REPUBLICAN GOVERNORS

PUBLIC POLICY COMMITTEE

A New Medicaid: A Flexible, Innovative and Accountable Future

Republican Governors Public Policy Committee
Health Care Task Force
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The Republican Governors Public Policy Committee (RGPPC) is the official policy organization of the nation's Republican governors. The RGPPC brings together 31 state governors to speak with one voice on public policy issues that impact their states.[1]

This report is a collection of policy ideas from the RGPPC Health Care Task Force. This report does not constitute an endorsement of the policy prescription by any specific governor. Instead, these policy proposals should be viewed as among the best ideas from the states to be considered in reforming the nation's health care system. While this report is focused on specific solutions for the Medicaid program, it is important to note that Medicaid is only one segment of the entire health care system and cannot be considered separately from the overall health care insurance system.

[1] In this report, the term "states" generally refers to the governments of the states, the territories and the District of Columbia.

Introduction: The Critical Role of Governors in Achieving Health Care Reform

In May 2011, House Energy and Commerce Committee Chairman Fred Upton and Senate Finance Committee Ranking Member Senator Orrin Hatch sent a joint letter to Republican governors seeking their guidance in reforming and improving the Medicaid program. Chairman Upton and Senator Hatch described the urgent need for reform in grave terms stating, "We are concerned that the program is failing patients; is a target for waste, fraud and abuse; and is bankrupting both state and federal governments."

Republican governors share Chairman Upton and Senator Hatch's concerns and have accepted the charge of outlining for Congress a set of guiding principles for a new Medicaid. Since May, the Republican Governors Public Policy Committee (RGPPC) Health Care Task Force has facilitated an ongoing and substantive dialogue among Republican governors centered on addressing the challenges of the nation's Medicaid crisis. In June, 29 Republican governors submitted written principles to Chairman Upton and Senator Hatch. These seven guiding principles are central to building a flexible, innovative and accountable future for the Medicaid program.

A New Medicaid: A Flexible, Innovative and Accountable Future is the culmination of the combined efforts of policymakers and health care administrators in the nation's Republican-led states. This report will serve as the basis for dialogue during the upcoming RGPPC-sponsored Health Care Summit to be held in Washington D.C., on Oct. 24-25, 2011.[2] The summit will feature governors, their senior health care staff, key House and Senate staff, and representatives from both the private sector and policy community. Together, stakeholders will engage in a serious – and much-needed – discussion focused on Medicaid reform and the policy options proposed by the nation's Republican governors.

The RGPPC Health Care Summit is significant in that it will bring forward specific policy solutions for health care reform from the nation's governors for the first time. Despite repeated efforts by governors from both parties to engage in the debate leading up to the passage of the Patient Protection and Affordable Care Act (PPACA), the White House largely ignored state input.[3] This is in stark contrast to the welfare reform debate of the 1990s, in which governors played a major role in identifying the solutions that culminated in the 1996 passage of the bipartisan Personal Responsibility and Work Opportunity Reconciliation Act.

By carrying out a partisan and exclusively federal debate, the White House only made the health care crisis worse. Today, Americans are no closer to affordable health care with the passage of the PPACA than they were before the debate began. This makes the RGPPC's efforts

[2] The Health Care Summit was originally scheduled for Aug. 29-30, 2011, but was rescheduled due to Hurricane Irene.

[3] Governors from both parties were excluded from the White House-arranged health care reform meeting at Blair House on Feb. 25, 2010, which was billed as a bipartisan, open and honest discussion among health care reform's key stakeholders.

to identify improvements to provide health care to the most vulnerable individuals all the more important.

The PPACA expansion of the Medicaid program is the largest expansion of this program in history. As a result, we are deeply concerned the existing challenges Medicaid faces today will be exacerbated by the program's unprecedented growth over the next few years. We must think about a new Medicaid program—one that more easily adjusts to the needs, ideas and culture of each state.

Republican governors stand ready to work with Congress and the Administration to develop a better and more efficient Medicaid system, one that gives states greater flexibility, spurs delivery innovation, encourages greater accountability, and reduces the cost of the program to states and the federal government alike.

Governors and states that provided input for this report include:

Governor Robert Bentley, Alabama
Governor Sean Parnell, Alaska
Governor Jan Brewer, Arizona
Governor Rick Scott, Florida
Governor Nathan Deal, Georgia
Governor Eddie Baza Calvo, Guam
Governor Butch Otter, Idaho
Governor Mitch Daniels, Indiana
Governor Terry Branstad, Iowa
Governor Sam Brownback, Kansas
Governor Bobby Jindal, Louisiana
Governor Paul LePage, Maine
Governor Rick Snyder, Michigan
Governor Haley Barbour, Mississippi
Governor Dave Heineman, Nebraska
Governor Brian Sandoval, Nevada
Governor Chris Christie, New Jersey
Governor Susana Martinez, New Mexico
Governor Jack Dalrymple, North Dakota
Governor John Kasich, Ohio
Governor Mary Fallin, Oklahoma
Governor Tom Corbett, Pennsylvania
Governor Luis Fortuno, Puerto Rico
Governor Nikki Haley, South Carolina
Governor Dennis Daugaard, South Dakota
Governor Bill Haslam, Tennessee
Governor Rick Perry, Texas
Governor Gary Herbert, Utah
Governor Bob McDonnell, Virginia
Governor Scott Walker, Wisconsin
Governor Matt Mead, Wyoming

Medicaid and the States

States have always played a central role in ensuring medical care for the neediest Americans. Until 1965, health care for low-income and disabled citizens was a state and local issue with limited federal involvement. With the passage of Title XIX of the Social Security Act of 1965, Medicaid was created as a means-tested joint program, or "partnership," between the federal and state governments.

Under this joint program, states could design and administer their own programs, but the federal government would monitor the programs and establish requirements for service delivery, quality and eligibility standards. To determine federal funding levels, the Social Security Act of 1965 outlined Federal Medical Assistance Percentages (FMAP) to calculate the federal government's financial contribution to each state's specific program. The FMAP rates are based on each state's three-year rolling average per capita income compared to the continental United States income.[i] In 2010, the federal government paid a nationwide average of 57 cents on every dollar spent on Medicaid.[ii]

Over the past 45 years, the Medicaid program has evolved into a cumbersome, complicated and unaffordable burden on nearly every state. The Department of Health and Human Services Centers for Medicare & Medicaid (CMS) *2010 Actuarial Report on the Financial Outlook for Medicaid* paints a grim picture for the more than 45 states and the District of Columbia that have projected budget shortfalls for FY 2012.[iii] State Medicaid expenditures are projected to reach $327.6 billion by FY 2019, increasing at a compounded annual growth rate of 9.8 percent, or more than twice the historical rate.[iv]

The dramatic increase in projected state Medicaid expenditures is in large part due to the PPACA, which mandates states expand their Medicaid eligibility standards to include all individuals at or below 138 percent of the Federal Poverty Level (FPL) beginning in 2014.[4]

Annual state Medicaid rolls have swelled to more than 69.5 million enrollees, or more than 1 in 5 Americans, in 2011.[v] Medicaid enrollment now exceeds Medicare enrollment by more than 8.1 million people on an average monthly basis.[vi] After PPACA's mandated eligibility expansion goes into effect in 2014, CBO projects that an additional 25.6 million people[vii] will enroll in Medicaid in the next decade, increasing state administrative costs by $12 billion.[viii] Overall, PPACA's new eligibility groups are expected to cost the states a total of more than $118 billion through 2023.[ix]

Beyond the administrative demands of expanded Medicaid eligibility, the inclusion of tax credits for individuals up to 400 percent of the FPL, under the PPACA, poses an

[4] The PPACA mandates states expand eligibility standards to 133 percent of the FPL, but includes a subsequent provision that disregards the first 5 percent of an individual's income, therefore making the expansion equivalent to 138 percent of the FPL.

access to care concern for enrollees, the insured and states. Today, coverage by Medicaid does not immediately equate to access to appropriate care. Increasingly, individuals and families enrolled in the Medicaid program face barriers to receiving care from primary care physicians, specialists and behavioral health professionals.

The PPACA only exacerbates the access problem as Medicaid rolls are expected to balloon to more than 95.1 million Americans.[x] Left unaddressed, the negative impact will be felt financially and from a public health perspective as current Medicaid patients routinely receive services delivered in the most costly care settings (i.e., emergency rooms):

- A nationwide survey of physicians, published in June 2010, found that 54.5 percent of primary care physicians, 45.6 percent of medical specialists, and 49.3 percent of surgical specialists are no longer accepting new Medicaid patients.[xi]
- In a separate 2010 survey of 1,800 emergency room physicians, 71 percent of respondents expect emergency visits to increase, and 47 percent anticipate conditions will worsen for patients.[xii]
- Even more overutilization of America's emergency departments by Medicaid enrollees could cost states, hospitals and physicians as much as $35.8 billion over the next decade in unaccounted for expenditures.[xiii]

Medicaid is a severe budgetary threat to states and a barrier to quality care for the neediest Americans. Washington is passing the buck on budget leadership and entitlement reform without giving states the freedom to design a program that works best for their citizens. Bending the unsustainable trajectory of the Medicaid program will require flexibility, accountability and innovative solutions at the state level.

Congress and the Administration cannot continue to simply shift the cost of the Medicaid program onto states in an effort to proclaim federal deficit reduction. As governors, we believe there is an opportunity to reduce Medicaid costs for both states and the federal government while improving the quality of the program overall. Financing reforms at the federal level must be partnered with new and aggressive state flexibility measures that provide every governor and state government the ability to best manage their programs.

Moving Forward: Flexibility, Innovation and Accountability

The first and best step toward a successful Medicaid transformation is repealing the PPACA and replacing it with market-based, common sense reforms to our health care system. As discussed earlier in this document, true health care reform cannot be done in a silo or only through Medicaid. For example, reform of the tax code is essential to true reform of our health care system.

All components of the health care system should be part of the reform efforts. Regardless of the outcome of the PPACA debate, Medicaid must be transformed – not just reformed around the edges or managed through the cumbersome and outdated waiver process. If the PPACA is upheld by the Supreme Court, it will be essential to have a Medicaid program that taps into the innovation that states have been known for throughout the history of the Medicaid program.[5] Therefore, it is imperative that the system be modified immediately to assist states with their current programs.

States must have the flexibility to create and manage a Medicaid program within their boundaries that is consistent with each state's needs and culture. Each state Medicaid program should be accountable for measured improvement in the health status of their Medicaid populations based on quality and outcome metrics,[6] rather than compliance with bureaucratic processes that, in too many cases, have no impact on improving the lives of the most vulnerable Americans, or promoting efficiency and prudent utilization of taxpayers' dollars. Measurements of health status should include items that reflect individual behavior and responsibility in one's own health.

The policy options presented in this report are the result of discussions among numerous state officials (i.e., governors, secretaries of health and human services; Medicaid program directors and representatives; and governors' senior policy staffs). States may choose to utilize these policies to transform their respective Medicaid programs into cost-effective and efficient operations that emphasize a patient-centered approach to achieve higher quality outcomes. Outlined in this document are policy

[5] In Oklahoma, SoonerCare deployed utilization review to identify and educate frequent Medicaid Emergency Room (ER) users (4 or more visits per quarter). From January 2006 to March 2009, SoonerCare contacted 20,491 members that accounted for 107,435 ER visits during that period. The state estimates that the utilization review program led to a reduction of 51,628 visits (48%) and a savings of more than $12 million in unnecessary ER expenditures.
In Pennsylvania, the Healthy Hoops program was established in response to an increase in asthma-related hospital admissions. By targeting the at-risk population, the state deployed a comprehensive approach that led to a 10% increase in medication adherence and a dramatic decline in ER use.
In Arizona, the adoption of a statewide Medicaid managed care model resulted in a 7% savings over fee-for-service delivery over a 10-year period.

[6] For example, the number of people who are monitoring their A1C (blood sugar) measurements; a decline in readmission rates and emergency room visits; weight loss and disease management; or medication adherence.

solutions that would increase Medicaid's efficiency and effectiveness as a part of the overall health care delivery system regardless of whether or not PPACA is repealed.

Policy Solutions

A New Medicaid: A Flexible, Innovative and Accountable Future offers a pathway for true innovation in our Medicaid programs as state leaders seek to provide cost effective, quality health care for their most vulnerable populations.

Principle #1: States are best able to make decisions about the design of their health care systems based on their respective needs, culture and the values of each state.

The term "partnership" between states and the federal government is a misnomer. Rather than acting as a partner, the federal government dictates and micromanages rules and regulations that, in many cases, impede a state's ability to innovate and create programs that improve the health of its citizens and contain costs. Medicaid programs are and should be far more accountable to its citizens at the state and local levels, both in the scope and quality of services provided and the budgetary reality, than to current procedural regulations and rules issued by the Centers for Medicare & Medicaid Services (CMS).

Solution #1: Provide states the option to define and negotiate a broad outcome-based Program Operating Agreement (POA) with CMS. The only notification required would be when a state elects to update or change an agreed upon POA. States would publicly report the outcome measures established within the POA on a routine basis. CMS oversight should only be triggered when there is a significant deviation in the reported versus projected measure. The number of measures should be finite. Eliminate the onerous federal review process for operating the Medicaid program within each state, such as requiring waivers for designing systems, benefits, services, and payment and reimbursement rates. The relationship between the federal and state government should be based on the principles of value-based purchasing rather than rigorous, complex and lengthy processes.

Solution #2: States can create a specific "dashboard" to measure accountability utilizing recognized measures of quality, cost, access and customer satisfaction that reflects the states' priorities and permits an assessment of program performance over time. Where possible, states will utilize the expertise of state, local and national organizations that have developed appropriate measures. In many cases, states already have developed extensive measures of quality and accountability, including customer satisfaction. These dashboards should utilize those processes instead of recreating onerous administrative burdens for states.

Solution #3: Repeal Maintenance of Effort (MOE) requirements established by the PPACA. This would return flexibility to states and allow them to make changes in eligibility that are essential to the efficient and effective operation of their programs.

Solution #4: Program integrity should be the responsibility of the state. Currently, common practice is to utilize federal contractors for program integrity initiatives, most of whom are not familiar with individual state programs and simply engage in "pay and chase," where claims are paid and then states seek payments afterward. Instead, states and their staffs should be able to utilize existing federal funding sources to proactively fight fraud and abuse activities.

Solution #5: Require the federal government to take full responsibility for the uncompensated care costs of treating illegal aliens.

Principle #2: States should have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and hold states accountable for efficiency and quality health care. Such mechanisms may include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

The Medicaid program currently has a variety of federal matching rates based on program areas (e.g., administration, benefits, state Children's Health Insurance Program (SCHIP), information technology), as well as a Federal Medical Assistance Percentage (FMAP) methodology that is both outdated and not responsive to a state's true financial need.

It is almost impossible for anyone to understand the scope and complexity of funding for Medicaid. Medicaid financing should be fully transparent and consistent with the goals of providing assistance to states with a significant percentage of their population at or below the poverty level. Every financial system should be designed to encourage innovation and efficient delivery of health care services.

Solution #6: Allow 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.

Solution #7: Federal and state financial participation in the Medicaid program should be rational, predictable and reasonable. As aforementioned, the dramatic expansion of Medicaid scheduled for 2014 could have dire consequences on the management of the program. Because of PPACA, there are essentially two different programs within Medicaid and states are expected to maintain duplicate systems for program eligibility and program financing.

Solution #8: If a state can demonstrate budget neutrality, provide states the ability to use state or local funding, now spent as match funding, for certain health services that would pay for Medicaid services or health system improvements that are currently not "matchable," but are cost effective and improve the value of the Medicaid program. This could include Health Information Exchanges, increased benefits for some individuals, improved care management and local care coordination, and pilot programs to test innovations.

Solution #9: States should be encouraged to develop innovative programs to reduce chronic illnesses and the burden of associated health care costs to individuals and the taxpayers. Allow states to invest in alternative programs that reduce hospital emergency room visits and other community-based programs to reduce hospitalizations.

Solution #10: Program integrity should be the responsibility of the states. In order to properly insure the taxpayers' investment in Medicaid is protected:

- All sources of federal funding allocated to combat waste, fraud and abuse should be included in any block grant or alternative financing mechanism proposal.
- An enhanced contingency fee should be paid to states for increasing their efforts to decrease waste, fraud and abuse. The current system's development matching rate of 90/10 should be allowed for improvements to states' current fraud and abuse, and eligibility systems. Innovative programs that show a positive return on investment for both the state and federal governments should be allowed without the onerous waiver process.
- The entire appeals process for any recoupments and overpayments should be exhausted prior to paying the federal share of the recovery.

Principle #3: Medicaid should be focused on quality, value-based purchasing and patient-centered programs that work in concert to improve the health of states' citizens and drive value over volume, quality over quantity, and, at the same time, contain costs.

Alternative payment mechanisms, including those where payments are capitated,[7] present a host of policy solutions for state policymakers. These alternative mechanisms have enabled states to improve access to care through private insurance networks, facilitate care coordination across providers, instill provider accountability and deliver better outcomes. But the federal government continues to present numerous barriers to their use within the Medicaid program by requiring a state to go through the cumbersome, subjective waiver process to implement innovative alternative payment mechanisms, or include individuals who are exempt from these plans but would benefit from care coordination.

[7] A set or actuarially sound global provider fee is established regardless of the types or volume of treatment.

Unless a state is granted a waiver, there are restrictions on which Medicaid populations can participate in alternative payment methodologies and how much control plans can exert over provider networks. These restrictions limit the effectiveness of care coordination and shortchange Medicaid recipients. Existing restrictions include: a requirement to offer the program statewide or meet certain CMS population requirements, limits on cost sharing (co-payments, deductibles, co-insurance), limits on closed network providers/services, retroactivity (requiring payment of all covered services provided within three months of being determined eligible), and requirements related to the number of plans offering managed Medicaid services.

Solution #11: Provide states with the flexibility, without requesting waivers or initiating the state plan amendment process, to pay providers based on providers meeting quality care and value-based criteria rather than the current fee-for-service approach. Allow innovative payment methodologies to encourage care coordination for all Medicaid eligibles, without exception. Other options could be capitated payments, shared savings, and incentive arrangements when such payments encourage coordination, reduce cost shifting and improve care delivery.

Solution #12: Provide states with the ability to implement bundling projects (a provider is paid an amount for a discrete event, such as hip replacement, and that provider pays other providers for all necessary care for the event, with providers sharing in savings).

Solution #13: Give states the ability to use only one managed care organization if client volume in an area is insufficient to support two. CMS now requires at least two managed care organizations in each area.

Principle #4: States must be able to streamline and simplify the eligibility process to ensure coverage for those most in need, and states must be able to enforce reasonable cost sharing for those able to pay.

A national discussion regarding Medicaid eligibility and the scope of government assistance is urgently needed. In addition, a plan for self-sufficiency, where possible, similar to that designed in welfare reform, must be part of that discussion.

Solution #14: Establish reasonable, rational and consistent asset tests for eligibility. Amend PPACA's definitions of income to count child support payments (current law in Medicaid), and reverse the use of Modified Adjusted Gross Income (MAGI) in order to avoid new eligibility for higher-income Americans.

Solution #15: Give states the flexibility to streamline and improve the eligibility determination system by contracting with private firms.

Solution #16: Within a state's fair share of federal funding, there should be significant flexibility regarding how a state provides eligibility for its population in need.

Solution #17: Eliminate the marriage penalty.

Principle #5: States can provide Medicaid recipients a choice in their health care coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace.

Medicaid recipients should have a stake in their personal health care, and the Medicaid program, by design, should make room for recipients to play a role in the decision-making process. Personal responsibility and consumer choice for Medicaid recipients must be standard components of a new Medicaid. Medicaid recipients, like the rest of Americans, should be given both the freedom to choose their health plans and the responsibility to contribute to their health care costs at a level that is appropriate. Under current law, cost sharing (i.e., a co-payment) is not enforceable at the point of service if the individual is below 100 percent of the FPL.

A successful example can be found in Indiana. In 2007, Indiana launched the Healthy Indiana Plan (HIP), which extends high deductible health plans and accounts similar to health savings accounts (HSA) to low-income parents of children covered by Medicaid and SCHIP, as well as childless adults, through a waiver.

Solution #18: Eliminate the obsolete mandatory and optional benefit requirements. Provide states the flexibility to design appropriate benefit structures to meet the needs of their recipients in a cost-effective and efficient manner as part of the state's negotiated plan.

Solution #19: Eliminate benefit mandates that exceed the private insurance market benchmark or benchmark equivalent. Design benefit packages that meet the needs of specific populations, including allowing a plan that puts non-disabled populations into Section 1937 benchmark plans.[xiv] Amend Section 1937 to include cost-sharing provisions and allow states the authority to enforce cost sharing.

Solution #20: Purchase catastrophic coverage combined with an HSA-like account for the direct purchase of health care and payment of cost sharing for appropriate populations determined by each state.

Solution #21: Provide states the option of rewarding individuals who participate in health promotion or disease prevention activities.

Solution #22: Provide states with the ability to offer "value-added" or additional services for individuals choosing a low-cost plan or managed care plan (i.e., additional services and benefits offered by coordinated care companies for successful completion of healthy baby programs, or an adult dental benefit).

Solution #23: Allow states the option of contributing to a private insurance benefit for all members of the family. Require all members of the family to participate in cost-effective coverage.

Solution #24: Lower the threshold for premium payments to 100% FPL to encourage a sense of shared beneficiary ownership in health care decisions.

Principle #6: Territories must be ensured full integration into the federal health care system so they can provide health care coverage to those in need with the flexibility afforded to the states.

Currently, the FMAPs for the territories are set by statute at artificially low rates compared with the 50 states, and are subject to arbitrary caps. This unequal funding places a crippling burden on territorial budgets, limits the services that territories can provide for their Medicaid-eligible populations, and encourages the residents of the territories – who are Americans – to move to states, where they can receive better-funded Medicaid services.

Additionally, the federal government's patchwork approach to the application of Medicaid regulations to the territories has limited the territories' ability to develop and implement programs specific to the needs of their populations. For example, under current law, the authority of the secretary of the Department of Health and Human Services to waive or modify Medicaid requirements beyond the FMAP, Medicaid cap, and/or the scope of allowable Medicaid services, extends to the 50 states, American Samoa and the Northern Mariana Islands, but is not extended to the territories of the Virgin Islands, Guam and Puerto Rico.

Solution #25: The territories should be treated consistently, fairly and rationally in funding, services and program design.

Principle #7: States must have greater flexibility in eligibility, financing and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves. New federal requirements threaten to stifle state innovation and investment. In addition, since dual eligibles (individuals who are eligible for both Medicare and Medicaid) now constitute 39 percent [xv] of Medicaid spending, Medicare policies that shift costs to the states must be reversed, and the innovative power of states should be rewarded by a shared-savings program that allows full flexibility to target and deliver services that are cost effective for both state and federal taxpayers.

As a result of mandatory expansions under the PPACA, Medicaid covers even more non-disabled individuals at higher income levels. In addition, in the current Medicaid program, the majority of the Medicaid population has at least one family member in the workforce. The transformation of Medicaid must include changes in the design and expectations of the program to reflect this reality.

Federal law also specifies services that must be covered by Medicaid programs. States have the option of offering other services if they are approved by the Centers for Medicare & Medicaid Services (CMS), which administers these programs. However, the "mandatory" and "optional" benefit structure of Medicaid has been obsolete for decades.[8]

The original program and health care, in general, reflects medical care provided in hospitals and other acute care settings. With the advancements in medicine and an increased number of people living with chronic diseases, such as cancer, heart disease and diabetes, treatment protocols have changed as have the locations of those treatments. As medical costs generally have shifted from the treatment of infectious or high-mortality diseases in hospital settings to more chronic diseases treated in outpatient settings, the mandatory and optional benefit categories are no longer relevant to today's health care needs and do not reflect medical advances. Starting with the increased importance of prescription drugs in medical care (i.e., managing diabetes with medication versus an amputation procedure) and continuing through the emergence of home- and community-based services, these categories must be re-examined. Under current Medicaid rules, for example, an individual is entitled to a nursing home bed, but medical services to allow an individual to stay at home are optional. States must rely upon "waivers"[xvi] or a state plan amendment process to respond to the changing health care delivery system, including the ability to provide many home- and community-based services for long-term care.

Solution #26: At a state's discretion, permit states to redesign Medicaid into multiple parts. Medicaid Part A would focus on preventive, acute, chronic and palliative care services; and Part B would focus on long-term supports and services (LTSS). This would enable a state to better manage the different needs between populations who only need LTSS. Eligibility for Part B would be based on income and functional screening of an individual's long-term services and LTSS needs.

Solution #27: Engage in shared savings arrangements for dual eligible members when the state can demonstrate the Medicare program reduced costs as a result of an action by a state Medicaid program.

[8] Federal law also specifies services that must be covered by Medicaid programs. Other services may be offered, at a state's option, if approved by CMS. Mandatory coverage includes: inpatient hospital services, excluding services for mental disease; outpatient hospital services; federally qualified health center services; rural health clinic services (if permitted under state law); laboratory and x-ray services rendered outside a hospital or clinic; nursing facility services for beneficiaries age 21 and older; physician services; certified pediatric and family nurse practitioner services (when licensed to practice under state law); nurse midwife services; medical and surgical services of a dentist; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children; family planning services and supplies; home-health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan, including intermittent or part-time nursing services, home health aide services and medical supplies and appliances for use in the home; and pregnancy-related services and services for other conditions that might complicate pregnancy, as well as postpartum care for 60 days.

Solution #28: Repeal restrictions that impede self-direction of long-term care supports and services (LTSS) and allow states the ability to design programs that meet their needs and are cost effective.

Solution #29: At the state's option, replace Medicare cost-sharing with state-administered, 100% federal grants.

Solution #30: Give states the flexibility to enroll more members, especially families, in premium assistance programs including Medicare benefits, when it is cost efficient. Medicaid should be the payer and insurer of last resort.

Solution #31: Extend Medicare coverage of skilled nursing facilities by 60 days.

Conclusion

Our nation is at a crossroads. We have the ability to transform our health care system to make it more responsive to the needs of our citizens by being more efficient and effective. This cannot be done by taking the entire U.S. health care system and making it a federally-sponsored and controlled entitlement program. Instead, we must build on the strength of our private insurance market, and encourage value-based purchasing and personal responsibility, while continuing to protect our most vulnerable populations.

The Medicaid program must be truly transformed, not just reformed around the edges. The RGPPC looks forward to participating in this ongoing dialogue as we work together, with both state governments and the federal government, to critically analyze and improve health care delivery.

Endnotes

[i] Assistant Secretary for Policy Evaluation, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures," Department of Health and Human Services, http://aspe.hhs.gov/health/fmap.htm.
[ii] Paul Ryan, "The Path to Prosperity," House Committee on the Budget, April 5, 2011.
[iii] Office of the Actuary, "2010 Actuarial Report on the Financial Outlook for Medicaid," Department of Health and Human Services, Centers for Medicare & Medicaid Services, Dec. 21, 2010.
[iv] Elizabeth McNichol, Phil Oliff, and Nicholas Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, Feb. 10, 2011.
[v] Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid," http://www.cbo.gov/budget/factsheets/2011b/medicaid.pdf.
[vi] Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicare," http://www.cbo.gov/budget/factsheets/2011b/medicare.pdf.
[vii] Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid," http://www.cbo.gov/budget/factsheets/2011b/medicaid.pdf.
[viii] Office of the Actuary, "2010 Actuarial Report on the Financial Outlook for Medicaid," Department of Health and Human Services, Centers for Medicare and Medicaid Services, Dec. 21, 2010.
[ix] Senate Finance Committee, Orrin Hatch, Ranking Member and House Energy & Commerce Committee, Fred Upton, Chairman, "Medicaid Expansion in the New Health Law: Costs to the States," Joint Congressional Report, http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf.
[x] Congressional Budget Office, "Spending and Enrollment Detail for CBO's March 2011 Baseline: Medicaid," http://www.cbo.gov/budget/factsheets/2011b/medicaid.pdf.
[xi] "Medicare/Medicaid Acceptance Trends Among Physicians," AmeriMed Consulting, June 2010, http://amerimedconsulting.com/home/wp-content/uploads/press/pdf/AmeriMedTrendTracker-2010.pdf.
[xii] "ER Docs Predict Jump in Emergency Room Visits," *U.S. News and World Report,* May 17, 2010.
[xiii] Douglas Holtz-Eakin and Michael Ramlet, "Healthcare Reform and Medicaid: Patient Access, Emergency Department Use, and Financial Implications for States and Hospitals," American Action Forum, September 2010.
[xiv] Section 1937 of the Social Security Act defines what populations can be offered an alternative benefit package that must be equivalent to a "benchmark" place also established in this section of the Act.
[xv] Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," The Henry J. Kaiser Family Foundation, May 2011, http://www.kff.org/medicaid/upload/4091-08.pdf
[xvi] Waivers refer to the authority of the Department of Health and Human Services (HHS) secretary to "waive" certain provisions of federal law. Medicaid waivers include:
Section 1115 Research & Demonstration Projects: This section provides the HHS secretary broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.
Section 1915(b) Managed Care/Freedom of Choice Waivers: This section provides the HHS secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.
Section 1915(c) Home and Community-Based Services Waivers: This section provides the HHS secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.