ programs.

PROPOSAL

Explore implementation of a new prescription drug payment mechanism.

EXPLANATION

Under current law, the state formula uses the average wholesale price (AWP) as a major factor in setting reimbursement. A December 2004 Congressional Budget Office (CBO) report indicates that using AWP has resulted in substantially inflated pharmaceutical reimbursement costs for both states and the federal government. In essence, this proposal would parallel the reimbursement approaches codified in the MMA, Section 303. If enacted, this proposal could lead to substantial savings for both the federal and state governments.

PROPOSAL

Preserve targeted case management (TCM) as a means to connect vulnerable populations to needed medical, social, educational, and other services.

1. Oppose any proposal lowering the federal matching rate for TCM services.
2. Oppose any prohibition on particular populations that can be targeted for receiving TCM services.

EXPLANATION

The TCM target population groups in many states include some of the most vulnerable citizens—including those who are mentally ill, abused and neglected, seriously emotionally disturbed, sensory impaired, with HIV/AIDS, and addicted to alcohol and other drugs. The case management services these vulnerable individuals require are much more specialized. Therefore, reimbursement for services to these groups at the regular Federal Medical Assistance Percentage (FMAP) rate is consistent with the higher level of care required to meet their needs.

According to the federal statute that allows TCM, targeting may be done based on age, type, or degree of disability; illness or condition; or any other identifiable characteristic or combination thereof. This broad range of possible populations that can be targeted is necessary to cover the different types of vulnerable individuals that may require TCM services. Historically, states have been appropriately applying TCM services to targeted groups approved by CMS through state plan amendments.

PROPOSAL

Coordinate Medicare- and Medicaid-funded services.

EXPLANATION

The passage of MMA and the issuance of the final rule implementing the law have resulted in the federal government funding outpatient prescription drugs for the first time. However, Medicaid will continue to be the primary payer of services for the dual eligibles, including their long-term care needs. States will continue to pay 90 percent, phasing down to 75 percent over 10 years, of prescription drug costs for dual eligibles under the MMA phased-down state contribution system. Because of the joint role of Medicaid and Medicare in funding care for the dual eligibles, these two programs are inextricably linked. As the new Medicare Part D program is implemented, it is important for the federal government to receive input on implementation from state Medicaid administrators.

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Although Medicare will be funding a portion of the prescription drug costs for the dual-eligible population, Medicaid will still be responsible for funding the majority of their long-term care costs. The federal government can enhance opportunities for states to manage these long-term care costs. The lack of coordination between Medicare and Medicaid contributes to fragmentation of acute and long-term care. Individuals in long-term care settings generally have many acute care needs as well. This lack of coordination can lead to preventable hospitalizations and higher costs for both Medicare and Medicaid. Over the past decade, several states have been granted federal waivers to test models linking acute care and chronic care benefits into a single management structure for persons eligible for both programs.

The coordination of Medicare and Medicaid can lead to better, integrated care for dual-eligible beneficiaries and to cost savings to the federal government and states. APHSA suggests the following approaches:

1. The federal government should support state waiver proposals to integrate care for persons eligible for both Medicaid and Medicare. In computing the budget neutrality of such waivers, the federal government should recognize the potential cost savings not only for Medicaid, but also for Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI). Assessing cost neutrality based only on Medicaid expenditures does not provide an objective assessment of the success of waiver programs of all types in achieving cost savings. A more objective assessment of cost neutrality could also result in greater innovation among the states in creating new programs.

2. Current law requires a two-year waiting period for individuals with disabilities to become eligible for Medicare. The two-year period begins once SSA makes the determination that the individual is eligible. APHSA recommends phasing out the two-year waiting period for persons with disabilities and those with life-threatening illnesses to become eligible for Medicare.

PROPOSAL

Oppose any proposals to reduce federal reimbursement for Medicaid administration, such as an allotment or cap on state administrative expenditures. In addition, oppose proposals to reduce annual reimbursement for Medicaid administrative expenditures by the amount states received in their TANF block grant allotments.

EXPLANATION

Proposals to end or reduce the federal match for Medicaid administrative costs would dramatically impede states' ability to manage the program, comply with federal mandates, and deliver services to those enrolled in the program. The administrative claiming or "expenditure allotment" proposal would threaten many initiatives that could help save Medicaid (both state and federal shares) billions of dollars. Many of these initiatives, such as MMIS system redesigns and updates, would provide states with substantial new tools to better manage their programs and better coordinate medical care and other services. Although the administrative claiming proposal would appear to continue matching MMIS expenditures at the 90 percent federal rate, states' allotments might quickly be exhausted by these large investments. With nearly half of states in the process of implementing large-scale system redesigns in the next two years, an administrative allotment or cap could quickly block these important investments or force states to choose between providing services for critically ill beneficiaries or investing in innovations to ensure the program's future viability. Also, states would not have access to the resources necessary to comply with the federal mandate to enroll millions of low-income elderly into the new Medicare Part D benefit due to take effect in January 2006.

APPROACHES TO ACHIEVING PROGRAM EFFICIENCIES

PROPOSAL

There is growing consensus that achieving enhanced program efficiencies in Medicaid could produce both federal and state cost savings. These efficiencies could potentially be realized through changes to benefit design; better program management; and adjustments in prescription drug purchasing, an important cost driver for Medicaid over the last several years.

EXPLANATION

One major area in which states could make changes to address rapidly rising Medicaid costs is through changes to the currently mandated benefits package. For example, states could use limited resources more efficiently if they are granted additional latitude in designing specific benefit packages. This increased latitude might include the ability to determine "amount, duration, and scope" of the program, statewide availability, and eligibility rules without the need for a waiver. The issue of cost neutrality, which has been addressed previously, is also important to fostering innovation. Allowing states to design benefit packages that may not be cost neutral to the Medicaid program itself, but are cost neutral when taking into account all federal and state spending, would allow states to create more innovative and cost-efficient programs.

Changes to program management may provide the best approach to achieving additional efficiencies. For example, while waivers have allowed states to be highly innovative in addressing the needs of their Medicaid populations, the use of waivers has also been criticized as inefficient, particularly due to the substantial administrative burdens that waiver programs must shoulder. If the waiver process were largely eliminated and replaced with specific statutory authority under Title XIX, states would be able to offer optional services to broader populations. For the waivers that remain in place, greater efficiencies could be achieved by making the waiver process less complex, more transparent, and more predictable with respect to timeframes and the approval process.

Between 2000 and 2003, cumulative growth in prescription drug spending by Medicaid was 36.4 percent. By comparison, inpatient hospital spending increased by 14.3 percent during the same period. Increasing pharmacy costs are the number-one cost driver for increases in Medicaid expenditures. One solution to this issue, consistent with our recommendation that the HHS secretary be permitted to negotiate drug prices, is that states should be given greater ability to use the purchasing leverage of Medicaid and other state programs (as well as other states) to achieve better pricing. At the present time, there are at least two multistate pharmacy purchasing pools in place attempting to realize such economies of scale. Another means to address reducing pharmaceutical pricing is to encourage pharmaceutical manufacturers to increase Medicaid rebate programs.

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EASING STATE BURDENS IN THE MEDICAID PROGRAM

PROPOSAL

Expand the efficiency of the Medicaid program and require CMS to follow the formal rulemaking process with respect to the Medicaid program.

EXPLANATION

The Medicaid statute has evolved more slowly than the health care system, current medical practices, and the needs of state Medicaid programs for enhanced flexibility. States must have greater latitude to manage the Medicaid program with respect to eligibility, benefits, cost sharing, and coordination with private-sector insurance. To help states make the best use of Medicaid laws, the federal government should follow prescribed administrative processes and issue regulations through notices of public rulemaking.

PROPOSAL

Oppose the proposed Payment Error Rate Measurement (PERM) system.

EXPLANATION

The Improper Payments Information Act of 2002 (IPIA) requires federal agencies to annually review and identify those programs and activities that may be susceptible to erroneous payments, estimate the amount of improper payments, and submit those estimates to Congress. IPIA requires that HHS establish a nationwide improper payment rate. The Payment Accuracy Measurement (PAM) project

was the precursor to PERM. PAM was a three-year pilot program that used a claims-based sample and review methodology to estimate a state-specific payment error rate. The state-specific error rates were subsequently used to make national-level payment estimates. While IPIA requires determination of a national error rate, there is no specific requirement for a state-specific error rate. PERM is a comprehensive non-risk-based model that was designed solely to determine an error rate for the Medicaid program and SCHIP. Most of the PAM project states believe that the project was neither beneficial nor cost-effective in addressing improper payments. Furthermore, states are concerned that the PERM model design will cause state agencies to redirect resources from high-risk areas that result in significant savings and recoveries to traditionally low-recovery areas.

PROPOSAL

The federal government should permit states to replicate demonstrations previously approved in other states; the process for waiver approval should be streamlined so that it is more predictable across states and regions.

EXPLANATION

With increasing frequency in recent years, states have been denied approval for demonstration authority for the same programs approved and successfully operating in other states. States have based their applications on these other state models and have carefully coordinated with the other states, but their applications are then rejected. States should routinely be permitted to replicate successful demonstrations approved in other states. This would improve efficiency and give states additional control and predictability over Medicaid programs.

PROPOSAL

Proposed SPAs should not be used a mechanism to review and sanction states' unrelated Medicaid activities.

EXPLANATION

Delays in approving SPAs have hampered states' ability to maintain their Medicaid programs and added significant additional costs for defending their requests and operations. This practice has had the chilling effect of dampening states' innovation efforts and their willingness to risk having an SPA embargoed while federal agencies investigate a whole range of issues unrelated to the SPA under consideration. Written guidance should be developed that clarifies federal policy related to SPAs. The current "trial-and-error" process is costly, cumbersome, and confusing to state policymakers.

MMA AND PRESCRIPTION DRUG COSTS

PROPOSAL

APHSA recommends seeking statutory or regulatory change, as appropriate, to establish a single MMA Part D eligibility point of contact.

EXPLANATION

This proposal would entail repealing federal mandates on states to determine eligibility for the Medicare Part D program. The burden of eligibility determinations cannot be overstated. Specifically, determining low-income subsidy eligibility will not be a one-time event but will require redetermination on a regular basis, given the fluctuations in beneficiary assets and income levels. When these additional costs are coupled with expected outreach and education efforts, the costs to states associated with implementation will be significant. Moreover, with recent proposals calling for an overall cap on state administrative costs, states are concerned that there will be even less funding available to meet obligations under Medicare Part D.

Medicaid coverage, as well as federal financial participation in 2006, should not expire for dual eligibles until they have voluntarily enrolled in a Part D plan or until CMS or the state has automatically enrolled them in a plan.

PROPOSAL

The federal government should adequately fund state costs associated with implementing Medicare Part D.

EXPLANATION

Under current law and regulations, states have not received additional funding for the implementation costs associated with MMA. Given the emphasis on states' roles in outreach to beneficiaries, education efforts, and eligibility determinations, among other state responsibilities, states require additional funding to meet their obligations.

PROPOSAL

APHSA recommends seeking statutory or regulatory change, as appropriate, to allow states to contract with SSA for Part D low-income subsidy eligibility determinations and appeals.

EXPLANATION

Current law requires states to have in place a parallel system for determining eligibility for the low-income subsidy. This duplication, although explicitly required by law, constitutes an unneeded redundancy that could potentially be addressed through a contractual agreement.

PROPOSAL

Medicaid coverage, as well as federal financial participation in 2006, should not expire for dual eligibles until they have voluntarily enrolled in a Part D plan or until CMS or the state has automatically enrolled them in a plan. In addition, there should be a transition period of 60 to 90 days for individuals taking prescription drugs for chronic and other long-term conditions.

EXPLANATION

This type of interim period is essential to help ensure continuity of care for full-benefit dual-eligible beneficiaries. Such an interim period is especially important for patients who are on medications that are taken for extended periods of time and that are not included on the prescription drug formularies from plans available in their areas. In addition, this approach could be a contingency plan for difficulties that may occur in the eligibility and enrollment process for prescription drug plans.

A grace or other interim enrollment period is essential to help assure continuity of care for full-benefit dual-eligible beneficiaries. In the case of drugs that require lengthy periods to determine “stable” doses, a prescription transition to another drug in the same class could have adverse health effects for some beneficiaries, including some dual-eligible patients who are frail and unstable. Drug categories for patients that might require additional transition time include psychotropic compounds, HIV/AIDS medications, cardiac regimens, and anti-convulsants. In addition, such an interim period is especially important for patients on medications that are taken for extended periods of time and that are not included on the prescription drug formularies offered by prescription drug and Medicare Advantage plans available in their areas. This approach could also be a contingency plan for difficulties that may occur in prescription drug plans’ eligibility and enrollment processes.

PROPOSAL

CMS should require that prescription drug plans providing benefits under Medicare Part D share prescription drug data with state Medicaid programs regardless of whether these programs directly provide payment for prescription drugs.

EXPLANATION

The MMA final rule encourages, but does not require, MMA sponsors to share prescription drug utilization data with Medicaid programs. APhSA believes that state Medicaid programs should have access to this information from prescription drug plans, since these data are critical to states’ ability to manage the total health care of Medicaid recipients as well as the costs of other aspects of health care states continue to fund.

PROPOSAL

CMS should include drug rebates and cost-containment savings attributable to the calendar year 2003 baseline clawback calculation.

EXPLANATION

The final regulations issued by CMS indicate that the prescription drug expenditures for the full-benefit dual-eligible population in 2003 will be based on Medicaid Statistical Information System (MSIS)–reported data as adjusted by drug rebate benefits. Although CMS does specify how it will consider drug rebate savings in the phased-down state contribution, its process understates the amount of states’ actual 2003 rebates. Drug rebates reported on the CMS-64 reports for 2003 may not reflect all rebates attributable to their prescription for drug expenditures for full-benefit dual eligibles. In addition, a number of states have implemented new laws and prescription drug cost containment programs, such as preferred drug lists, fail-first, and pre-authorization. In some cases,

the benefits of these pharmacy cost-containment initiatives fail to appear in 2003 data, but will show up in subsequent years' data and result in lower Medicaid drug costs. APHSA encourages CMS to take these factors into account and modify the phased-down state contribution accordingly.

PROPOSAL

Because of the significance of MMA's phased-down state contribution baseline number for state budgets in the foreseeable future, CMS should consider developing a separate appeals process for the phased-down state contribution calculation.

EXPLANATION

This appeals process should enable states to challenge final phased-down state contribution calculations based on all available evidence and data. The appeals process should also allow for a trigger for states to argue that their clawback calculation does not achieve budget neutrality.

PROPOSAL

APHSA recommends that Congress consider the financial benefits of reimporting prescription drugs and consider legislation to permit states and other localities to reimport prescription drugs.

EXPLANATION

Many believe that drug reimportation offers a potential solution to the high prices paid by American consumers for prescription drugs. In fact, in recent years, the percentage growth of prescription drug spending has exceeded that of other health expenditures. Specifically, prescription drug spending grew at an inflation-adjusted rate of 14.5 percent from 1997 to 2002.

This translates into a 10.5 percent share of total national health care expenditures in 2002 versus only 5.8 percent in 1992. Prices for patented prescription drugs are lower in other countries such as Canada, Great Britain, and in European Union countries. For example, Canada's Patented Medicine Prices Review Board (PMPRB), which regulates drug pricing, estimates that U.S. prices were 67 percent higher on average than Canadian prices for the same compound in 2002. This disparity has led some American consumers to purchase drugs from Canada for personal use. If this practice could be expanded to a commercial reimportation system, it is possible that consumers could realize significant price savings on pharmaceuticals. By some estimates, allowing open pharmaceutical markets could save American consumers at least \$38 billion per year.

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PROPOSAL

APHSA proposes a modification in MMA to provide the federal government with authority to negotiate prices with drug companies.

EXPLANATION

The MMA contains a provision prohibiting the federal government from negotiating drug prices with drug manufacturers. This provision should be modified to allow such negotiations. Allowing the provision preventing the federal government from negotiating with drug manufacturers undermines one of the strongest controls on drug pricing. Recently released figures estimate the cost of Medicare's Part D benefit during FYs 2006 through 2015 illustrate the consequences of not being able to control drug spending. Specifically, CMS estimates that the Part D benefit will cost \$1.2 trillion during that period. Even when accounting for offsets from states and premiums that are paid by beneficiaries, this figure is \$754 billion. Proponents have argued that the emergence of managed care in pharmacy benefits would help stem the tide of increasing prescription drug costs. Allowing the government to negotiate prices for pharmaceuticals would likely result in lower prices because of the sheer size of the federal government's buying power. Other agencies, such as the Department of Defense and Veterans Affairs, have authority to negotiate pricing directly with drug manufacturers.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

PROPOSAL

Oppose any changes to SCHIP that would result in a loss of funding for states to administer this vital program for insuring low-income children.

EXPLANATION

Proposals have been made to reauthorize SCHIP before it formally expires and to reduce the length of time states have to spend their SCHIP allotments from three years to two years. These changes, taken together, could have a devastating effect on SCHIP programs by drastically reducing the funds available to states. Compounding the dilemma is a proposal to spend \$1 billion on outreach over two years to get more children enrolled in SCHIP. The combination of decreased federal support for SCHIP and increased demand for program enrollment would exacerbate the fiscal pressures on the program.

PROPOSAL

Revise and reauthorize the State Children's Health Insurance Program.

EXPLANATION

1. SCHIP eligibility definitions should be examined to consider coverage of children of low-income public employees.
2. A standard formula should be established that is based on state population and other specific state information such as SCHIP enrollment, SCHIP population, remaining SCHIP dollars, and needed SCHIP dollars.
3. Title XXI should be amended to include the process of redistributing SCHIP funds for each state at the end of each budget cycle. The process of redistributing allocated funds would then no longer be subject to annual review.

4. The Medicaid and SCHIP statutes should be amended to permit blending of public and private health insurance coverage and continuity of care as children move between programs. State proposals to subsidize employer-based health insurance for low-wage workers should be considered.
5. CMS should allow a broadening of the use of HIFA waivers to allow the uninsured to buy into Medicaid or SCHIP.