MACPAC

Key Medicaid Reform Proposals

Presidents' budgets, blue ribbon policy commissions, Medicaid commissions, think tanks, and governors' associations

Medicaid and CHIP Payment and Access Commission

This information was prepared at the request of Representative Fred Upton, Chairman, Energy and Commerce Committee; Senators Orrin Hatch, Chairman, Senate Committee on Finance, and Lamar Alexander, Chairman, Committee on Health, Education, Labor, and Pensions; and Representative Joseph Pitts, Chairman of the Health Subcommittee.

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Introduction

Since the enactment of Medicaid and the State Children's Health Insurance Program (CHIP), policymakers have debated program changes intended to stem program spending, change eligibility, allow greater state flexibility in program design and management, and improve access to higher quality care, among other objectives. Proposals have been offered across the political spectrum and include federal and state perspectives from presidents and governors. They reflect different objectives, ideas about the role of federal and state governments, and the particular policy discourse taking place at the time.

At the request of Members of Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) undertook a review of major Medicaid reform approaches offered over the past several decades from presidents' budgets, blue ribbon policy commissions, think tanks, governors' associations and Medicaid commissions. The following tables summarize the results of that request. This work is part of a broader effort to analyze and evaluate financing and other significant reforms in Medicaid policy.

Methodology

MACPAC conducted a literature search, identifying Medicaid and CHIP reform proposals described in presidents' budgets as well as those made by blue ribbon policy commissions and Medicaid commissions, think tanks, and governors' associations. For purposes of this project, blue ribbon policy commissions and Medicaid commissions were considered as one category. Generally, proposals offered from 1997 (the year CHIP was enacted) through 2015 were included, except as noted below.

Proposal source	Approach
Presidents' budgets	We included major federal budget proposals offered by Presidents Ronald Reagan, George H.W. Bush, Bill Clinton, George W. Bush, and Barack Obama. In a few cases, major proposals were offered outside of the annual budget process are captured here, but most proposals included were those in these administrations' annual budget submissions to Congress. Given the recent changes in the Medicaid program and the health system more broadly as well as the difficulty in securing electronic source material prior to 1980, budget proposals prior to the Reagan administration were not included.
Think tanks	We reviewed proposals offered since 1997 and included proposals recommending federal changes to Medicaid, CHIP, or programs serving people dually eligible for Medicare and Medicaid. We included only those think tanks and other organizations if the organizations were generally regarded as sources of policy expertise and not affiliated with or representing the interests of providers or other specific stakeholders, and their proposals had a national (rather than state) focus.
Blue ribbon policy commissions and Medicaid commissions	We included proposals offered by congressional and other federal commissions if they had a national focus and were offered after 1990. Given the relatively small number of Medicaid commissions and the comprehensive nature of a 1990 commission proposal, we opted to include proposals from commissions back to 1990.
Governors' associations	We included proposals offered by national associations representing governors in this review if they were offered after 1997 by the National Governors Association, the Republican Governors Association, and the Southern Governors Association, which are comprised of sitting governors. Recommendations made by individual governors and state-specific proposals were not

Limitations of this analysis include:

- The proposals we analyzed are limited to those categories identified by congressional requestors: presidents' budgets, think tanks, blue ribbon policy commissions, Medicaid commissions, and governors' associations. Therefore, our analysis does not include Medicaid reform bills introduced by Members of Congress. These bills would also be a useful source of information in considering future reforms.
- While some proposals reviewed here are highly detailed, most offer broad outlines with few details on key design issues such as eligibility, benefits, and financing. When a particular provision is not clear, we quote the proposal rather than make a judgment regarding its intent.

EXHIBIT 1. Summary of Medicaid Proposals in President's Budgets 1980–2015: Ronald Reagan

President Reagan's Medicaid proposals primarily were aimed at controlling Medicaid spending by capping federal contributions for the program. Other cost-reducing provisions were sometimes included such as requiring additional cost sharing from beneficiaries and reducing the cost of nursing home care by allowing states to impose liens.

Proposal Summary	
FY 1982	
Financing	Cap on federal spending: limits to 5 percent the rate of federal Medicaid spending growth in the following year.
Status of enactment	The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) reduced Medicaid payments to states by 3 percent, 4 percent, and 4.5 percent respectively in FYs 1982, 1983, and 1984.
Source	Congressional Quarterly (CQ). 1981. *CQ Almanac*, 1981. 97th Congress, 1st Session, 477. Washington, DC: 1981.
FY 1983	
Program structure	Part of New Federalism plan for the federal government to assume responsibility for Medicaid, beginning in FY 1984. Creates a new welfare administration block grant for states, ending separate Medicaid funding for administrative costs.
Cost sharing	Requires copayments of $1 to $2 per visit or day of hospitalization for Medicaid beneficiaries, intended to "make recipients more cost conscious."
Financing	Cuts the federal matching rate for optional services such as clinics or drugs by three percent; ends federal matching payments for state purchases of Medicare coverage for the elderly poor; ends the 90 percent federal matching rate for family planning services, bringing the rate down to between 50 and 78 percent, depending on state income per capita.
Other features	Requires states to eliminate all errors by 1986, with a punitive reduction in funds for states failing to achieve a zero error rate. Permits states to require children of institutionalized Medicaid beneficiaries to pay part of the cost of their parents' care. Permits states to take such steps as placing liens on property before the death of an institutionalized beneficiary to facilitate recovery of Medicaid costs after the death of the beneficiary.
Status of enactment	The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248) allowed states to impose nominal cost sharing on certain Medicaid beneficiaries and services.
Source	Congressional Quarterly (CQ). 1982. Reagan calls for $4 billion in cuts in Medicare and Medicaid. *CQ Weekly Report*. February 13.
FY 1984	
Cost sharing	Requires beneficiaries to pay nominal copayments for services. Beneficiaries eligible on the basis of income pay $1 per doctor visit; $1 per hospital day. Medically needy pay $1.50 per doctor visit; $2 per hospital day.
Financing	Extends permanently a three percent reduction in Medicaid payments to states (enacted by OBRA 1981) with provisions for a state to earn back part or all of the money if it had a hospital rate review program, an unemployment rate that exceeded 150 percent of the national average, a record of recovering more than 1 percent of federal expenditures from anti-fraud and anti-abuse activities or a record of program spending below set target levels.
Other features	Requires beneficiaries to assign health insurance rights to enable a state agency to collect payments from private insurers, and state child support enforcement agencies to petition courts to include medical coverage available to a parent as part of any child support order.

Status of enactment	Section 1912 of the Social Security Act was enacted, requiring that individuals eligible for medical assistance assign the state rights to collect payments from third parties for services provided under the plan. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993, P.L. 103-66) closed certain loopholes and required that states have laws regarding recipients' assignment of their rights.
Source	Congressional Quarterly (CQ). 1983. Reagan foresees triple-digit 84–88 deficit. *CQ Weekly Report*. February 5.
FY 1985	
Cost sharing	Requires beneficiaries to pay nominal copayments for services.
Financing	Extends the 1981 Medicaid cut of 3 percent, due to expire at the end of the fiscal year, unless the state meets certain criteria (see
Status of enactment	Not enacted
Source	Congressional Quarterly (CQ). 1984. CQ Weekly Report. February 4.
FY 1986	
Benefits	Gives states latitude to collect private insurance payments and determine eligibility for Medicaid benefits to aid them in reducing costs.
Financing	Institutes a cap on federal contributions. Under this proposal: - federal expenditures would be held at the FY 1986 level, which would reduce spending from FY 1985; - to help states get through the year, a one-time pool of $300 million would be available; and - beginning in 1987, federal Medicaid spending is limited to the Consumer Price Index (CPI) for health care, and states would be required to make up the difference if total costs exceed that rate.
Status of enactment	Not enacted
Source	Congressional Quarterly (CQ). 1985. *CQ Weekly Report.* February 9.
FY 1987	
Financing	Cap on federal contributions. Appears to be the same policy as in FY 1986 budget.
Status of enactment	Not enacted
Source	Congressional Quarterly (CQ). 1986. *CQ Weekly Report.* February 8.
FY 1988	
Financing	Cap on federal contributions. Appears to be the same policy as in previous proposals.
Status of enactment	Not enacted
Source	Congressional Quarterly (CQ). 1987. *CQ Weekly Report.* January 10.
FY 1989	
Financing	Reduces spending by $413 million. No additional information available.
Source	Congressional Quarterly (CQ). 1987. CQ Weekly Report. January 10.
FY 1990	
Financing	Reduces the federal match rate by as much as three percentage points in 1990, four percentage points in 1991, and four and a half percentage points thereafter. Reduces the federal share of certain administrative costs.
Status of enactment	Not enacted
Source	Congressional Budget Office (CBO). 1989. *Analysis of President Reagan's budget request for FY 1990.* February 1989. www.cbo.gov/sites/default/files/101st-congress-1989-1990/reports/1989_02_reagan.pdf.

EXHIBIT 2. Summary of Medicaid Proposals in Presidents' Budgets 1980–2015: George H.W. Bush

Early in President George H.W. Bush's Administration, his Medicaid proposals would have extended Medicaid coverage to certain low-income pregnant women and children and increased the use of Medicaid managed care. In later years, his budget included more sweeping reforms. In 1992, the budget proposal would have capped year-over-year increases in the federal contribution toward Medicaid costs and in 1993, Medicaid reforms were included in a larger health reform proposal that would have replaced the non--institutional components of the program with capped block grants.

Proposal summary	
Fiscal year (FY) 1989	
Eligibility	Expands Medicaid eligibility, requiring states to extend services to pregnant women and to infants up to age one in families with incomes below 130 percent of FPL. Existing law at the time was phasing in coverage for those with incomes up to 100 percent of FPL.
Benefits	Extends Medicaid coverage for immunizations against childhood diseases for all children up to age five who are eligible for food stamps. Reduces red tape in establishing eligibility by allowing parents to show up at immunization clinics and present their food stamp card.
Financing	Contains most of the spending reductions that had been proposed in the Reagan budget. Remaining proposed reduction comes from special administrative funding that the federal government provided to the states.
Status of enactment	Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369); Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985, P.L. 99-272); Omnibus Reconciliation Act of 1986 (OBRA 1986; P.L. 99-509); Omnibus Reconciliation Act of 1987 (OBRA 1987, P.L. 100-203); Medicare Catastrophic Coverage Act of 1988 (MCCA; P.L. 100-360); Family Support Act of 1988 (P.L. 100-485); Omnibus Budget Reconciliation Act of 1989 (OBRA 1989, P.L. 101-239); Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, P.L. 101-508) included expansions for certain pregnant women and children and other family members. OBRA 89 mandated coverage for pregnant women and children under age six in families with incomes at or below 133 percent of FPL (whether or not they were receiving AFDC cash assistance); expanded the EPSDT benefit for children under age 21 to include needed diagnostic and treatment services even if the services were not covered for adult beneficiaries; and required states to cover services provided by federally-qualified health centers (FQHCs).
Note	President Bush did not submit a revision of President Reagan's FY 1990 budget. Instead, he submitted a 193-page message to Congress as part of an address to Congress on February 9, 1989, which included revised budget proposals.
Source	Congressional Quarterly (CQ). 1989. *CQ Weekly Report*. Feb 11. Christensen, M. 2012. Submission of the President's budget in transition years. Washington, DC: Congressional Research Service. https://www.fas.org/sgp/crs/misc/RS20752.pdf. Kaiser Family Foundation. *Medicaid: A timeline of key developments.* Washington, DC: Kaiser Family Foundation. https://kaiserfamilyfoundation.files.wordpress.com/2008/04/5-02-13-medicaid-timeline.pdf.

FY 1990	
Eligibility	Requires states to extend services to pregnant women and to infants up to age one in families with incomes below 130 percent of the federal poverty threshold. Current law has been phasing in coverage for those with incomes up to 100 percent of poverty.
Benefits	Extends Medicaid coverage for immunizations against childhood diseases for all children up to age five who are eligible for food stamps. Reduces red tape in establishing eligibility by allowing parents to show up at immunization clinics and present food stamp cards.
Financing	Restores most of what President Reagan had proposed in spending reductions. Remaining reductions decrease special administrative funding the federal government had provided to states.
Status of enactment	DEFRA, COBRA 1985, OBRA 1986, OBRA 1987, MCCA, the Family Support Act of 1988, OBRA 1989, and OBRA 1990 all included expansions for certain pregnant women and children and other family members. The Vaccines for Children program was established in OBRA 1993.
Source	Congressional Quarterly (CQ). 1989. Bush's budget revisions put Congress in a box. *CQ Almanac* .
FY 1991	
Program structure	The federal government pays higher matching rates for three years to encourage states to enroll Medicaid recipients in managed care plans. After that, reduced rates are paid for beneficiaries not enrolled in managed care plans. As an additional incentive to use managed care systems, permits states to enroll beneficiaries without asking for waiver authority. Lifts a number of restrictions on health maintenance organizations.
Financing	Proposes user fees to cover the costs of inspecting and certifying hospitals, nursing homes and home health agencies for both Medicaid and Medicare. Under existing policy, these activities were funded by federal, state, and local governments.
Status of enactment	The Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) included a provision to allow managed care enrollment for certain Medicaid recipients without the need for a 1915(b) waiver.
Source	Congressional Quarterly (CQ). 1990. An analysis of the President's budgetary proposals. *CQ Weekly Report.* February 3. https://www.cbo.gov/sites/default/files/101st-congress-1989-1990/reports/90-cbo-008.pdf
FY 1992	
Eligibility	Expands Medicaid access for certain medically needy individuals by raising the income standards for medically needy pregnant women and children to levels for other pregnant women and children.
Financing	Enhances authority to collect medical support payments and allow custodial parent to file directly with the non-custodial parent's insurer for reimbursement for a child's medical payments. Reduces federal spending for survey and certification of nursing facilities by funding the activities through user fees to be collected from providers and deposited in a revolving fund.
Status of enactment	OBRA 1993 required states to enact laws prohibiting insurers from taking Medicaid status into account in enrollment or payment for benefits and to enact laws giving the state rights to payments by liable third parties. The Deficit Reduction Act of 2005 (DRA 2005, P.L. 109-171) required states to attest that they have laws in place to require health insurers to provide the information necessary to identify Medicaid enrollees with third party coverage and, within specified time limits, respond to inquiries from the state regarding claims, as well as to agree not to deny claims for specific administrative reasons.
Source	Congressional Budget Office (CBO). 1991. *Analysis of the President's budgetary proposals for fiscal year 1992.* March 1991. www.cbo.gov/sites/default/files/102nd-congress-1991-1992/reports/1991_03_analysisofpres.pdf.

FY 1993	
Program structure	Proposes an entitlement cap on all entitlements combined except Social Security, adjusting the total each year by the increase in eligible participants and general inflation, and then allowing a specific growth rate above that. Growth rate is higher prior to a comprehensive health reform (an average of 2.5 percent annually) and lower after that (average of 1.6 percent annually). Any projected increases above the cap require congressional action to bring the programs back into compliance. Lack of congressional action triggers automatic spending reductions.
Status of enactment	Not enacted
Source	Congressional Quarterly (CQ). 1992. *CQ Weekly Report*. Feb. 1.

President Bush Health Reform Proposal	
1993	**Proposal details**
Program structure	Proposes a comprehensive health care reform program, which includes the following components: - Low- and moderate-income families are eligible for transferable tax credits to help them pay for coverage. - Low-income families with no tax liability may collect their tax credits in a state-administered voucher that they could use to purchase private purchase insurance. - The credit and deductible amounts are indexed for inflation. - States, in collaboration with private insurers, develop basic benefit packages that match the price levels of the tax credit. State mandated benefits, premium taxes and limits on managed care arrangements are preempted. States are required to ensure that at least two companies offer basic policies at affordable prices. - Issuers are required to insure all those seeking coverage and coverage is guaranteed and renewable. The use of pre-existing condition exclusions is limited. - Premiums that insurers charge for similar policies cannot not vary by more than 50 percent. - To help pay for the tax credits, the open-ended entitlement for most of the acute care portions of Medicaid are eliminated and states receive an annually appropriated lump sum, based on each state's total per capita costs in 1992 and adjusted thereafter for inflation. During a phase-in period, states receive an extra payment, the total of which is lower than projected costs. - Medicaid for institutional care for elderly and disabled individuals and individuals dually eligible for Medicare and Medicaid is not affected.
Status of enactment	The Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) limited pre-existing condition exclusions for certain individuals. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) established tax credits for low- and moderate-income families to help them pay for health insurance coverage and extended the prohibitions on pre-existing condition exclusions. It included certain market reforms including guaranteed availability and prohibited pre-existing condition exclusions.
Source	Congressional Quarterly (CQ). 1992. *CQ Weekly Report*, 305–309. February 8.

EXHIBIT 3. Summary of Medicaid Proposals in Presidents' Budgets 1980–2015: Bill Clinton

President Clinton's proposed Health Security Act, described below, would have replaced Medicaid benefits for non-disabled, non-elderly beneficiaries with a voucher/premium subsidy for private coverage offered through regional health alliances. In 1996, President Clinton's Medicaid budget proposal revisited that approach by proposing to establish a per-person cap on Medicaid spending.

In President Clinton's second term, in addition to repeating the proposal to establish a per-person cap on Medicaid spending (1997), other Medicaid proposals addressed options for expanding coverage for new immigrants, for parents of low-income children, the working disabled, women with breast and cervical cancer, and people in need of an institutional level of care.

Proposal summary	
Fiscal year (FY) 1994	
Benefits	Lifts the requirement that states pay for personal-care services both in the home and outside the home. Assumes that if the mandate were lifted, most states would elect not to cover personal-care expenses.
Financing	Reduces federal share of Medicaid administrative costs so that it is 50 percent for all services.
Status of enactment	Not enacted
Source	Congressional Quarterly (CQ). 1993. *CQ Weekly Report,* 370-373. February 20. Congressional Budget Office (CBO): 1993. *An analysis of the President's budgetary proposals for FY 1994.* March 1993. https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/doc25.pdf.
FY 1995	
Program structure	Incorporates the Administration's health reform proposal described in more detail below. Under the proposal, most Medicaid beneficiaries receive subsidies toward the purchase of a privately sponsored health insurance plan offered through regional alliances.
Financing	Provides emergency medical care under Medicaid for undocumented immigrants through creation of a grant program providing $150 million each year in discretionary funds to help states with a disproportionate burden of funding those emergency services.
Other features	Provides increased funding for the Vaccines for Children (VFC) program.
Status of enactment	The Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) provided temporary grants to states for undocumented immigrants.
Source	*The budget message of the President, FY 1996.* www.gpo.gov/fdsys/pkg/BUDGET-1996-BUD/pdf/BUDGET-1996-BUD.pdf. Congressional Budget Office (CBO): 1993. *An analysis of the President's budgetary proposals.* March 1993, https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/doc25.pdf.

FY 1996	
Financing	Provides $150 million to cover some of the emergency medical costs of undocumented immigrants under Medicaid; $300 million in funding to states to help cover costs associated with incarcerating criminal illegal aliens; $100 million to help school districts with high numbers of immigrant students; and imposes a limit on pensions paid to veterans receiving nursing home care paid for by Medicaid. About half of those savings are offset by proposed higher Medicaid costs.
Status of enactment	The Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33) provided temporary grants to states for undocumented immigrants.
Source	Congressional Budget Office (CBO): 1995. *An analysis of the President's budgetary proposals for fiscal year 1996.* April 1995. www.cbo.gov/sites/default/files/104th-congress-1995-1996/reports/doc05-entire_0.pdf. *The budget message of the President, FY 1996.* https://fraser.stlouisfed.org/docs/publications/usbudget/BUDGET-1996-BUD.pdf.
FY 1997	
Program structure	Imposes per capita caps on federal payments to the states and limits the growth in those caps to slightly more than the rate of economic growth per person. Retains eligibility and benefit guidelines in place at the time. Establishes caps for the four main groups of people eligible for Medicaid: aged, disabled, children, and other low-income adults. Allows states whose average spending for one group was below the cap to apply the savings to other groups.
Financing	Limits Medicaid payments to disproportionate share hospitals (DSH). Savings are partly offset by supplemental payments for federally qualified health centers, rural health clinics, and other purposes.
Payment	Repeals the Boren amendment eliminating federal provider payment requirements for hospitals and nursing homes.
Other features	Allows states to extend Medicaid to people with income below 150 percent of the federal poverty level (FPL), to enroll individuals into managed care plans, and into home and community based services (HCBS) care without federal waivers.
Status of enactment	The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) enacted a state option for coverage of individuals with income below 138 percent FPL. As noted above, BBA 1997 included a state option to enroll certain Medicaid beneficiaries into managed care plans without the need for waivers and also repealed the Boren amendment. Ceilings on Medicaid payments to DSH hospitals were initially established in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) but those caps were lowered in BBA 1997. The Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) later raised those caps. Subsequent legislation, including the ACA has reduced then raised those amounts repeatedly.
Source	*Budget of the United States Government, FY 1997.* https://www.gpo.gov/fdsys/pkg/BUDGET-1997-BUD/pdf/BUDGET-1997-BUD.pdf.

FY 1998	
Program structure	Imposes per capita caps on federal payments to the states and limits the growth in those caps to slightly more than the rate of economic growth per person.
Eligibility	Adds more children to the program by allowing states to guarantee at least 12 months of continuous eligibility after a child becomes eligible for Medicaid. Increases Medicaid enrollment among children who are already eligible for benefits as a by-product of giving states grants to expand children's health insurance coverage. Repeals provisions in the prior year's welfare reform enacted in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193) that removed certain legal aliens and disabled children from the Medicaid rolls.
Financing	Limits Medicaid DSH payments. Savings are partly offset by supplemental payments for federally qualified health centers, rural health clinics, and other purposes. Increases the federal government's share of Medicaid spending for the District of Columbia by having the federal government pay the minimum allowable state match in addition to the federal match that it then was paying. The total share of Medicaid borne by the federal government increases to 70 percent from 50 percent.
Status of enactment	BBA 1997 (enacted in August of 1997) restored eligibility for legal immigrants who entered the country prior to August 22, 1996 and later became disabled. BBA 1997 also continued Medicaid eligibility for children with disabilities who would have lost their Supplemental Security Income (SSI) and Medicaid eligibility due to the restrictions on legal aliens enacted in 1996. BBA 1997 also reduced Medicaid payments to DSH hospitals.
Source	Congressional Budget Office (CBO): 1997. *An analysis of the President's budgetary proposals for fiscal year 1998.* March 1997. www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/Pb03-97.pdf
FY 1999	
Eligibility	Allows states to conduct presumptive checks of Medicaid eligibility at a broader range of sites; permits states to restore Medicaid benefits for legal immigrant children; and increases aid to U.S. territories to purchase health insurance for children.
Financing	Reduces the federal matching rate for Medicaid administrative expenses from 50 percent to 47 percent and increases funding in order to expand the use of a $500 million fund to help states determine eligibility for people who lose welfare benefits but retain Medicaid eligibility.
Status of enactment	The Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L. 106-113) extended the availability of the $500 million fund to assist with the transitional cost of PRWORA.
Source	Congressional Budget Office (CBO): 1998. *An analysis of the President's budgetary proposals for FY 1999.* March 1998. www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/pb03-98.pdf

FY 2000	
Eligibility	Key provisions of the President's proposed FY 2000 budget include: - extending Medicaid to older foster children (up to age 21 but who left the system at age 18) and to pregnant qualified immigrants who entered the country after August 22, 1996; - restoring SSI for qualified aliens, regardless of age, who entered U.S. after August 22, 1996, who became disabled anytime after and who have been here at least 5 years but barred from SSI under restrictions imposed by the welfare reform law (PRWORA) enacted in 1996; - giving states the option to expand Medicaid and CHIP to qualified children who entered the U.S. after August 22, 1996, who also lost coverage due to 1996 welfare reform law (PRWORA); and - improving transitional Medicaid programs to help working poor by eliminating burdensome reporting requirements that enable them to retain temporary health insurance through Medicaid until they can afford private health insurance. Additionally, existing law provided a state option to expand Medicaid eligibility to workers with disabilities with earned income up to 250 percent of poverty, and they could require these individuals to pay a state-established premium to qualify. The budget proposal expands this Medicaid buy-in by allowing states to cover people with disabilities with earned income above 250 percent of poverty, and by lifting or relaxing then current limits on assets and on unearned income. The proposal also gives states the option to extend Medicaid to individuals with incomes up to 300 percent of SSI if the state determines that they need an institutional level of care and if they receive services under the plan. Permits states to target this eligibility option to individuals receiving specific kinds of long-term care services; for example, personal care services. Under existing law at the time, an individual could only qualify for Medicaid under the higher income level if they entered a nursing home or if they are served under a state's HCBS waiver program for long-term care.
Benefits	Provides $50 million in demonstration grants to states for testing innovative asthma disease management techniques for children enrolled in Medicaid.
Payment	Provides for a one year increase of $9 million to the DSH cap for the District of Columbia in FY 2000 to reflect the BBA increase in the FMAP for the District from 50 percent to 70 percent.
Financing	Establishes an inflation-based rebate for generic drugs; reduces duplicate Medicaid payments that were improperly included in Temporary Assistance for Needy Families (TANF) block grants and also charged to Medicaid.
Status of enactment	The Foster Care Independence Act of 1999 (P.L. 106-169) gave states the option to extend Medicaid coverage to former foster care recipients who are age 18, 19, or 20. In addition, the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) allowed states the option to cover working persons with disabilities at higher income and resource levels.

Source	U.S. Department of Health and Human Services (HHS). 1999. HHS Budget in Brief for FY 2000. http://wayback.archive-it.org/3920/20130927190105/http://archive.hhs.gov/budget/fy01budget/hhs2000.pdf; Congressional Budget Office (CBO): 1999. *An analysis of the President's budgetary proposals for FY 2000.* April 1999. cbo.gov/sites/default/files/106th-congress-1999-2000/reports/pb04-99.pdf.
FY 2001	
Eligibility	The proposed Family Care Program would increase funding for Medicaid and the State Children's Health Insurance Program (CHIP) over five years to give states the option to expand coverage to parents of eligible children. Accelerates enrollment of uninsured children eligible for Medicaid and CHIP by giving states the option to share federally funded free and reduced-price school lunch program eligibility information with the state Medicaid agency, and expanding the sites that may determine presumptive eligibility. Requires states to apply the same applicability and eligibility simplifications to the Medicaid program as states apply to the CHIP program. Repeats proposals from FY 2000 budget related to giving states the option to extend coverage to immigrants who lost coverage due to PRWORA, expand eligibility for children through age 20, extend transitional Medicaid, and extend Medicaid to individuals with incomes up to 300 percent of SSI. Creates a new Medicaid eligibility option for states to cover uninsured women who have been diagnosed with breast cancer or cervical cancer through the Centers for Disease Control (CDC) early detection program. Women covered under this option would receive the full Medicaid benefits package for the entire time they require cancer treatment. Also gives states the option to allow qualified entities to determine such women to be presumptively eligible for up to two months so that cancer treatment can begin without delay while the regular application process takes place.
Benefits	Provides funding to selected state Medicaid programs on a competitive basis to improve treatment of asthma. Requires states to cover prescription and certain non-prescription smoking cessation drugs at the regular matching rate. Gives states authority to decide which non-prescription drugs to cover.
Payment	Increases transparency by requiring the Secretary of the U.S. Department of Health and Human Services (the Secretary) to disclose drug average manufacturer prices (AMPs) to states to use in setting drug payment rates.
Financing	Reduces duplicate Medicaid payments that are improperly included in TANF block grants and also charged to Medicaid, and applies an inflation based rebate to generic drugs.
Other features	Establishes a new enforcement tool for the Secretary to reduce Federal Medical Assistance Percentages (FMAP) when a state fails to comply with federal requirements, and includes several child support enforcement proposals including requiring states to review child support orders for TANF families every three years that would result in Medicaid savings.
Status of enactment	The Breast and Cervical Cancer Treatment and Prevention Act of 2000 (P.L. 106-354) allowed states to extend coverage to uninsured women needing treatment for breast or cervical cancer.
Source	U.S. Department of Health and Human Services (HHS). 2000. HHS budget in brief for FY 2001. www.hhs.gov/asfr/ob/budgets-in-brief-performance-reports.html.

Health Security Act (President Clinton's Health Reform Proposal)	
1993	**Proposal details**
Program structure	Establishes federally administered regional purchasing cooperatives through which everyone purchases health insurance coverage, including most Medicaid beneficiaries. People entitled to Medicaid benefits because they also receive cash welfare payments may obtain subsidies subject to a ceiling for health coverage through Medicaid but, like almost everyone else, receive coverage only for standard benefits offered by health plans available through the regional alliances. Other non-cash beneficiaries are no longer be eligible for Medicaid, but most are eligible for subsidies toward their premiums for coverage purchased through alliances. Other provisions encourage more work-sponsored health benefits, presumably reducing Medicaid enrollment. States assume responsibility for the long-term care portion of Medicaid under a program of capped grants.
Benefits	Proposes that Medicaid beneficiaries receive the same standard benefit package that others receive under health plans sold through regional alliances. Children, however, continue to have access to all current Medicaid benefits. Those wrap-around benefits are fully paid for by the federal government. Those receiving Medicaid benefits who do not receive cash benefits no longer qualify for the program but may obtain an income based premium subsidy toward a plan offered through regional alliances. Proposes that enrollees with disabilities receive services under a new matching HCBS grant program to states. Federal contributions for the program are capped and grants rise each year to account for changes in the consumer price index and the size of the disabled population. Under the HCBS program, states are required to impose cost-sharing requirements on all program participants on a sliding scale according to income: participants with family income below 150 percent of the poverty level pay nothing; those with family income at or above 250 percent of the poverty level pay the maximum cost-sharing rate of 25 percent. Proposes to gives states the option to raise the amount of assets that may be excluded when determining the eligibility of single individuals for nursing home services (the asset disregard) from the existing limit of $2,000 to as high as $12,000. Requires states to grant eligibility for nursing home services to people who would meet the income and asset requirements for eligibility if their nursing home expenses were deducted from their income. At the time, states have the option to grant eligibility to this group of people, but about one-third of the states do not do so. A third provision requires all states to allow nursing home residents who are Medicaid beneficiaries to keep at least $50 a month for their personal needs. The federal government pays for the resulting increase in Medicaid spending.
Cost sharing	People under 150 percent of FPL receive full premium subsidies pegged to the average cost plan. Special subsidies for cost sharing also apply to Medicaid beneficiaries, who pay only 20 percent of the copayment amounts required by lower- or combination-cost-sharing plans. The plans themselves generally finance the cost-sharing subsidies for Medicaid beneficiaries.
Financing	Requires states to contribute to the cost of premium subsidies for cash beneficiaries using normal federal matching percentages. In addition, requires states to make maintenance of effort payments to the federal government for the spending on Medicaid that would have occurred under the traditional program.
Other features	Discontinues payments to disproportionate share hospitals. Establishes a Medicaid commission to study options regarding the use of a block grant or other mechanisms to convert payments for services not covered in the comprehensive benefit package using approaches that give the states greater flexibility in targeting and delivering needed services. The commission would also study the integration of acute and long-term care services together into comprehensive benefit packages, and consolidating institutional and HCBS long-term care under a global budget for long-term care services.

Status of enactment	Most provisions were not enacted.
Note	The text of the insurance provisions of the Health Security Act was introduced as a bill, H.R. 3600, in the 103rd Congress in November of 1993 and can be found here: https://www.gpo.gov/fdsys/pkg/BILLS-103hr3600ih/pdf/BILLS-103hr3600ih.pdf.
Source	Congressional Budget Office (CBO): 1994. *An analysis of the administration's health proposal.* February 1. https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/doc07.pdf.

EXHIBIT 4. Summary of Medicaid Proposals in Presidents' Budgets 1980–2015: George W. Bush

The Medicaid proposals offered in President George W. Bush's first term included new flexibilities for states and addressed cost containment for the program. Through waiver initiatives and other proposals, states would have had more flexibility to use private health insurance, to keep people who are in need of institutional care in the community, and to increase access to health insurance among the uninsured under Medicaid in a budget neutral fashion. Cost containment proposals mostly focused on Medicaid financing mechanisms such as intergovernmental transfers and upper payment limits (UPL), and would have modified Medicaid drug rebates and tightened eligibility rules regarding assets and asset transfers.

In President Bush's second term, the number of Medicaid proposals grew and more were added focusing on financial integrity and reducing program spending. Some of those proposals required legislation, but some would have required administrative actions such as regulations or guidance. Especially in 2008 and 2009, President Bush's budget proposals included strengthening financial integrity by tightening the use of provider specific taxes, UPL, and claiming around school based services. Savings would have been achieved through eliminating payments for graduate medical education, reductions in federal matching for administrative costs, targeted case management and additional rebates for prescription drugs.

Proposal summary	
FY 2002	
Program structure	Encourages the purchase of private health insurance through health care tax credits. It also explores "a range of options for reforming Medicaid and the State Children's Health Insurance Program (SCHIP) to improve the way these programs provide health care to the poor and near poor. After consulting with the states, the Administration would develop ideas to increase State flexibility, emphasizing giving states the flexibility to use private insurance, when possible, and to coordinate with employment-based insurance for those who have access to it. The Administration would also work with states to maintain and reinforce the fiscal integrity of the Medicaid and SCHIP programs by controlling Medicaid costs and ensuring the fiscally prudent management of these programs."
Financing	Prohibits new hospital UPL plans approved after December 31, 2000 from receiving the higher UPL proposed in the final rule, which had allowed local government-operated hospitals to receive up to 150 percent of what Medicare would pay for the same services.
Status of enactment	Not enacted. (UPL was addressed in subsequent regulations.)
Source	U.S. Department of Health and Human Services (HHS). 2001. HHS budget in brief for FY 2002. http://www.hhs.gov/asfr/ob/budgets-in-brief-performance-reports.html

FY 2003	
Program structure	Includes the New Freedom Initiative: An initiative to remove barriers to community living for people with disabilities. Proposes three new demonstrations: - Two of the proposed demonstrations would provide respite services, one for caregivers of disabled adults and the other for caregivers of children with substantial disabilities. - The third proposed demonstrations would make home and community-based services (HCBS) waiver services available to children residing in psychiatric residential treatment facilities. In addition, proposes to fund a discretionary demonstration designed to address shortages of community direct care workers. Also includes the Health Insurance Flexibility and Accountability (HIFA) Demonstraiton. In August 2001, the Administration introduced the HIFA demonstration initiative to give states "the flexibility they need to design innovative ways to increase access to health insurance coverage for the uninsured." Building on HIFA, the budget proposes to work with stakeholders to develop proposals to give states: 1) the statutory authority to provide broader coverage to low-income uninsured Americans and 2) the flexibility to design innovative programs without the use of waivers. States would be encouraged to use their current resources to extend coverage to more of their neediest residents and reduce their uninsured population, focusing on those with incomes at or below 200 percent of the Federal Poverty Level (FPL).
Eligibility	Extension of Transitional Medical Assistance (TMA). Enacted in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193), also referred to as welfare reform, TMA was scheduled to sunset in September 2001. Congress extended the sunset date until September 30, 2002. The proposal extends it for one additional year, and saves money by establishing a standard for accuracy in Supplemental Security Income (SSI) disability awards identical to the one which applies to Social Security Disability Insurance (SSDI).
Benefits	Proposes model drug waiver for states to offer drug-only coverage to low-income Medicare beneficiaries.
Financing	Changes the way the Medicaid drug rebate is calculated from the difference between a manufacturer's best price and the Average Manufacturer's Price (AMP) to the difference between the best price and the Average Wholesale Price (AWP). Requires manufacturers to report both AMP and AWP to the U.S. Department of Health and Human Services (HHS).
Other features	Provisions related to program integrity strengthen enforcement of Medicare upper payment limits (UPL) and school-based health reimbursements.
Status of enactment	The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) addressed the definition of AMP and made other changes to prescription drug rebate provisions as did the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Both bills also addressed Medicaid program integrity as did the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). TMA was made permanent in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).
Source	U.S. Department of Health and Human Services (HHS). HHS budget in brief for FY 2003. http://www.hhs.gov/asfr/ob/budgets-in-brief-performance-reports.html.

FY 2004	
Program structure	Includes the Money Follows the Individual Rebalancing Demonstration. Under this proposed five-year demonstration project, the federal government will fully reimburse states for one year of Medicaid services for individuals who moved from institutions into home care. After this initial year, states are responsible for matching the federal government at their respective Federal Medical Assistance Percentage (FMAP) rates. Eliminates the legislative prohibition on developing more Partnership for Long-Term Care programs. The Partnership was formulated to explore alternatives to long-term care financing by blending public and private insurance. Four states had these partnerships at the time, whereby private insurance was used to cover the initial cost of long term care. Consumers who purchased Partnership-approved insurance policies could become eligible for Medicaid services after their private insurance was exhausted without divesting all their assets as is typically required to meet Medicaid eligibility criteria.
Eligibility	Extends the Qualifying Individual (QI) program benefit for five years; and TMA through FY 2008. Proposes to simplify TMA by giving States the option to offer 12 months of continuous eligibility to eligible participants; allow states to waive income reporting requirement for beneficiaries; and allow states with Medicaid eligibility for children and families with incomes up to 185 percent FPL to waive their TMA program requirements. It also gives states the option of offering TMA recipients "Health Coupons" to purchase private health insurance instead of offering traditional Medicaid benefits. Other key provisions related to eligibility include: - New Freedom Initiative: proposes the same demonstrations as proposed in FY 2003 budget. - Presumptive eligibility for community-based services: establishes a state Medicaid option allowing presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community. Intent is to increase number of beneficiaries who received HCBS.
Benefits	Vaccines for Children program: lifts the price cap on the tetanus-diphtheria booster to increase access to eligible children. Also allows under-insured children to receive VFC administered inoculations at state and local health departments in addition to Federally Qualified Health Centers. Clarifies state ability to purchase allowable durable medical equipment or assistive devices up to 60 days prior to patient discharge from a nursing home.
Payment	Eliminates the requirement that states make room and board payments to hospice for Medicaid and dually eligible beneficiaries residing in a nursing facility who are also receiving hospice services. Requires the state to make these room and board payments directly to the nursing facilities.
Financing	Requires states to review child support cases for TANF families every three years, increasing the number of state medical child support reviews for TANF recipients.
Status of enactment	DRA 2005 established the Money Follows the Person demonstration for a limited number of states to make targeted reforms to strengthen the community-based infrastructure and “rebalance” their long-term care support systems.
Source	U.S. Department of Health and Human Services (HHS). 2004. HHS budget in brief for FY 2004. www.hhs.gov/asfr/ob/budgets-in-brief-performance-reports.html.

FY 2005	
Program structure	Includes the same proposals for Money Follows the Individual and for Partnership for Long-Term Care as in the FY 2004 budget proposal. Also includes proposals for Living with Independence, Freedom, and Equality (LIFE) Accounts: gives states the option of allowing individuals who self-direct all of their community-based long-term care services to accumulate savings and still retain eligibility for Medicaid and SSI.
Eligibility	Key eligibility provisions include the following: - an extension of QI program through FY 2005 and TMA program beyond FY 2004, but does not specify for how long; - the same proposed demonstrations for the New Freedom Initiative in the FY 2004 budget proposal; - presumptive eligibility for community-based services, as proposed in the FY 2004 budget proposal; and - provisions related to the spousal exemption, extending eligibility for Medicaid benefits to the spouses of individuals with a disability who are entering the workforce. Also includes proposals related to the refugee and asylee exemption extension. Under existing law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date were not eligible for SSI (and therefore Medicaid) until they had resided in the country for five years or have obtained citizenship. Refugees and asylees on SSI were exempted from this ban for the first seven years they resided in the U.S. “Procedural delays and asylee waiting lists have created a situation in which seven years may not be enough for these groups of immigrants to gain American citizenship.” To assure that refugees and asylees have ample time to complete the citizenship process, proposes that the seven year exemption be extended to eight years. The policy would continue through 2007.
Benefits	Same provisions related to the Vaccines for Children program as proposed in the FY 2004 President's budget.
Financing	Restricts the use of intergovernmental transfers and limit federal matching to state and local government providers to the cost of providing services to Medicaid beneficiaries. Reduces the enhanced federal matching rate for information and claims managements systems from 90 percent to 75 percent.
Other features	Allows states to seek medical child support from both custodial and non-custodial parents and to require states to review child support orders for TANF families every three years.
Status of enactment	The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) permanently extended TMA.
Source	U.S. Department of Health and Human Services (HHS). 2004. HHS budget in brief for FY 2005. www.hhs.gov/asfr/ob/budgets-in-brief-performance-reports.html.

FY 2006	
Program structure	Same proposals for the Money Follows the Individual and Partnership for Long Term Care programs as proposed in the FY 2004 President's budget.
Eligibility	Extends the QI program for one year and TMA benefits through September of 2006 (Congress had extended TMA through March 2005). Permits states the option to offer 12 months of continuous coverage to eligible participants; waives income reporting requirements for beneficiaries; and allows states that offered Medicaid eligibility for children and families with incomes up to 185 percent of FPL to waive TMA assistance altogether. Also includes the same proposals related to presumptive eligibility for community-based services as proposed in the FY 2004 President's budget. Additionally includes two legislative changes to the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) to ensure that Medicaid and SCHIP beneficiaries receive the benefits of HIPAA related coverage: (1) that the determination of eligibility for Medicaid or SCHIP as a qualifying event allow access to employer-sponsored insurance (ESI). This change allows families to enroll in ESI through special enrollment even if they miss their employer's open period for enrollment. (2) Requires SCHIP programs to issue certificates of creditable coverage, which, in turn, verifies the period of time an individual is covered by a specific health insurance policy.
Benefits	Establishes a 10-year Community Alternative to Children's Residential Treatment Facilities demonstration to enable states to offer HCBS to children who would otherwise be served in psychiatric residential treatment facilities. Also establishes the Respite for Caregivers of Disabled Adults demonstration and the Respite for Caregivers of Children with a Substantial Disability to test whether respite care, or temporary care, reduces primary caregiver "burn-out" that often leads to institutionalization of individuals with disabilities; to allow states to provide respite care to caregivers of children with substantial disabilities; and to enable HHS to collect specific data about the cost and utilization of respite services for caregivers of disabled children. Includes the same provisions related to the Vaccines for Children Program as proposed in the FY 2005 President's budget.
Payment	Restructures pharmacy reimbursement to more closely align pharmacy reimbursement to pharmacy acquisition costs; clarifies which services could be claimed under targeted case management (TCM) and provides for lower reimbursement for TCM services to the administrative matching rate of 50 percent. Also codifies Medicaid free care policy in regulation. Under then current rules, the Medicaid program prohibited states from billing the federal program for any service that would be provided to non-Medicaid eligible individuals free of charge. The proposed regulatory change codifies this policy in regulation to eliminate any legal ambiguity surrounding this topic.

Financing	Under then current law, taxes imposed on providers could not exceed 6 percent of total revenues and had to be applied uniformly across all health care providers in the same class.The proposal: (1) phases down the allowable tax rate from six percent to seven percent; and (2) requires managed care organizations (MCOs) to meet the same provider tax requirements as other classes of health providers. The proposal also: - curtails the practice of transferring of assets to obtain Medicaid eligibility for LTC services by tightening existing rules; - curtails inefficient Medicaid administrative spending by establishing an allotment for Medicaid administrative claiming; - increases the number of audits and evaluations of state Medicaid programs, and to allocate $20 million from the Health Care Fraud and Abuse Account and $5 million in discretionary funding to finance this work; and - replaces best price with a budget neutral flat rebate, allowing private purchasers to negotiate lower drug prices.
Status of enactment	DRA 2005 revised Medicaid asset transfer rules, included a number of new program integrity provisions, specified a definition for targeted case management services, and revised the federal upper limits applicable to multiple source drugs and the definition of a multiple source drug.
Source	U.S. Department of Health and Human Services (HHS). 2005. HHS budget in brief for FY 2006. http://wayback.archive-it.org/3920/20130927185724/http:/archive.hhs.gov/budget/06budget/.
FY 2007	
Eligibility	Extends TMA through September 30, 2007 (DRA 2005 extended it through December 2006). Includes the same HIPAA proposals as the FY 2006 President's budget. Cover the Kids: Provides $100 million in annual grants in the State Grants and Demonstrations account for states working with schools and community organizations to enroll and provide coverage to eligible children in Medicaid and SCHIP.
Payment	Lowers Medicaid reimbursement for targeted case management services to the administrative matching rate of 50 percent and limits Medicaid reimbursement for multiple source drugs to 150 percent percent of the average manufacturers' price. Additionally, caps payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries, and recovers federal funds that are diverted from government providers and retained by the state. Prohibits federal reimbursement for school-based administration or transportation costs.

Financing	Includes the following key financing provisions: - changes third party liability rules by allowing states to avoid costs for prenatal and preventive pediatric care claims where a third party is responsible through a non-custodial parent's obligation to provide coverage; - explicitly permits states to use liens against liability settlements to recover federal matching payments; - updates drug rebate calculations and allows private purchasers to negotiate lower drug prices; - allows states to use managed formularies to leverage discounts through negotiations with drug manufacturers; - reduces duplicate Medicaid payments that were improperly included in TANF block grants and also charged to Medicaid; - strengthens third party liability for prescription drug costs, requiring states to uphold the cost avoidance standard for pharmacy claims, thereby eliminating what is known as pay and chase; and - reforms provider taxes by phasing down the allowable provider tax rate from six percent to three percent, and issuing regulations clarifying existing policies used to determine what provider taxes comply with statute and regulations.
Other features	Clarifies allowable services that can be claimed as rehabilitation services for DSH hospitals.
Status of enactment	The Tax Relief and Health Care Act of 2006 (P.L. 109-432) codified the maximum rate at which a state can tax its health care providers at six percent, in effect on November 1, 2006. It also lowered the rate temporarily through 2011, after which it reverted to six percent. The same legislation extended TMA through June 30, 2007. MACRA permanently extended TMA.
Source	U.S. Department of Health and Human Services (HHS). 2006. HHS budget in brief for FY 2007. https://wayback.archive-it.org/3920/20130927190142/http:/archive.hhs.gov/budget/07budget/centersformed.html.
FY 2008	
Eligibility	Extends QI and TMA programs through September 2008. Includes refugee exemption extension similarly proposed in FY 2005, and modifications to HIPAA as proposed in the budget proposals for FYs 2006 and 2007. Eliminates the state option to increase the $500,000 home equity limit.
Benefits	Clarifies in regulation services that may be claimed as rehabilitation services, which are optional Medicaid services typically offered to individuals with special needs or disabilities. Issues guidance defining 1915(b)(3) in order to clarify which services provided under section 1915(b)(3) of the SSA are allowed.

Payment	Includes the following key payment provisions: - reimburses TCM at 50 a percent matching rate; - reduces the federal UPL for multiple source drugs to 150 percent percent of the AMP of the lowest priced drug in the group; - allows states to use private sector management techniques to leverage greater discounts through negotiations with drug manufacturers; - replaces the best price component of the Medicaid drug rebate formula with a budget neutral flat rebate; - revises “upper payment limit” payments for government providers by recovering federal funds diverted from government providers and retained by the state; - caps payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries. - utilizes administrative actions to phase out Medicaid reimbursement for some school-based services including transportation and administrative claiming related to Medicaid services provided in schools; - eliminates Medicaid funding for graduate medical education (GME); and - provides further clarification of allowable DSH costs that may be claimed for federal reimbursement.
Financing	Includes the following key financing provisions: - clarifies provider tax limitations; - aligns all administrative federal matching rates at 50 percent; - reduces duplicate Medicaid payments that were improperly included in TANF block grants and also charged to Medicaid; - avoids costs for prenatal and preventive pediatric claims where a third party is responsible; - collects for medical child support where health insurance is derived from a non-custodial parent’s obligation to provide coverage; and - recovers Medicaid expenditures from beneficiary liability settlement.
Other features	Requires states to report on Medicaid performance measures and link performance to Federal Medicaid grant awards; and uphold the cost avoidance standard for pharmacy claims, and eliminate waivers that permit pay and chase. Also requires tamper-resistant prescription pads. Expands the Social Security Adiminstration's pilot using electronic financial records to verify an applicant’s assets. Extends the renewal period for 1915(b) freedom of choice waivers from two to three years.
Status of enactment	TMA was extended several times and ultimately made permanent in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).
Source	U.S. Department of Health and Human Services (HHS). HHS budget in brief for FY 2008. https://wayback.archive-it.org/3920/20130927185643/http://archive.hhs.gov/budget/08budget/2008budgetinbrief.pdf.

FY 2009	
Program structure	Establishes a state plan amendment option to expand on the flexibility provided in the DRA, which allows states to offer private sector-type coverage to certain Medicaid populations. Provides states with greater flexibility for determining cost effectiveness and information sharing with employers to streamline the implementation of Medicaid employer-sponsored insurance programs. Gives states greater flexibility in coordinating care for special populations by allowing them to enroll populations described in Section 1932(a)(2) of the Social Security Act (the Act) into managed care programs under the state plan. Also extends the renewal period for 1915(b) freedom of choice waivers from two to three years to simplify program administration.
Eligibility	Extends the QI program through September 30, 2009 and TMA through September 30, 2009. Modifies HIPAA as proposed in the budgets for FYs 2006-2008, and extends the refugee exemption proposed in the budget for FY 2008.
Payment	Aligns federal matching rates for administrative activities at 50 percent, famility planning services and supplies to a state's regular FMAP, targeted case management services with the standard administrative matching rate of 50 percent, and the QI prorgram to a state's regular FMAP. Also reduces the federal upper limit on reimbursement for multiple source drugs to 150 percent. Codifies in regulation the long-standing Medicaid free care policy under which providers cannot bill Medicaid for services furnished to the public and other payors at no cost.
Financing	Includes the following key financing provisions: - removes the state option to increase the $500,000 home equity limit. Codifies the limit at $500,000 increased by the Consumer Price Index (CPI) for years after 2011; - replaces the best price component of the Medicaid drug rebate formula with a budget neutral flat rebate; - enhances Third Party Liability related to prenatal and preventive pediatric claims, as proposed in the FY 2008 President's budget; - provides technical corrections to the web based asset verification demonstration included in the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (P.L. 110-90), and extends the demonstration permanently; - implements cost allocation, recouping duplicative administrative costs inappropriately included in the TANF block grants; and - issues regulation defining 1915(b)(3) services, specifying which services are allowable for managed care savings under section 1915(b)(3) of the Social Security Act.

Other features	Requires states to report on performance measures and link to federal Medicaid grant awards and to participate in the Public Assistance Reporting Information System (PARIS) to verify an applicant's eligibility for services through state and federal data matching. Includes the National Correct Coding Initiative to correct coding by providers and prevent inappropriate billing for services. Publishes the Annual Actuarial Report, increasing transparency through the publication of an annual actuarial report. Clarifies Inflation Protection in Partnership long-term care programs by establishing that long-term care insurance policies that include future purchase option inflation protection do not qualify as Partnership policies.
Status of enactment	The ACA made changes to the calculation for the federal upper limit on multiple source drugs.
Source	U.S. Department of Health and Human Services (HHS). 2008. HHS budget in brief for FY 2009. http://wayback.archive-it.org/3920/20131025141029/http://www.hhs.gov/about/budget/fy2009/fy2009bib.pdf.

EXHIBIT 5. Summary of Medicaid Proposals in Presidents' Budgets 1980–2015: Barack Obama

President Obama's first term included a set of miscellaneous Medicaid provisions. Because major Medicaid changes were enacted in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) the budget proposals often addressed fixes or minor improvements to the program that were not addressed in the ACA. In addition, in response to the recession, the fiscal year (FY) 2011 budget included a proposal to extend fiscal relief for states.

During President Obama's second term, a focus has been on program integrity proposals. The number of new proposals has increased each consecutive year, including those focusing on the prescription drug rebate program. Other proposals addressed an array of priorities such as strengthening services for children with mental health conditions, aligning care for dually eligible enrollees; and savings items, such as extending cuts to disproportionate share hospital (DSH) payments and capping payments for durable medical equipment (DME).

Proposal Summary	
FY 2010	
Benefits	Gives states the option to expand family planning services to non-pregnant women.
Financing	Increases minimum brand-name drug rebate from 15.1 percent to 22.1 percent of average manufacturer price (AMP) and extends drug rebates to Medicaid managed care organinizations (MCOs). Eliminates the loophole that enabled drug manufacturers to circumvent the additional rebate by creating new formulations of drugs and charging higher initial prices for these drugs. Also eliminates the Medicaid Improvement Fund and reallocates these savings to support broader reform of health care.
Other features	Mandates the National Correct Coding Initiative (NCCI) to promote correct coding by providers and prevent inappropriate billing for services that have been improperly coded.
Status of enactment	The ACA included provisions addressing all of these items
Source	U.S. Department of Health and Human Services (HHS). 2009. HHS budget in brief for FY 2010. http://wayback.archive-it.org/3920/20131028125705/http://www.hhs.gov/about/budget/fy2010/fy2010bib.pdf.
FY 2011	
Financing	Six-month temporary Federal Medical Assistance Percentage (FMAP) increase, extending by six months the temporary increased FMAP that was first provided by the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). Provides the increased FMAP rate to states through June 30, 2011.
Other features	Requires states to track and monitor prescription drug billing, prescribing, and utilization patterns that could be indicative of abuse or over-utilization.
Status of enactment	ARRA provided a temporary increase in the FMAP. This temporary increase had three components: (1) hold harmless provision ensuring that the base FMAP rate could not decrease in FYs 2009, 2010, or the first quarter of 2011; (2) a 6.2 percentage point FMAP increase for all states; (3) additional increases based on the severity of unemployment in each state.

Source	U.S. Department of Health and Human Services (HHS). 2010. HHS budget in brief for FY 2011.https://wayback.archive-it.org/3920/20140402145447/http://www.hhs.gov/about/budget/fy2011/fy2011bib.pdf
FY 2012	
Benefits	Extends Qualifying Individual (QI) and Transitional Medical Assistance (TMA) programs through September 2012.
Payment	Rebases DSH Allotments in FY 2021 to maintain the FY 2020 level of reductions in the ACA, and determines future allotments from the rebased level using existing law methodology. Also limits reimbursement for a state's aggregate Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services.
Financing	Phases down the Medicaid provider tax threshold from the existing law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond. Also prevents states from using federal funds to pay the state share of Medicaid or the State Children's Health Insurance Program (CHIP) unless authorized under law to specifically match Medicaid or CHIP funds.
Other features	Establishes a permanent hold harmless provision to adjust the poverty guidelines only when there is an increase in the Consumer Price Index for All Urban Consumers (CPI-U). Strengthens third-party liability to improve states' and providers' abilities to receive third-party payments for beneficiary services, as appropriate. This proposal allows states to avoid costs for prenatal and preventive pediatric claims when third parties are responsible, and allows providers to collect medical child support where health insurance is derived from a non-custodial parent, and to recover Medicaid expenditures from beneficiary liability settlements. Requires states to track high prescribers and utilizers of prescription drugs that may indicate abuse or excessive utilization of certain prescription drugs. Requires drug manufacturers to repay states for improperly reported items for Medicaid-covered prescription drug coverage. Requires full restitution to states for any covered drug improperly reported by the manufacturer on the Medicaid drug coverage list. Proposes to conduct regular audits of drug manufacturer compliance with requirements of Medicaid drug rebate agreements, to the extent they are cost effective. Increases penalties collected from drug manufacturers for fraudulent non-compliance with Medicaid prescription drug rebate agreements. Requires drugs to be properly listed with the FDA in order to receive Medicaid coverage (aligns Medicaid coverage requirements with Medicare requirements).
Status of enactment	Several subsequent bills enacted extension of DSH reductions, TMA, and the QI program. They include Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96); American Taxpayer Relief Act of 2012 (P.L. 112-240); Bipartisan Budget Act of 2015 (P.L. 114-67); and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).
Source	U.S. Department of Health and Human Services (HHS). 2011. HHS budget in brief for FY 2012. https://wayback.archiveit.org/3920/20140402145406/http://www.hhs.gov/about/budget/index.html#HHSBudgetinBriefandPerformanceHighlights.

FY 2013	
Benefits	Provides states with the flexibility to provide benchmark equivalent benefits to non-elderly, non-disabled adults with income that exceeds 133 percent of the federal poverty level (FPL). Extends TMA through calendar year (CY) 2013 and QI through CY 2014.
Payment	Rebases DSH allotments in FY 2021 to maintain the FY 2020 level of reductions in the ACA, and determine future allotments from the rebased level using existing law methodology, as proposed in the FY 2012 budget. Limits reimbursement for a state's aggregate Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services, as proposed in the FY 2012 budget.
Financing	Applies a single blended matching rate to Medicaid and CHIP starting in 2017 that would automatically increase if a recession forced enrollment and state costs to rise. Phases down the Medicaid provider tax threshold from the existing law level of six percent in FY 2014, to 4.5 percent in FY 2015, four percent in FY 2016, and 3.5 percent in FY 2017 and beyond (same as FY 2012).
Other features	Establishes a permanent hold harmless provision to adjust the poverty guidelines only when there is an increase in the Consumer Price Index for All Urban Consumers (CPI-U), as proposed in the FY 2012 budget. Also includes the same program integrity provisions as the FY 2012 proposal as well as the following: - requires drugs to be electronically listed with Food and Drug Administration (FDA) to receive Medicaid coverage; - increases penalties for fraudulent non-compliance on rebate agreements; - prevents use of federal funds to pay state share of Medicaid or CHIP; and - consolidates redundant error rate measurement programs, specifically the Medicaid Eligibility Quality Control (MEQC) and Medicaid Payment Error Rate Measurement (PERM) programs. See the FY 2013 Budget in Brief for additional integrity protection provisions applicable to both Medicare and Medicaid.
Status of enactment	See above for bills extending QI, TMA and Medicaid DSH.
Source	U.S. Department of Health and Human Services (HHS). 2012. HHS budget in brief for FY 2013. https://wayback.archive-it.org/3920/20140403203230/http://www.hhs.gov/budget/fy2013/budget-brief-fy2013.pdf.
FY 2014	
Benefits	Allows states to provide benchmark equivalent benefit coverage for non-elderly, non-disabled adults with income over 133 percent FPL, as proposed in the FY 2013 budget. Extends TMA and QI programs through CY 2014.
Payment	Rebases future DSH allotments. Legislation had extended DSH reductions through FY 2022, but in FY 2023, allotments would revert to levels that had been in effect prior to the ACA. Bases future state DSH allotments on states' actual DSH allotments as reduced by the ACA. Begins ACA DSH reductions one year later, in FY 2015 instead of the scheduled FY 2014. Spreads the payment reductions scheduled for FY 2014 over FY 2016 and FY 2017. Limits reimbursement for a state's aggregate Medicaid spending on certain DME services to what Medicare would have paid in the same state for the same services, as proposed in the FYs 2012 and 2013 proposals.

Other features	The proposal also: - establishes a permanent hold-harmless provision to adjust the poverty guidelines only when there is an increase in the CPI-U, as proposed in FYs 2012 and 2013; - clarifies Medicaid drug rebate and payment definitions and calculations, providing for a number of changes to clarify and improve the way Medicaid determines the Average Manufacturer Price (AMP) and Federal Upper Limits (FUL), including clarifying the definition of brand drugs, removing brand-name and authorized generic drug prices from the FUL and brand rebate calculations, and correcting the rebate formula for new drug formulations; - expands Medicaid Fraud Control Unit (MFCU) review to additional care in home and community-based services (HCBS) settings; - strengthens Medicaid third party liability by allowing states to delay payment of costs for prenatal and preventive pediatric claims when third parties are responsible to the extent beneficiary access to care is not negatively impacted, allowing states to collect medical child support where health insurance is available from a non-custodial parent, and allowing Medicaid to recover costs from beneficiary liability settlements; - includes program integrity provisions related to prescription drugs and rebates, which are similar to the proposals in the FY 2013 President's budget; and - for dually eligible individuals, provides the Secretary the authority to implement a streamlined appeals process for Medicare-Medicaid beneficiaries by allowing for more efficient integration of program rules and requirements, and ensures retroactive Medicare Part D coverage of newly eligible low-income beneficiaries. See FY 2014 HHS Budget in Brief for additional integrity protection provisions applicable to both Medicare and Medicaid.
Status of enactment	See above for laws extending QI, TMA and Medicaid DSH. TMA was extended several times and ultimately made permanent in MACRA 2015.
Source	U.S. Department of Health and Human Services (HHS). 2013. HHS budget in brief for FY 2014. https://wayback.archive-it.org/3920/20150326110529/http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.
FY 2015	
Eligibility	Permanently extends Express Lane Eligibility (ELE) for children. The CHIP Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) authorized ELE allowing state Medicaid or CHIP agencies to use another public program's eligibility findings to streamline eligibility and enrollment into Medicaid or CHIP. This authority was scheduled to expire at the end of FY 2014.
Benefits	Allows states to provide HCBS waiver services to children and youth eligible for psychiatric residential treatment facilities. Without this change, children and youth who meet this institutional level of care would not have the choice to receive HCBS waiver services and could only receive care in an institutional setting where residents are eligible for Medicaid. Provides states the flexibility to allow benchmark equivalent benefit coverage for non-elderly, non-disabled adults with income that exceeds 133 percent of FPL, as proposed in the budgets for FYs 2013-2014. Extends TMA through CY 2015 (existing law extended it through March 31, 2014). States that adopt the Medicaid expansion would be able to opt out of TMA, consistent with a related Medicaid and CHIP Payment and Access Commission (MACPAC) recommendation. Also extends the QI program through CY 2015 (existing law extended it through March 31, 2014.)

Payment	Extends the primary care payment increase through CY 2015. Includes mid-level providers and excludes emergency room codes to better target primary care. Rebases future DSH allotments. Existing legislation had extended DSH reductions through FY 2023. This would have extended them through FY 2024. Otherwise the allotments would revert to levels in effect prior to the ACA. Additionally, limits Medicaid reimbursement of DME based on Medicare rates, as proposed in the budgets for FYs 2012–2015.
Financing	Prohibits use of federal funds to pay state share of Medicaid or CHIP and strengthens the Medicaid drug rebate program by - clarifying the definition of brand drugs; - requiring an additional rebate for generic drugs whose prices grow faster than inflation; - clarifying the inclusion of certain prenatal vitamins and fluorides in the rebate program; - correcting a technical error to the ACA alternative rebate for new drug formulations; - limiting to twelve quarters the timeframe for which manufacturers can dispute drug rebate amounts; - excluding authorized generic drugs from average manufacturer price calculations for rebates for brand drugs; and - improving Medicaid drug pricing by calculating Medicaid Federal Upper Limits based only on generic drug prices.

Other features	Includes program integrity provisions related to prescription drugs and rebates, as proposed in the budgets for FYs 2013–2014. Requires manufacturers to make the drug rebate equal to the entire amount that the state has paid for the drugs in cases where the state improperly reported non-drug products to the Centers for Medicare and Medicaid Services (CMS) as covered outpatient drugs or reported drugs that the FDA has found to be less than effective under the Drug Efficacy Study Implementation as if they were not found to be less than effective. This would eliminate the incentive for manufacturers to improperly report information about drugs in these situations. Allows more regular audits and surveys of drug manufacturers to ensure compliance with requirements of Medicaid drug rebate agreements to the extent they are cost effective. Additionally, requires drugs to be electronically listed with FDA in order for them to be included in Medicaid coverage; increases penalties for fraudulent non-compliance on rebate agreements; and increases access to and transparecy of Medicaid drug pricing by funding a nationwide retail pharmacy survey. Also includes provisions relating to individuals dually eligible for Medicare and Medicaid. Provides the Secretary with the authority to implement a streamlined appeals process for dually eligible beneficiaries. Ensures retroactive Medicare Part D coverage of newly eligible low-Income beneficiaries.Pilots the Program of All-Inclusive Care for the Elderly (PACE) to individuals between age 21 and 55. Existing law limits PACE to individuals who are 55 years old or older and who meet, among other requirements, the state's nursing facility level of care. Includes additional program integrity proposals. Increases program integrity funding by $25 million per year (adjusted by the CPI-u) and expands the statutory authority for the Medicaid Integrity Program to increase program flexibility. Encourages territories to establish Medicaid Fraud Control Units (MFCUs) by exempting federal support for MFCUs from the cap on territories' funding and by exempting territories from the statutory ceiling on quarterly federal payments for the units. Allows MFCUs to receive federal matching funds for the investigation or prosecution of abuse and neglect in non-institutional settings. Requires states to track high prescribers and utilizers of prescription drugs in Medicaid. Alleviates state program integrity reporting requirements and creates a streamlined audit program by consolidating the Medicaid Eligibility Quality Control and Medicaid Payment Error Rate Measurement programs. See FY 2015 HHS Budget in Brief for additional integrity protection provisions applicable to both Medicare and Medicaid.
Status of enactment	See above for bills extending QI, TMA and Medicaid DSH. TMA was extended several times and ultimately made permanent in MACRA.
Source	U.S. Department of Health and Human Services (HHS). 2014. HHS budget in brief for FY 2015. www.hhs.gov/about/budget/fy2015/budget-in-brief/cms/program-integrity/index.html.

FY 2016	
Program structure	Establishes a demonstration testing a comprehensive long-term care state plan option for up to five states. Under the eight-year pilot, states are authorized to provide HCBS care at the nursing facility level of care, creating equal access to HCBS care and nursing facility care. Gives the Secretary the discretion to make these pilots permanent at the end of the eight years.
Eligibility	Establishes a state option to provide 12-month continuous Medicaid eligibility for adults. Permanently extends the ELE option for children, as proposed in the budget for FY 2015. Expands eligibility for the 1915(i) HCBS state plan option: Would update eligibility requirements to increase states' flexibility in expanding access to HCBS under section 1915(i) of the Social Security Act (the Act). Under existing law, certain non-categorically eligible individuals who meet the needs-based criteria can only qualify for HCBS through the 1915(i) state plan option if they are also eligible for HCBS through a waiver program. Removing this requirement would reduce administrative burden on states and increase access to HCBS for the elderly and individuals with disabilities. Allows full Medicaid benefits for individuals in a HCBS state plan option: Under existing law, when a state elects to not apply the community income and resource rules for the medically needy, these individuals can only receive 1915(i) services and no other Medicaid services. Allows pregnant women choice of Medicaid eligibility category: Pregnant women are categorically eligible for Medicaid if they have income under 133 percent of the FPL, so under current law they are excluded from the new adult Medicaid expansion group. Because the benefits and delivery system may differ between the pregnant women and the new adult groups in states that elect to expand, women enrolled in the new adult group who become pregnant as well as postpartum women may have to change providers which would disrupt continuity of care. Expands eligibility under the Community First Choice Option making medical assistance available to individuals who would be eligible under the state plan if they were in a nursing facility. Under existing law, any state interested in the Community First Choice Option must create or maintain a 1915(c) waiver with at least one waiver service to make the benefit available to the special income group or provide eligibility for the Community First Choice benefit through another eligibility pathway. Because this approach is administratively burdensome for states, this proposal would provide equal access to services under the state plan option and provide states with additional tools to manage their long-term care HCBS delivery systems. Establishes a permanent hold harmless provision to adjust the poverty guidelines only when there is an increase in the CPI-U, as proposed in the budgets for FYs 2012–2015.

Benefits	Allows age-specific home health programs. Currently, states are required to cover health home services for all categorically needy individuals with the specified chronic condition(s), regardless of age. Flexibility on targeting of health home models could allow states to better serve the needs of youth with chronic conditions. Requires coverage of Early and Periodic Screening, Diagnostic and Treatment Benefit for children in inpatient psychiatric treatment facilities: While Medicaid coverage is available for children and young adults under age 21 receiving inpatient psychiatric services, they are excluded from coverage of comprehensive preventive and medically necessary items and services to which Medicaid enrolled children are otherwise entitled. This proposal would lift the federal Medicaid exclusion of comprehensive children's coverage to reduce the financial burden on states and Medicaid families and encourage the provision of critical mental health services to children in Medicaid. Allows states to provide HCB waiver services to children who are currently institutionalized or meet the institutional level of care, as proposed in the FY 2015 President's budget. Without this change, children and youth who meet this institutional level of care do not have the choice to receive HCBS waiver services and can only receive care in an institutional setting where residents are eligible for Medicaid. The proposal additionally: - allows states the flexibility to provide benchmark equivalent benefit coverage for non-elderly, non-disabled adults with income that exceeds 133 percent of the FPL, as proposed in the President's budgets for FYs 2013–2015; - requires full coverage of preventive health and tobacco cessation services for adults in traditional Medicaid; - extends TMA through CY 2016, allows determination of eligibility for TMA to be calculated using Modified Adjusted Growth Income consistent with the ACA, and allows states that adopt the Medicaid expansion to opt out of TMA; and - extends the QI Program through calendar year (CY) 2016. Current law extends this program through March 31, 2015.
Payment	Extends the primary care payment increase through CY 2016 and includes additional providers, as proposed in the budget for FY 2015. Rebases future Medicaid DSH allotments, as proposed in the budgets for FYs 2013-2015. Limits Medicaid reimbursement of DME based on Medicare rates, as proposed in the budgets for FYs 2012–2015. Calculates Medicaid FULs based only on generic drug prices.
Financing	Prevents use of federal funds to pay the state share of Medicaid or CHIP. Also includes the following provisions related to Medicaid prescription drug payment: - clarifies the definition of brand drugs, collecting an additional rebate for generic drugs whose prices grow faster than inflation; clarifies the inclusion of certain prenatal vitamins and fluorides in the rebate program; corrects a technical error to the ACA alternative rebate for new drug formulations; - limits to twelve quarters the timeframe for which manufacturers can dispute drug rebate amounts; - excludes authorized generic drugs from average manufacturer price calculations for determining manufacturer rebate obligations for brand drugs; and - exempts emergency drug supply programs from the Medicaid rebate calculations.

Other features	Includes provisions related to promoting program integrity for Medicaid drug coverage. Requires manufacturers to pay states back for drugs in cases where the manufacturer has either improperly reported non-drug products to CMS or has reported drugs that the FDA has found to be less than effective. Enhances existing enforcement of manufacturer compliance with drug rebate requirements by allowing more regular audits and surveys of drug manufacturers where cost effective. Requires drugs to be electronically listed with FDA in order for them to be included in Medicaid coverage, thereby aligning Medicaid drug coverage requirements with Medicare drug coverage requirements. Increases penalties for fraudulent non-compliance on rebate agreements, particularly where drug manufacturers knowingly report false information under their drug rebate agreements, similarly proposed in the budget for FY 2015. Increases access to and transparency of Medicaid drug pricing data, as proposed in the FY 2015 President's budget. Includes provisions related to dually eligible individuals. Allows for federal/state coordinated review of Dual Special Need Plan marketing materials. Would introduce flexibility to rules around the review of marketing materials provided by Dual Special Needs Plans to beneficiaries by providing CMS with the ability to perform coordinated reviews of these marketing materials for compatibility with a unified set of standards instead of separate state and federal reviews as required under existing law. Additionally creates a pilot to expand PACE eligibility to individuals between age 21 and 55, as proposed in the budget for FY 2015; ensures retroactive Part D coverage of newly eligible low-income beneficiaries; and integrates the appeals process for Medicare-Medicaid enrollees, as proposed in the budgets for FYs 2014–2015. Additionally, includes provisions related to program integrity: - expands funding and authority for the Medicaid Integrity Program; - supports MFCUs for the territories; - expands MFCU review to additional care settings; - requires states to track high prescribers and utilizers of prescription drugs in Medicaid; and - consolidates redundant error rate measurement programs, specifically MEQC and PERM. For program integrity proposals applicable to both Medicaid and Medicare, see the FY 2014 Budget in Brief. www.hhs.gov/about/budget/budget-in-brief/cms/program-integrity/index.html#.
Status of enactment	Not enacted
Source	U.S. Department of Health and Human Services (HHS). 2015. HHS budget in brief for FY 2016. http://www.hhs.gov/about/budget/fy2016/budget-in-brief/index.html.

EXHIBIT 6. Key Medicaid Reform Proposals Offered by Think Tanks

Proposal summaries

American Enterprise Institute	
2015	**Improving Health and Health Care; An Agenda for Reform**
Program structure	Replaces the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) with a system of refundable tax credits for individuals who do not have access to employer-sponsored coverage. Divides Medicaid into two parts, one for able-bodied adults and children, the other for disabled and elderly. States receive fixed per capita payments from the federal government for the two groups, based on historical spending patterns. Gives states more authority to manage the program.
Eligibility	A five-year transition period allows for a new federal Medicaid eligibility standard which would be in between the ACA coverage levels and the coverage levels for states that have not expanded under the ACA although individuals eligible under the ACA expansion who are not income eligible under the new standard would not become ineligible. They would retain Medicaid until they cycle off for other reasons.
Benefits	Allows states to explore options of their choosing, but provides a federal template for able-bodied adults and children to receive a federal tax credit towards the cost of health insurance. Allows federal tax credit to be supplemented by state and federal Medicaid funding up to the cap. Allows states to design the subsidy schedules.
Financing	Explores two options for financing – block grants and per capita caps.
Other features	Gives states more flexibility to pursue reforms of their long-term care and home and community-based services (HCBS).
Status of enactment	Not enacted
Source	Antos, J., J.C. Capretta, L.J.Chen, S. Gottlieb, Y. Levin, T.P. Miller, R. Ponnuru, A. Roy, G.R. Wilensky, and D. Wilson. 2015. *Improving health and health care: An agenda for reform.* Washington, DC: American Enterprise Institute. https://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf.
2014	**A Health Reform Framework: Breaking out of the Medicaid Model**
Program structure	Recommends that Medicaid enrollees be provided with premium and cost sharing support to use toward purchase of competing private and/or public options.
Cost sharing	Allows states to design subsidies to include premium and cost sharing contributions from those participating in the program.
Financing	Provides all individuals without employer-sponsored health insurance (ESI), including those with Medicaid, with a universal refundable tax credit. Deregulates Medicaid so that states can supplement the base federal tax credit.
Payment	Recommends that the federal government explore the use of competitive bidding.
Other features	Further recommends federal government explore using private clinics to improve the health status of poor households with an emphasis on new technology, innovative ways of delivering services to hard-to-reach households, and performance measurement.
Status of enactment	Not enacted
Source	Antos, J., and J.C. Capretta. 2014. A health reform framework: Breaking out of the Medicaid model. Health Affairs Blog. July 10. http://healthaffairs.org/blog/2014/07/10/a-health-reform-framework-breaking-out-of-the-medicaid-model/
2013	**Best of Both Worlds: Uniting Universal Coverage and Personal Choice in Health Care**
Program structure	Replaces most of Medicaid with government financed premium support for a basic health plan at no cost and to more generous health plans at significantly reduced costs. Retains Medicaid coverage of Medicare premiums, home health and long-term care.

Eligibility	Ends income eligibility for Medicaid at 100 percent of federal poverty level (FPL) in every state unless an individual qualifies through disability or chronic illness.
Benefits	Requires a standardized package of benefits for the basic health insurance package for all plans offered through a private national health insurance exchange.
Cost sharing	Qualifies all individuals for a basic plan at no cost. Beyond that, requires individuals to make premium contributions and be responsible for deductibles on a sliding scale based on a measure of burden in which illness or health expenditures and income are taken into account.
Financing	Premium support paid entirely by the federal government.
Other features	Eliminates the tax exemption for ESI and instead, proposes a safety-net tax to finance emergency care for those with acute conditions not covered by insurance. Allows health plans to be individually underwritten but rating based on race, national origin and sexual orientation would not be allowed.
Status of enactment	Not enacted
Source	Bhattacharya, J., A. Chandra, M. Chernew, et al. 2013. *Best of both worlds: Uniting universal coverage and personal choices in health care.* Washington, DC: American Enterprise Institute. http://www.aei.org/wp-content/uploads/2013/08/-best-of-both-worlds-uniting-universal-coverage-and-personal-choice-in-health-care_081610171236.pdf.

Bipartisan Policy Center Debt Reduction Task Force	
2010	**Restoring America's Future: Reviving Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System**
Program structure	Controls Medicaid costs in the short term by applying "managed care principles in all states to aged Supplemental Security Income (SSI) beneficiaries" by providing routes around the barriers for states. Controls Medicaid costs in the long term by reducing per person cost growth by one percentage point through various options. One option is changes to the shared financing arrangement between the federal government and states so that each fully finances and administers its own selected components of the program.
Eligibility	Notes that maintenance of effort requirements "might be warranted."
Benefits	Notes that maintenance of effort requirements "might be warranted."
Financing	Recommends "modifying the rules around the upper payment UPL…to encourage institutional providers to enroll dual eligibles in risk contract arrangements." Under the longer term swap proposal "a process would be set in motion to determine the optimal allocation of program responsibilities between the two parties, at the conclusion of which the federal government and the states would divide up responsibility for fully financing different components of the Medicaid program." "Because the per-capita cost of Medicaid varies across states, the state payments in the early years would have to be equalized to ensure that every state has an adequate initial fiscal base to run the nationally uniform set of programs that the states would be required to assume." The swap could be based on population groups or benefits and could incorporate other programs for low-income populations. Under the swap proposal, per capita spending growth would be reduced by one percentage point per year. Also recommends that Congress consider swap legislation on a fast track.
Status of enactment	Not enacted
Source	Domenici, P., and A. Rivlin. 2010. *Restoring America's future: Reviving economy, cutting spending and debt, and creating a simple, pro-growth tax system.* Washington, DC: Bipartisan Policy Center. http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf.

2012	Debt Reduction Task Force Plan 2.0
Financing	Replaces FMAPs with a single, blended rate for each state that rises during recessions and declines in times of growth and reduces provider tax threshold.
Payment	Limits reimbursement for durable medical equipment to Medicare rates.
Status of enactment	Not enacted
Source	Domenici, P., and A. Rivlin. 2012. Domenici-Rivlin debt reduction task force plan 2.0. Washington, DC: Bipartisan Policy Center. http://bipartisanpolicy.org/library/domenici-rivlin-debt-reduction-task-force-plan-20/
2013	**A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment**
Program structure	Improves the coordination of Medicare and Medicaid by expanding upon existing duals demonstrations by incorporating additional shared savings opportunities and alternate delivery care models that include Medicare benefits. Recommends adopting a broad strategy to deliver Medicare and Medicaid services for dually eligible individuals through a single integrated program.
Eligibility	Reduces barriers to enrollment for low-income Medicare beneficiaries who qualify for assistance with Medicare premiums and cost sharing.
Cost sharing	Expands cost sharing assistance for Medicare beneficiaries with income up to 150 percent FPL.
Payment	Recommends that the Centers for Medicare & Medicaid Innovation test alternative models of reimbursement to achieve quality and value in particular related to Federally Qualified Health Centers.
Other features	Implements MACPAC's recommendations to strengthen Medicaid program integrity.
Status of enactment	The ACA established the Medicare-Medicaid Coordination office at the Centers for Medicare & Medicaid Services (CMS) tasked with aligning and coordinating benefits between the two programs and partnering with states to develop new care delivery models to improve the way dually eligible enrollees receive care.
Source	Rivlin, A., B. Frist, P. Domenici, et al. 2013. *A Bipartisan Rx for patient-centered care and system-wide cost containment.* Washington, DC: Bipartisan Policy Center. http://bipartisanpolicy.org/library/health-care-cost-containment/.

Bipartisan Policy Center	
2015	**The Role and Future of the Children's Health Insurance Program.**
Program structure	Proposal extends State Children's Health Insurance Program (CHIP) funding by minimum of two years; eliminates gaps in coverage (including addressing the ACA family glitch). Over time, modifies eligibility for public and private coverage (Medicaid, employer-sponsored coverage, exchange-based insurance) to allow children and parents to be enrolled in the same insurance plan, eliminating the need for CHIP while also monitoring to ensure that differences in benefits and out-of-pocket costs do not result in loss of important benefits for children.
Status of enactment	The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA 2015, P.L. 114-10) extended CHIP funding for a period of two years (through FY 2017).
Source	The Bipartisan Policy Center. 2015. *The role and future of the Children's Health Insurance Program.* March. http://bipartisanpolicy.org/wp-content/uploads/2015/03/BPC_Health_CHIP.pdf.
2015	**Improving and Expanding Health Insurance Coverage through State Flexibility**
Program structure	Proposal describes opportunities and limitations in the use of Section 1332 waivers including through combining Section 1332 waivers with Medicaid demonstration waivers under Section 1115 of the Social Security Act. Recommends HHS apply its guidance in a way that fosters state innovation, allows for budget neutrality calculations to be applied across programs, and for states to form interstate compacts to sell insurance across state lines.
Eligibility	Recommends correcting the family glitch wherein families' eligibility for exchange subsidies are based on affordability taking into account only the individuals worker's premium for ESI rather than the family's premium for ESI.
Status of enactment	Not enacted
Source	The Bipartisan Policy Center. 2015. *Improving and expanding health insurance coverage through state flexibility.* http://bipartisanpolicy.org/wp-content/uploads/2015/11/BPC-Health-Improving-Expanding-Coverage.pdf.

Brandeis University: Schneider Institutes for Health Policy - Institute on Healthcare Systems	
2002	**Reimagining Medicaid: the Evolving Federal Role in Medicaid, Background, Issues and Challenges**
Program structure	Proposal does not offer specific recommendations for program features, but recommends characteristics of the federal/state relationship that could contribute to a successfully reformed Medicaid. The recommendations are that increased federal funding is necessary for achieving broad coverage expansions; state or privately administered systems are preferable to federally administered systems; and based upon the CHIP example, broad state flexibility can be contained within federally-prescribed corridors.
Status of enactment	The ACA enacted a set of broad coverage expansions with primarily federal funding. The Deficit Reduction Act of 2005 (DRA 2005, P.L. 109-171) provided for new flexibilities for states on benefits, allowing states to offer benchmark benefits instead of the standard Medicaid benefit package to certain beneficiaries, a concept based on the CHIP program. It also allowed states greater ability to collect premiums and to require cost sharing.
Source	Doonan, M., and D. Shactman. 2002. *Reimagining Medicaid: the evolving federal role in Medicaid, background, issues, and challenges.* Waltham, MA: Council on Health Care Economics and Policy.

Brookings Institution: Engelberg Center for Health Care Reform	
2013	**Bending the Curve: Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth**
Program structure	Proposal builds on previous Medicaid recommendations to create an alternative to the waiver approval process under which state reforms that incorporate reductions in per capita costs while maintaining or improving quality of care would be fast tracked. Aligns Medicaid reforms with other programs for lower-income individuals, for example, by having Medicaid managed care organization plans participate in exchanges; by coordinating with other safety net providers; and expanding and making permanent the financial alignment demonstration for dually eligible individuals.
Benefits	Gives states increased authority to reform benefit design.
Payment	Gives states increased authority to reform provider payments.
Financing	Uses base per capita and global spending projections. States share in savings and risk for spending below or in excess of expected benchmark trends.
Other features	Requires CMS to develop standard performance measures that apply consistently across states and implement ongoing evaluation and tracking systems.
Status of enactment	Not enacted
Source	Antos, J., K. Baicker, M. Chernew, et al. 2013. *Bending the curve: person-centered health care reform: a framework for improving care and slowing health care cost growth.* Washington, DC: Brookings Institution. http://www.brookings.edu/~/media/Research/Files/Reports/2013/04/person-centered-health-care-reform/person_centered_health_care_reform.PDF?la=en.
2009	**Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth**
Program structure	Recommends reforming provider payment systems to create accountability for lower-cost, high quality care. Supports increasing CMS resources and streamlining processes to pilot promising alternative payment methodologies.
Benefits	Targets obesity reduction through price incentives and aggressive piloting and evaluation.
Cost sharing	Recommends enhanced episode-based payment system pilots, which could include tiered copayments, but recommendation does not specifically relate to Medicaid.
Payment	Initial proposed reforms include: - increasing use of bundled payments for services such as hospital and post-acute care, hospital and physician services, and high-cost episodes of care and expanding the use of pay for performance; - increased payment rates for primary care offset by reductions for specialty care; - providing additional payment during transition period to physician practices serving as patient-centered medical homes; and - building new payment systems to promote accountability for health outcomes and overall costs including through accountable care organizations, enhanced episode-based payment systems and other promising payment systems including competitive bidding with risk adjustment. Notes that other promising reforms "that might be piloted" include pay for performance and care coordination bonuses.
Status of enactment	The ACA established the Center for Medicare & Medicaid Innovation which is tasked with identifying, testing and spreading "innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care" for those people receiving Medicare, Medicaid, or CHIP. The ACA also included enhanced federal matching funds for health homes – another value-based delivery system
Source	Antos, J., J. Bertko, M. Chernew, et al. 2009. Bending the curve: Effective steps to address long-term health care spending growth. Washington, DC: Brookings Institution. http://www.brookings.edu/~/media/research/files/reports/2009/9/01-btc/0826_btc_fullreport.pdf.

Cato Institute	
2010	**Downsizing the Federal Government: Medicaid Reforms**
Block grant - Program structure	Proposal presents two approaches to restructure Medicaid to control costs – (1) to convert the program into block grants for states; and (2) to convert the program into a system of direct aid to recipients by means of a voucher or refundable tax credit. Each of those ideas is described in more detail below.
Block grant - Eligibility	Gives states flexibility to change eligibility to at least some extent (see quotation below) but proposal is not explicit.
Block grant - Benefits	Gives states flexibility to change benefits to at least some extent (see quotation below) but proposal is not explicit.
Block grant - Payment	Gives states flexibility to change payment to at least some extent (see quotation below) but proposal is not explicit.
Block grant - Financing	Freezes the federal spending for Medicaid including acute care and long-term care at current levels and converts into a block grant.
Block grant - Other features	Notes that "with a fixed amount of federal funding and fewer federal regulations, the state would be strongly encouraged to target their most needy populations and to reduce coverage for non-essential services. "
Vouchers - Program structure	Allows individual beneficiaries to choose among different insurance and health care options including a high-deductible insurance plan using a voucher provided to them directly by the government. Additionally, "much of Medicaid's regulatory apparatus would be eliminated."
Vouchers - Other features	Notes that "in the long run, federal Medicaid spending should be phased out completely."
Status of enactment	Not enacted
Source	Edwards C. 2010. *Downsizing the Federal Government: Medicaid Reforms.* http://www.downsizinggovernment.org/hhs/medicaid-reforms
2005	**Roadmap for Medicaid Reform**
Program structure	Eliminates the federal entitlement to Medicaid benefits; freezes payments to states; and gives states maximum flexibility to meet a few broad policy goals. These are: target medical assistance to the truly needy, reduce dependency, cut down on crowd-out of private insurance and charitable care, and promote competitive markets for medical care and insurance.
Eligibility	Eliminates the federal entitlement to Medicaid benefits and gives states flexibility to target medical assistance to the truly needy.
Status of enactment	Not enacted
Source	Cannon, M.F., and A. Aldredge. 2005. *Roadmap for Medicaid reform.* Washington, DC: Cato Institute. http://www.cato.org/publications/commentary/roadmap-medicaid-reform

Center for American Progress	
2011	**The Senior Protection Plan**
Program structure	Increases value and efficiency to reduce costs without harming beneficiaries or shifting spending among payers. Recommends allowing states to form accountable care states subject to a global cap on health care spending, including Medicaid spending. Recommends alternative payment approaches and improved care coordination.
Benefits	Recommends requiring Medicaid managed care programs be to use competitive bidding and pay for performance.
Payment	Incorporates competitively bid prices in such areas as medical devices, laboratory tests, advanced imaging services, and all other health care products to Medicaid.
Financing	Gives accountable care states a global target for all health spending by both public and private payers and enhanced flexibility and implementation grants to develop and implement savings plans. Also recommends subjecting them to shared risk and shared savings bonuses, which would be available if states meet performance targets on publicly reported measures of cost, quality, and access including generic substitution rates and measures related to the supply of expensive diagnostic technologies. Would extend disproportionate share payment reductions, initially passed under the ACA, for years after 2020. Alternate payment methodologies, such as bundling, would be in place for least 75% of payments in every hospital referral region within 10 years.
Other features	Allows all dually eligible individuals to choose a primary care medical home, which would coordinate care as well as claims submissions and interactions with Medicare and Medicaid. Those programs would incorporate shared (Medicare) savings for states if their programs meet minimum quality standards. States could retain 60 percent of savings to Medicare in the first three years and 75 percent of savings starting in the fourth year. Recommends that CMS develop online care planning and management tools that primary care medical homes can access for free. If states achieve a minimum level of savings, they must share the savings with primary care medical homes. In turn primary care medical homes would be allowed to keep a share of the savings but reinvest some portion of it to further improve care coordination. Recommends that the federal government provide bonus payments to states that meet scope-of-practice standards regarding the use of non-physician providers delineated by the Institute of Medicine, and that Medicaid payment for non-physician providers allow them to practice to the full extent permitted under state law. Also recommends maximizing use of generics pharmaceuticals by reducing the federal upper limit (FUL) on drug payments, tying the FUL to the lowest price of equivalent drugs instead of the average, and applying the policy to drugs with two or more equivalent drugs instead of three; providing financial incentives to states that boost generic utilization.
Status of enactment	Several subsequent bills enacted extensions of DSH reductions: Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96); American Taxpayer Relief Act of 2012 (P.L. 112-240); Bipartisan Budget Act of 2013 (HJ Res. 59, P.L. 113-67); and MACRA.
Source	Center for American Progress (CAP). 2012. *The senior protection plan.* November 13. https://www.americanprogress.org/issues/healthcare/report/2012/11/13/44590/the-senior-protection-plan/

Committee for a Responsible Federal Budget Moment of Truth Project	
2013	**A Bipartisan Path Forward to Securing America's Future**
Program structure	Proposal allows states to share in Medicaid savings if they lower per capita health care cost growth by both public and private payers to a certain target, such as GDP growth. Recommends including bonus payments for states that meet various performance targets on cost, quality, and access; increasing shared-savings opportunities for states in providing care for beneficiaries dually eligible for Medicare and Medicaid; and encouraging them to explore alternative models for such care, such as the financial integration of prescription drugs. Recommends that CMS test a model where states contract with CMS to provide the full range of Medicare and Medicaid services through the Medicare program.
Payment	Reduces payments for durable medical equipment, and eliminates double counting for administrative costs funded under Temporary Assistance for Needy Families (TANF) block grants.
Financing	Gives states the option to accept a single blended rate for all services if the Secretary of the U.S. Department of Health and Human Services (the Secretary) determines the rate would not increase federal cost. Recommends gradually phasing out the safe harbor for provider specific taxes which was, at the time this report was issued, six percent of provider revenue. Disproportionate share payment reductions, initially passed under the ACA, would be extended for years after 2020. Additional savings options include reducing intergovernmental transfers and administrative matching
Other features	Increases flexibility for the states through a new waiver program. Under this new program, 10 states would qualify for fast track waivers if they meet certain quality, efficiency, and cost criteria and if the waiver would not increase the uninsured population. Waivers to improve coordination for individuals dually eligible for Medicare and Medicaid would be included. States would be able to share in Medicaid savings if they hold per capita health care cost growth by both public and private payers to a certain target.
Status of enactment	Several subsequent bills enacted extensions of DSH reductions: PAMA, Middle Class Tax Relief and Job Creation Act of 2012, American Taxpayer Relief Act of 2012,Bipartisan Budget Act of 2013, and MACRA.
Source	Simpson, A., and E. Bowles. 2013. A bipartisan path forward to securing America's future. Washington, DC: Committee for a Responsible Federal Budget. http://momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf

Commonwealth Fund	
2009	**The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way**
Program structure	National health reform proposal that incorporates significant changes to Medicaid. Proposal recommends increasing use of alternative payment methodologies and delivery system reforms in Medicare, Medicaid, and under a new public health insurance plan offered through a national health insurance exchange. Alternative payment methodologies and delivery system reforms, including medical homes, bundled payments, global hospital case rates, would reward increased quality and reduced costs. Payment reforms would be combined with coverage expansions including expanding Medicaid.
Eligibility	Expands acute care coverage through Medicaid and CHIP to all households with income below 150 percent FPL, including childless adults. Also enhances the federal match to finance the expansion and offset state costs, and eliminates Medicare's two-year waiting period for the disabled.
Benefits	For newly eligible beneficiaries, provides minimum essential coverage for acute care.
Cost sharing	For newly eligible beneficiaries, imposes no premium and low copayments.
Financing	No other financing initiatives beyond the alternative payment methodologies described in program structure.

Status of enactment	The ACA extended Medicaid coverage for individuals with income below 138 percent FPL and established the Center for Medicare & Medicaid Innovation, which is tasked with identifying, testing and spreading "innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care" for those people receiving Medicare, Medicaid, or CHIP. The ACA also included enhanced federal matching funds for health homes, another value based delivery system innovation.
Source	The Commonwealth Fund Commission on a High Performance Health System. 2009. *The path to a high performance U.S. health system: A 2020 vision to pave the way.* February. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2009/feb/the-path-to-a-high-performance-us-health-system/1237_commission_path_high_perform_us_hlt_sys_web_rev_03052009.pdf. Guterman, S., K. Davis, C. Schoen, et al. 2009. *Reforming provider payment: Essential building block for health reform.* Washington, DC: The Commonwealth Fund Commission on a High Performance Health System. http://www.commonwealthfund.org/publications/fund-reports/2009/mar/reforming-provider-payment-essential-building-block-for-health-reform

Commonwealth Fund Task Force on the Future of Health Insurance	
2000	**Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs**
Program structure	Proposal allows states to design a buy-in program for people receiving a new tax credit for the purchase of health insurance to buy into Medicaid and CHIP.
Eligibility	Allows states to determine who would be eligible for the expanded Medicaid or CHIP programs.
Benefits	Allows states to design benefits.
Cost sharing	Expects but does not require states to provide a zero premium plan.
Status of enactment	Not enacted
Source	Weil, A. 2000. *Buying into public coverage: Expanding access by permitting families to use tax credits to buy into Medicaid or CHIP programs.* Washington, DC: Commonwealth Fund Task Force on the Future of Health Insurance Coverage. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2000/dec/buying-into-public-coverage-expanding-access-by-permitting-families-to-use-tax-credits-to-buy-into/weil_workable_422-pdf.pdf
2000	**Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs**
Program structure	Proposal gives states the option to extend CHIP to small employers and self-employed individuals.
Eligibility	Allows states to set the eligibility thresholds. For employees with family income below 100 percent FPL, the subsidy would be 100 percent of the employee share for a benchmark premium. For those with income below 150 percent FPL, the subsidy would be equal to 75 percent of the employee's share; and for others, the subsidy would be 50 percent of the employee share. Provides an alternative subsidy schedule for eligibility based on wage rates.
Benefits	Applies CHIP benchmark benefit rules. Requires maternity coverage.
Cost sharing	As under the existing CHIP program, allows states to structure cost sharing for enrolled workers. However, does not permit cost sharing for well-baby and well-child care.
Status of enactment	Not enacted
Source	Rosenbaum, S., P.C. Borzi, V. Smith. 2000. Allowing small businesses and the self-employed to buy health care coverage through public programs. Washington, DC: Commonwealth Fund Task Force on the Future of Health Insurance. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2000/dec/allowing-small-businesses-and-the-self-employed-to-buy-health-care-coverage-through-public-programs/rosenbaum_workable_419-pdf.pdf

Economic and Social Research Institute	
2014	**Medicaid Coverage for Poor Adults: A Potential Building Block for Bipartisan Health Reform**
Program structure	Explores policy pathway for expanding Medicaid to cover adults.
Eligibility	Recommends providing states with an option to expand Medicaid to cover adults with income below some percentage of the FPL.
Financing	Recommends alternate ways of enhancing federal matching rates to encourage state take up of the ACA's Medicaid expansion, including providing a CHIP-like enhanced matching rate for new eligibles or alternately providing for a small increase in the usual FMAP across the board. Also explores incorporating a statewide allotment cap for enhanced payments to states. Those states that don't expand coverage would forego their allotments and the funds would be redistributed among other states. Also presents an alternative to capped allotments under which enhanced matching funds would be phased in by income or age. For example, enhanced matching would be provided for adults with income below 50 percent FPL in year one and then 60 percent in year two and beyond.
Status of enactment	The ACA enacted a set of broad coverage expansions to low income adults with enhanced federal matching payments.
Source	Dorn, S. 2004. Medicaid coverage for poor adults: A potential building block for bipartisan health reform. Economic and Social Research Institute.

Heartland Institute	
2014	**Liberating the Poor from the Medicaid Ghetto**
Program structure	Proposal replaces Medicaid and CHIP with finite and fixed block grants for states and allows states to redesign their health care safety net programs.
Eligibility	Eliminates the coverage expansion under the ACA. Gives states the option of providing vouchers, but requires that vouchers be subject to a work requirement for able-bodied individuals.
Benefits	Permits states to incorporate vouchers to pay for private health insurance and health savings accounts.
Financing	Replaces federal matching requirements with fixed, finite block grants.
Status of enactment	Not enacted
Source	Ferrara, P. 2014. Liberating the poor from the Medicaid ghetto. Arlington Heights, IL: Heartland Institute. https://www.heartland.org/policy-documents/liberating-poor-medicaid-ghetto

Heritage Foundation	
2014	**Capitol Hill Briefing**
Program structure	Proposal recommends over the long term breaking Medicaid into separate components for (1) elderly and disabled; (2) children and families; and (3) childless adults. Recommends implimenting different solutions for each category, using new financing that is not open ended and can be targeted where it is needed the most.
Eligibility	Recomends against adding new eligible populations.
Financing	Ends ACA enhanced matching rate.
Other features	Expands and accelerates competition through Medicaid managed care and competition among managed care contractors through waivers or through additional federal flexibility in order to inject free market reforms into Medicaid.
Status of enactment	Not enacted

Source	Owcharenko, N. 2014. Capitol Hill Briefing. May 27, 2014 , Washington, DC: Heritage Foundation. http://www.cato.org/events/economics-medicaid-need-reform.

National Center for Policy Analysis	
2014	**Congressional Brief: Health Care**
Program structure	Restructures Medicaid as a block grant for those with earnings below 100 percent FPL.
Eligibility	Recommends encouraging "states to not expand Medicaid eligibility above 100 percent of the federal poverty level. This will allow those earning above poverty to purchase subsidized coverage in the exchange."
Benefits	Allows "states broad flexibility to tailor their Medicaid programs to meet each state's unique needs."
Cost sharing	Allows "states broad flexibility to tailor their Medicaid programs to meet each state's unique needs."
Payment	Allows "states broad flexibility to tailor their Medicaid programs to meet each state's unique needs."
Financing	Converts federal CHIP funding into refundable child tax credits for people who can provide proof of creditable public or private health insurance.
Status of enactment	Not enacted
Source	Goodman, J. 2014. Congressional brief: Health care. Washington, DC: National Center for Policy Analysis. ttp://www.ncpa.org/pdfs/cbrief-Health-Carenew.pdf

New America Foundation	
2007	**A Sustainable Health System for All Americans: The Next Social Contract**
Program structure	Recommends a national health reform in which all individuals with income below 67 percent of national median income are provided with an almost full subsidy for the purchase of a basic health plan; and Medicaid and CHIP are retained only for the disabled, elderly, and uninsurable. Proposed reform includes an individual mandate; a federally managed health insurance purchasing exchange through which individuals and employers would buy privately sponsored basic health plans; and subsidies toward the basic health plan for low-income individuals. Allows issuers to sell a cost sharing supplement through exchanges which would be free to those households earning less than 67 percent of median income.
Eligibility	Proposal eliminates the need for Medicaid and CHIP except for those who are disabled (or uninsurable) and elderly who are dually eligible for Medicare. Requires other individuals to obtain basic health plan coverage with their subsidies.
Benefits	Benefits included in a basic plan would be specified by a Benefits Board.
Cost sharing	Individuals with income below 67 percent of national median income who leave Medicaid to purchase a basic health plan, "might" face payments of $5 for an individual policy and $10 for a family policy. In keeping with a guiding principle of personal responsibility, the reform requires even the poorest to pay a nominal fee at the point of service. Allows providers to waive the fee, however, at their discretion in hardship cases.
Financing	Funds reforms in part by ending the existing tax exemption for employer-paid health insurance.
Other features	Incorporates market reforms, health information technology proposals, increased outcomes and comparative effectiveness research, and malpractice reform.
Status of enactment	The ACA enacted broad Medicaid coverage expansions and subsidies for the purchase of health insurance for others and included a number of private health insurance market reforms.
Source	Nichols, L. 2007. *A sustainable health system for all Americans: The next social contract.* Washington, DC: New America Foundation. https://www.newamerica.org/economic-growth/a-sustainable-health-system-for-all-americans/.

2013	The Next Priority for Health Care: Federalize Medicaid
Program structure	Recommends federalizing Medicaid and in doing so, eliminating the disparities across states in federal contributions for beneficiaries.
Financing	Offers several alternative approaches for raising federal revenues to financing what would have been the state share of the program, including combining a tax on upper income taxpayers with a modest payroll tax, and increasing the Medicare payroll tax.
Status of enactment	Not enacted
Source	Anrig, G. 2013. The next priority for health care: Federalize Medicaid, renewing the American social contract. Washington, DC: New America Foundation. https://www.newamerica.org/economic-growth/renewing-the-american-social-contract-a-new-vision-for-improving-economic-security/.

Robert Wood Johnson Foundation Covering America Project	
2001	**Assessing the Combination of Public Programs and Tax Credits**
Program structure	Proposal recommends extending CHIP or Medicaid to individuals based on their income.
Eligibility	Expands eligibility for comprehensive coverage using CHIP or Medicaid to all individuals with income below 150 percent FPL, and expands benefits with some premiums and cost sharing to those with income between 150 percent and 200 percent FPL. Additionally, “people with incomes above 200 percent FPL could be allowed to 'buy in' to public coverage by paying a sliding-scale premium based on income.”
Benefits	Recommends including comprehensive coverage for those below 150 percent FPL.
Cost sharing	Does not recommend cost sharing for individuals below 150 percent FPL. However, notes that “it might be appropriate to apply some premiums and cost sharing in the income range between 150 and 200 percent of poverty (up to a maximum of 5% of family income.)”
Financing	Discusses the need for increased federal matching rates beyond the usual FMAP or even full federal funding, but makes no specific recommendations.
Other features	Recommends that “if resources allow…avoid current S-CHIP rules in many states that deny coverage for a period of time to those who have had employer-sponsored coverage...”
Status of enactment	The ACA enacted broad expansions to Medicaid for low income adults with enhanced federal financing.
Source	Feder, J., L. Levitt, E. O’Brien, et al. *Assessing the combination of public programs and tax credits, covering America: Combination of public programs and tax credits.* Princeton, NJ: Robert Wood Johnson Foundation Covering America Project. http://www.rwjf.org/en/library/research/2003/10/assessing-the-combination-of-public-programs-and-tax-credits.html.
2003	**Expanding Health Insurance Coverage: A New Federal/State Approach**
Program structure	Recommends establishing a new CHIP-like public program to provide coverage for people with income up to 250 percent FPL.
Status of enactment	Not enacted
Source	Holahan, J., L. Nichols, and L. Blumberg, 2003. *Expanding health insurance coverage: A new federal/state approach.* Pricenton. NJ: Robert Wood Johnson Foundation Covering America Project. http://www.urban.org/research/publication/expanding-health-insurance-coverage

2003	An Adaptive Credit Plan for Covering the Uninsured
Program structure	Proposal recommends that subsidies be provided for low-income individuals to purchase comprehensive coverage from a “publicly chosen insurer (Medicaid, CHIP, the insurance plan for state employees, or insurance with the same coverage and policies as Medicare).”
Eligibility	Provides free comprehensive insurance to all low-income people. Households between 125 percent and 300 percent FPL receive a credit for part of the premium for comprehensive coverage.
Status of enactment	The ACA enacted broad Medicaid coverage expansions for low-income adults and established subsidies for other individuals and families without access to employer sponsored insurance.
Source	Pauly, M. 2003. An adaptive credit plan for covering the uninsured. Princeton, NJ: Robert Wood Johnson Foundation Covering America Project. http://www.rwjf.org/en/library/research/2003/10/an-adaptive-credit-plan-for-covering-the-uninsured.html.

Urban Institute	
2011	Restructuring Medicaid through a Swap: An Alternative to a Block Grant
Program structure	Proposal recommends restructuring Medicaid through a swap whereby the federal government takes over spending for Medicaid; premium and cost sharing for dually eligible beneficiaries; and acute care for children, adults, and non-dually eligible persons with disabilities. In turn, states take full responsibility for long-term care services financed with a closed-end matching grant. Proposal notes that CHIP would probably need to be integrated with Medicaid and state spending on CHIP incorporated into the claw-back.
Eligibility	Recommends developing a set of federal guidelines to provide minimum federal standards for eligibility and benefits states must meet to get continued federal funds.
Benefits	Recommends developing a set of federal guidelines to provide minimum federal standards for eligibility and benefits states must meet to get continued federal funds. Under this proposals, acute care benefits would be the same across all states. If tightened, then some services could shift back to being a state responsibility. There would no longer be mandatory and optional services.
Financing	Requires states to make a claw-back payment equal to current state payments for acute care services that would be inflated over time by a factor such as the GDP, which would be below the anticipated growth in state Medicaid spending under the existing program structure. The claw-back would also be adjusted for changes in the benefit package. State would receive a matching grant for long-term care services that would be adjusted over time by the GDP and the number of individuals in the population over age 65. Medicaid disproportionate share payments would be eliminated or greatly reduced.
Status of enactment	Not enacted
Source	Holahan, J. 2011. Restructuring Medicaid through a swap: An alternative to a block grant. Washington, DC: The Urban Institute. http://www.urban.org/research/publication/restructuring-medicaid-through-swap-alternative-block-grant.

George Mason University Mercatus Center	
2013	**Welfare Block Grants as a Guide for Medicaid Reform**
Program structure	Notes that the experience of welfare reform demonstrates that block grants offer a viable means of tailoring programs for state conditions and creating better incentives for spending tax dollars efficiently.
Status of enactment	Not enacted
Source	Sutter, D. 2013. *Welfare block grants as a guide for Medicaid reform.* Arlington, VA: George Mason University Mercatus Center. http://mercatus.org/publication/welfare-block-grants-guide-medicaid-reform.
2014	**May 27, 2014 Capitol Hill Briefing**
Financing	Proposes changing incentives in financing Medicaid to improve the program.
Status of enactment	Not enacted
Source	Fichtner, J. Capitol Hill Briefing. Washington, DC, May 27, 2014: Cato Institute. http://www.cato.org/events/economics-medicaid-need-reform.

EXHIBIT 7. Key Medicaid Reform Proposals from Governors' Associations

Proposal summaries

National Governors Association	
2015	**Health Care Transformation Retreats**
Note	No products or proposal released at time of research.
Source	National Governors Association (NGA). 2015. Health Care Transformation Retreats. October 5. http://www.nga.org/cms/home/news-room/news-releases/2015-news-releases/col2-content/govs-states-health-care-retreats.default.html.
2014	**Health Care Sustainability Task Force Report**
Program structure	In 2013, the task force identified the following principles as a basis of state-federal efforts to control costs, enhance health care quality and improve population health. - financial sustainability, including reducing the rate of growth of Medicaid spending; - flexibility for states to pursue delivery system changes provided that eligibility and benefits are not substantially changed; - federal investment in Medicaid; - payment for performance; - accountability and transparency; and - pursuing partnerships with other payers beyond Medicaid. Recommends that the Centers for Medicare & Medicaid Services (CMS) build on guidance for states to innovate with respect to delivery systems and payment models and streamline approval processes. Recommends a process for states to pursue alternatives to the financial alignment initiatives and that the federal government work with states to establish shared risk/savings demonstrations for long-term services and supports (LTSS). Also recommends that Congress develop incentives for the private payment of long-term services and supports and family caregiving, and to encourage people with disabilities to participate in the labor force.
Benefits	Recommends that CMS streamline home and community-based services (HCBS) LTSS options including the Balancing Incentive Program and the Money Follows the Person demonstration into a permanent optional benefit. To encourage people with disabilities to participate in the workforce, states should have an option to pay for personal care attendants, transportation or other limited support services for individuals with disabilities and income below 300 percent of the federal poverty level (FPL).
Financing	"If a state can demonstrate significant savings to the federal government, CMS should provide that state with the maximum federal financial participation allowable for efforts to increase the use of lower-cost HCBS that achieve savings for the federal government." Also recommends federal matching for limited room and board supplements in a community-based residential alternative setting, in particular for people with income at or below the Supplemental Security Income (SSI) federal benefit rates.
Other features	Recommends a path to permanency for Medicaid waivers that have been shown to work effectively and a rapid cycle evaluation process to allow for quicker learning and replication in other states.
Status of enactment	Not enacted
Source	National Governors Association (NGA). 2014. Health care sustainability task force report. February 24. http://www.nga.org/cms/home/special/col2-content/nga-health-care-sustainability-t.html.

2005	Bipartisan Roadmap; NGA's Short-Run Medicaid Reform
Program structure	Proposes additional flexibilities for states on benefits and cost sharing, including prescription drug improvements; policies to discourage asset transfers and increase beneficiary contributions for long-term care, comprehensive waiver reform and judicial reform, improvements for territories, tax incentives for long-term care insurance, improving access to HCBS care, and chronic care management.
Eligibility	Recommends a set of provisions to limit asset transfers including increased penalties for people who transfer assets before entering a nursing home, an increase in the look-back period used to calculate the waiting period for Medicaid eligibility, and limits on the amount and types of funds that can be sheltered in an annuity.
Benefits	Recommends making Medicaid benefits rules more like CHIP rules, under which states have more flexibility to modify benefit packages. Proposals related to prescription drugs include allowing closed formularies and encouraging states to join multi-state purchasing pools. Recommends policies to encourage HCBS care which "could include the elimination of the requirement for a waiver for HCBS care." and policies to improve chronic care management such as shared savings through an enhanced federal medical assistance percentage (FMAP), and providing states with the authority to "provide financial incentives for care management methods that save money and improve outcomes outside of the targeted case management benefit."
Cost sharing	Recommends making Medicaid cost sharing rules more like CHIP rules, under which states have greater discretion to charge premiums, copayments, or deductibles subject to a cap based on family income.
Payment	Does not make specific recommendations, but notes that the clawback payments for Medicare Part D coverage "should not be a further financial burden on state."
Financing	Recommends a set of prescription drug provisions that increase rebates, encourage use of generics, and increase sanctions for misreporting prices. Recommends rebalancing the federal relationship with territories.
Other features	Recommends policies to encourage private funding of long-term care, such as reverse mortgages and long-term care insurance. Includes comprehensive waiver reform recommendations to increase the ease with which states can obtain waivers, expand the types of changes states can pursue, and eliminate the need for many waivers altogether, specifically those waiving freedom of choice, comparability, and state-wideness requirments. Includes provisions to automatically convert a waiver to state plan features after the first renewal and a five-year approval period; eliminate budget neutrality requirements; and allow for superwaivers for states to waive currently unwaivable provisions to develop programs that meet their citizens unique needs. Additionally, recommends judicial reforms to protect states that make decisions about aspects of the Medicaid program in a manner that is consistent with legislative and congressional intent. Includes recommendations for private market reforms.
Status of enactment	The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) incorporated a number of NGA's recommendations. It limited asset transfers and increased the look-back period used to calculate the waiting period for Medicaid eligibility. It provided additional flexibilities for states on benefits, allowing states to offer benchmark benefits instead of the standard Medicaid benefit package to certain beneficiaries. It also allowed states greater ability to collect premiums, to require cost sharing and provided for up to 10 demonstrations to test the use of health opportunity accounts combined with high deductible health plans. States were also provided with the ability to offer HCBS instead of nursing home care as a state option without the need for a waiver approval.
Source	Huckabee, M., and M. Warner. 2005. Bipartisan roadmap: NGA's short run Medicaid reform. Testimony before the U.S. House Committee on Energy and Commerce, June 15, 2005. Washington, DC. http://www.gpo.gov/fdsys/pkg/CHRG-109hhrg22983/html/CHRG-109hhrg22983.htm.

2003	NGA Medicaid Reform Task Force
Program structure	Retains existing program structure, but recommends additional flexibilities for states in a number of areas. Also recommends full federalization of program costs for dually eligible individuals to be phased in over time.
Eligibility	Recommends providing states with greater flexibility over application of eligibility rules and determination processes.
Benefits	Recommends allowing states to purchase prescription drugs with other state programs, to implement tiered copayments, use closed formularies and to impose medical necessity requirements. Also recommends encouraging the use of HCBS without creating new entitlements; allow HCBS without waivers; and allow states to establish different levels of care for HCBS than for nursing home care. Other benefits recommendations would: - provide more flexibility in designing benefit packages for optional populations and possibly for mandatory populations; - encourage more consumer-directed care; and - give states more flexibility to determine amount, duration and scope and to apply benefits less than statewide.
Cost sharing	Recommends updating copayment regulations and making copayments enforceable.
Financing	Recommends that full federal financing for dually eligible individuals be implemented gradually.
Other features	Other recommendations in this proposal include eliminating the need to obtain most waivers and making the waiver process less complex and cumbersome; and giving individuals additional flexibility to use employer subsidies and buy-in programs. Also recommends with respect to long term care, encouraging the role of non-Medicaid funding sources through, for example, other federal programs, tax policies, private insurance, employer involvement, and increased responsibility on behalf of individuals/families/communities; tightening up provisions allowing people to spend down assets through estate planning; and expand Long-Term Care Insurance Partnerships to all states.
Status of enactment	DRA 2005 incorporated a number of NGA's recommendations. It limited asset transfers and increased the look-back period used to calculate the waiting period for Medicaid eligibility. It provided additional flexibilities for states on benefits, allowing states to offer benchmark benefits instead of the standard Medicaid benefit package to certain beneficiaries. It also allowed states greater ability to collect premiums, to require cost sharing and provided for up to 10 demonstrations to test the use of health opportunity accounts combined with high deductible health plans. States were also provided with the ability to offer HCBS instead of nursing home care as a state option without the need for a waiver approval.
Source	National Governors Asssociation (NGA) Medicaid Reform Task Force. 2005. All-governor letter on 2003 Medicaid reform task force. January 10. http://www.nga.org/files/live/sites/NGA/files/pdf/011005LETTERTOALLGOVSMEDICAID.pdf
1997	**Medicaid Reform: The Governors' View. Testimony before the Subcommittee on Health and Environment of the Committee on Commerce**
Program structure	Proposes additional flexibilities for states in a number of areas.
Benefits	Recommends more flexibility to limit services under the EPSDT benefit and the freedom to vary the Medicaid benefit package by category of eligibility and geographic area of the state.
Cost sharing	Recommends greater flexibility for states in charging premiums and cost sharing.
Payment	Recommends allowing states to pay cost sharing for dually-eligible beneficiaries at Medicaid instead of Medicare rates and repealling the Boren amendment and cost-based reimbursement for federally qualified health centers (FQHCs).

Other features	Recommends allowing managed care enrollment without the need for waivers, including for dually eligible individuals and greater ability to selectively contract with providers. Recommends state-developed quality assurance plans and lists elements that would be included in those plans. Also recommends allowing states to enroll populations into managed care plans without the need for a waiver and giving them the ability to replicate research and demonstration waivers granted to other states.
Status of enactment	DRA 2005 incorporated a number of NGA's recommendations. It limited asset transfers and increased the look-back period used to calculate the waiting period for Medicaid eligibility. It provided additional flexibilities for states on benefits, allowing states to offer benchmark benefits instead of the standard Medicaid benefit package to certain beneficiaries. It also allowed states greater ability to collect premiums, to require cost sharing and provided for up to 10 demonstrations to test the use of health opportunity accounts combined with high deductible health plans. States were also provided with the ability to offer HCBS instead of nursing home care as a state option without the need for a waiver approval.. In addition, cost-based reimbursement for FQHCs was subsequently replaced.
Source	Leavitt, M. and B. Miller. 1997. Medicaid reform: The Governors' view. Testimony before the U.S. House of Representatives Subcommittee on Health and Environment of the Committee on Commerce, March 11, 1997. Serial No. 105-8.

Republican Governors Association	
2011	**A New Medicaid: and Innovative and Accountable Future**
Program structure	The forward to this document notes that the report is a collection of the best policy ideas from the health care task force and should not be viewed as an endorsement of a particular policy prescription. Begins by noting that "the first and best step toward a successful Medicaid transformation is repealing the ACA and replacing it with market-based, common sense reforms." Supports promoting flexibility by allowing states to design and implement changes to their Medicaid programs without CMS approval of state plan amendments, so long as a set of outcome measures are met; and to innovate by "using flexible accountable financing mechanisms that are transparent and hold states accountable for efficiency and quality health care…may include a block grant, a capped allotment" or other accountable and transparent financing approaches. These changes would eliminate the federal review process for waivers and for designing systems, benefits, services, and payment and reimbursement rates.
Eligibility	Eligibility proposals include repealing the maintenance of effort requirements under the ACA, and allowing states to streamline eligibility determination thresholds and processes.
Benefits	Benefit proposals include eliminating the mandatory and optional benefit requirements in order to give states more flexibility to design benefit structures to meet their recipients' needs, including through contributing to private health insurance benefits and paying a share of their premiums.
Financing	Financing proposals include requiring the federal government to take full responsibility for the uncompensated care costs of treating undocumented immigrants. Recommends allowing "states to pilot self-directed alignment structures for state and federal health care programs to reduce the incidence of cost-shifting from one program to another, encourage efficiency in complementary programs and ensure program integrity." Also recommends allowing states to share in savings for dually eligible beneficiaries whose Medicare costs are reduced as a result of an action by a state Medicaid program.
Other features	Other proposals include incorporating the use of alternative payment mechanisms such as bundling and paying for value, increased use of managed care, and rewards for healthy behaviors. Also recommends allowing more flexibility for states to design LTSS systems and programs for dually eligible individuals that incorporate shared savings arrangements.

Status of enactment	Not enacted
Source	Republican Governors Association (RGA): Republican Governors Public Policy Committee Health Care Task Force. 2011. A new Medicaid: An innovative and accountable future. August 30. http://www.rga.org/homepage/gop-govs-release-medicaid-reform-report/.

Republican Governors and Congress Task Force for Restructuring Medicaid	
1995	**Restructuring Medicaid**
Program structure	References to this work suggest this group recommends a block grant with greater flexibility for states, but an original source for this group's recommendations has not yet been found.
Source	Pear, R. 1995. Republican governors working with Congress to shift Medicaid authority to states. The New York Times, April 2. http://www.nytimes.com/1995/04/02/us/republican-governors-working-with-congress-to-shift-medicaid-authority-to-states.html. Thompson, F. 2012. Medicaid politics: Federalism, policy durability, and health reform. Washington, DC: Georgetown University Press.

EXHIBIT 8. Key Medicaid Reform Proposals Offered by Blue Ribbon Policy Commissions

Proposal summaries

Commission on Long-Term Care	
2013	**Report to Congress**
Program structure	Makes recommendations in three areas: service delivery, workforce, and financing. Explores two possible models for comprehensive social insurances, through Medicare or a new public program.
Eligibility	Recommends a Medicaid demonstration to provide workers with disability coverage of long-term services and supports (LTSS) to remain employed, and encourages more uniform Medicaid buy-in provisions for states opting to provide those benefits to people with significant disabilities.
Benefits	Recommends incentivizing services at settings that are most integrated, prioritizing home and community-based services (HCBS), and building options, including in Medicaid, for people to stay in the community. Recommends increasing care integration by establishing a single point of contact on a care team for people needing LTSS. Also recommends aligning incentives to improve the integration of LTSS with other health services in a person- and family-centered approach including through accountable care organizations. Supports a demonstration project to test the feasibility of providing LTSS to those who work despite having a significant disability.
Financing	Presents and evaluates alternate approaches to support payment for long-term care through long-term care insurance and expanding use of 529 accounts (Qualified Tuition Programs) for LTSS.
Other features	Recommends reducing Medicaid waiver complexity for HCBS waivers. Also recommends developing improved tools for assessing cognitive and functional capacity to allow for a single plan of care across care settings, using health information technology to improve information sharing among providers, and incorporating LTSS care plans into the electronic health record. Also recommends: - expanding an options counseling program to ensure a “no wrong door” approach to help individuals navigate LTSS; - increasing focus and funding for quality measurement; - providing incentives for purchasing LTC insurance; - eliminating Medicare three-day stay requirement; - establishing site neutral Medicare payment policies; - incorporating family caregivers as part of care team and studying caregiver interventions such as respite care; - developing meaningful career ladders for direct care workers, integrate them into care team, and permitting nurses to delegate and supervise certain tasks to direct care workers; - examining barriers to state sharing of information on workers’ background checks; and - CMS exploration of national training standards.

Status of enactment	Not enacted
Note	Created as part of the American Taxpayer Relief Act of 2012, the Commission on Long-Term Care was charged with creating a plan for the “establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system” to ensure the availability of LTSS to individuals who need them.
Source	Commission on Long-Term Care. 2013. Report to Congress. September 2013. Washington, DC: Commission on Long-Term Care. http://ltccommission.org/.

U.S. Department of Health and Human Services (HHS) Medicaid Advisory Commission	
2006	**Final Report and Recommendations of the Medicaid Commission**
Program structure	Retains the current program with significant new flexibilities for states and a federal refundable tax credit or subsidy for uninsured to avoid their enrollment into the Medicaid program. Proposes a new state option to integrate Medicare and Medicaid for dually eligible enrollees called Medicaid Advantage, administered by states. States and the federal government share in program savings.
Eligibility	Recommends simplifying Medicaid eligibility by permitting states to consolidate or redefine eligibility categories without a waiver, provided that they are cost neutral to the federal government.
Benefits	Recommends giving states greater flexibility to design separate benefit packages for separate populations without a waiver, and to reward beneficiary behaviors, for example by offering alternative benefits or by offering Medicaid Assistance Accounts where beneficiaries earn credits for healthy behaviors. Notes that states should be able to offer premium assistance for beneficiaries to use for private insurance. Proposes that all Medicaid beneficiaries be in a coordinated system of care “premised on a medical home” without the need to seek a waiver or obtain federal approval. Also recommends that states be allowed to integrate acute and long-term care benefits for dual eligibles through special needs plans (SNPs) as a state plan option that incorporates automatic enrollment with an opt-out option. Notes that administrative barriers to such integration should be reduced.
Financing	Recommends a study of a “scaled match” funding formula where lower-income populations have enhanced matching.

Other features	Recommends promoting private long-term care insurance by enacting federal and tax incentives to encourage individuals to purchase it; a study of policy options for alternative insurance models for long-term care services; and unspecified changes in Medicaid policy to address Medicaid's institutional bias. Recommends additional flexibility for states to replicate demonstrations that have operated successfully for at least two years in other states using an abbreviated application process; and that states agressively pursue policies and financing initiatives to promote interoperable health information technology, including a requirement that all Medicaid beneficiaries have an electronic health record. Encourages increased transparency to promote prudent purchasing by requiring state Medicaid agencies to make the amounts of payments they make to contracted providers for common inpatient, outpatient and physician services available to beneficiaries. Proposes that a National Health Care Innovations Program be established at CMS to support the implementation of state-led, system-wide demonstrations in health reform. This program would provide funding for investments in quality and outcomes measurement and data.
Status of enactment	The ACA included a state option for health home services and established the Center for Medicare and Medicaid Innovation at CMS.
Source	Sundquist, D., A. King. 2006. Final report and recommendations of the Medicaid commission. December 29, 2006. Washington, DC: U.S. Department of Health and Human Services Medicaid Advisory Commission. http://www.allhealth.org/briefingmaterials/HHS-MedicaidCommissionReport-638.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC)	
2012, 2013, and 2014	**Reports to Congress on Medicaid and CHIP**
Program structure	Recommends extending federal State Children's Health Insurance Program (CHIP) funding for two transitional years through 2017 to enable policymakers to develop sound policies for children covered by CHIP (June 2014).
Eligibility	To improve continuity of coverage for low income populations, recommends giving states the option to provide 12 month continuous Medicaid eligibility for adults and for children in CHIP; eliminating the sunset date for Transitional Medical Assistance (TMA), and elimintating waiting periods for CHIP.
Benefits	Recommends requiring states to provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children, and that the three federal agencies tasked with responsibility for overseeing individual responsibility provisions under the ACA specify that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans. Recommends updating and improving quality assessment and accelerating program innovations to support high-quality cost effective care for people with disabilities.
Cost sharing	Recommends that children with family incomes below 150 percent of the federal poverty level (FPL) not be subject to CHIP premiums.

Other features	Recommends program integrity improvements and that data regarding non-DSH (UPL) supplemental payments be collected and made publicly available at the provider level in a standard format that enables analysis.
Status of enactment	The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA 2015, P.L. 114-10) extended CHIP funding through 2017 and eliminated the sunset date for TMA.
Source	Medicaid and CHIP Payment and Access Commission (MACPAC). 2012, 2013, 2014. Reports to Congress on Medicaid and CHIP. Washington, DC: MACPAC. https://www.macpac.gov/publication/.

Medicare Payment Advisory Commission (MedPAC)	
2008, 2012, and 2013	**Reports to Congress**
Program structure	2013: Recommends improvements to SNPs including permanently reauthorizing institutional and dual eligible SNPs (D-SNPs), authorizing the Secretary of the U.S. Department of Health and Human Services (the Secretary) to align Medicare and Medicaid appeals and grievance processes, and allowing plans to market their benefits as a combined Medicare-Medicaid package. 2012: Recommends improvements to the Program of All-Inclusive Care for the Elderly (PACE) including paying PACE providers using rates established through the Medicare Advantage (MA) program, expanding eligibility for PACE to beneficiaries under age 55, prorating Medicare payments to PACE providers, providing PACE providers with outlier protection, and publishing select quality data on PACE providers. 2008: Recommends improvements to SNPs, including that the Secretary establish additional tailored performance measures specifically for SNPs and evaluate their performance on those measures within three years; that Congress direct the Secretary to require chronic condition SNPs to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems; that Congress require D-SNPs within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits; and that Congress require SNPs to enroll at least 95 percent of their members from their target populations.
Eligibility	Recommends extending eligibility for the PACE program to individuals under age 55.
Status of enactment	Not enacted
Source	Medicare Payment Advisory Commission (MedPAC). 2008, 2012, 2013. Reports to Congress. Washington, DC: MedPAC. http://www.medpac.gov/-documents-/reports.

National Bipartisan Commission on the Future of Medicare	
1999	**Building a Better Medicare for Today and Tomorrow**
Program structure	Proposes full federal funding for coverage of prescription drugs for Medicaid beneficiaries with income up to 135 percent of the federal poverty level (FPL).

Financing	Proposes that the costs of drug coverage for beneficiaries currently dually eligible for Medicare and Medicaid continue to be shared by the states and the federal government, and that the new drug coverage be fully federally financed. In addition, recommends that the federal government provide grants to states to offset the additional costs to states of new enrollment among existing eligibles, also referred to as the woodwork effect.
Other features	Notes that the prescription drug coverage could be provided through high-option private plans once other reforms take place, including premium support in Medicare.
Status of enactment	Medicare prescription drug coverage was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA, P.L. 108-173) in 2003.
Source	National Bipartisan Commission on the Future of Medicare 1999. *Building a better Medicare for today and tomorrow.* March 16. Washington, DC: National Bipartisan Commission on the Future of Medicare. http://rs9.loc.gov/medicare/bbmtt31599.html. Lemieux, J. 1999. Cost estimate of the Breaux-Thomas proposal. Memorandum to the Medicare commission. March 14, 1999. http://thomas.loc.gov/medicare/cost31499.html.

National Council on Disability

2005	The State of 21st Century Long-Term Services and Supports: Financing and Systems Reform for Americans with Disabilities
Program structure	Recommends a comprehensive framework for LTSS policies, programs, and funding. Two separate streams of recommendations are provided: one targets improvements to the existing systems of LTSS and a second would establish a "new millennium policy." Among the almost 600 pages of recommendations are several focusing on the Medicaid program.
Eligibility	Proposes decoupling eligibility for HCBS from determination of nursing home eligibility to address Medicaid institutional bias.
Benefits	Proposes increasing support for informal caregivers by increasing respite care options and establishing a National Resource Center on Lifespan respite care to provide training, technical assistance, etc.
Financing	Proposes conducting feasibility studies and tests new insurance products and options to finance Medicaid LTSS, or to encourage private coverage with Medicaid LTSS as a supplement.
Other features	Other key provisions include increasing the supply, retention, and performance of direct support workers, and improving consumer understanding regarding person-centered planning and self-directed care. Describes a long-term national program, AmeriWell, that is a prefunded, mandatory LTSS system that provides coverage for LTSS services delinked from Medicaid and Medicare to all Americans of any age and functional capacity. It would be funded by individual contributions to AmeriWell accounts beginning at birth which are pooled together to finance LTSS, health care and prescription drugs for those eligible based on poverty and disability status. Medicaid elderly and disabled populations would be moved to AmeriWell. Tax deductible private AmeriWell accounts would be available and the program would be financed in part by a "sales commission levied on daily stock transactions."
Status of enactment	Not enacted

Source	National Council on Disability. 2005. The state of 21st century long-term services and supports: Financing and systems reform for Americans with disabilities. December 15. Washington, DC: National Council on Disability. https://www.ncd.gov/publications/2005/12152005

National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)	
2010	**A Long-Term Plan for Medicare and Medicaid**
Program structure	Recommends savings proposals over the short run as described below. Over the longer term, recommends: - setting targets for the total federal budgetary commitment to health and further structural reforms if federal health spending exceeds program-specific and overall targets; - limiting per person spending growth to GDP growth plus one; - structural reforms, which could include premium support for Medicare; -"giving CMS authority to be a more active purchaser of health care services using coverage and reimbursement policy to encourage higher value services"; - expanding the Independent Payment Advisory Board (IPAB); and - reforming the federal-state responsibility for Medicaid possibly providing for block grants for the federal portion of the program.
Benefits	Recommends giving states full responsibility for dually eligible enrollees, and requiring that they be enrolled in Medicaid managed care programs.
Financing	Recommends eliminating the exclusion for employer-provided health insurance as a potential way to reduce growth in health care spending. Also recommends short-term savers including extending Medicaid's drug rebates to dually eligible individuals in Medicare Part D; eliminating the safe harbor for provider-specific taxes; and recouping duplicative administrative costs inappropriately included in the Temporary Assistance for Needy Families (TANF) block grants.
Other features	Recommends allowing for expedited Medicaid waivers for up to 10 states in order to give states new flexibility to control costs and improve quality.
Status of enactment	Not enacted
Note	Proposal was presented to the commission but not adopted.
Source	Ryan, P., A.Rivlin. 2010. A long-term plan for Medicare and Medicaid. Presentation to the National Commission on Fiscal Responsibility and Reform. November 17. Washington, DC. http://budget.house.gov/news/documentsingle.aspx?DocumentID=225826.

The Pepper Commission: U.S. Bipartisan Commission on Comprehensive Health Care	
1990	**Final Report of the Pepper Commission**
Program structure	Recommends a new universal coverage program to replace much of Medicaid combined with a national long term care system to replace Medicaid LTC services. The universal coverage program would be a joint state-federally financed program that would phase in coverage for the unemployed and other people without health insurance. States would continue to contribute toward the universal health plan in an amount that would be limited in real terms to their current Medicaid contribution. It would be implemented incrementally beginning with expanding Medicaid coverage for certain low-income pregnant women and infants. The next phase would be to implement an employer mandate. Finally, the federal program would cover all non-workers. Recommends social insurance for all Americans that would cover HCBS care and three months of nursing home care, and would protect $30,000 or $60,000 of assets excluding homes for individuals or couples.
Eligibility	Reccomends establushing new criteria for qualifying for public benefits based on disability. Also recommends that severely disabled individuals be directed to a case manager.
Benefits	Recommends that the universal coverage program include a minimum benefit package. Medicare or the reformulated Medicaid program would pay Medicare premiums, deductibles, and cost sharing for all elderly people with income below 200 percent FPL. The LTC social insurance program would additionally cover personal care, homemaker or chore services, shopping and other support services, day care for disabled adults and children, respite services, training for family caregivers and skilled nursing and rehabilitative care. Case managers would allocate services and monitor service delivery within a budget set by the federal government.
Cost sharing	Recommends that cost sharing be allowed on all but preventive services under the universal coverage program.
Payment	Recommends that the federal government establish provider payment mechanisms and determine payment rates. Notes that prospective payment systems may be used. Notes that payment rates should be increased gradually to ensure an adequate supply and quality of services.
Financing	States and the federal government would share in the financing for the universal coverage program. The social insurance portions of the public long-term care program would be fully financed by the federal government. The states and the federal government would share in the cost for long nursing home stays. Makes recommendations for criteria to consider in enacting new taxes to fund the benefits, including that the new taxes are progressive, grow at a pace to keep up with benefits growth, and come from people of all ages.
Other features	Recommends development and implementation of national practice guidelines and standards of care, and federal support for health promotion, disease prevention, risk reduction, and health education programs. Recommends incremental implementation that would begin with limited home care benefits to relieve family caregivers; in year two, nursing home coverage would begin. Full implementation would take place over four years.
Status of enactment	Not enacted
Source	U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission). 1990. A call for action: Final report of the Pepper Commission. September 25. Washington, DC: Pepper Commission.