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Medicaid and SCHIP: FY2007 Budget Issues

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Medicaid and SCHIP: FY2007 Budget Issues

Summary

Current law requires the President to submit a comprehensive federal budget proposal to Congress no later than the first Monday in February. Once it is submitted, the Congressional Budget Office (CBO) analyzes the proposal using its own economic assumptions and estimation techniques. Then, the House and Senate Budget Committees each develop a budget resolution after reviewing the President's budget, the views of other committees, and information from CBO. Differences between the houses are supposed to be resolved by April 15, but this deadline is rarely met. Although it is not binding, the resolution provides a framework for subsequent legislative action on the budget (e.g., annual appropriations bills).

The President's FY2007 budget contains a number of proposals that would affect Medicaid and the State Children's Health Insurance Program (SCHIP). Some are program expansions, and others are designed to reduce federal spending. While certain proposals would require legislative action, others would be implemented administratively (e.g., via regulatory changes, issuance of program guidance, etc.).

On March 9, 2006, the Senate Budget Committee reported a budget resolution (S.Con.Res. 83) for consideration by the full Senate. A summary of the Chairman's mark indicates that it includes funding for four of the President's Medicaid and SCHIP proposals. The House Budget Committee has yet to mark up a budget resolution.

This report will be updated as the FY2007 budget process unfolds.

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Introduction

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This report provides information on Medicaid and State Children's Health Insurance Program (SCHIP) issues. It will be updated as the FY2007 budget process unfolds.

Medicaid and SCHIP in the President's FY2007 Budget

The President's FY2007 budget contains a number of proposals that would affect Medicaid and SCHIP. Some are program expansions, and others are designed to reduce federal spending. For each of the proposals, this report provides:

- background information;
- a description of the proposal based on available information;[1] and
- a list of relevant Congressional Research Service (CRS) reports.

The proposals generally are presented in the order in which they appear in the Department of Health and Human Services' (HHS) *Fiscal Year 2007 Budget in Brief*. The description of each proposal includes HHS and CBO estimates of its cost or

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[1] Sources include Department of Health and Human Services (HHS), *Fiscal Year 2007 Budget in Brief*, available at [http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf]; HHS, Centers for Medicare and Medicaid Services, *Fiscal Year 2007 Justification of Estimates for Appropriations Committees*; Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2007*, available at [http://www.whitehouse.gov/omb/budget/fy2007]. CBO cost estimates are from *Preliminary Analysis of the President's Budget Request for 2007* (Mar. 3, 2005), available at [http://www.cbo.gov/showdoc.cfm?index=7055&sequence=0&from=7].

savings in FY2007 and over the FY2007-FY2011 period. These estimates are summarized in **Table 1**.

CRS staff contact information by Medicaid and SCHIP topic area is provided in **Table 2** at the end of the report.

Legislative Versus Administrative Proposals

As shown in **Table 1**, some of the President's proposals would require legislative action, while others would be implemented administratively (e.g., via regulatory changes, issuance of program guidance, etc.).

In their analyses of the President's budget, both CBO and executive branch agencies such as HHS and the Office of Management and Budget (OMB) provide baseline (current law) estimates of Medicaid and SCHIP spending along with estimated costs and savings of proposed changes. However, the two differ in their treatment of legislative and administrative proposals.

In executive branch documents describing the President's budget, implementation of proposed administrative changes is assumed in estimates of baseline Medicaid and SCHIP spending, and estimates for legislative proposals are presented separately.[2] In general, CBO only adjusts its baseline estimates to account for administrative changes as they are implemented — rather than as they are proposed — and only provides separate estimates for legislative proposals. For this reason and others, CBO and executive branch estimates of Medicaid and SCHIP spending will differ.

Table 1. Cost (Savings) of Medicaid and SCHIP Proposals in the President's FY2007 Budget

Proposal	Outlays in millions			
	HHS estimate		CBO estimate	
	FY2007	FY2007-FY2011	FY2007	FY2007-FY2011
Medicaid	($1,487)	($14,015)	($948)	($4,545)
Legislative proposals	($158)	($1,772)	($948)	($4,545)
Transitional medical assistance (Medicaid impact)	$180	$360	$129	$526
Vaccines for Children	$140	$700	$115	$715
Expand third party liability[a]	($90)	($525)	($105)	($265)
Reduce targeted case management match	($208)	($1,187)	($250)	(1,485)
Amend drug rebate formula	$0	$0	$0	$0
Restructure pharmacy reimbursement	($130)	($1,285)	($275)	($2,325)
Optional managed formulary for prescription drugs	($15)	($177)	($10)	($200)
Administrative cost allocation	($280)	($1,770)	($280)	($1,770)

[2] For a description of adjustments made to arrive at baseline FY2007 Medicaid expenditures, see HHS, Centers for Medicare and Medicaid Services, *Fiscal Year 2007 Justification of Estimates for Appropriations Committees*, pp. 138-145.

Proposal	Outlays in millions			
	HHS estimate		CBO estimate	
	FY2007	FY2007-FY2011	FY2007	FY2007-FY2011
Refugee exemption extension	$42	$134	$5	$17
Health Insurance Portability and Accountability Act modifications	$0	$0	—	—
Modify SCHIP redistribution to address FY2007 shortfalls (Medicaid impact)	—	—	($290)	($235)
Cover the Kids (Medicaid impact)	$203	$1,978	$13	$477
Administrative proposals[b]	($1,329)	($12,243)	—	—
Eliminate pay and chase for pharmacy	($105)	($430)	—	—
Phase down provider tax	$0	($2,070)	—	—
Issue provider tax regulation	$0	$0	—	—
Cap government providers	($384)	($3,812)	—	—
Stricter reimbursement for rehabilitative services	($225)	($2,286)	—	—
Eliminate school-based administration and transportation	($615)	($3,645)	—	—
Clarify disproportionate share hospital provisions in regulation	$0	$0	—	—
SCHIP	$704	$440	$570	$483
Legislative proposals	$704	$440	$570	$483
Transitional medical assistance (SCHIP impact)	—	—	($3)	($3)
Modify SCHIP redistribution to address FY2007 shortfalls (SCHIP impact)	$635	$110	$570	$460
Health Insurance Portability and Accountability Act modifications	$0	$0	—	—
Cover the Kids (SCHIP impact)	$69	$330	$3	$26
Total Medicaid and SCHIP	($783)	($13,575)	($378)	($4,062)
Health Care Fraud and Abuse Control account (Medicaid and SCHIP financial management)	$10	$26	—	—

Source: Department of Health and Human Services, *Fiscal Year 2007 Budget in Brief*, available at [http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf] and Congressional Budget Office, *Preliminary Analysis of the President's Budget Request for 2007* (Mar. 3, 2005), available at [http://www.cbo.gov/showdoc.cfm?index=7055&sequence=0&from=7].

Note: Numbers in parentheses represent savings. Estimates for proposals that do not show a dollar figure were not provided in the documents cited above.

a. CBO noted that it did not have enough information to estimate the part of the proposal that would expand the use of liens for certain liability settlements.
b. In executive branch documents describing the President's budget, implementation of proposed administrative changes is assumed in estimates of baseline Medicaid and SCHIP spending, and estimates for legislative proposals are presented separately. In general, CBO only adjusts its baseline estimates to account for administrative changes as they are implemented — rather than as they are proposed — and only provides separate estimates for legislative proposals.

Medicaid: Transitional Medical Assistance

Background. States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance

(TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections. It also permanently requires four months of TMA for families who lose Medicaid eligibility due to an increase in earned income or hours of employment.

However, Congress expanded work-related TMA benefits in 1988, requiring states to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards allow families to qualify for Medicaid at higher income levels for a set period of time). Congress has acted on numerous occasions to extend these expanded TMA requirements (which are outlined in Section 1925 of the Social Security Act) beyond their original sunset date of September 30, 1998. They are currently set to expire on December 31, 2006.

Proposal. The President's budget seeks legislation to extend expanded TMA requirements through September 30, 2007. HHS estimates that the proposal would cost Medicaid $180 million in FY2007, and $360 million over the FY2007-FY2011 period (the budgetary effects extend beyond FY2007 because families are still entitled to up to 12 months of TMA if they qualify on or before the expiration date). CBO estimates that the proposal would cost Medicaid $129 million in FY2007, and $526 million over the FY2007-FY2011 period. CBO also estimates that the proposal would save SCHIP $3 million in both FY2007 and over the FY2007-FY2011 period.

Reports. See CRS Report RL31698, *Transitional Medical Assistance (TMA) Under Medicaid*, by April Grady.

Medicaid: Vaccines for Children

Background. The Vaccines for Children (VFC) program is funded by federal Medicaid appropriations and administered by the Centers for Disease Control and Prevention (CDC). Under Section 1928 of the Social Security Act, children who are (1) Medicaid recipients, (2) uninsured, (3) American Indians or Alaska Natives, or (4) "underinsured" because their health insurance does not cover qualified pediatric immunizations are entitled to receive VFC vaccines free of charge. Currently, children in the first three categories may receive VFC vaccines from any program-registered provider (as defined in Section 1928(c) of the Social Security Act), while underinsured children may only receive VFC vaccines at federally qualified health centers (FQHCs) or rural health clinics.

In 2002, there were approximately 42,000 active VFC provider sites (30,000 private and 12,000 public).[3] In 2000, an estimated 57% of children receiving VFC vaccines were eligible because they were Medicaid recipients. Another 36%

[3] Centers for Disease Control and Prevention, *VFC Program Data*, available at [http://www.cdc.gov/nip/vfc/st_immz_proj/data/data.htm].

receiving VFC vaccines were uninsured, while 5% were underinsured and 2% were American Indians or Alaska Natives.[4]

Proposal. The President's budget seeks legislation to improve vaccine access by allowing underinsured children to receive VFC vaccines at state and local health clinics, rather than only at FQHCs and rural health clinics. HHS estimates that the proposal would cost $140 million in FY2007, and $700 million over the FY2007-FY2011 period. CBO estimates that the proposal would cost $115 million in FY2007, and $715 million over the FY2007-FY2011 period.

Reports. For general information on FQHCs and rural health clinics, see CRS Report RL32046, *Federal Health Centers Program*, by Sharon Kearney Coleman.

Medicaid: Expand Third-Party Liability

Background. Third-party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under Medicaid. In general, federal law requires Medicaid to be the payer of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual.

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. If a state has determined that probable liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third-party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase").

States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay-and-chase method. However, there are two statutory exceptions to this rule. In the case of prenatal and preventive pediatric care, states are required to use pay and chase. In the case of a Medicaid beneficiary whose parent provides medical support (e.g., health insurance coverage via an employer) as part of a child support order being enforced by the state, the state must use pay and chase if a provider has not been paid under the medical support arrangement within 30 days.

In some cases, a Medicaid beneficiary may be required to reimburse the state for Medicaid expenses paid on his or her behalf. To facilitate such reimbursement, the state may place a lien on the Medicaid beneficiary's property. With certain exceptions, federal law generally prohibits states from imposing Medicaid liens on the property of living beneficiaries. In contrast, federal law permits Medicaid liens on the estates of deceased beneficiaries in a wider variety of situations.

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[4] Institute of Medicine, *Calling the Shots: Immunization Finance Policies and Practices* (Washington: National Academy Press, 2000), pp. 77-85.

Proposal. The President's budget seeks three legislative changes. The first would require providers to bill third parties for prenatal and preventive pediatric care services and wait at least 90 days before billing Medicaid. The second would require providers to bill third parties in the case of medical support provided via a child support order and wait at least 90 days before billing Medicaid. The third would explicitly permit states to use liens against liability settlements to recover Medicaid amounts paid on behalf of beneficiaries. HHS estimates that the proposal would save $90 million in FY2007, and $525 million over the FY2007-FY2011 period. CBO estimates that the first two parts of the proposal would save $105 million in FY2007, and $265 million over the FY2007-FY2011 period (CBO noted in its preliminary analysis that it did not have enough information to estimate the third part).

Reports. Currently, no other CRS reports address this topic.

Medicaid: Reduce Targeted Case Management Match

Background. Under current law, case management is an optional benefit under the Medicaid state plan that assists Medicaid beneficiaries in gaining access to needed medical, social, educational and other services. The term "targeted case management" refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of individuals (e.g., those with AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, or children in foster care) or persons who reside in a specific area. Since case management is not an administrative activity, the federal government matches payments for such services at the rate applicable to Medicaid benefits. This rate ranges from 50% to 83% (statutory upper boundary) depending on the state. In FY2006, 12 states had a federal matching rate for benefits equal to 50%.

Proposal. The President's budget seeks legislation to change the reimbursement level for targeted case management to the 50% matching rate that states currently receive for most Medicaid administrative costs. HHS estimates that the proposal would save $208 million in FY2007, and $1.187 billion over the FY2007-FY2011 period. CBO estimates that the proposal would save $250 million in FY2007, and $1.485 billion over the FY2007-FY2011 period.

Reports. For general information on Medicaid administrative costs, see CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Amend Drug Rebate Formula

Background. Under Medicaid, drug manufacturers that wish to have their drugs available for Medicaid enrollees are required to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under the agreements, pharmaceutical manufacturers must provide state Medicaid programs with rebates on drugs paid on behalf of Medicaid beneficiaries. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs. Rebate calculations depend on the type of drug.

For single source and innovator multiple source drugs, basic rebate amounts are determined by comparing the average manufacturer price (AMP) for a drug (the average price paid by wholesalers) to the "best price," which is the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, nonprofit, or public entity. The basic rebate is the greater of 15.1% of the AMP or the difference between the AMP and the best price. Additional rebates are required if the weighted average prices for all of a given manufacturer's single source and innovator multiple source drugs rise faster than inflation. For non-innovator multiple source drugs, basic rebates are equal to 11% of the AMP.

Proposal. The President's budget seeks legislation to eliminate the "best price" from the rebate formula for single source and innovator multiple source drugs, changing the best price-based formula to a flat rebate. This change is intended to be made in a budget neutral manner. HHS explanatory materials describe the proposal as a way to simplify drug rebate calculations and allow private purchasers to negotiate lower drug prices. HHS estimates that the proposal would have no cost impact in FY2007 or over the FY2007-FY2011 period. CBO estimates that the proposal would have no cost impact in FY2007 or over the FY2007-FY2011 period.

Reports. For a general background on Medicaid prescription drug coverage and pricing including a description of drug rebates, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Restructure Pharmacy Reimbursement

Background. Under current law, state Medicaid programs set the prices paid to pharmacies for Medicaid outpatient drugs. Federal reimbursements for those drugs, however, are limited to a federal upper limit (FUL). The FUL that applies to drugs available from multiple sources (generic drugs, for the most part) is calculated by the Centers for Medicare and Medicaid Services (CMS) to be equal to 150% of the lowest published average wholesale price (AWP) for the least costly therapeutic equivalent. The upper limit that applies to brand-name and other drugs is equal to the acquisition cost as estimated by the states. Recently, the President signed the Deficit Reduction Act of 2005 (DRA 2005) which will change the FUL formula for multiple source drugs. Beginning January 1, 2007, the FUL for these drugs will be equal to 250% of the average manufacturer's price (AMP, the average price paid by wholesalers to manufacturers).

Proposal. The President's budget seeks legislation that would build on changes made by DRA 2005 to achieve additional savings in the Medicaid program. The proposal would reduce the FULs on multiple source drugs from 250% of the AMP to 150% of the AMP. HHS estimates that the proposal would save $130 million in FY2007, and $1.285 billion over the FY2007-FY2011 period. CBO estimates that the proposal would save $275 million in FY2007, and $2.325 billion over the FY2007-FY2011 period.

Reports. For more information on the Medicaid provisions of DRA 2005, see CRS Report RL33131, *Budget Reconciliation FY2006: Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) Provisions*, by Evelyne P. Baumrucker, et al. and CRS Report RL33251, *Side-by-Side Comparison of Medicare,*

Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005, by Karen Tritz, et al. Additional background information on Medicaid prescription drugs can be found in CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Optional Managed Formulary for Prescription Drugs

Background. Federal statute allows state Medicaid programs to establish formularies, or lists of preferred pharmaceuticals to be made available to Medicaid beneficiaries. When health care insurers or providers cover only those drugs on the list and deny payment for others, the list is referred to as a "closed formulary." Medicaid formularies are seldom as restrictive as the closed formularies found in the private market for insurance because of two requirements: (1) states are required to provide any non-formulary drug (with the exception of drugs in specific categories, described below) that is specifically requested and approved through a prior authorization process, and (2) states are required to cover all drugs offered by manufacturers entering into rebate agreements with the Secretary of HHS.

States, on the other hand, are permitted to exclude certain categories of drug products from Medicaid coverage. These include drugs used: (a) to treat anorexia, weight loss or weight gain; (b) to promote fertility; (c) for cosmetic purposes or hair growth; (d) for the relief of coughs and colds; (e) for smoking cessation; and (f) prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations; (g) non-prescription drugs; (h) barbiturates; (i) benzodiazepines; and (j) drugs requiring tests or monitoring that can only be provided by the drug manufacturer. Formularies may also exclude a drug for which there is no significant therapeutic advantage over other drugs that are included in the formularies as long as there is a written explanation of the reason for its exclusion and the explanation is available to the public. As of January 1, 2006, federal law also prohibits federal Medicaid funds from being used to pay for drugs for the treatment of sexual or erectile dysfunction.

Proposal. The President's budget seeks legislation to allow states to use private sector management techniques to leverage greater discounts through negotiations with drug manufacturers. Supporting material describes these management techniques as common cost control tools for private insurers. No other description of the management techniques is provided. HHS estimates that the proposal would save $15 million in FY2007, and $177 million over the FY2007-FY2011 period. CBO estimates that the proposal would save $10 million in FY2007, and $200 million over the FY2007-FY2011 period.

Reports. For a general background on Medicaid prescription drug benefits, formularies, and other cost control mechanisms used in administering those benefits, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

Medicaid: Administrative Cost Allocation

Background. Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. Under the former Aid to Families with Dependent Children (AFDC) cash welfare program, AFDC and Medicaid program eligibility were linked, and many AFDC families also qualified for food stamps. As a result, states often collected necessary information for all three programs during a single eligibility interview or performed other shared administrative tasks and charged the full amount of the cost to AFDC as a matter of convenience. Since the federal government reimbursed states for 50% of administrative expenditures for all three programs, total federal spending was not affected by the way in which states allocated the programs' common administrative costs.

When Congress replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant program in 1996, the 50% federal match for expenditures related to cash welfare assistance ended and the automatic link between cash welfare and Medicaid eligibility was severed. Later, HHS clarified that states are required to allocate common administrative costs for TANF, Medicaid, and food stamps based on the relative benefits derived by each program. A remaining issue of controversy stems from the fact that TANF block grants are calculated in part on the basis of pre-1996 federal welfare spending, including any amounts received by states as reimbursement for common administrative costs. As a result, TANF block grants are higher in many states than they would be if common administrative costs attributable to Medicaid and food stamps were excluded from block grant calculations. To compensate, Congress has permanently reduced federal reimbursement for food stamp administrative costs in most states by a flat dollar amount that reflects the administrative costs attributable to food stamps that are included in each state's TANF block grant (the annual reductions total nearly $200 million). Congress has not reduced federal reimbursement for Medicaid administrative costs in a similar manner.

Proposal. The President's budget seeks legislation to recoup Medicaid administrative costs assumed in states' TANF block grants. HHS estimates that the proposal would save $280 million in FY2007, and $1.770 billion over the FY2007-FY2011 period. CBO estimates that the proposal would save $280 million in FY2007, and $1.770 billion over the FY2007-FY2011 period.

Reports. See CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview*, by April Grady.

Medicaid: Refugee Exemption Extension

Background. Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date, are not eligible for Supplemental Security Income (SSI) benefits — and thus, SSI-related Medicaid — until they have resided in the country for five years or have obtained citizenship. Refugees and asylees are currently exempted from this ban for the first seven years they reside in the United States.

Proposal. The President's budget seeks legislation to extend the exemption for refugees and asylees from seven years to eight years, allowing additional time for individuals to complete the citizenship process without losing SSI and SSI-related Medicaid eligibility. HHS estimates that the proposal would cost $42 million in FY2007, and $134 million over the FY2007-FY2011 period. CBO estimates that the proposal would cost $5 million in FY2007, and $17 million over the FY2007-FY2011 period.

Reports. For general background information, see CRS Report RL31269, *Refugee Admissions and Resettlement Policy*, by Andorra Bruno; CRS Report RL31630, *Federal Funding for Unauthorized Aliens' Emergency Medical Expenses*, by Alison M. Siskin; and CRS Report RL31114, *Noncitizen Eligibility for Major Federal Public Assistance Programs: Policies and Legislation*, by Ruth Wasem.

Medicaid: Eliminate Pay and Chase for Pharmacy

Background. As described earlier (under the "expand third party liability" proposal), if a state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

Proposal. The President's budget would, through administrative action, require states to use cost avoidance by eliminating the pay and chase waiver option for pharmacy claims. HHS estimates that the proposal would save $105 million in FY2007, and $430 million over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. Currently, no other CRS reports address this topic.

Medicaid: Phase Down Provider Tax

Background. Under federal law and regulations, a state's ability to use provider-specific taxes to fund its state share of Medicaid expenditures is limited. If states establish provider-specific taxes, those taxes generally cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures and the state cannot provide a guarantee to the providers that the taxes will be returned to them. However, if the taxes returned to a provider are less than 6% of the provider's revenues (a ceiling created in regulation by HHS), the prohibition on guaranteeing the return of tax funds is not violated. As a result, a state could impose a provider tax of 6% of revenues, return those revenues to the provider in the form of a Medicaid "payment," and receive a federal match for those amounts. In effect, the state has temporarily borrowed funds from the provider for the purpose of inflating federal matching funds.

Proposal. The President's budget seeks a regulatory change to phase down the allowable provider tax rate from 6% to 3%. HHS estimates that the proposal would have no budget impact in FY2007, and would save $2.070 billion over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. For background information on provider taxes, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

Medicaid: Issue Provider Tax Regulation

Background. See the "phase down provider tax" proposal above.

Proposal. The President's budget seeks to clarify, through regulation, existing policies used to determine whether or not provider taxes comply with statute and regulations. HHS estimates that the proposal would have no cost impact in FY2007 or over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. For background information on provider taxes, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

Medicaid: Cap Government Providers

Background. Aggregate Medicaid payments to specific groups of institutional providers (e.g., hospitals and nursing facilities) cannot exceed a reasonable estimate of what would have been paid under Medicare payment principles. This is called the Medicaid upper payment limit (UPL) rule. In many states, Medicare payment rates for hospital and nursing home care are higher than corresponding Medicaid payment rates. The UPL based on Medicare payment principles has enabled some states to draw down additional federal dollars that exceed what they would have received based on Medicaid payment rates. These additional funds are paid to government providers which are sometimes required by states to transfer all or a portion of the extra payments received (i.e., some or all of the difference between the Medicare and Medicaid payment rates) back to the state through an intergovernmental transfer (IGT). Instead of financing more or improved Medicaid services, in some cases states have used the additional federal dollars for non-health services, or to make up part of the state share of Medicaid costs to draw down another round of federal dollars.

During 2000-2002, Congress and the Clinton and Bush Administrations revised UPL rules by changing permissible accounting methods used to claim federal matching payments. These changes significantly reduced the excess federal dollars states received under approved UPL plans that involved IGTs. However, these reforms did not eliminate all such excess payments because no changes were made to the Medicaid UPL standard which remains tied to the Medicare payment rate, nor to federal statute or regulations governing IGTs. Administration officials have taken additional steps to curb what they have identified as improper state financing

mechanisms, especially certain intergovernmental transfers. In late 2003, CMS began requesting detailed information regarding the sources of the state share of Medicaid costs from states applying for Medicaid waivers and submitting Medicaid state plan amendments. In some cases, these proposals were modified to minimize the use of improper IGTs (i.e., IGTs that use "recycling mechanisms" under which payments to providers are returned to the state, artificially inflating the federal matching rate).

Proposal. The President's budget would, through administrative action: (1) recover federal payments resulting from improper IGTs and (2) cap payments to government providers to no more than the cost of providing services to Medicaid beneficiaries, rather than to Medicare payment principles. HHS estimates that the proposal would save $384 million in FY2007, and $3.812 billion over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. See CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia J. Herz.

Medicaid: Stricter Reimbursement Policies for Rehabilitation Services

Background. Since the inception of Medicaid in 1965, states have been authorized to cover "other diagnostic, screening, preventive, or *rehabilitative* services" as an optional Medicaid service.[5] In subsequent legislation (OBRA 90, P.L. 101-508), Congress clarified the benefit as "including any medical or remedial service (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." The rehabilitation benefit allows states to cover a broad range of services to individuals with various types of conditions and disabilities. Under the rehabilitation benefit, states often cover ongoing mental health and/or substance abuse services, early intervention services for children with disabilities, rehabilitation for individuals with physical disabilities, school-based rehabilitation, and services for children in foster care and juvenile justice programs.

Both the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) have reported that the Medicaid rehabilitation benefit has been used by some states to bill Medicaid for activities that are not allowable as rehabilitation services, and/or to pay rehabilitation providers using methods that did not meet the statutory requirement for being "efficient and economical."[6] [7] Further,

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[5] Section 1905(a)(13) of the Social Security Act.

[6] K. Allen, *States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*, Government Accountability Office, Testimony Before the U.S.

(continued...)

CMS financial management officials reported to GAO that they believed that states "were inappropriately filing claims for services that were the responsibility of other state programs."[8]

Proposal. The President's budget seeks to clarify, through regulation, which services may be claimed as Medicaid rehabilitation services. HHS estimates that the proposal would save $225 million in FY2007, and $2.286 billion over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. Currently, no other CRS reports address this topic.

Medicaid: Eliminate School-Based Administration and Transportation

Background. Medicaid pays for covered medical services provided to Medicaid-eligible children with Individualized Family Service Plans (IFSP) and Individualized Education Plans (IEP), pursuant to the Individuals with Disabilities Education Act (IDEA). In its budget documents, the Administration notes that Medicaid claims for services provided in school settings have been prone to abuse and overpayments, especially with respect to transportation and administrative activities. Over the past few years, several GAO and HHS OIG studies have reached similar conclusions.[9]

For transportation services, examples of inappropriate Medicaid billing include (1) no verification that transportation was in fact provided, (2) a Medicaid-covered school health service other than transportation was not provided on the day that transportation was billed, and (3) child/family plans did not include a recommendation for transportation services, or there was no IEP or IFSP.

School districts may perform administrative functions for Medicaid purposes, including for example, outreach, eligibility intake, information and referrals, health service coordination and monitoring, and interagency coordination. Examples of inappropriate Medicaid billing include (1) payments based on inaccurate time studies used to allocate the cost of these administrative activities across funding sources

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[6] (...continued)
Senate, Committee on Finance, GAO-05-836T, June 28, 2005. (Hereafter cited as "GAO Testimony, June 2005.")

[7] HHS, Office of Inspector General, *Audit of Medicaid Claims for Iowa Rehabilitation Treatment Services Family-Centered Program*, A-07-02-03023, July 2004.

[8] GAO Testimony, June 2005.

[9] For example, see HHS, Office of Inspector General (OIG), *Review of Medicaid Transportation Claims Made by the New York City Department of Education*, A-02-03-01023, Sep. 2005; HHS, OIG, *Audit of LaPorte Consortium's Administrative Costs Claimed for Medicaid School-Based Services*, A-06-02-00051, Jan. 2006; and Government Accountability Office, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, GAO/HES/OSI-00-69, Apr. 2000.

including Medicaid, (2) expenditures for school employees who do not perform Medicaid administrative activities, (3) expenditures for operating costs such as nursing supplies, non-Medicaid outreach supplies, and education-related expenditures, (4) expenditures for personnel funded by other federal programs, and (5) payments for personnel who render only direct medical services.

Proposal. The President's budget would, through administrative action, prohibit federal reimbursement for IDEA-related school-based administration and transportation costs. HHS estimates that the proposal would save $615 million in FY2007, and $3.645 billion over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. See CRS Report RS22397, *The Link Between Medicaid and the Individuals with Disabilities Education Act (IDEA): Recent History and Current Issues*, by Elicia J. Herz, and CRS Report RL31722, *Individuals with Disabilities Education Act (IDEA) and Medicaid*, by Richard N. Apling and Elicia J. Herz.

Medicaid: Clarify DSH Provisions in Regulation

Background. States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under broad federal guidelines, each state determines which hospitals receive disproportionate share hospital (DSH) payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments are capped at a statewide ceiling, referred to as the state's DSH allotment, and DSH payments to each hospital are capped at a hospital-specific ceiling.

Proposal. The President's budget seeks to clarify, through regulation, provisions related to the allowable uses of DSH funds. HHS estimates that the proposal would have no cost impact in FY2007 or over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal (see earlier discussion under "Legislative Versus Administrative Proposals").

Reports. For background information on Medicaid DSH payments, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

SCHIP: Modify Redistribution to Address 2007 Shortfalls

Background. The Balanced Budget Act of 1997 established SCHIP. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. States may choose among three benefit options when designing their SCHIP programs. They may enroll targeted low-income children in Medicaid, create a separate state program, or devise a combination of both approaches. All states, the District of Columbia, and five territories have SCHIP programs. Nearly $40 billion

has been appropriated for SCHIP for FY1998-FY2007. The authorized appropriation for FY2007 is $5.0 billion. Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children, and low-income uninsured children in the state, and includes a cost factor that represents the average health service industry wages in the state compared to the national average.

States have three years to spend each annual allotment (e.g., states have until the end of FY2007 to spend their FY2005 allotments). At the end of the applicable three-year period, unspent funds are reallocated among states based on year-specific rules. In the early years of the SCHIP, both states that did and did not fully exhaust their original allotments received unspent funds. For more recent years, only those states that fully exhaust their original allotments receive unspent funds. Some states have experienced shortfalls in SCHIP funds, meaning at the end of a given fiscal year, they have spent all federal SCHIP funds available to them at that point in time, including original allotments and reallocations of unspent funds from other states.

Proposal. The President's budget seeks legislation to better target SCHIP funds in a more timely manner to address potential state shortfalls in FY2007. HHS estimates the cost of the proposal at $635 million in FY2007, with a net cost of $110 million over the FY2007-FY2011 period. CBO estimates the SCHIP cost of the proposal at $570 million in FY2007, with a net cost of $460 million over the FY2007-FY2011 period. CBO also estimates that the proposal would save Medicaid $290 million in FY2007, with a net savings of $235 million over the FY2007-FY2011 period.

Reports. For more information, see CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz, Bernadette Fernandez, and Chris L. Peterson; CRS Report RL32807, *SCHIP Financing: Funding and Projections and State Redistribution Issues*, by Chris L. Peterson; CRS Report RS22289, *Impact on States of Revised Redistribution of Unspent FY2002 SCHIP Allotments*, by Chris L. Peterson; and CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz, et al.

Medicaid and SCHIP: HIPAA Modifications

Background. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established a number of rules for employer-based health insurance plans to improve access to and portability of plans for people enrolled or enrolling into those plans. One of those provisions requires employer-based health plans to allow for new enrollment into the plan during periods outside of the typical annual open enrollment period for certain special reasons. Examples of those reasons include when an eligible employee (or their dependent) exhausts COBRA continuation coverage, or when an employee gains a new dependent through birth or adoption. Another HIPAA provision limits the ability of private health insurance plans to exclude coverage for pre-existing conditions during what are known as "pre-existing condition exclusion periods." The allowable length of such pre-existing condition exclusion periods depends on the amount of time the new

enrollee had been covered by prior "creditable" health insurance coverage.[10] A beneficiary can prove they have had prior creditable coverage by providing certificates issued by insurers at the end of each year. Because HIPAA was created in law before SCHIP was established, SCHIP was not included on the list of types of health insurance that can be considered as prior creditable coverage.

Proposal. The President's budget seeks two legislative changes relating to HIPAA. The first would define a determination of Medicaid or SCHIP eligibility as a qualifying event allowing for a special enrollment period into employer-based health insurance plans. This provision is intended to improve Medicaid and SCHIP programs' ability to coordinate coverage with private employer-offered coverage. The second proposal would require SCHIP programs to issue certificates of creditable coverage. This provision is intended to improve the reach of HIPAA's portability provisions by recognizing SCHIP coverage as prior creditable coverage. Both of these interpretations have previously been promulgated in a final regulation implementing HIPAA's portability for group health plan provisions.[11] HHS estimates that the proposal would have no cost impact in FY2007 or over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal in its preliminary analysis.

Reports. For general information on HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda R. Chaikind, Jean Hearne, Bob Lyke, and Stephen Redhead.

Medicaid and SCHIP: Cover the Kids

Background. According to the latest available official statistics, in FY2004, the number of children ever enrolled in SCHIP reached nearly 6.2 million. In FY2003, the number of children ever enrolled in Medicaid during that year reached 27.4 million. There have been ongoing concerns about take-up rates among children who meet eligibility standards but are not covered by these two programs. Estimates of the number of children eligible but not enrolled in Medicaid or SCHIP have varied considerably over time. By 2002, national survey data showed that 2.8 million children under age 19 were uninsured but eligible for SCHIP, and an additional 3.4 million were uninsured but eligible for Medicaid.[12]

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[10] Not all prior health insurance coverage is considered to be creditable. For a discussion of creditable coverage, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda R. Chaikind, Jean Hearne, Bob Lyke, and Stephen Redhead.

[11] 69 *Federal Register* 78720, *Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA* Titles I and IV, Dec. 30, 2004.

[12] Statistics taken from T. Selden, J. Hudson, and J. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2000," *Health Affairs*, vol. 23, no. 5 (Sept./Oct. 2004), pp. 39-50.

Outreach can be financed under the Medicaid and SCHIP programs. Under Medicaid, the federal matching rate for administrative expenses which include outreach activities is set at 50% for all states. There is a limit on federal spending for SCHIP administrative expenses, which also include outreach. For federal matching purposes, a 10% cap applies to state administrative expenses. This cap is tied to the dollar amount that a state draws down from its annual SCHIP allotment to cover benefits, as opposed to 10% of a state's total annual allotment.

Proposal. The Cover the Kids outreach program would provide annual grants to states, working with schools and community organizations to enroll eligible children in Medicaid and SCHIP. The grant is not part of the Medicaid or SCHIP budget proposals, but rather is a component of the State Grants and Demonstrations budget proposals under the jurisdiction of CMS (which is responsible for oversight of Medicaid and SCHIP). The grant would cost $100 million in FY2007, and $500 million over the FY2007-FY2011 period. HHS estimates that the impact of the grant on Medicaid spending would result in additional costs of $203 million in FY2007, and $1.978 billion over the FY2007-FY2011 period. Likewise, HHS estimates that the impact of the grant on SCHIP spending would be $69 million in FY2007, and $330 million over the FY2007-FY2011 period. CBO estimates that the proposal would increase Medicaid spending by $13 million in FY2007, and $477 million over the FY2007-FY2011 period. CBO also estimates that the proposal would increase SCHIP spending by $3 million in FY2007, and $26 million over the FY2007-FY2011 period.

Reports. Currently, no other CRS reports address this topic.

Health Care Fraud and Abuse Control Account

Background. The Health Insurance Portability and Accountability Act of 1996 established a national Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (HI, also known as Medicare Part A) trust fund. The HCFAC account funds the Medicare Integrity Program within CMS and certain health care fraud and abuse activities within the Federal Bureau of Investigation (FBI). Additional HCFAC funds are earmarked specifically for Medicare and Medicaid activities of the HHS OIG, and remaining "wedge" funds are divided among other HHS agencies (including CMS) and the Department of Justice. Annual mandatory minimum and maximum HCFAC appropriations are specified in statute.

Proposal. The President's budget seeks legislation to increase HCFAC funding with a discretionary appropriation. While the proposal would not directly affect Medicaid or SCHIP spending, it would fund Medicaid and SCHIP financial management activities at CMS and supplement HCFAC funding for other agencies with Medicaid and SCHIP oversight responsibilities (e.g., HHS OIG). HHS estimates that the CMS portion of the proposal would cost $10 million in FY2007, and $26 million over the FY2007-FY2011 period. CBO did not provide an estimate for the proposal in its preliminary analysis.

Reports. For information on HCFAC and related changes made by DRA 2005, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*, by Karen Tritz, et al.

Congressional Budget Resolution Action

On March 9, 2006, the Senate Budget Committee reported a budget resolution for consideration by the full Senate (S.Con.Res. 83). A March 8, 2006 summary of the Chairman's mark indicates that it includes four of the President's Medicaid and SCHIP proposals:[13]

- TMA extension ($523 million over five years);
- Vaccines for Children proposal allowing health departments to provide vaccines ($715 million);
- Cover the Kids initiative ($874 million);[14] and
- SCHIP funding boost in 2007 and 2008 ($225 million).

The House Budget Committee has yet to mark up a budget resolution.

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[13] Senate Budget Committee, *Chairman's Mark: FY2007 Budget* (Mar. 8, 2006), available at [http://budget.senate.gov/republican/pressarchive/MarkSummary.pdf].

[14] In addition to the Medicaid and SCHIP costs, this amount presumably includes the state grant costs of the proposal that are not borne directly by Medicaid or SCHIP.

Table 2. CRS Staff Contact Information by Medicaid and SCHIP Topic Area

Topic	Staff member	Phone number
Medicaid		
Administration	April Grady	7-9578
Benefits and eligibility		
Aged	Julie Stone	7-1386
Children, families, immigrants, other non-disabled adults	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
Individuals with disabilities, medically needy	Julie Stone Karen Tritz	7-1386 7-4898
Consumer-directed care	Karen Tritz	7-4898
Expenditure data	April Grady Karen Tritz	7-9578 7-4898
Dual eligibles	Karen Tritz	7-4898
Financing		
Disproportionate share hospital payments	Jean Hearne	7-7362
Federal medical assistance percentage	April Grady	7-9578
General issues	April Grady Jean Hearne Elicia Herz	7-9578 7-7362 7-1377
Intergovernmental transfers	Jean Hearne Elicia Herz	7-7362 7-1377
Upper payment limits	Elicia Herz	7-1377
Fraud, waste, and abuse	April Grady	7-9578
Long-term care	Julie Stone Karen Tritz	7-1386 7-4898
Managed care	Elicia Herz Karen Tritz	7-1377 7-4898
Prescription drugs	Jean Hearne	7-7362
Provider payment issues	Jean Hearne Karen Tritz	7-7362 7-4898
Territories	Evelyne Baumrucker Jean Hearne Elicia Herz	7-8913 7-7362 7-1377
Waivers		
Section 1115	Evelyne Baumrucker	7-8913
Section 1915(c)	Karen Tritz	7-4898
SCHIP		
Financing	Evelyne Baumrucker Chris Peterson	7-8913 7-4681
General issues	Evelyne Baumrucker Elicia Herz	7-8913 7-1377
Section 1115 waivers	Evelyne Baumrucker	7-8913

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