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**CONGRESS CONSIDERS MEDICAID SPENDING CUTS:  
IMPLICATIONS FOR CALIFORNIA'S MEDI-CAL BENEFICIARIES AND  
SAFETY-NET PROVIDERS**

**INTRODUCTION**

A major debate over the future of federal funding for Medicaid has begun.<sup>1</sup> Congress has already decided to reduce federal spending on the program. What remains to be decided is precisely how large these cuts will be and how they will be achieved. This debate is set in the context of the federal budget for federal fiscal year (FFY) 2006 that begins on October 1, but the outcome could shape the Medicaid Program for the next five to 10 years – or beyond. Since California accounts for over 10 percent of all federal Medicaid dollars and about 18 percent of all Medicaid beneficiaries, this debate has important implications for low-income Californians and safety-net providers.<sup>2</sup>

At the same time, the Schwarzenegger Administration is negotiating with the federal government over renewal of a hospital financing waiver that is scheduled to expire June 30. The outcome of these negotiations will have significant fiscal and policy implications for California's public and private safety-net hospitals, which serve a large number of Medicaid and uninsured patients.<sup>3</sup> Taken together, the Congressional debate and the waiver negotiations will affect billions of federal Medicaid dollars for California.

Both the federal budget process and the waiver negotiations are moving targets, neither is particularly transparent, and most of the critical details are not yet public. This *Budget Brief* summarizes what is known about the federal Medicaid budget debate and how that debate might affect both the waiver negotiations and the overall Medi-Cal Program. Specifically, this paper:

- Reviews the Bush Administration's FFY 2006 Medicaid proposals, including a proposal to limit fees imposed on providers and managed care organizations, which California and other states use to finance their share of Medicaid spending; and
- Analyzes how the Budget Resolution passed by Congress in April could affect federal Medicaid funding for California.

As of this writing, the hospital financing waiver negotiations have not concluded and safety-net providers and others have expressed concern about the outcome.<sup>4</sup> However, a new waiver will not necessarily protect California from additional federal Medicaid budget cuts.

## **THE PRESIDENT'S FFY 2006 MEDICAID BUDGET PROPOSALS**

On February 7, the President submitted to Congress his proposed budget for FFY 2006, which included reductions in federal Medicaid spending of \$20.2 billion over five years.<sup>5</sup> The policy changes the Administration proposed to achieve these reductions fall into two categories: changes that will reduce both federal *and* state Medicaid spending and changes that will reduce federal spending without reducing state spending.

### **Changes That Would Reduce Federal and State Medicaid Spending**

Using the Administration's estimates of its proposals, about \$6.9 billion, or one-third, of the reductions are attributable to changes that would reduce federal *and* state Medicaid spending. These include proposals to:

- Tighten the penalty against beneficiaries for transferring assets in order to qualify for Medicaid-funded nursing home care; and
- Reduce state and federal Medicaid payments to pharmacists for prescription drugs.

The proposal to reduce payments to pharmacists, for example, is estimated to result in federal savings of \$5.4 billion over five years. Since federal spending is approximately 57 percent of total Medicaid spending nationally, state savings would be about \$4.1 billion over five years. From the pharmacists' standpoint, the total estimated revenue loss (combined federal and state spending reductions) would be \$9.5 billion. The state would save one dollar for each dollar of federal savings attributable to California.

In short, changes such as reducing payments to pharmacists for prescription drugs they dispense will lower both federal and state spending, since they lead to lower overall Medicaid spending on an item or service.

### **Changes That Would Reduce Federal Medicaid Spending Without Reducing State Spending**

The remaining \$13.3 billion, or two-thirds, of the Administration's proposed Medicaid spending reductions come from changes that would reduce federal spending only. Policy changes that only reduce federal spending without generating state savings would leave California in the position of making up for the lost federal funds or reducing Medi-Cal eligibility, benefits, or provider payments. To avoid cutbacks, California would have to reallocate funds from other parts of its budget to Med-Cal or raise new state revenues. Changes that would reduce federal spending only include proposals to:

- Cap federal matching payments for administrative costs;
- Limit federal matching payments for targeted case management services;
- Limit the use of intergovernmental transfers (IGTs) – public funds transferred by counties and other public entities to the state, which California and other states use to finance their share of Medicaid spending; and
- Limit states' ability to raise revenues from providers and managed care organizations.<sup>6</sup>

The nonpartisan Congressional Budget Office (CBO), in its re-estimate of the President's budget, could only identify a total of \$13.8 billion, not \$20.2 billion, in federal reductions over five years because the Administration "has not provided enough details for CBO to prepare its own estimates for some of the proposals."<sup>7</sup>

## **California Would Face Hard Choices if Proposal to Limit State Revenues from Managed Care Organizations Is Adopted**

No details are available for most of these proposals. However, sufficient information is available to evaluate the proposal to prohibit states from imposing assessments on managed care organizations (MCOs), or subsidiaries of MCOs, that enroll only Medicaid beneficiaries.

Under current federal Medicaid law, a state may impose assessments, fees, or other forms of taxes on providers and health plans in order to raise revenues that will enable the state to satisfy its share of Medicaid spending. In order for the revenues from these taxes to be allowable as state share, the taxes must meet certain requirements that have been set forth in federal statute and regulation since the early 1990s. For example, states may impose taxes on Medicaid MCOs, so long as those taxes are broad-based, uniformly applied, and do not hold the MCOs harmless against the cost of the tax.<sup>8</sup>

Under this authority, California has enacted a "quality improvement fee" for Medi-Cal MCOs that, according to the Legislative Analyst's Office (LAO), is expected to generate \$207 million in General Fund revenues in 2005-06.<sup>9</sup> The LAO expects that, under current law, the fee will be approved by the federal Centers for Medicare and Medicaid Services (CMS) and can be implemented by July 2005.<sup>10</sup> At the state's federal Medicaid matching rate of 50 percent, \$207 million represents \$414 million in Medi-Cal spending.

It appears that the Bush Administration's proposed change would alter current law to invalidate California's MCO quality improvement fee as currently structured. If this assumption proves correct, and if Congress decides to achieve federal Medicaid savings by adopting the Administration's proposal, which the CBO has scored as saving the federal government \$1.2 billion over five years, California would face several choices. It could:

- Attempt to persuade Congress to "grandfather" the state's current quality improvement fee, potentially reducing the ability of the House and Senate to achieve their spending reduction targets (see following section);
- Enact a new quality improvement fee that meets the new federal requirements by applying to all MCOs, not just those with Medi-Cal business;
- Replace the \$207 million with other state revenues; or
- Reduce Medi-Cal spending by \$414 million.

## **THE CONGRESSIONAL BUDGET RESOLUTION AND MEDICAID FUNDING**

### **Budget Resolutions: A Framework for Achieving Congress' Budgetary Goals**

In theory, Congress makes spending and taxing decisions under the guidance of an annual budget resolution. The budget resolution is a framework, intended to ensure that decisions on individual bills are consistent with agreed-upon budget goals, such as the size of the budget

deficit or surplus. Budget resolutions are not essential to the operation of the federal government; programs such as Medicare and Medicaid can continue to operate in their absence. The importance of a budget resolution to a program like Medicaid is procedural: its adoption by both the House and Senate paves the way for budget “reconciliation” legislation that makes changes in the program. Budget reconciliation bills require only 51 rather than 60 votes to pass the Senate.<sup>11</sup>

## **The House Budget Resolution**

The House version of the Budget Resolution, approved on March 17, would have required reductions in federal Medicaid spending of at least \$14.9 billion and as much as \$20 billion between FFY 2006 and FFY 2010. These figures exceed the \$13.8 billion in cuts over that period attributable to policy changes proposed by the Administration, as estimated by the CBO.<sup>12</sup> The House version of the Budget Resolution did not specify how the \$14.9 billion to \$20 billion in proposed federal Medicaid spending reductions were to be achieved.

## **The Senate Budget Resolution**

The Senate version of the Budget Resolution, approved on March 18, did not require reductions in federal Medicaid spending. Instead, the Senate Budget Resolution provided for the establishment of a national commission to make recommendations to the Congress for reforming Medicaid.<sup>13</sup>

## **The Final Budget Resolution**

The final Budget Resolution, adopted by both the House and the Senate on April 28, assumes up to \$10 billion in Medicaid spending reductions between FFY 2007 and FFY 2010. This assumption is set forth in “reconciliation instructions” to the committees with jurisdiction over Medicaid – the Senate Finance Committee and the House Energy and Commerce Committee. The reconciliation instructions give each committee a numerical target and a date by which to act. However, the instructions do not specify which policy changes the committee must make in order to achieve its target. That task is left to the committees. For example, the final Budget Resolution instructs the Senate Finance Committee to report out, by September 16, \$10 billion in federal savings between FFY 2007 and FFY 2010.<sup>14</sup> The Budget Resolution assumes these reductions will come from changes in Medicaid law, but the Committee could also comply with the reconciliation instruction by making changes to other entitlement programs in its jurisdiction, such as Medicare or the State Children’s Health Insurance Program (SCHIP), known in California as Healthy Families.<sup>15</sup> The CBO determines whether the Committee’s policy changes achieve the savings target.

The final Budget Resolution does not include a call for the establishment of a national commission. Nonetheless, on May 19, Health and Human Services (HHS) Secretary Leavitt signed a charter establishing a Medicaid Commission to provide two sets of recommendations to the Agency Secretary. The first set, due September 1, will focus on how to achieve \$10 billion in federal Medicaid reductions over five years. The second set, due December 31, 2006, will focus on the future of Medicaid to ensure “the long-term sustainability of the program.”<sup>16</sup> The Secretary will appoint all 15 voting members. Nominations were due June 3. The National Governors Association and Democratic Congressional leaders have indicated that they will not participate in the Commission.

## **California's Lack of a Strong Presence on Key Committees and in the Majority Leadership Could Put the State at a Disadvantage**

Since federal Medicaid policy changes affect states in different ways, the changes adopted by a committee tend to reflect the interests of the states represented. However, California lacks a strong presence on key Congressional committees and in the majority leadership. This could put California at a disadvantage as the House and Senate attempt to negotiate proposed reductions in federal Medicaid spending.

For example, there are no Californians on the Senate Finance Committee. Furthermore, of the 57 members on the House Energy and Commerce Committee, six are from California – two of whom, Representatives Bono and Radanovich, are among the 31 committee members in the Republican majority. Differences between House and Senate committee recommendations must be resolved through negotiations in a House-Senate conference committee, where House and Senate leaders and Budget Committee chairs sometimes play an important role. There are no Californians among the majority leadership, but the House Minority Leader, Representative Nancy Pelosi, is from California.

## **Key Considerations as the Federal Budget Process Moves Forward**

**Any Medicaid Program Improvements Will Require Additional Spending Cuts.** Since Congress has adopted a reconciliation savings target of \$10 billion over five years, any new federal Medicaid spending that Congress wants to enact must be “paid for” with *additional* offsetting spending reductions. For example, under current law, about 29 states, not including California, will experience a reduction in their federal Medicaid matching rates beginning October 1. Assume, for example, that the CBO determines that holding these states harmless against these matching rate drops over the next two years will cost the federal government about \$1.1 billion. Most of the Senators on the Finance Committee represent affected states. Therefore, if this bipartisan majority decides that it wants to protect the 29 states from a reduction in their federal matching rates, and if they decide to meet the \$10 billion reconciliation target entirely with savings from Medicaid, they will have to reduce federal Medicaid spending by \$11.1 billion between FFY 2006 and FFY 2010.

**A Cut Is Only Worth What the CBO Says It's Worth.** In deciding whether reduction targets have been met, Congress uses the CBO's estimates, not the Administration's. For example, the Administration believes its proposed limits on IGTs will reduce federal spending by \$9.0 billion over five years. However, the CBO does not attribute any federal savings to the Administration's proposals. Therefore, in order to achieve \$9.0 billion in reductions as “scored” or estimated by the CBO, Congress might have to impose even more restrictive limits on IGTs than what the Administration has proposed or enact some other policy for reducing federal spending by this amount, as scored by the CBO.

**The Terms of Waivers May Change if the Federal Medicaid Statute Is Changed.** Safety-net providers, county officials, and others have expressed concerns regarding the outcome of negotiations between the state of California and the HHS Secretary over the renewal of California's hospital financing waiver. The Schwarzenegger Administration suggests that there is no cause for alarm. In an April 4<sup>th</sup> letter responding to concerns expressed by Congressman Henry Waxman, California Health and Human Services Secretary S. Kimberly Belshé wrote:

“In the event Congress adopts requirements that prohibit ‘inappropriate’ inter-governmental transfers (IGTs) or requires states to pay public hospitals at cost, the waiver protects California by bringing the State into compliance with these major changes proposed in the President’s budget.”<sup>17</sup>

This statement implies that the hospital financing waiver agreement will protect California against the loss of federal funds associated with changes in the federal Medicaid statute that have not yet been enacted.

This implication is misguided. The HHS Secretary has authority to grant waivers of Medicaid statutory requirements, but that authority, like the statute itself, may be changed by Congress. If Congress decides to enact changes in federal Medicaid IGT law to achieve the reconciliation savings target of \$10 billion, the CBO will determine whether those changes will produce the required reductions. However, in order to meet the savings target, Congress may not be able to exempt California – which accounts for 10 percent of federal Medicaid spending – from the changes, even if the state has an approved waiver that complies with the President’s IGT policies. Of course, if Congress enacts IGT limits, California could request an amendment to the waiver that protects it from the new requirements. However, approval of such an amendment would be at the discretion of the HHS Secretary, who has proposed to reduce federal Medicaid spending by \$20.2 billion over the next five years.

## **MEDICAID SPENDING REDUCTIONS COULD DISPROPORTIONATELY AFFECT CALIFORNIA**

All states are at risk of losing federal Medicaid matching funds in the current Congressional budget debate. However, the burden of these cuts is unlikely to be distributed equally among the states and could disproportionately affect California. The budget process resembles a zero-sum game. A fixed budget target is established – in this instance, \$10 billion over four years – and policies that, in the CBO’s estimation, achieve those targets have different distributional impacts.

For example, the Administration has proposed to reduce the federal matching rate on targeted case management services to 50 percent. The federal savings from this change, estimated at \$1.5 billion over five years, would come at the expense of the high-match states that cover this service, such as New Mexico, and would not affect states such as California, whose matching rate is already set at 50 percent. One can reasonably expect the higher-match states to object and to look for alternatives that extract the required savings from lower-match states or from other sources, such as reducing amounts paid to pharmacists, as suggested by the Administration.

California is at particular risk regardless of whether the state is able to renegotiate its hospital financing waiver by June 30. The sheer size of California’s Medicaid program, second only to that of New York, makes it almost inevitable that the state will have to “contribute” significant amounts to any reductions in federal Medicaid spending if Congress is to achieve its \$10 billion savings target, even if Congress decides not to take all of these savings from Medicaid. In addition, the absence of a strong California presence on key committees makes it more difficult for California to protect existing arrangements or new waiver agreements. In this zero-sum game, if California contributes less toward federal spending reductions, other states will have to

contribute more. Alternatively, Congress could make federal policy changes that reduce both federal and state spending, such as increasing rebates paid by drug manufacturers on products purchased by Medicaid.<sup>18</sup>

## CONCLUSION

In September, Congress will begin legislating changes to Medicaid that would reduce federal spending by as much as \$10 billion over four years. The details of those changes, and their impact on California, cannot be assessed at this time. Nonetheless, three points are clear:

- California is at risk for substantial reductions in federal Medicaid funding, since because it has the second largest state Medicaid program and lacks significant representation on key Congressional committees that will consider Medicaid spending cuts.
- Whatever the outcome of the current negotiations over the hospital financing waiver, any agreement between the state and the HHS Secretary will not immunize California from subsequent Congressional action that reduces federal Medicaid spending.
- How Congress decides to reduce federal Medicaid spending will have major implications for California's Medi-Cal beneficiaries and safety-net providers. For example:
  - If Congress decides to reduce federal Medicaid spending by increasing the rebates that manufacturers must pay for drugs purchased by Medicaid, California and other states will also save state funds, and beneficiaries and safety-net providers will not be harmed.
  - However, if Congress limits states' ability to raise revenues from providers and managed care organizations, California may lose significant state revenues, reducing the amount available for the state share of Medi-Cal and increasing the fiscal pressure to reduce eligibility, benefits, and/or provider payments.

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*Andy Schneider of Medicaid Policy, LLC prepared this Budget Brief. Support for this Brief was provided by The California Endowment. Medicaid Policy, LLC is a consulting firm based in Washington, DC that specializes in federal Medicaid issues affecting state agencies, providers, and program beneficiaries. The California Budget Project (CBP) was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. General operating support for the CBP is provided by foundation grants, individual donations, and subscriptions. Please visit the CBP's website at [www.cbp.org](http://www.cbp.org).*

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## ENDNOTES

<sup>1</sup> Medi-Cal is California's Medicaid program, a program jointly funded by state and federal dollars that provides health coverage to low-income individuals who cannot afford or who do not have access to private coverage. For an overview of the Medi-Cal Program, see California Budget Project, *Budget Background: Medi-Cal Program* (March 2005).

<sup>2</sup> Safety-net hospitals include public, children's, teaching, and private hospitals that provide access to care for low-income and uninsured persons.

<sup>3</sup> Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), pp. C-83 to C-101.

<sup>4</sup> See California Budget Project and Center on Budget and Policy Priorities, *Governor's Plan to Restructure Medi-Cal Is Financially Risky and Could Undermine Access to Affordable Health Coverage* (May 2005), pp. 11-13.

<sup>5</sup> Office of Management and Budget, *Major Savings and Reforms in the President's 2006 Budget* (February 11, 2005).

<sup>6</sup> Victoria Wachino, Andy Schneider, and Leighton Ku, *Medicaid Budget Proposals Would Shift Costs to States and Be Likely to Cause Reductions in Health Coverage* (Center on Budget and Policy Priorities: February 18, 2005).

<sup>7</sup> Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006* (March 2005), p. 8.

<sup>8</sup> Section 1903(w)(7)(A)(viii) of the Social Security Act, 42 U.S.C. §1396b(w)(7)(A)(viii), as implemented by CMS regulations at 42 C.F.R. §433.56(a)(8).

<sup>9</sup> Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), p. C-67.

<sup>10</sup> Legislative Analyst's Office, *Analysis of the 2005-06 Budget Bill* (February 2005), p. C-66.

<sup>11</sup> For a brief overview, see Martha Coven and Richard Kogan, *Introduction to the Federal Budget Process* (Center on Budget and Policy Priorities: December 29, 2004).

<sup>12</sup> Congressional Budget Office, *CBO Estimates of Medicaid and SCHIP Proposals in the President's Budget for Fiscal Year 2006* (March 2005), p. 1.

<sup>13</sup> S. Con. Res. 18, as passed by the Senate, contained no spending reconciliation instructions to the Senate Finance Committee (Section 201(a)). Instead, it would have established a reserve fund to authorize funding for the creation of a 23-member bipartisan commission to make recommendations for reforming Medicaid (Section 310).

<sup>14</sup> H. Con. Res. 95. The reconciliation instruction specifies that the savings are to be achieved over a five-year period, but the statement of managers of the House-Senate conference committee states that "[n]o savings are assumed in fiscal year 2006 in the Medicaid Program. See *Concurrent Resolution on the Budget for Fiscal Year 2006*, H. Rept. 109-62 (April 28, 2005), p. 71. The Medicaid reductions represent one-third of the reductions in entitlement spending required by the Budget Resolution. For an overview, see James Horney, *Assessing the Conference Agreement on the Budget Resolution* (Center on Budget and Policy Priorities: May 6, 2005).

<sup>15</sup> The corresponding reconciliation instruction to the House Energy and Commerce Committee is to report, also by September 16, reductions in federal entitlement spending of \$14.7 billion between FFY 2007 and FFY 2010. (The reconciliation instruction specifies five years, but the statement of managers of the House-Senate conference committee directs only a \$2 million reduction in FFY 2006. See *Concurrent Resolution on the Budget for Fiscal Year 2006*, H. Rept. 109-62 (April 28, 2005), p. 69.) While \$10 billion is assumed to come from Medicaid, the committee could meet the entire \$14.7 billion target with Medicaid cuts or extract less than \$10 billion from Medicaid and more from other entitlement programs within its jurisdiction.

<sup>16</sup> Robert Pear, "New Panel Will Study Medicaid with Eyes Toward Big Changes," *New York Times* (May 12, 2005). The Medicaid Commission charter and the May 20 *Federal Register* notice are available at [www.cms.hhs.gov/faca/mc/details.asp](http://www.cms.hhs.gov/faca/mc/details.asp).

<sup>17</sup> Letter from Kimberly Belshé, Secretary, California Health and Human Services Agency, to Representative Henry Waxman (April 4, 2005), p. 3.

<sup>18</sup> The CBO estimates that increasing the flat rebate on brand-name drugs from 15.1 percent to 20 percent of Average Manufacturer Price (AMP) would generate federal Medicaid savings of \$6.1 billion over five years and corresponding state savings of \$4.6 billion over the same period. Congressional Budget Office, *Budget Options* (February 2005), p. 173.