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As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality:

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008

Prepared by
Vernon Smith, Ph.D., Kathleen Gifford and Eileen Ellis
Health Management Associates
and
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Kaiser Commission on Medicaid and the Uninsured

October 2007

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Executive Summary

As states finalized Medicaid policy decisions for fiscal year 2008, an improved fiscal environment coupled with modest Medicaid spending and enrollment growth allowed states to focus on program restorations, improvements and expansions for acute and long-term care that have not been possible for the last several years. States are placing a high priority on measuring and improving quality of Medicaid-financed health care, often through enhancements in managed care or disease management. More broadly, almost all states report that they are moving forward with initiatives to address the increasing number of uninsured and that Medicaid is a key building block and critical component of financing for these strategies. Despite a more positive fiscal environment, states reported on-going pressures to control Medicaid spending growth.

The Medicaid program, which provides health coverage and long-term care support services to 58 million individuals, has been faced with some enormous challenges over the last few years. A severe economic downturn beginning in 2001 put Medicaid at the center of budget debates at the state and federal levels of government. Medicaid spending and enrollment growth peaked at the same time state revenues plummeted in 2002 forcing states to implement an array of measures to control Medicaid spending growth. As this period of fiscal stress abated, two major pieces of federal legislation with significant implications for Medicaid were implemented. The Medicare Modernization Act (MMA) was implemented in January 2006, causing over 6 million low-income seniors and individuals with disabilities who previously received their drug coverage through Medicaid to transition to Medicare Part D plans. The Deficit Reduction Act (DRA) enacted in February 2006 presented states with new Medicaid requirements as well as some new options.

For the seventh consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. This report presents findings for state fiscal years 2007 and 2008.

Medicaid spending continued to grow slowly in state fiscal year (FY) 2007 after reaching an all-time low in 2006, and state revenues remained strong in most states. Total Medicaid spending growth hit a record low of just 1.3 percent for FY 2006 and states reported that total Medicaid spending growth continued at a higher but still relatively slow pace of 2.9 percent in FY 2007. Lower Medicaid spending growth occurred at the same time revenue growth in most states was strong in 2006 and remained strong, though somewhat lower into 2007. This picture is dramatically different from the depth of the economic downturn in 2002 when Medicaid spending growth hit a high of 12.7 percent at the same time state revenues plummeted hitting a low of -10.6 percent. Moving into FY 2008, state legislatures authorized total Medicaid spending growth that averaged 6.3 percent as state revenue growth was projected to be still relatively strong but somewhat less robust than it was in 2007.

For state policy makers, the state general fund cost of Medicaid is a key factor. For the last few years, the state share of Medicaid spending has increased more rapidly than total Medicaid spending as the federal matching rate (the Federal Medical Assistance Percentage, or FMAP) had declined for over half of states. The FMAP is recalculated annually based on average personal

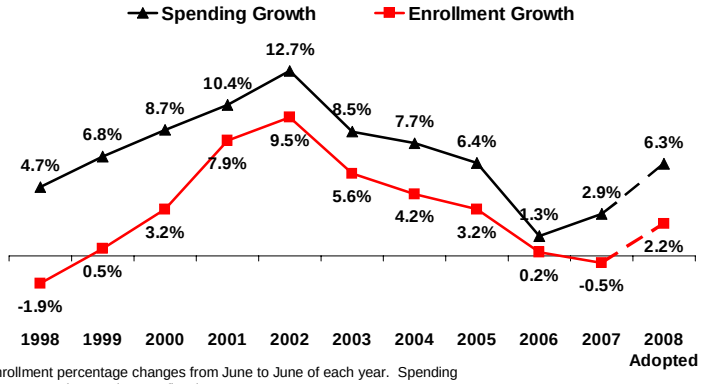
income for each state. Declines in the FMAP place pressure on states to allocate additional state general revenues to maintain current program levels. State general fund spending for Medicaid increased on average by 3.0 percent in 2006 and by 3.2 percent in 2007. State legislatures appropriated an increase in state general fund spending for Medicaid that averaged 7.8 percent for 2008. For each of these years, the growth in state funding was greater than for total Medicaid spending.

Slow enrollment growth and the transition of prescription drug costs for duals from Medicaid to Medicare Part D were the two primary factors contributing to lower Medicaid spending growth. States attributed the slowdown in Medicaid spending growth to two primary factors: low enrollment growth and the impact of Medicare Part D. First, Medicaid enrollment growth was low in 2006, and in 2007, enrollment actually decreased. The drop in enrollment was relatively small, about one-half of one percent, but it was the first decline since 1998. Many states cited the implementation of the new citizenship and identity requirements as a factor contributing to this decline. Medicaid enrollment growth is also tied to the economy. During an economic downturn more people are likely to be unemployed, move into poverty, lose employer sponsored health coverage and subsequently become eligible for the program and the reverse is true when the economy is strong. At the depth of the economic downturn in 2002, Medicaid enrollment grew by 9.5 percent. From that point through 2007, growth each year has been less than the previous year. States projected Medicaid enrollment to increase to about 2.2 percent in 2008 as states implement recently adopted program expansions.

Second, the implementation of Medicare Part D transferred responsibility for prescription drugs for individuals on Medicaid also enrolled in Medicare (the "duals") from Medicaid to Medicare in January 2006. States are still obligated to pay a maintenance-of-effort payment each month (known as the Clawback) based on the number of duals and the cost of their drugs, but these payments are now counted as a source of financing for Medicare and not as Medicaid spending (even though most states appropriate these payments as part of their Medicaid budgets). The cumulative effect of state cost containment efforts also contributed to lower Medicaid spending growth (Figure 1).

Figure 1

Percent Change in Medicaid Spending and Enrollment, FY 1998- FY 2008



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentage changes in state fiscal year.

SOURCE: Enrollment Data for 1998-2006: *Medicaid Enrollment in 50 States: June 2006.* KCMU, October 2007. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2007 and FY 2008 spending and enrollment data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

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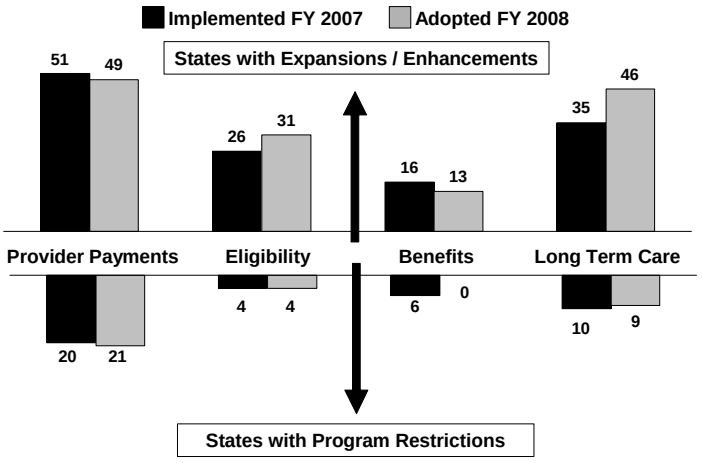
More states than in any of the last seven years removed restrictions or adopted policies to improve or expand their Medicaid programs in FY 2007 and FY 2008. Most notably, every state implemented some type of provider rate increase in 2007 and 49 states planned to increase rates for at least one provider group in 2008. During the economic downturn, cutting or freezing provider rates was a primary mechanism states used to control Medicaid spending growth. States indicated that improving Medicaid provider payment rates is necessary to maintain access to services and important for state strategies that use Medicaid to expand coverage to more of the uninsured. More than half of all states in 2007 and in 2008 made positive eligibility changes such as increasing the income limit for eligibility, expanding eligibility for a new group such as foster children or persons with disabilities who were working, or by streamlining and simplifying the application or renewal processes. A few states restored or added new benefits. Compared to previous years, fewer states restricted provider payments, limited eligibility or cut benefits. For the first time since at least 2003, no state planned a cut in benefits for 2008 (Figure 2). States have largely kept in place and strengthened strategies to control costs, particularly strategies to control prescription drug spending that had been implemented in earlier years.

Figure 2

State Policy Actions Implemented in FY 2007 and Adopted for FY 2008



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

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Nearly three out of four states said that the new citizenship and identity documentation requirements have contributed to slowing enrollment growth and 45 states say the requirements have increased administrative costs. As part of the DRA, states were required to obtain documentation to prove citizenship and identity for individuals applying for or renewing Medicaid coverage starting July 1, 2006. This was not a change in eligibility requirements for the program, but it did represent a major change in state enrollment practices. Prior to the DRA, 47 states allowed applicants to self-declare their citizenship status. Thirty-seven states specifically identified the new citizenship and identity documentation requirements as contributing to slower enrollment growth or actual drops in the number enrolled; several states said that this was one of the most significant factors impacting Medicaid enrollment. On the administrative front, states have had to train eligibility workers, make changes to their enrollment processes, set up systems to do data matching of vital records, or roll back some eligibility simplifications that had been in place (such as reinstating the face-to-face interview). States reported that the new requirements had caused

delays in processing new applications and renewals, and that in most cases these delays were for individuals otherwise eligible for the program.

Few states have taken advantage of new options to change benefits or impose new cost sharing requirements that were granted as part of the DRA. To date, eight states have used or reported plans to use the new DRA options related to benefits. Kentucky, West Virginia and Idaho moved quickly to take advantage of the new flexibility to do a comprehensive redesign of their Medicaid benefits. Five other states are using this new flexibility in a much more targeted way. In FY 2007, Virginia converted its existing disease management program from a voluntary "opt-in" program to a voluntary "opt-out" DRA benchmark program and Washington implemented a chronic care management pilot program under DRA authority. In FY 2008, Kansas is adding personal assistance services for participants in the state's Ticket-to-Work Medicaid buy-in program. Also in FY 2008, South Carolina will implement a voluntary one-county pilot "Health Savings Account" plan using the State Employee High Deductible Health plan as the benchmark plan and Wisconsin is planning to offer a modified benefit package adapted from Wisconsin's largest commercial, low-cost health care plan to the BadgerCare Plus expansion population. Kentucky was the only state to use DRA authority to impose higher than nominal cost sharing amounts and to make co-payments enforceable (meaning that providers or pharmacists could deny services for individuals who could not pay their co-payment at the point of service).

States continue to expand home and community-based care services (HCBS) to balance their long-term care delivery systems and some states are using new long-term care (LTC) options provided under the DRA. States continue to expand home and community-based long-term care services. In FY 2007, 35 states expanded LTC services while in FY 2008 a total of 46 states planned to do so. The most commonly reported LTC expansion in both years was expanding existing HCBS waivers or adopting new ones. States also continued to add Programs for All-Inclusive Care for the Elderly (PACE). The DRA presented states with a number of options intended to give states increased flexibility to deliver long-term care services and supports. Thirty-one states are using the DRA "Money Follows the Person" initiative which encourages states to reduce reliance on institutional care by transitioning individuals from institutions to the community to support HCBS efforts. Nearly half (24) of states had plans to implement a Long Term Care Partnership Program in 2008 to help increase the role of private long-term care insurance. Thus far, there has been limited take-up of new DRA state plan options around cash and counseling or the HCBS state plan options, although states continue to pursue these strategies using waivers. As states expand community-based services, nine states in 2007 and eight states in 2008 implemented cost controls for institutional providers including policies designed to reduce the number of institutional beds.

States are increasingly focusing on Medicaid quality improvement and initiatives to get better value from public Medicaid expenditures. Many states have made quality improvement a priority. The development of HEDIS® and CAHPS® by the National Committee on Quality Assurance (NCQA) provided nationally accepted quality measures. In 2008, 44 states will be using HEDIS® and/or CAHPS® performance data from managed care organizations to measure and provide incentives for improved performance. An increasing number of states are also requiring their health plans to be accredited by a national organization such as NCQA or implementing Medicaid pay-for-performance (P4P) reimbursement policies to reward and encourage quality care. By 2008,

a total of 27 states will have pay-for-performance programs for managed care. A few states have reimbursement systems that reward performance for hospitals, physicians and nursing homes.

States are committed to program integrity, but many report that they are frustrated and concerned about the administrative burdens imposed by federal oversight activities. Program integrity remains a high priority for state Medicaid officials. In 2007 and 2008, states implemented an array of strategies such as increasing staff, creating new organizational units to provide centralized control and coordination, or hiring new contractors aimed at enhancing program integrity. Concerns at the federal level about Medicaid spending, payment policies and program integrity have prompted more intense federal oversight of state Medicaid programs. State officials recognized and agreed with the role of the federal agencies in ensuring fiscal and programmatic integrity in Medicaid. However, they also expressed strong concerns about the administrative burden imposed on states by the new level of federal audits, reviews and other federal efforts to examine the program. State officials also mentioned frustration at new federal interpretations of long-standing, previously approved Medicaid policies which in some cases have had the effect of shifting federal Medicaid costs to the states.

To address a growing number of uninsured individuals, 42 states are moving forward with or developing plans to expand health insurance coverage and almost all rely extensively on Medicaid to support and finance these plans. Despite a year dominated by program enhancements, Medicaid directors said that increasing program costs remains a top concern; however, the singular urgency of this issue has significantly abated as state revenues rebounded in recent years. The latest census figures show that in 2006 there were 47 million uninsured Americans, an increase of 2.2 million from 2005. Forty-two states reported that they have efforts underway to expand coverage to the increasing number of uninsured. Almost all of these states are looking to Medicaid as a vehicle to help finance new coverage efforts. Many strategies include Medicaid or SCHIP expansions and promotion of private health insurance coverage. The outlook for state revenue growth as well as the outcome of the reauthorization of SCHIP and federal support for these expansions will determine how far states can go in expanding coverage. As state efforts continue, Medicaid is likely to stay at the forefront of the policy debate as the larger discussions around health care reform including issues of coverage, costs, quality and long-term care continue to play out at both the state and national level into the 2008 election cycle.

Methodology

For the seventh consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. The survey also asked Medicaid officials about the impact of Medicare Part D and the DRA on their programs. The KCMU/HMA survey on which this report is based was conducted in July and August 2007 to document the policy actions states had implemented in the previous year, state FY 2007, and new policy initiatives that they had adopted, or expected to implement, in state FY 2008, which for most states had begun on July 1, 2007. The data in this report were based on survey responses and interviews with Medicaid directors and staff for all 50 states and the District of Columbia. Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey.

For FY 2007 and 2008, average rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states using Medicaid expenditures reported in: National Association of State Budget Officers (NASBO), *State Expenditure Report*, October 2006, and state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2006.

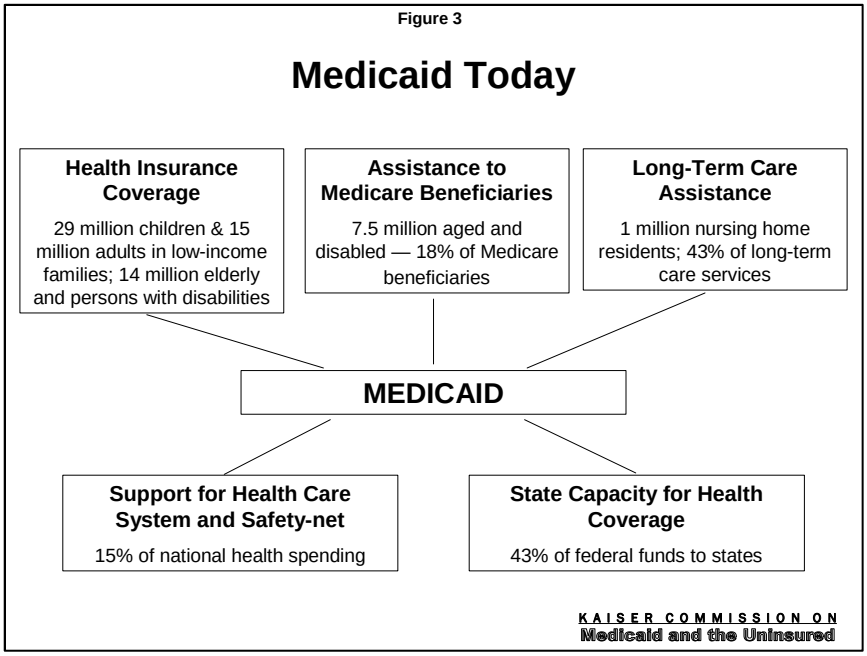
Background / Introduction

The last few years have presented some enormous challenges for states in administering the Medicaid program. A severe economic downturn put Medicaid at the center of budget debates at the state and federal levels of government. States worked aggressively to implement an array of measures to control Medicaid spending growth while simultaneously facing increasing enrollment trends, rising health care costs, more uninsured residents and demographic trends resulting in more elderly and persons with disabilities who could qualify for Medicaid. Fiscal pressures at the federal level were coupled with an interest in cutting taxes and cutting the federal deficit. These factors contributed to the passage of the Deficit Reduction Act that included a large number of changes in Medicaid policy.

Just as state revenues were starting to recover, states were also faced with new challenges associated with implementing Medicare Part D which involved transitioning over 6 million low-income seniors and individuals with disabilities (dual Medicaid – Medicare enrollees) from Medicaid drug coverage to newly created Medicare Part D plans starting in January 2006. As states finished their 2007 fiscal year and started 2008, the fiscal environment was dramatically different from prior years with many states experiencing stronger than expected revenues. Many states were able to use these additional resources to strengthen their Medicaid programs or to develop broader plans to expand health care coverage to uninsured residents. While states were moving forward to expand coverage, the number of uninsured hit a record high of 47 million in 2006.

Medicaid serves multiple roles in the health care system. The program provides health coverage and long-term care assistance to over 44 million people in low-income families and nearly 14 million elderly and disabled people, including 7.5 million low-income Medicare beneficiaries for whom it fills gaps in Medicare coverage. Medicaid provides critical funding for a range of safety-net providers. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all health care spending in the U.S. and nearly half of all nursing home care. Finally, Medicaid represents the largest source of federal revenue to states which helps support state capacity to finance health coverage (Figure 3).

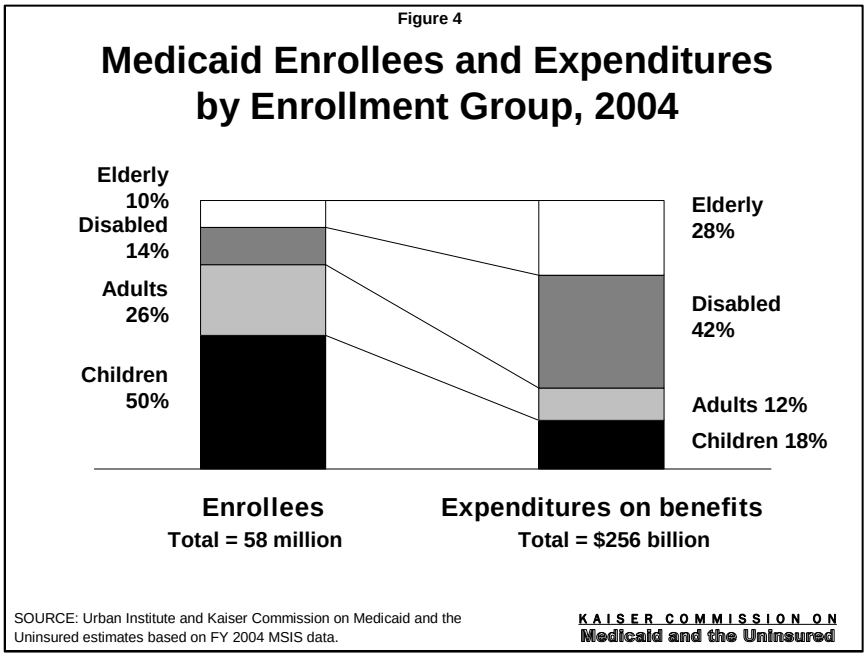
Figure 3



Within the federal guidelines, each state defines its own program, including deciding who qualifies for coverage, what medical benefits to cover, how much to pay medical providers who serve enrolled individuals, whether to use managed care or another delivery system, how the program is organized and administered, and how to use Medicaid to address state policy priorities such as covering uninsured children and adults. Each state Medicaid program is unlike any other state's program, based on how each state makes these and other decisions.

To be eligible for Medicaid, individuals must meet income and asset requirements and also fall into one of the categories of eligible populations. The federal government sets minimum eligibility standards, and states have the option to expand beyond these minimum levels or to cover optional groups. About three-quarters of the beneficiaries served by the program are children and non-disabled adults, mostly parents. States are not able to cover adults without dependent children without a Medicaid waiver. The elderly and people with disabilities represent a smaller share of program enrollees, but account for 70 percent of program spending because these groups tend to have higher utilization of acute and long-term care services (Figure 4). A further refinement of Medicaid data shows that about four percent of Medicaid beneficiaries account for nearly 50 percent of program spending.[1] This distribution of spending has been the basis for more concentrated state efforts to better coordinate care for high-cost cases.

Figure 4

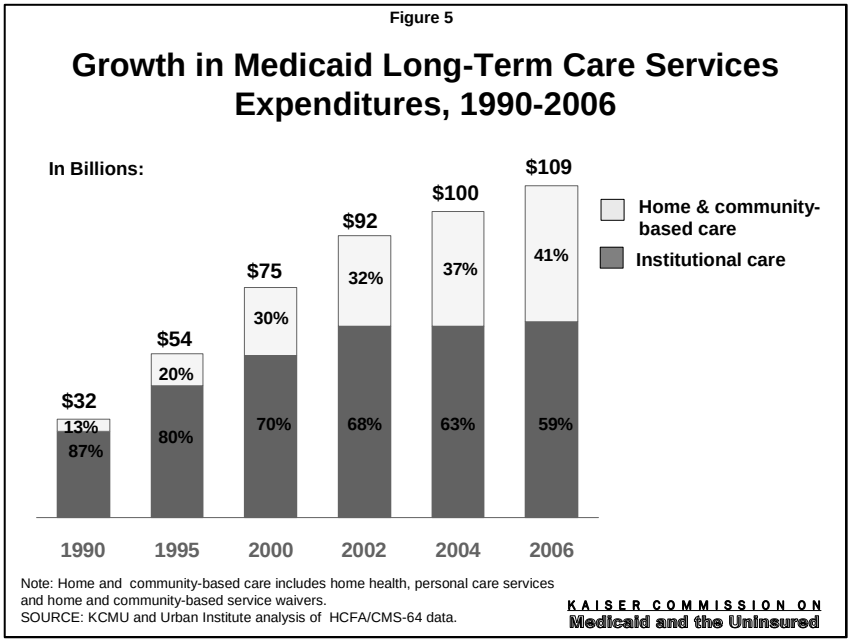


Spending on long-term care services represents over a third of total Medicaid spending. Medicaid is the nation's major source of financing for long-term services and supports, covering services for both elderly and non-elderly persons in institutional settings and in home and community-based settings. Over the past two decades spending on Medicaid home and community-based services has been growing as more states attempt to balance their long-term care programs by increasing community-based service options. In 2006, spending on home and community-based services

[1] Anna Sommers and Mindy Cohen. "Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?" *KCMU*, March 2006. http://www.kff.org/medicaid/7490.cfm

accounted for 41 percent of total Medicaid long-term care spending, up from 13 percent in 1990 (Figure 5).

Figure 5

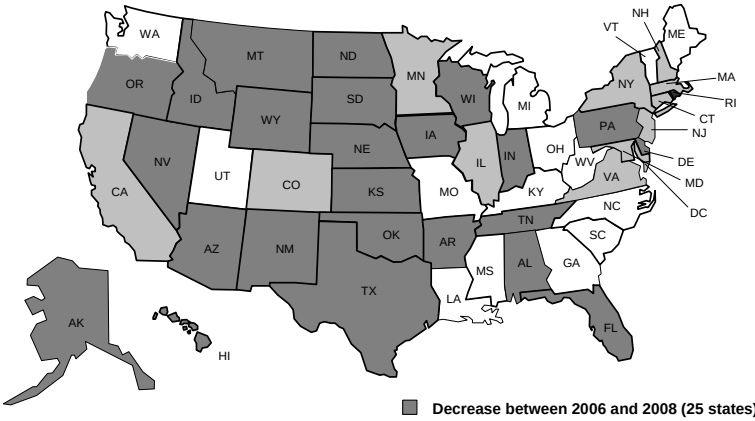


Medicaid Financing. The Medicaid program is jointly funded by states and the federal government. In 2006, total Medicaid expenditures well exceeded $300 billion. The federal government guarantees matching funds to states for qualifying Medicaid expenditures that states make for Medicaid services to Medicaid enrollees. The federal matching percentage (officially known as the Federal Medical Assistance Percentage, or FMAP) varies by state from a floor of 50 percent to a potential high of 83 percent. It is based on an annual calculation using a formula set forth in the Social Security Act.[2] The FMAP is inversely proportional to a state's average personal income, relative to the national average. States with lower average personal incomes have higher FMAPs. Personal income data is lagged so data for FY 2007 is from 2002 to 2004. In 2008, half of the states had FMAPs that were lower than what they were in 2006, twelve states had no change in their FMAP and 14 states saw an increase in their FMAP.[3] Most of the states that did not experience a decline in FMAP were states that were at the 50 percent floor.[4] Declines in FMAPs place pressure on states to allocate additional state general revenues to maintain current level programs (Figure 6).

[2] In FY 2008, 13 states had an FMAP at the statutory minimum of 50.0 percent: CA, CO, CT, DE, IL, MD, MA, MN, NH, NJ, NY, VA and WY. In addition, the FMAP is set in statute for the territories at 50 percent, with a cap on federal matching funds.
[3] 27 states had an FMAP decline in federal FY 2007 and 20 states in FFY 2008
[4] Vic Miller, Federal Funds Information for States, Issue Briefs 06-42 and 07-01.

Figure 6

Half of the States Experienced a Reduced FMAP from 2006 to 2008



SOURCE: http://aspe.os.dhhs.gov/health/fmap.htm

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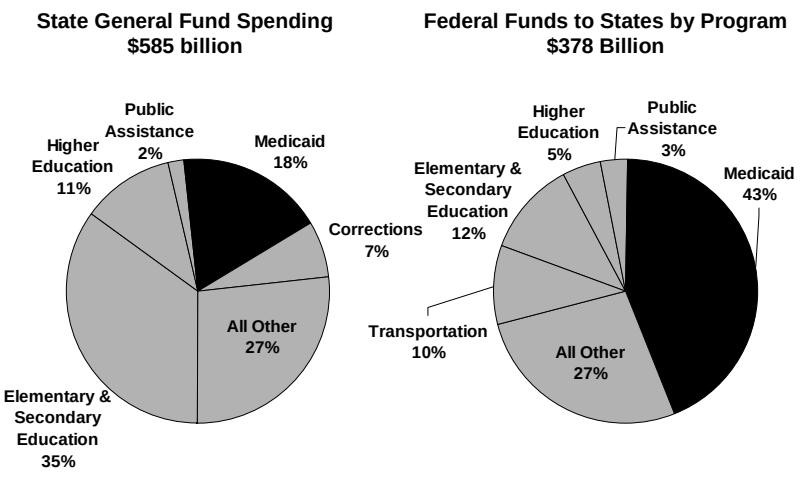
Because of the matching formula, growth in state spending on Medicaid brings increased federal dollars to the state and provides an important incentive for states to increase funding for health and long-term care services. At a minimum, states draw down $1.00 of federal money for every dollar of state funds spent on Medicaid. Federal Medicaid dollars represent the single largest source of federal grant support to states, representing an estimated 44 percent of all federal grants to states in 2005. On average, states spend about 18 percent of their own funds on Medicaid, making it the second largest program in most states' general fund budgets following spending for elementary and secondary education which represented 35 percent of state spending in 2006 (Figure 7).

Figure 7

Medicaid Spending In the States, 2006



SOURCE: National Association of State Budget Officers, 2005 State Expenditure Report, Fall 2006

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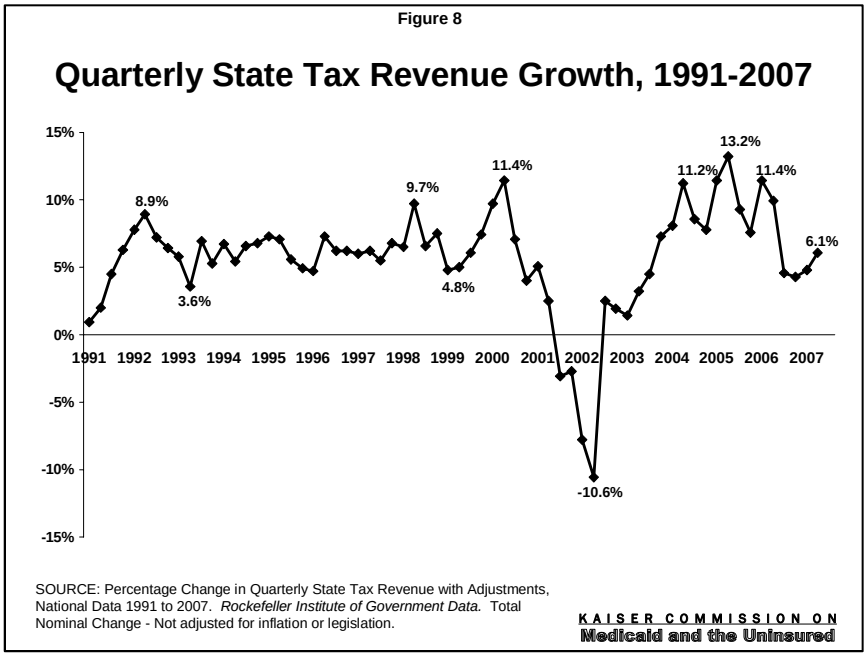
Beginning in 2001, the national economy worsened, state tax revenue plummeted, health care costs continued to rise, and more people became eligible for Medicaid as unemployment increased, employers sponsored coverage declined and poverty rates increased. From 2001 to 2004 cumulative state budget shortfalls exceeded $250 billion. In response to the fiscal crisis, states cut spending for services, raised taxes or fees and used reserve funds to balance their budgets. Recognizing the extraordinary state fiscal pressures, Congress passed the Jobs and Growth Tax Relief Reconciliation Act of 2003 that provided $20 billion in temporary federal fiscal relief to the states to ease budgetary pressures. Of the $20 billion total, $10 billion was provided through a temporary 2.95 percent FMAP increase. This fiscal relief (in effect for fifteen months from April 1, 2003 though June 30, 2004) proved instrumental in helping states to meet Medicaid and overall state budget shortfalls, to avoid making potentially larger Medicaid program cuts and to preserve eligibility.

FY 2005 marked the start of the fiscal recovery for many states that continued through FY 2006 when all states met or surpassed their revenue projections.[5] While fiscal conditions remained strong in 2007, fewer states (41) met or exceeded revenue estimates, year-end balances fell from 13.4 percent to 11.5 percent and quarterly state revenue collections appear to be steady but lower than SFY 2006.[6] Looking ahead to FY 2008, revenue projections are expected to slow and to fall behind spending leading to a decline in year-end balances[7] (Figure 8).

Figure 8



[5] Fiscal Survey of the States: June 2007. *National Governors Association and National Association of State Budget Officers.*
[6] Ibid, State Budget and Tax Actions 2007: Preliminary Report. *National Conference of State Legislatures*, and Percentage Change in Quarterly State Tax Revenue with Adjustments, National Data 1991 to 2007. *Rockefeller Institute of Government Data. http://www.rockinst.org/WorkArea/showcontent.aspx?id=11920*
[7] State Budget and Tax Actions 2007: Preliminary Report. *National Conference of State Legislatures.*

Medicare Part D. Individuals covered by both the Medicare and Medicaid programs (duals) represented only 14 percent of program enrollees, but accounted for 42 percent of total Medicaid spending in 2003. The duals rely on Medicaid to pay Medicare premiums, cost sharing, and to cover critical benefits not covered by Medicare, such as long-term care. Prescription drug coverage for the duals was transitioned to the Medicare Part D program on January 1, 2006; however, states are now obligated to finance a portion of this Medicare coverage through a payment referred to as the "clawback" to the federal government. Most states continue to include the clawback payments as part of the state Medicaid budget, but these payments are not matched with federal funds and they are not included in calculations of federal Medicaid spending. In fact, the federal government accounts for these payments as Medicare revenue. States paid $5.5 billion to the federal government for the clawback in calendar year 2006. Projections are for state Clawback payments to total $6.6 billion for 2007 and $6.8 billion for 2008.[8]

Deficit Reduction Act. The DRA, signed into law in February 2006, contains extensive Medicaid policy changes related to benefits, cost sharing, long-term care services, program integrity and eligibility. When the DRA was passed, the Congressional Budget Office (CBO) estimated that the Act would generate $26.1 billion in savings to the federal government over the next ten years. A few states that were in the midst of developing Medicaid reform Section 1115 waiver proposals (such as Kentucky, West Virginia and Idaho) were poised to take advantage of the new flexibility around benefit design early instead of going through the waiver process. In addition to the new options, the DRA included several mandatory provisions, including changes related to reimbursement for Medicaid prescription drugs, asset transfer rules that could affect eligibility for nursing home services and documentation requirements for citizens applying for Medicaid. The DRA also included several other provisions including the creation of the Medicaid Program Integrity Program and a number of grant and demonstration programs. Many states have already been awarded Medicaid Transformation Grants (to fund research, design and implement new systems to enhance quality and efficiency of care) and Money Follows the Person Grants (to help move individuals from institutional to community based long-term care settings).

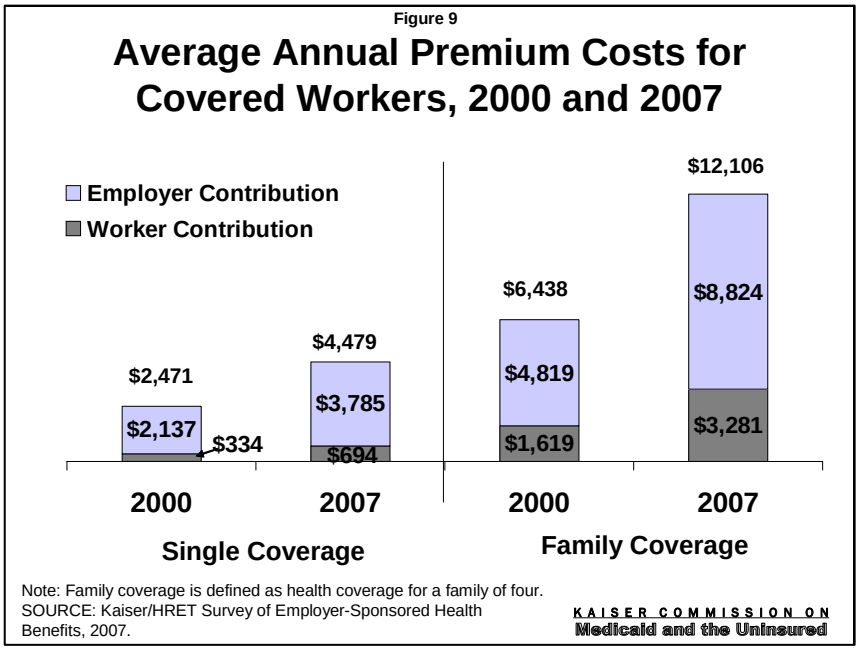
State and Federal Coverage Issues. The number of uninsured Americans grew by 2.2 million to a total of 47 million in 2006. Most of the uninsured are non-elderly adults, but there are about 9.4 million uninsured children. After the enactment of SCHIP in 1997, states expanded eligibility, increased outreach efforts and worked aggressively to make the application, enrollment and renewal processes for Medicaid and SCHIP easier in both SCHIP and Medicaid. The result was a decade of significant progress in reducing the uninsured rate for children, especially low-income children; however, an increase in the number of uninsured children was reported for both 2005 and 2006.

The large increase in the uninsured is tied to a decline in employer-sponsored coverage for both children and adults. While the growth in the cost of health insurance premiums has moderated somewhat in recent years, the cumulative growth in health insurance premiums for workers from 2000 to 2007 was 88 percent, compared to an increase in workers wages of just 25 percent over the same time period. The result has been an increasing problem of affordability for health care coverage particularly for low-income workers. Average worker premiums for a family were $12,106 in 2007 which is roughly equal to the earnings of a minimum wage worker (Figure 9). In

[8] Vic Miller, Federal Funds Information for States, Issue Brief 07-24, May 3, 2007.

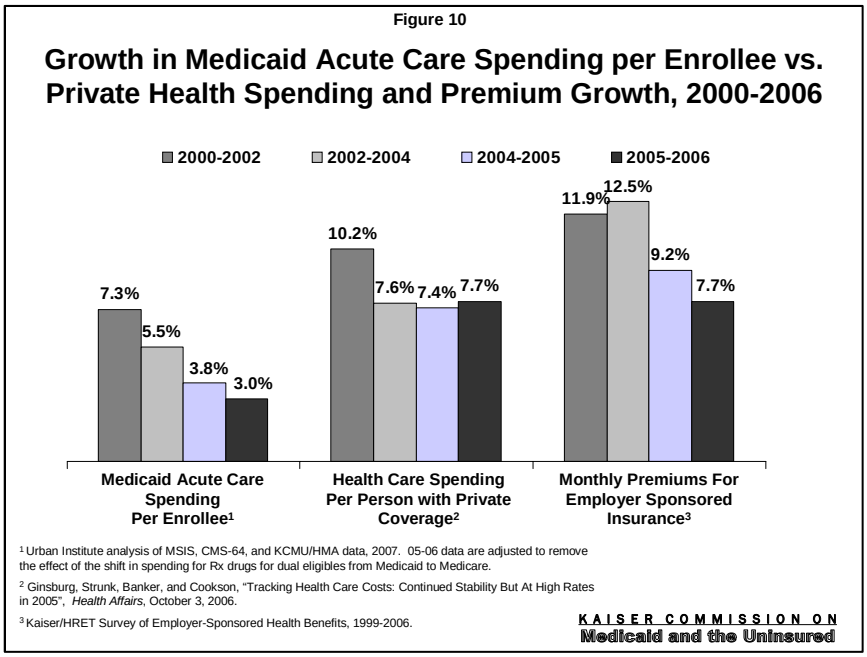
addition to increasing costs, the percentage of small firms offering health insurance coverage has dropped from 68 percent in 2001 to 59 percent in 2007.

Figure 9



With an improved fiscal climate and higher than expected revenues, many states have enacted or proposed plans to expand health coverage to a growing number of uninsured residents. While some states have focused on children, others are pursuing more broad health reform plans. The details of the plans vary, but most plans build on Medicaid and SCHIP coverage and rely extensively on federal Medicaid financing. Using Medicaid as a base for additional coverage is efficient because systems are in place and because on a per person basis, Medicaid spending has been growing slower than private health spending or premiums for employer sponsored coverage (Figure 10).

Figure 10



At the time of this report, the outcome of SCHIP reauthorization was unknown. The House and Senate had reached agreement on a bill that passed with bi-partisan support. The President vetoed that bill on October 3, 2007 and it seemed unlikely that Congress could override the veto. To prevent SCHIP from expiring, legislation was passed to continue the program, at current funding levels through mid-November, but current funding levels could result in 36 states with federal financing shortfalls in FY 2008. The compromise bill had provisions that would override guidance that was released by CMS in August that will essentially limit SCHIP coverage to children with family incomes below 250 percent of poverty. Without legislative action, or a court challenge, this guidance stays in place limiting states' ability to maintain coverage and expand coverage to children with moderate family incomes. The ultimate outcome of the SCHIP reauthorization debate could have implications for Medicaid and the number of children with or without insurance. The ideological debate around SCHIP is a foreshadowing of the debate that will ensue over the next year as we hear Presidential candidates talking about health reform proposals. The core of the debate around the appropriate role of public coverage will almost certainly keep Medicaid in the mix during the discussion about health reform.

Methodology

The Kaiser Commission on Medicaid and the Uninsured (KCMU) commissioned Health Management Associates (HMA) to conduct this survey of Medicaid directors in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy making. This is the tenth KCMU/HMA survey of Medicaid officials designed to address these issues, including seven surveys conducted at the beginning of state fiscal years 2002 through 2008, and three mid-year surveys during the economic downturn in fiscal years 2002, 2003 and 2004 when deepening state revenue shortfalls forced many states to make mid-year Medicaid policy changes.[9]

The KCMU/HMA survey on which this report is based was conducted in July and August 2007. The survey was designed to document the policy actions states had taken in the previous year, state FY 2007, and new policy initiatives that they had implemented or expect to implement in state FY 2008, which for most states had begun on July 1, 2007.[10] Legislatures had adopted the FY 2008 Medicaid budget at the time each survey was finalized, although as of October 1, 2007 overall state budgets for FY 2008 were not finalized in Michigan and Wisconsin. In addition, a special legislative session was called for October 2007 in Florida to deal with a state revenue shortfall. For these states, responses to the survey were re-confirmed on October 1, but remained subject to change depending on the outcome of state budget decisions.

The 2007 survey instrument was designed to provide information that was consistent with previous surveys. As with previous surveys, specific questions were added to reflect current issues. For this survey, new questions were included about: state quality initiatives; implementation of the Deficit Reduction Act of 2005 (DRA); the impact of federal oversight activities, and the potential fiscal and enrollment implications for Medicaid of the pending reauthorization of the State Children's Health Insurance Program (SCHIP), and the role of Medicaid in state health reform initiatives.[11]

The data on which this report is based were provided directly by Medicaid directors and other Medicaid staff in response to a written survey and telephone interview. The survey was sent to each Medicaid director in late June 2007. Personal telephone interviews were scheduled for July and August 2007. The telephone interview provided an opportunity to review the written responses or to conduct the survey itself, if the survey had not been completed in advance. As in past years, these interviews were invaluable to clarify responses and to record the nuances of state actions. Generally, the interview included the Medicaid director along with policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid budget or policy official. Survey responses were received from all 50 states and the District of Columbia.

As has been the case in each annual survey, the focus of the 2007 survey was on policy directions, policy changes and new initiatives. The survey did not attempt to catalog all current policies, but asked state officials to describe new policy changes that were implemented in FY 2007 or would be implemented in FY 2008. Policy changes under consideration for which there was not yet a

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[9] For previous survey results, see the following links: http://www.kff.org/medicaid/7569.cfm; http://www.kff.org/medicaid/7392.cfm; http://www.kff.org/medicaid/7001.cfm; http://www.kff.org/medicaid/kcmu4137report.cfm; http://www.kff.org/medicaid/4082-index.cfm

[10] Fiscal years begin on July 1 for all states except for: New York on April 1, Texas on September 1, Alabama, Michigan and the District of Columbia on October 1.

[11] The survey instrument is in Appendix C to this report.

definite decision to implement in FY 2008 were not recorded in this survey. It is important to note that some actions that were adopted or planned for implementation in FY 2008 at the time the survey was completed might not be implemented in that year. Medicaid policy initiatives often involve complex administrative changes, computer system updates, specific advance notice requirements and various political considerations. It sometimes happens that policy changes are not implemented within the original timelines, or that policy makers reconsider previous decisions as the impacts become better understood. The actions reported here for FY 2008 are those for which Medicaid officials indicated that as of the date of the survey response a definite decision had been made to implement during the fiscal year. The actions reported here for FY 2007 are those state officials reported that they had actually implemented in the past year.

This report also includes case studies of three states (Indiana, Massachusetts and Pennsylvania) that were profiled as illustrative examples of policy changes in states in FY 2008. Every state is unique in its Medicaid policy making, and these case studies show how these states are using Medicaid in innovative ways to expand coverage to the uninsured and taking steps to improve the quality and cost-effectiveness of care. These profiles are included as Appendix B in the report.

Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey. For example, in addition to showing the number of states implementing specific Medicaid cost containment in FY 2007 and FY 2008, information from previous surveys was used to chart the number of states adopting these actions over the six-year period from fiscal years 2003 to 2008.

For FY 2007 and FY 2008, annual rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states. Average annual Medicaid spending growth was calculated using weights based on state Medicaid expenditure data reported in the National Association of State Budget Officers (NASBO) *State Expenditure Report*, November 2006. Average annual Medicaid enrollment growth is calculated based on weights developed from state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2006. For years prior to the periods covered by the KCMU/HMA surveys, Medicaid spending and enrollment data are based on estimates prepared by the Urban Institute using data from Medicaid financial management reports (CMS Form 64), adjusted for state fiscal years.

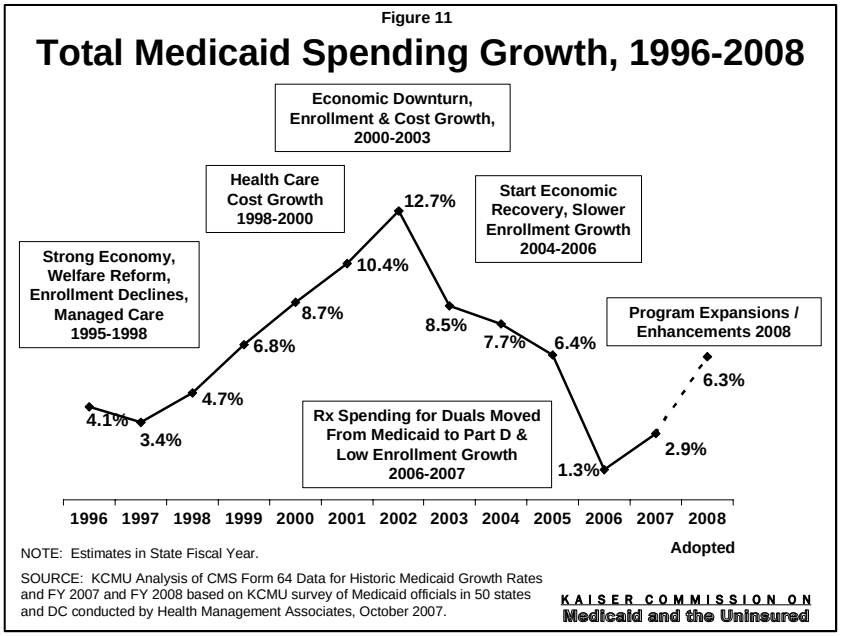
Survey Results for Fiscal Years 2007 and 2008

1. Medicaid Spending Growth Rates

Total Medicaid Spending Growth

Overall Medicaid spending increased by just 1.3 percent in FY 2006, the lowest rate in program history. The previous record low rate of growth in total Medicaid spending had been the 3.4 percent annual growth in 1997. The average growth of 1.3 percent in FY 2006 was a drop from 6.4 percent in the previous year and a dramatic drop from the 12.7 percent annual growth in spending that occurred just four years earlier in FY 2002, a year when states were suffering the effects of a severe economic downturn.[12] For fiscal year 2007, states estimated that total Medicaid spending continued to increase slowly at an average rate of 2.9 percent across all states, however, this reversed a four-year period in which the annual rate of growth had been lower than in the previous year. State legislators authorized growth that averaged 6.3 percent in total Medicaid spending for state fiscal year 2008 (Figure 11). Total Medicaid spending includes all payments made to medical providers for the services they provide to Medicaid beneficiaries, and also includes special Disproportionate Share Hospital (DSH) payments to hospitals that qualify because of the volume of services they provide to persons who are on Medicaid or are uninsured. Total Medicaid payments do not include administrative expenses.[13]

Figure 11



[12] Actual total spending growth in state fiscal year 2006 was 1.3 percent. In our previous report published in October 2006, states reported average annual average Medicaid spending growth for 2006 at 2.8 percent. The 2.8 percent growth included state payments for the Medicare Part D Clawback. For the 2007 survey a question was added that asked states to report Medicaid spending changes net of the Clawback. In this report, calculations of Medicaid spending growth exclude the Clawback.

[13] Medicaid agencies were asked to use a consistent definition of expenditures from year to year when calculating annual growth rates. Across states, there was variation in the definition of what expenditures were included when calculating a rate of growth in Medicaid spending. For example, a Medicaid agency may not have had access to information about Medicaid-financed services in another agency, such as Mental Health or Public Health. The national spending growth rate in this report is calculated as a weighted average of growth rates indicated by each state.

State officials had indicated that two factors were primary contributors to the historic low rate of spending growth in 2006. The first was the transfer of spending for prescription drugs for dual Medicaid – Medicare enrollees from Medicaid to Medicare when Medicare Part D was implemented in January 2006.[14] The second key factor was low Medicaid enrollment growth that averaged just 1.6 percent in 2006, the lowest rate of growth states had experienced since 1999.

For FY 2007, state officials indicated that minimal growth or actual declines in Medicaid enrollment and the impact of Medicare Part D continued to be the two most significant contributors to the low growth in total Medicaid spending. Over half of states identifying the drivers of slower spending growth indicated that the most significant factor was low or decreasing enrollment growth, while about one in four listed the impact of Medicare Part D. Since the transfer of spending for prescription drugs for dual eligibles occurred in January 2006, midway through state fiscal year 2006, the first full year of impact was in SFY 2007.[15] States paid $5.5 billion to the federal government for the clawback in calendar year 2006. Estimates show states owing $6.6 billion for calendar year 2007 and $6.8 billion in calendar year 2008.[16] This would be about $2.8 billion for SFY 2006, $6 billion for SFY 2007 and $6.7 billion for SFY 2008.

In addition to low or negative Medicaid enrollment growth and the impact of Medicare Part D, states identified other factors that also contributed to slower overall Medicaid spending growth in FY 2007. Nearly one out of four states mentioned specific state initiatives involving care management, disease management or increased use of managed care. Other states mentioned the effect of cost containment strategies, in particular those that were designed to control utilization, increase use of home and community-based services and enhance efforts to control pharmacy spending and fraud and abuse.

Initially, state legislatures had authorized total Medicaid spending increases of 5.0 percent for FY 2007. Actual spending growth averaged 2.9 percent in FY 2007. As a result, in FY 2007 there was a significantly lower likelihood of a shortfall in Medicaid spending than in recent years. A total of 21 states had reported a Medicaid budget shortfall in 2006. Only 15 states in 2007 reported that actual spending exceeded the original legislative authorization, the lowest number reported by states since 2002.

Looking ahead to fiscal year 2008, legislatures authorized growth in total Medicaid spending that averaged 6.3 percent, in contrast to the 5.0 percent average growth legislatures initially authorized for fiscal year 2007. Two-thirds of states indicated that provider rate increases were a key factor that would drive spending growth in FY 2008. Other factors included program expansions and some caseload growth, which was relatively low, but was still above that which occurred in FY 2007 when many states experienced enrollment drops. With a few exceptions, Medicaid directors believed the amount authorized by their state legislatures for FY 2008 would be sufficient to avoid a Medicaid budget shortfall. Over two-thirds of the states indicated that a Medicaid budget shortfall was not likely or almost certain not to occur. This was the highest level of confidence in

[14] For a description of the impact of the transition in drug spending for federal fiscal year 2006 see Holahan, Cohen, Rousseau. "Why Did Medicaid Spending Decline in 2006?" *KCMU*, September 2007

[15] Part D implementation was during but not exactly mid-way through state fiscal year 2006 in four states and DC whose fiscal years do not begin on July 1.

[16] "Medicare Part D Parameters Permit Calculation of State Clawbacks," FFIS, Issue Brief 07-24. May 3, 2007.

the adequacy of Medicaid appropriations in the seven years Medicaid officials have been surveyed on this question.

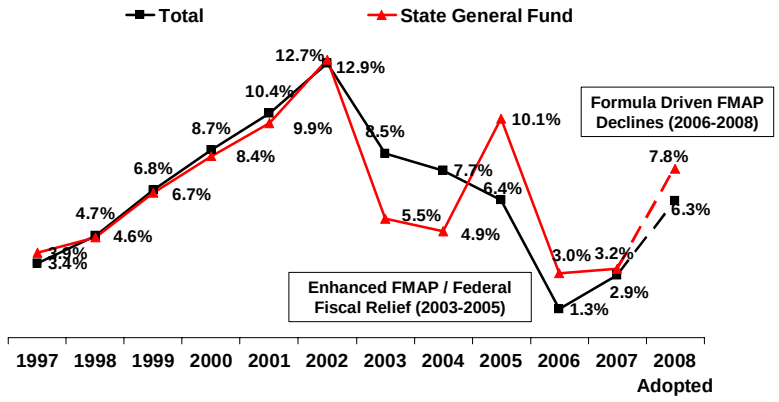
State General Fund Medicaid Cost Growth

Medicaid costs are shared by the states and the federal government. The split in financing is based on the federal Medicaid matching rate (FMAP) which relies on a states' relative per capital income. Typically, the state share and federal share of Medicaid growth is about even. However, during the economic downturn, the federal government provided additional fiscal relief to states by passing legislation that would temporarily increase the FMAP by 2.95 percentage points from April 2003 through June 2004. This had the effect of slowing the state share of Medicaid spending while increasing the federal share. When the period of fiscal relief ended there was an artificially large jump in the state share of Medicaid spending growth. More recently, many states have been faced with formula driven declines in their FMAP that have continued to cause the state share of Medicaid spending to grow faster than overall Medicaid spending.

In state fiscal year 2006, state general fund Medicaid spending increased by 3.0 percent at the same time that overall spending grew by just 1.3 percent. For state fiscal year 2007, states estimated that total Medicaid spending increased by 2.9 percent compared to a 3.2 percent increase in state funding for Medicaid.[17] For state fiscal year 2008, states reported that legislatures authorized increases in total Medicaid spending on average of 6.3 percent, but required increases of 7.8 percent on average in state general funds to support that level of program growth (Figure 12).

Figure 12

Total and State General Fund Medicaid Spending Growth, 1997-2008



SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and FY 2007 and FY 2008 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

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[17] It is noteworthy that state general funds increased on average across all states in 2006 and 2007, notwithstanding a significant influx of Katrina-related federal Medicaid funding that caused large negative growth rates for a few states in 2006 and 2007.

Comments of State Medicaid Officials on Pressures on Medicaid:

"Like a lot of states, we're seeing a bit of a rebound after the recession, and our Governor and Legislature have been looking for ways to expand the program."

"We are finishing with a surplus in every category."

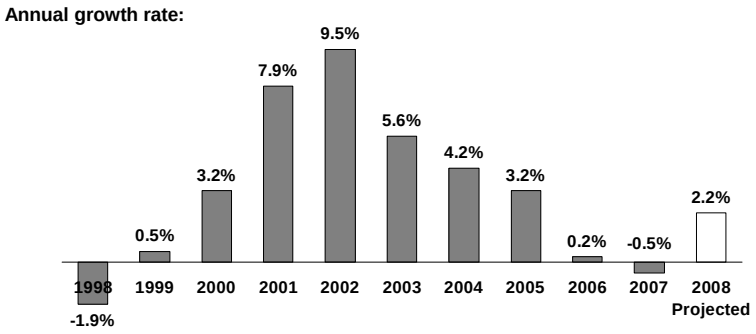
"We've been seeing a drop in our FMAP, with growth in the overall program. The legislature has had to come up with a lot of state money."

2. Medicaid Enrollment Growth

Changes in the number of people enrolled in Medicaid tend to be counter-cyclical with the economy. During the recent economic downturn, the number of individuals on Medicaid grew by over 40 percent from 2000 to 2006 and enrollment growth peaked at 9.5 percent in 2002. From 2003 through 2007, the pace of Medicaid enrollment growth each year has slowed compared to the previous year, with average growth dropping to 1.6 percent in 2006.[18] Enrollment actually declined in 2007 by .5 percent across all states. Fewer persons were enrolled in Medicaid in FY 2007 compared to FY 2006 in a total of 27 states. At the beginning of fiscal year 2007, states had projected enrollment to grow by an average of 2.6 percent, but instead enrollment dropped for the first time since 1998, when the economy was robust and states were implementing welfare reform. For 2008, Medicaid officials projected that Medicaid enrollment would increase on average by 2.2 percent. If this projection materializes, FY 2008 would be the first year since 2002 that Medicaid enrollment would grow at a faster pace than in the previous year (Figure 13).

Figure 13

Percent Change in U.S. Medicaid Enrollment, FY 1998- FY 2008



NOTE: Enrollment percentage changes from June to June of each year.

SOURCE: For 1998-2006: *Medicaid Enrollment in 50 States: June 2006 Data Update*, KCMU, October 2007. FY 2007 and FY 2008 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

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States were asked to identify the most significant factors that were contributing to increases or decreases in their Medicaid enrollment for FY 2007 and 2008. Thirty-seven states specifically identified the new Deficit Reduction Act requirement for citizenship and identity documentation as

[18] Some of the decline in enrollment in 2006 was attributable to large eligibility cuts in Mississippi, Missouri and Tennessee. These changes were reported last year's budget survey: http://www.kff.org/medicaid/7569.cfm

a factor causing a downward pressure on Medicaid enrollment. When asked specifically about the impact, a total of 13 states reported that the new requirements had a significant negative impact on enrollment and another 24 reported that they were seeing some or modest effects on enrollment while only eleven states reported insignificant or no enrollment effects.[19] Many states have implemented electronic data matching for vital records to help minimize the effects of the requirements.[20] The new documentation requirements were effective on July 1, 2006 as state FY 2007 began. Although some states were not able to fully implement the requirements immediately, many states indicated that eligible beneficiaries were finding it difficult to provide the required documentation. Some states indicated that the individuals most affected by the new law were citizens who were eligible for Medicaid, but who were not able to locate the needed documents.

The second most frequently mentioned factor contributing to lower Medicaid enrollment growth was the strong economy and lower unemployment. A few states reported they had experienced a modest drop in Medically Needy enrollment related to the new Medicare prescription drug benefit, noting that before Part D some individuals had attained Medicaid eligibility based on the high cost of their medications, and the costs of their medications were now covered by Medicare Part D.

At the same time that enrollment growth was slowing, 22 states in 2007 and 38 states in 2008 reported that there were factors putting upward pressures on enrollment. Nine states in 2007 and another 20 states in 2008 listed program or eligibility expansions as a key driver for increases in enrollment. Other states mentioned population growth, growth in the number of uninsured children and adults, continued erosion of employer sponsored health coverage, and economic and demographic trends, resulting in a growing elderly and disabled population. Increasing costs of private health insurance premiums coupled with a reduction over time in the percentage of firms offering coverage has led to declines in employer sponsored coverage and an increase in the number of uninsured Americans.

Comments of State Medicaid Officials on Enrollment:

"The last year we've seen almost a flat-lining of our enrollment. I'm not seeing anything this next year that will push it above flat-lining."

"Our enrollment declined for 18 consecutive months, but we've had increases for the past three months. For '08, we have an outreach budget for the first time since, I think, 2000."

"Enrollment has been impacted – not because people are not are not citizens but because citizens cannot produce documentation."

"*The consequence of the citizenship document requirement is that 20,000 people every month for a year do not have Medicaid. Most are kids.*"

[19] Three states indicated that they did not yet know what impact DRA documentation requirements were having on Medicaid enrollment.

[20] Some of these states had already had a vital records data match in place prior to implementation of the new DRA requirements.

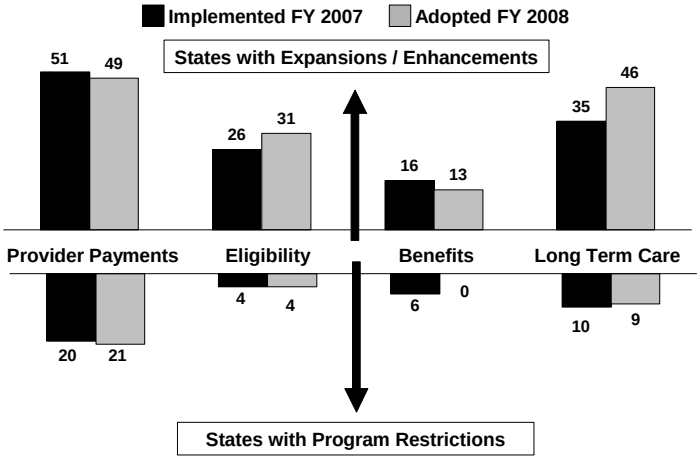
3. Medicaid Policy Initiatives for FY 2007 and FY 2008

In recent years, Medicaid policy making has been dominated by efforts to reduce costs or to slow program spending growth. For 2007 and 2008, state officials indicated that they have moved beyond a singular focus on cost containment toward positive program changes. Now, state efforts are more likely to be directed at initiatives to expand eligibility, increase provider reimbursement, improve benefits, enhance quality and rebalance long-term care delivery systems. Cost control remains an important focus of Medicaid, but the actions taken in 2007 and planned for 2008 tended not to be narrowly focused on cost reductions.

In FY 2007, 42 states implemented and in FY 2008 41 states adopted at least one new cost containment strategy. On the other hand, in FY 2007 and FY 2008, every state implemented policies or adopted policies that were positive for Medicaid providers and beneficiaries, through enhanced provider rates or restorations of benefits or eligibility. In addition, increasing numbers of states have initiated disease management and quality initiatives designed to improve health care for beneficiaries and to provide better value for the dollars the program spends. In long-term care, Medicaid programs continue to adopt policies directed at balancing the long-term care system. An increasing number of states are enhancing services provided in the home and community that can be used in place of care otherwise provided in an institutional setting, such as a nursing home (Figure 14). For more information on cost containment and positive policy actions taken by states see Appendices A-1 and A-2.

Figure 14

State Policy Actions Implemented in FY 2007 and Adopted for FY 2008



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

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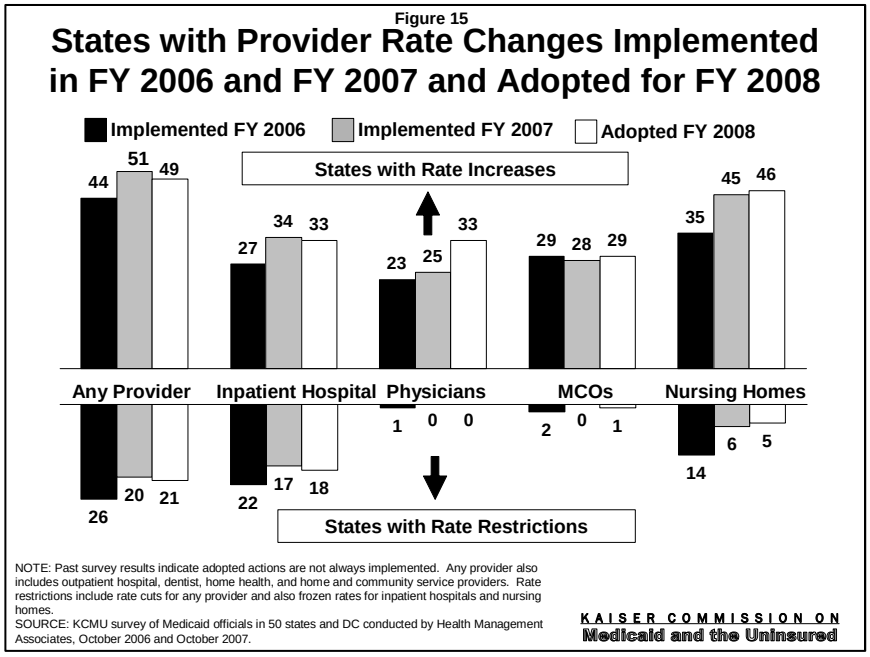
The following sections focus on specific categories of Medicaid policy actions taken by states in FY 2007 and FY 2008.

Provider Payment Rate Changes

State policy makers recognize that provider payment rates are an important determinant of access and availability of services for Medicaid beneficiaries. Nevertheless, in recent years, cutting or freezing provider payment rates was a primary policy option taken by states to help control Medicaid spending. In many states, automatic rate increases that had historically been in place were suspended for multiple years. As states emerged from the fiscal crisis, starting in FY 2004, states were less likely to cut provider rates and more likely to increase provider rates. In FY 2007, all states increased rates for at least one group of providers.[21] This trend will continue for FY 2008 with all states but Tennessee and Illinois indicating that they plan to increase rates for at least one group of providers. Some of these increases were making up for years with no rate increases or rate reductions during the fiscal downturn. Adequate provider payment rates are essential to ensuring access to services and also necessary if states are going to build on Medicaid to expand coverage.

Among the four major provider groups (inpatient hospitals, nursing homes, physicians and managed care organizations), payment rates for nursing facilities were the most likely to be increased for FY 2007 and FY 2008, followed inpatient hospital providers. Reimbursement methodologies for hospitals and nursing facilities often include automatic adjustments based on an index relating to the cost of services so these provider groups are typically more likely than others to show increases.[22] What is particularly notable is the number of states increasing Medicaid rates for physicians -- 33 states planned increases in FY 2008. Many states have experienced declining physician participation and are using enhanced payment rates as part of their strategy to improve physician participation and patient access (Figure 15).

Figure 15



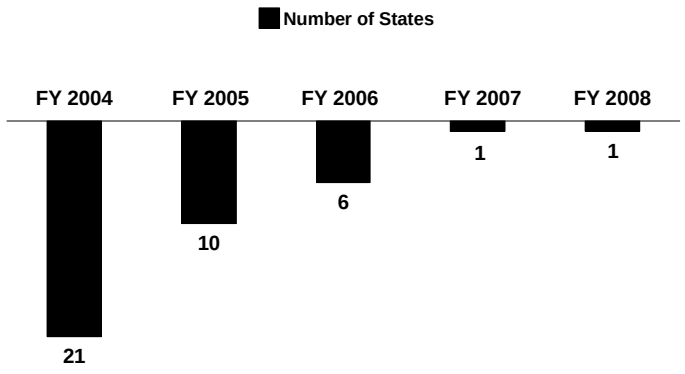
[21] The survey asked states about provider rates for the following eight categories: inpatient hospital, outpatient hospital, physician, nursing facility, managed care organization, dentist, home health agency, and home and community based service providers. References to "any provider" include all eight categories.

[22] When hospital and nursing facility rate increases are tied to new or increased provider taxes the real rate increase net of the provider tax could be less than the nominal increase.

Not only are states increasing more provider rates, fewer are restricting payments (reducing or freezing payments) in than in prior years. In FY 2007, 20 states were restricting payments for at least one provider (including four states that cut rates) and in FY 2008, 21 states planned to restrict payments (including one cut) for at least one provider.[23] Looking at the major provider groups (physicians, inpatient hospitals, nursing facilities or managed care organization), there has been a marked reduction in the number of states implementing rate reductions for one or more of these groups from 21 states in FY 2004, to only one state in each of FY 2007 and FY 2008. The 2007 cut was an inpatient hospital reduction of less than one percent that affected only a portion of the state's hospitals. For FY 2008 the one rate cut currently planned is an actuary-determined reduction in Managed Care Organization capitation rates, described by the state as part of the underwriting cycle and in part a correction of rates set too high for FY 2007 (Figure 16).

Figure 16

States Cutting Medicaid Rates for Inpatient Hospitals, Physicians, Nursing Facilities or Managed Care Organizations



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004, October 2005, October 2006 and October 2007.

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Comments of State Medicaid Officials on Provider Payment Rates

"Our (large) hospital rate increase in FY 2007 was the first rate increase our hospitals had received in 12 years."

"We've had some rate increases. Some of them were long overdue. In the long-term care area, some rates hadn't increased in 17 years."

"While our state ranks very high nationally in the generosity of Medicaid physician reimbursement we still have access concerns in a number of areas."

"Our state pays physicians at 100 percent of the Medicare rate. This has helped with access, especially in light of eligibility expansions. Doctors believe the state is 'serious.'"

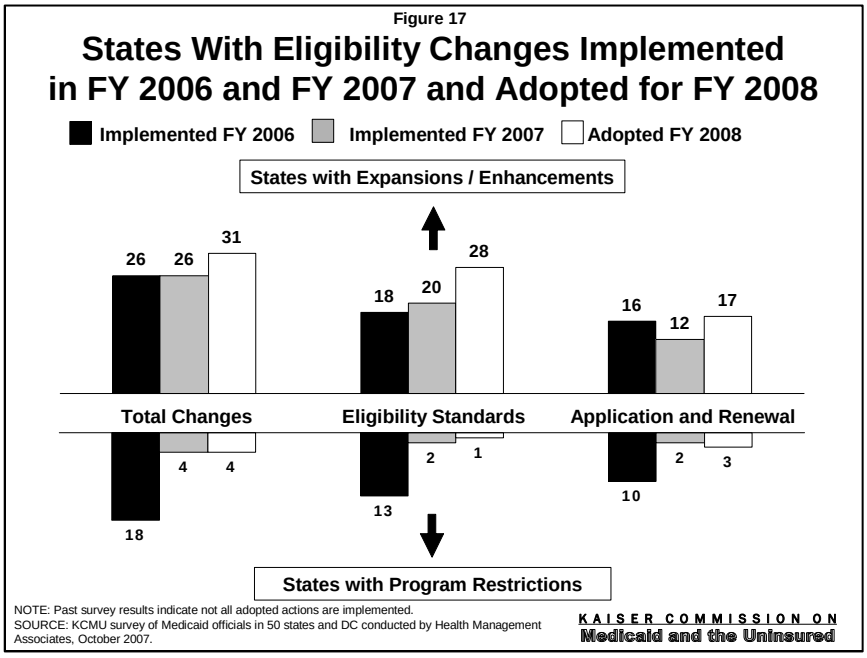
[23] The definition of "payment restrictions" in prior reports in this series included any instance in which provider rates were not increased. By policy some states do not make annual changes to rates for physicians, dentists, and other non-institutional providers, but rather make periodic rate changes designed to cover multiple years. For this report the definition of payment restrictions has been narrowed to include only rate freezes for institutional providers that typically have had annual cost of living adjustments (inpatient hospital and nursing facilities) or actual reductions in rates for any provider.

Eligibility and Enrollment Changes

Eligibility changes may be the result of changes to eligibility standards and changes to the application and renewal process that are designed to either expand or restrict coverage. Examples of changes to eligibility standards include increasing or reducing the income eligibility thresholds, adding or eliminating groups of individuals that are eligible for coverage and adding or changing asset tests. A state can also affect enrollment by making changes in its Medicaid application and renewal processes. Examples would include changes in state policies for continuous eligibility, face-to-face interview requirements, or presumptive eligibility. Many states reported that the new citizenship documentation requirements included in the DRA that were effective on July 1, 2006 also had significant implications for eligibility and enrollment and those specific issues will be discussed in the next section.

Almost all states made some eligibility restrictions during the economic downturn although some actions were much more severe than others. In FY 2007, 26 states implemented policies that would expand eligibility or facilitate enrollment and 31 states had plans to do so in FY 2008 compared to only four states that made restrictions in FY 2007 and four that had adopted plans to restrict eligibility in FY 2008. Many states are reversing restrictions that were put in place during the economic downturn or moving forward with coverage expansions to address the growing number of uninsured residents in their state (Figure 17).

Figure 17



Eligibility Standards

States implemented or are implementing a wide variety of changes that expand Medicaid eligibility in FY 2007 or FY 2008. The most common eligibility changes were increases of income or income disregards across eligibility groups. Twelve states were implementing programs for disabled individuals who return to work, allowing them to continue coverage under Medicaid through the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). Other states were expanding Medicaid to cover 19 to 20 year old youths who were covered by Medicaid while in

foster care and implementing expansions through premium assistance programs. Two states reported that they were implementing programs under the Family Opportunity Act (FOA), a new option established in the DRA to allow parents with disabled children to "buy-in" to the Medicaid program. The expansions for persons aging out of foster care or those with disabilities are expansions to generally high cost groups that typically cannot access affordable or adequate private health insurance.

In this survey only three states reported actions that in any way restrict Medicaid eligibility standards for FY 2007 or FY 2008. None were reductions in eligibility levels, but included adding an asset test, changing the effective date of retroactive Medicaid eligibility and eliminating a subsidy. Details on these eligibility expansions, along with information about application process and premium changes for FY 2007 and FY 2008 are described in detail in Appendices A-3a and A-3b.

Eligibility Expansion	States in FY 2007	States in FY 2008	States in Either FY 2007 or FY 2008
Increase an Income Limit or Earned Income Disregard	CO, IN, NM, NV	AK, AZ, CT, DC, IA, IN, LA, MT, NM, OH, OK, VT, WI	15
New or Expanded Coverage for Working Disabled	ID, LA, MD, ME, NY, TX, VA	DE, GA, MO, NV, OH	12
Cover Youth Aging out of Foster Care	CO, IA, MA, UT	MO, NC, OH, VA, WI	9
Premium Assistance	AR, MA, NV, OK, UT	MA, NY, OK	6
Implement or Expand a Family Planning Waiver	IL, LA, NM, TX	NM, MO, PA	6
12 Month Guaranteed Eligibility	OK	ND	2
Increasing Asset Limits	CO, ID, MT	MN	4
Add New Eligibility Group	DC, MD	HI	3
Family Opportunity Act		LA, ND	2
Other Expansion	IA, LA, WI	KS, MA, MN, MT, TN	8

Other Application and Renewal Process Changes

States were also asked whether they had made changes to their application and renewal process apart from the changes required by or implemented in response to the DRA citizenship verification requirements. Specific actions in response to the DRA requirements are discussed separately in the next section.

For FY 2007, 12 states reported that they made changes to simplify or streamline the application or renewal process and 17 states had plans to do so in FY 2008. The most common changes reported were simplification of application forms (eleven states), online applications (six states), extending renewal periods from six months to twelve months (three states), and elimination of face-to-face interview requirements (three states). Other initiatives for FY 2007 and 2008 include implementation of presumptive eligibility; the option to self-declare income; telephone renewal options; and web-based or on-line application processes or paperless renewal processes. Several states made or are making more than one type of change.

Aside from some other changes to comply with the new documentation requirements, only five states reported restrictive application changes in either FY 2007 or FY 2008. These changes included a more complex application form, increased documentation, instituting a face-to-face interview or implementing the use of an external data validation vendor to check reported assets and income. States are also looking to the private sector for some components of the eligibility determination process. At least one state plans to outsource the eligibility determination process on a phased-in basis during FY 2008.

Eligibility and Administrative Impact of the DRA Citizenship Documentation Requirements

Effective July 1, 2006, the DRA required all individuals applying for or renewing their Medicaid coverage to provide documentation of their citizenship status and identity. Prior to the DRA, 47 states allowed applicants to self-declare citizenship status. Only four states – Georgia, Montana, New Hampshire, and New York – required documentation of citizenship for all Medicaid applicants. The DRA requirements generally went beyond the existing documentation requirement even in the four states with citizenship documentation requirements. The rules specified that applicants must first use a Passport or birth certificate and then could use other evidence of citizenship only if those documents were not available. In addition to verification of citizenship or legal residency status, most individuals must also provide separate documentation of their identity. The initial federal rules exempted individuals also receiving Medicare or Supplemental Security Income. Subsequent rules exempted infants whose birth is covered by the Medicaid program until they reach one year of age. These changes affect the application process but do not change the Medicaid eligibility rules. As a result of the 1996 welfare reform legislation (the Personal Responsibility and Work Opportunities Reconciliation Act or PRWORA), Medicaid for legal immigrants was limited to individuals that had been legal US residents for at least five years even if they meet other program requirements and illegal immigrants are still only eligible for emergency Medicaid services.

In the current survey, several states indicated that implementation of the DRA citizenship and identity documentation requirements has occurred in several phases and in some cases continues to evolve. While the new requirement was effective on July 1, 2006, many states were unable to promulgate all of the detailed policy and procedure changes by that date. Federal guidance was issued just three weeks before the law took effect and the federal requirements and guidance have changed at least three times since the July 1, 2006 effective date.[24] More than two thirds of states indicated the new requirements increased application and renewal processing times, almost all states (45) reported that they had increased administration costs, and most states reported that the new requirements were negatively affecting enrollment. The effects of the new requirements on enrollment are discussed in the enrollment section (Figure 18).

[24] Ellis, Eileen & Duchon, Lisa, *The Deficit Reduction Act's (DRA) Citizenship Documentation Requirements for Medicaid Through the Eyes of State Officials in December 2006 and January 2007,* Robert Wood Johnson Foundation, July 2007 www.rwjf.org/pdf/CKFissuebrief3.pdf.
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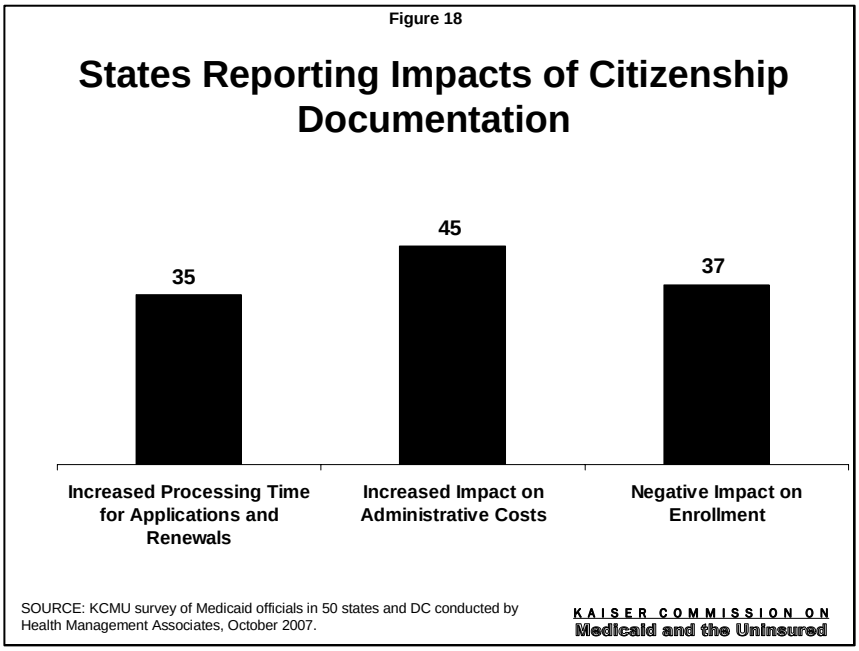
Figure 18



Impact on Application/Renewal Process: States were asked about the impact of the DRA citizenship documentation requirements on the processing times for Medicaid applications and renewals in their state. More than two-thirds of the states (35 states) indicated that application processing times increased, by as much as 25 percent to double in some states. Two states indicated that times had decreased since implementation of the DRA requirement, but other changes in their processes had occurred at the same time so that it was not possible to attribute results to any particular process change. Almost all states that were able to shorten or maintain current processing times had implemented a vital records data matching process. Several states did report that they added consumer notices about the new citizenship requirements to the materials they send to applicants and renewing beneficiaries. At least three states made changes to the applications forms so that the Medicaid application, once signed by a parent or guardian, serves as an affidavit of the identity of a child under the age of 16. Two states specifically reported a modification to their Medicaid application forms to learn the place of birth of the applicant. The survey did not ask for details about changes in the application and renewal process specifically made to accommodate the DRA citizenship requirements, so more states may have made changes.

Administrative Cost Impact: The states were asked to provide an assessment of the extent to which the DRA citizenship documentation requirements had resulted in increased administrative costs. Only six states indicated that the new administrative costs were insignificant or non-existent. Twenty-six states indicated that they had experienced some/modest cost increases. Nineteen states indicated that the administrative cost increases were significant. States were asked specifically if they had implemented or planned to implement procedures to do data matching with vital records agencies in the state. Thirty-five states had completed an automated data matching process at the time of the survey. Several of the 16 states that had not yet implemented an automated process indicated that automated data matches were either being explored or in development.

Comments of State Medicaid Officials on the Administrative Impact of the DRA Citizenship Documentation Requirements

"The (application processing) time has doubled."

"After a decade of streamlining and simplifying, the DRA has turned everything on its ear."

"I don't think you can overestimate the detrimental impact on Medicaid operations for very little program integrity gain. I would support any actions to change this."

"This went pretty well for us- we haven't experienced the hassle that I hear from my colleagues."

"This requirement has increased our administrative costs by $2.8 million per year."

Premium Changes

Historically, states have been prohibited from charging Medicaid enrollees premiums or enrollment fees outside of an 1115 waiver or various Medicaid "buy-in" programs that have been introduced for working individuals with disabilities who do not have access to employer based insurance.[25] The DRA gave states additional flexibility to impose premiums, but no state has used the new DRA authority to exercise this option. Using waiver authority, many states charge premiums to higher income individuals that participate in these programs.[26]

While no existing programs for the employed disabled population reported increased premiums, three new programs were introduced in FY 2007 and another three in FY 2008 that included premiums. Two states have similar premium programs as a part of their "Katie Beckett" waiver programs for disabled children in families with incomes that exceed the otherwise applicable Medicaid thresholds. Two states, Louisiana and North Dakota, reported new premium programs for FY 2008 under the Family Opportunity Act component of the DRA. Two states, Oklahoma and Arkansas, have Medicaid-funded programs that partner with businesses to support health care for the uninsured. While Massachusetts expands its Insurance Partnership Program in FY 2008, the state is simultaneously eliminating some existing premiums for individuals with incomes below 150 percent of the FPL. Fourteen states provided information on nineteen other premium programs, most of which applied to higher income recipients and were implemented under waiver authority. The income ranges varied, but most premium programs apply to individuals with incomes above 150 percent of the FPL.

[25] The Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentive Improvement Act (TWWIIA) of 1999 both included this type of program.

[26] For this report changes in Medicaid premiums have not been counted as a program expansion or a program restriction. Most of the premiums reported in this survey are associated with program expansions.

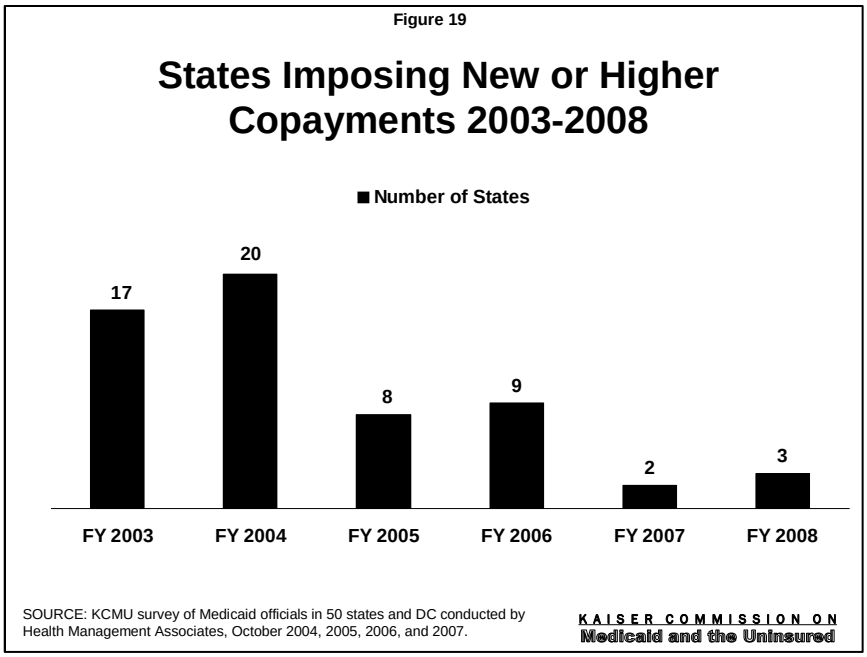
Copayment Requirements

Over the past several years, states have used new or higher copayments as part of their cost containment strategies. According to the results of this year's survey, a total of 44 states impose copayment requirements, including six states that impose copayments only on drugs. Only seven states responded that they had no copayment requirements at all.

Prior to the DRA, Federal law limited Medicaid copayments to nominal amounts, generally defined as $3.00 or less per service, and also prohibited states from applying copayments to certain services (e.g., emergency room visits) or certain eligibility groups (children and pregnant women). Federal law also required providers to render services regardless of whether the copayment was collected, although beneficiaries remained liable for the amounts. Subject to certain limits and exemptions, however, the DRA now provides new authority for states to charge greater than nominal cost-sharing on certain eligibility groups and most services. States may vary the premium and cost-sharing requirements by eligibility group and may also elect to make cost-sharing enforceable – that is, allow a provider to deny rendering services if the copayment requirement is not met.

In FY 2007, only two states (Idaho and Kentucky) imposed new or higher copayments, down from nine states in FY 2006 and eight in FY 2005 (Figure 19). Idaho imposed new $3 copayments on the use of ambulance transportation for non-emergent medical conditions and on the use of a hospital emergency room for a non-emergent condition. Kentucky was the only state that reported using the new DRA authority to impose higher than nominal cost sharing on certain eligibility groups and the only state to make copayments enforceable. In connection with the creation of four new DRA benchmark benefit packages, Kentucky imposed new copayment requirements that vary by benefit package and population including a $50 inpatient hospital copayment for non-pregnant, non-institutionalized adults. Aged and disabled beneficiaries requiring long-term care services have a $10 inpatient hospital copayment requirement. Other areas subject to new, mostly nominal, copayment requirements include physician services, laboratory, diagnostic and radiology services, dental services, therapy services, chiropractic services, drugs, non-emergency visits to the emergency room, DME, and outpatient hospital visits. Aggregate annual drug copayments are limited to $225, as are aggregate annual medical copayments. Also, there is an aggregate family cap equal to five percent of income.

Figure 19



In FY 2008, three states reported plans to impose new or higher copayments requirements. Two states (Maine and Rhode Island) are imposing new copayments on drugs and one state (Wisconsin) is using DRA authority to extend nominal copayment requirements, currently applicable to parents and children with incomes above 100 percent of the FPL in the fee-for-service system, to this same population enrolled in managed care plans.

A few states reduced or eliminated copayments in FY 2007 and FY 2008 (three states in each year). Florida's Medicaid reform waiver allowed health plans to waive or reduce – but not increase – cost sharing and a number of plans chose to do so to attract enrollees. Vermont eliminated drug copayments for persons aged 18 to 20 in FY 2007 and Massachusetts eliminated emergency room screening copayments for non-emergency services in the ER. In FY 2008, Oregon is eliminating copayments for generic drugs and drugs on its preferred drug list, Minnesota is exempting mental health services from copayment requirements and Pennsylvania is applying exemptions for tobacco cessation counseling and (using DRA authority) for all services for persons in a Personal Care Home or a Domiciliary Care Home.

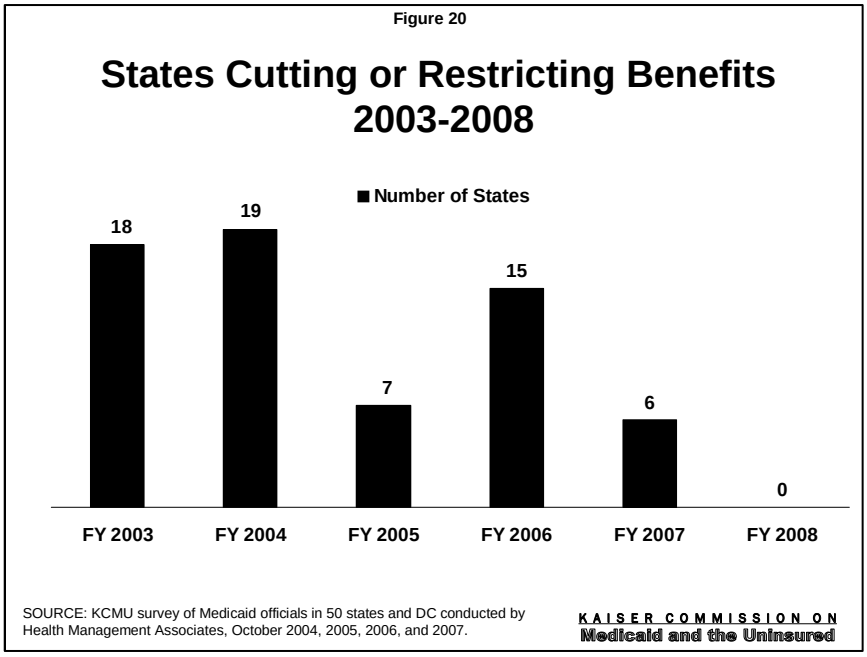
DRA Health Opportunity Accounts. The DRA also included a provision for up to ten states to participate in a five-year demonstration of the potential efficacy of Medicaid Health Opportunity Accounts (HOA). States would have the option of funding and enrolling some Medicaid beneficiaries into flexible consumer-based accounts which would give beneficiaries a greater role and responsibility in managing their health care. Participation would be targeted to children and families. If successful at the end of the five-year period the HOA feature would become a state plan option available to any state.

South Carolina was the first state to receive a HOA demonstration grant and the only state reporting a planned HOA demonstration in the survey. In FY 2008, South Carolina plans to implement two one-county pilots each limited to 1000 beneficiaries: a voluntary HOA demonstration for healthy adults and children and a voluntary "Health Savings Account" plan using DRA benefit flexibility (discussed in the benefits section). Once a beneficiary's HOA has been depleted, the member will have out-of-pocket responsibility for 10 percent of costs up to a maximum of $250 for an adult or $100 for a child. No additional cost-sharing is applied thereafter.

Benefits Changes

In both FY 2007 and FY 2008 many more states were implementing benefit restorations or expansions compared to restrictions. For FY 2007, 16 states reported benefit expansions and only six states implemented benefit cuts or restrictions. In FY 2008, 13 states planned to expand benefits while no state reported plans for cuts or restrictions. These results reflect a sharp decrease from FY 2006 when 15 states implemented benefit cuts or restrictions (Figure 20).

Figure 20



Of the six states reporting cuts or restrictions for FY 2007, three (Kentucky, West Virginia and Idaho) used the DRA benefit flexibility provisions to redesign their Medicaid benefit packages (described below). The remaining three states that reported benefit cuts or restrictions in FY 2007 made more narrowly targeted cuts: Georgia added prior approval requirements for hospital admissions, outpatient procedures and children's therapy visits in excess of eight per year, New York reduced Medicare Part D wrap-around coverage for dual eligibles and Utah eliminated dental and vision benefits for non-pregnant adults.

While only a few states reported cuts or restrictions, 16 states in FY 2007 and 13 states in FY 2008 adopted benefit restorations and expansions. This includes six states in FY 2007 and four states in FY 2008 that are restoring or expanding dental benefits. In FY 2008, Kansas is using the DRA benefit flexibility provisions to add personal assistance and related services (including self-directed and agency-directed options) for participants in the "Working Healthy," the state's TWWIAA Medicaid buy-in program. (See Appendices A-4a and A-4b for more detail on benefit related actions.)

DRA Benefit Flexibility. Prior to the DRA, all states were required to cover a set of mandatory services and states could receive federal match for covering optional services including drugs, dental care and personal care services. The DRA allows states to replace the traditional Medicaid benefits with new "benchmark" plans. This new flexibility allows states to vary benefits across beneficiary groups and across areas in the state. The DRA maintains Early Periodic Screening Diagnosis and Treatment (EPSDT) services as a wrap around for children.

The three states that used the DRA to do major benefits restructuring are described below:

- ***West Virginia*** has implemented (in three counties thus far) an alternative benefit package for healthy (non-pregnant) adults and children providing an "enhanced" benefit for persons that sign and conform to a "Medicaid Member Agreement" and a scaled-back benefit for those who fail to sign the agreement or do not fulfill their obligations under the agreement.

The Basic plan includes all mandatory and some optional services but is more limited than the standard Medicaid benefit package excluding, for example, diabetes care and mental health care and imposing a limit of four prescriptions per month. Children are covered for the EPSDT benefit in both the "Basic" and "Enhanced" plan.[27] West Virginia also plans to pilot "Healthy Reward Accounts" that will allow beneficiaries to earn credits for healthy behaviors that can be used to cover medical and pharmaceutical copays.

- ***Kentucky*** created four benefit packages with varying service limits and cost-sharing requirements: *Global Choices* (the "default" package for those not falling into another package); *Family Choices* (for children, including SCHIP); *Optimum Choices* (for persons with MR/DD needing long-term care services) and *Comprehensive Choices* (for elderly and disabled individuals in need of long-term care services). New service limits apply to audiometric services, chiropractic services, dental services, home health, and various therapies. The state also limits the amount of funding it will pay (imposes new dollar limits) for hearing aids, prosthetic devices and vision hardware. Kentucky's plan also includes "Get Healthy" incentives that will be awarded for compliance with a disease management program and can be used for additional services (dental, vision, or nutritional or smoking cessation counseling). Finally, Kentucky's plan established employer-sponsored insurance as an alternative benefit package providing premium assistance to beneficiaries choosing this option.

- ***Idaho*** offers three alternative benefit plans: the "Basic" plan for healthy low-income children and adults, the "Enhanced" plan for individuals with disabilities and special health care needs, and the "Coordinated" plan for dual eligibles that will enhance Medicaid and Medicare integration. The Enhanced and Coordinated plans include the full range of Medicaid services, while new restrictions and limitations apply to the Basic plan including: exclusion of long-term care benefits, limits on mental health services, and restrictions on some provider specialties (such as rehabilitation, mental health services, speech and hearing clinics, independent practical and registered nurse services, mental health and personal care case management) to diagnostic and evaluation services only. The Basic and Enhanced plans include a Personal Health Account component targeting individuals who use tobacco or who are obese. The state will issue vouchers to individuals who have earned credits which may be used to purchase goods and services related to tobacco cessation and weight loss.

In addition to West Virginia, Idaho and Kentucky, five other states are using the DRA benefit flexibility provisions in a more targeted way:

- In FY 2007, ***Virginia*** used DRA authority to convert its voluntary "opt-in" disease management program to a voluntary "opt-out" DRA benchmark program. Also, ***Washington*** used the DRA benchmark authority to implement a chronic care management pilot program that uses predictive modeling to identify high-risk clients. Disease management and chronic care management are discussed in a separate section later in the report.

[27] To date, only about 12.5 percent of children and adults have returned the Member Agreement Forms to their primary care providers to be placed into the enhanced benefit plans. "Medicaid Recipients Slow to Make Healthy Changes." Tom Breen, The Associated Press, July 22, 2007.

- In FY 2008, ***Kansas*** is adding personal assistance and related services (including self-directed and agency-directed options) for participants in "Working Healthy," the state's TWWIAA Medicaid buy-in program.

- In FY 2008, ***South Carolina*** will implement a voluntary one-county pilot "Health Savings Account" plan (limited to 1,000 beneficiaries) using the State Employee High Deductible Health plan as the benchmark plan. The pilot is open to all beneficiaries except duals, foster care and persons in institutions. (This action has not been counted as a benefit or copayment restriction or expansion.)

- In FY 2008, ***Wisconsin*** is seeking to use DRA benchmark authority to offer a modified benefit package to the BadgerCare Plus expansion population. The State is proposing a comprehensive benchmark plan adapted from Wisconsin's largest commercial, low-cost health care plan which is provided by United Healthcare. (This action has not been counted as a benefit restriction or expansion.)

Long-Term Care and Home and Community–Based Services

Over the past several years a growing number of states have taken action to balance their long-term care delivery systems by reducing reliance on institutional services and increasing access to home and community-based service (HCBS) options. Expansions or cost containment actions in long-term care may be the result of changes related to community-based long-term care services or changes related to nursing homes and ICFs/MR-DD. In FY 2007, 35 states took actions that expanded LTC services (primarily expanding HCBS programs), while even more states plan expansions in LTC services (46 states) in FY 2008. This compares to 29 states taking actions to expand LTC services in FY 2006. Conversely, a total of ten states took action to constrain LTC service costs in FY 2007 and nine states plan to cut or restrict LTC services in FY 2008.

The following section details state actions to both expand and control long-term care services in both institutional and community-based settings.[28] This section also includes results from survey questions about certain new DRA-related long-term care state options.

HCBS Programs. This year's survey found that states are increasingly focusing efforts on reorienting their Medicaid long-term care delivery systems towards more community-based services. States' efforts to expand HCBS options for long-term care are driven by consumer demand, the United States Supreme Court decision in Olmstead v. L.C. in June 1999 that stated that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act, and an effort to control long-term care costs which represent a third of total Medicaid spending.

By far, the most commonly reported LTC expansion change in both years was adopting new HCBS waivers or expanding existing waivers, including the implementation of DRA "Money Follows the Person"[29] and Psychiatric Residential Treatment Facility (PRTF) Demonstration Grant[30] initiatives.

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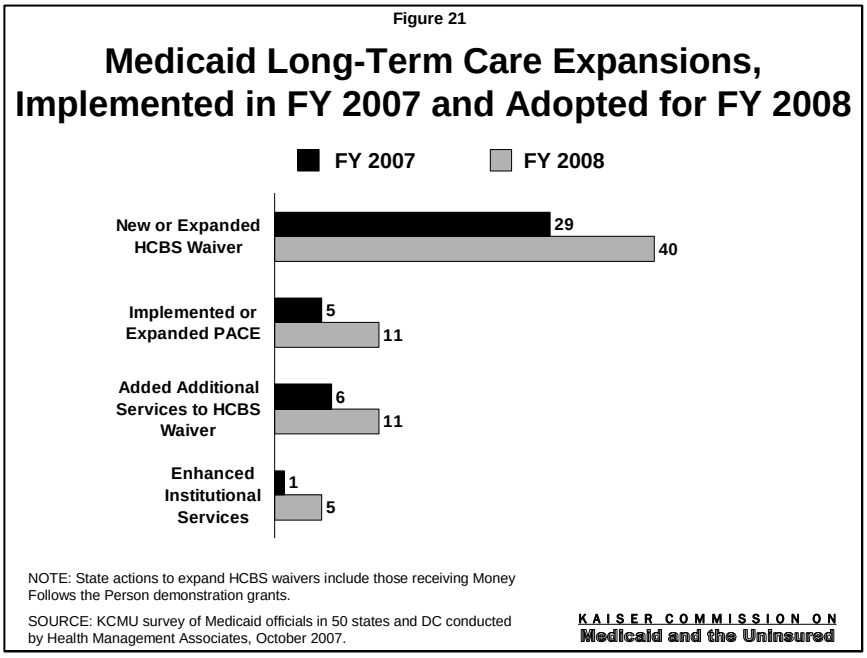
[28] Changes reported in this section exclude changes in financial LTC eligibility criteria which were reported under the "Eligibility section" of this report.

[29] As of May 2007, a total of 31 states have been awarded MFP grants totaling $1.4 billion to reduce reliance on institutional care by transitioning individuals from institutions to the community. The demonstration program provides an enhanced FMAP (75-90%) for an individual's costs for 12 months from the date of institutional discharge. Based on

Other examples of LTC expansions include adding additional services to an existing HCBS waiver and expanding PACE programs[31] (Figure 21).

Only two states in FY 2007 and one state in FY 2008 had new restrictions directed at HCBS programs. Most states already have limits in place for their community-based services such as coverage limits, enrollment caps, and waiting lists for services. This year's survey found that two states imposed utilization controls and placed lower limits on certain waiver or personal care services and one state made changes to its level of care (LOC) criteria making it more difficult to qualify for long-term care services.

Figure 21



Institutions. One state took positive action in FY 2007 and five states plan to take action in FY 2008 to remove restrictions on, or enhance institutional services. Nevada expanded a state mental hospital in Las Vegas and Colorado began the three-year conversion of over 300 developmental disability group homes to ICFs/MR-DD. Two states, Louisiana and Michigan, are changing nursing facility reimbursement policies to promote quality improvements in nursing facility structures: Louisiana is allowing nursing facilities to convert doubles to private rooms without a reimbursement penalty, and Michigan is reimbursing for facility innovative design programs. Finally, Oklahoma is implementing a tiered reimbursement structure that provides for enhanced

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the funds awarded to date, states plan to transition nearly 38,000 individuals into the community over the next five years.

[30] The PRTF Demonstration Grant program, created by the DRA, allows states to create home and community-based service alternatives for children with serious emotional disturbances who would otherwise be institutionalized in a PRTF. In December 2007, CMS announced grant awards to ten states: Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Montana, South Carolina, Virginia and Mississippi.

[31] The "Program of all All-Inclusive Care for the Elderly" (PACE) is a capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs.

funding for nursing facilities based on quality indicators and Indiana is allowing a nursing facility moratorium requirement to expire.

In FY 2007, nine states implemented cost controls related to nursing homes and ICFs/MR-DD, and eight states are planning reductions in FY 2008.[32] Examples include:

- policies designed to reduce the number of nursing home beds or ICFs/MR beds (through a tightening of a facility needs review process, extension of a bed moratorium or other bed closure effort),
- reductions in reimbursement for Medicare nursing home coinsurance costs,
- reductions in payments for bed holds,[33]
- implementation of pre-admission counseling, prior authorization or new pre-admission screening requirements for nursing home placements, and
- efforts to reduce the size of or close state-owned Mental Health/Mental Retardation facilities.

Other LTC Actions: A few states also reported other LTC policy initiatives underway to improve the delivery of LTC services and increase community-based alternatives. These initiatives are not counted as institutional or community-based expansions or restrictions in this survey, but were additional LTC actions reported by the states. State policies included implementation of a new market-based nursing facility reimbursement system designed to reduce payments for empty beds and conversion of a HCBS waiver program from a capitated reimbursement system to a fee-for-service system (at the direction of CMS). Additionally, four states in FY 2007 and seven states in FY 2008 implemented or expanded LTC managed care programs. Three states in FY 2007, and three states in FY 2008, implemented or enhanced existing estate recovery programs and one state eased its estate recovery hardship criteria in FY 2008.

DRA Long-Term Care Options

The DRA included new provisions intended to give states increased flexibility to deliver long-term services and supports. The survey asked states to report on their actions in FY 2007 and plans for FY 2008 regarding three DRA LTC-related options. Results found:

- ***Long-Term Care Partnership Programs –*** Five states in FY 2007 reported implementing a Long-Term Care Partnership Program and 24 states indicated that they were planning to implement a program in FY 2008. LTC Partnership programs are designed to increase the role of private long-term care insurance in financing long-term services by allowing persons who purchase qualified long-term care insurance policies to shelter some or all of their assets when they apply for Medicaid after exhausting their policy benefits. In addition to the 29 states that reported the implementation of new plans in FY 2007 or FY 2008, four states – California, Connecticut, Indiana and New York – have had demonstration model programs underway since 1992.

[32] Louisiana made changes to its level of care (LOC) criteria in FY 2007. This action was counted as a restriction for both institutional and community-based services.

[33] A bed hold day is defined as a day when the resident is not in the facility and has exhausted the allowable Medicaid leave days and the facility holds the bed for their return.

- ***Self-Direction of Personal Services*** – In 2007, only one state (Alabama) reported taking advantage of the option to allow for self-direction of personal assistance services, sometimes referred to as the "cash and counseling option." Seven states reported plans to implement this option in FY 2008. Nevada proposes to use the option in a targeted way to replace certain mental health services currently offered through the State Plan including therapeutic foster care, adult day health care, comprehensive outpatient rehabilitation and partial hospitalization, effective upon CMS approval.

- ***HCBS State Plan Option –*** Only one state (Iowa) reported taking advantage of the HCBS State Plan option in FY 2007. This new option allows states to offer HCBS services as a state plan option rather than through a 1915(c) waiver. Iowa used the option to add case management and habilitation services to a targeted population – persons with a history of mental illness who also meet certain risk factor criteria and have ongoing needs. Five additional states reported plans to implement the HCBS State Plan option in FY 2008.

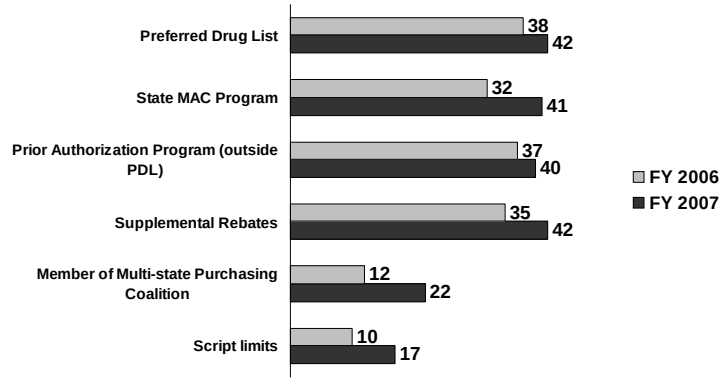
The survey results indicate widespread adoption of Long-Term Care Partnership Programs but little take up, thus far, of the cash and counseling or the HCBS State Plan options. Some states noted that they already had cash and counseling options in place under existing state waivers and therefore were not considering the DRA option while a number of other states indicated that both the cash and counseling and HCBS State Plan options were still being evaluated or were under consideration for possible implementation. A few states suggested that the HCBS State Plan option was "too limited," "not flexible enough" or was "not an attractive option" to meet the states' needs.

Prescription Drug Utilization and Cost Control Initiatives

Between 2001 and 2005, the vast majority of states aggressively implemented policies designed to slow the growth in Medicaid spending for prescription drugs. For the second year, the survey included questions designed to quantify the number of states that had certain pharmacy cost containment measures in place by the beginning of FY 2007. State responses show small increases for all categories compared to the responses for FY 2006 which revealed widespread adoption of prior authorization programs, preferred drug lists (PDLs), supplemental rebate programs, and state MAC programs. Significant increases (9 states each) occurred in membership in multi-state purchasing coalitions and participation in state MAC programs. The increase in multi-state purchasing coalitions was likely driven by the implementation of the Medicare prescription drug benefit in January 2006 which cut total state drug expenditures by almost half thereby reducing state purchasing power to negotiate supplemental rebates (Figure 22).

Figure 22

Medicaid Pharmacy Cost Containment Measures in Place by FY 2006 and by FY 2007



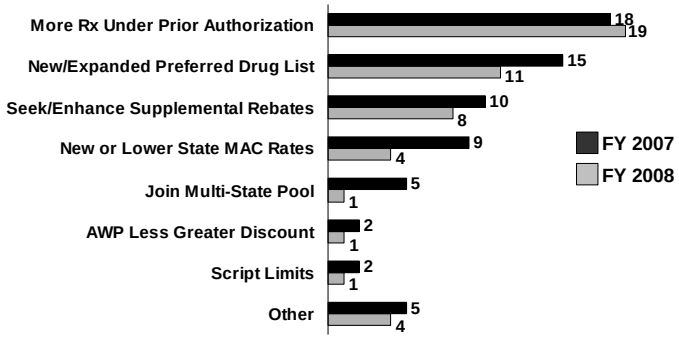
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

KAISER COMMISSION ON Medicaid and the Uninsured

Since 2005, the pace of change in Medicaid pharmacy policy has slowed. Thirty states in FY 2007 and 24 states in FY 2008 implemented cost-containment initiatives in the area of prescription drugs, comparable to the number in FY 2006 (29), but fewer than the numbers reported for FYs 2002 – 2005. Given the large number of states with prior authorization programs, PDLs, supplemental rebate programs, and state MAC programs already in place, it is not surprising that the majority of actions reported were described as additions, expansions or refinements to these programs. The most commonly implemented cost containment efforts include expansions of prior authorization programs, and establishing or enhancing a preferred drug list (Figure 23). No state reported decreasing pharmacy dispensing fees in either FY 2007 or FY 2008 while two states in FY 2007 and six states in FY 2008 increased dispensing fees.

Figure 23

Medicaid Prescription Drug Policy Changes FY 2007 and FY 2008



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

KAISER COMMISSION ON Medicaid and the Uninsured

Several states in both FY 2007 and FY 2008 reported other types of pharmacy cost containment measures including:

- two states (Pennsylvania and Virginia) implementing programs focusing on specialty pharmacy products;
- two states (Pennsylvania and Wyoming) implementing medication therapy or behavioral health pharmacy management programs;
- one state (New Jersey) imposing a moratorium on the enrollment of new pharmacy providers;
- one state (Iowa) eliminating its "pay and chase" policy relating to collection of third party liability for pharmacy claims;
- one state (Virginia) implementing rebate collections for physician administered drugs; and
- one state (Oregon) stream-lining its pharmacy lock-in program[34] and also allowing the dispensing of a 90-day supply (with only one copay) for drugs on the state's PDL.

See Appendices A-6a and A-6b for more detail on pharmacy cost containment actions.

DRA Federal Upper Limit (FUL) Changes. Few states reported taking action to change dispensing fees or ingredient cost reimbursement formulas, but a number of states suggested that future changes were likely to respond to changes mandated by the DRA to occur in CY 2008. The DRA changed the federal upper limit (FUL) on reimbursements for multi-source drugs from 150 percent of the Average Wholesale Price to 250 percent of the Average Manufacturer Price (AMP) for the lowest cost drug. Also, the DRA requires only two (instead of three or more) therapeutic equivalents before adding a drug to the FUL list. Approximately half of all Medicaid prescriptions are for multi-source drugs that could be affected by this change.[35]

CMS plans to publish the new FULs in December 2007 and update them monthly thereafter. Concerns have been raised, however, that the new AMP-based methodology may result in new FULS that are too low in some cases to cover the costs of acquisition for pharmacies. For this reason, a number of states indicated that pharmacy reimbursement policies, especially dispensing fee amounts, would be reviewed for possible changes following the publication of the new FULs to ensure adequate pharmacy access for Medicaid beneficiaries.

For the second year, the survey asked states to gauge the potential impact of the new DRA changes to the FUL program. States were asked whether, in FY 2008, they expected the changes to produce "none or insignificant savings," "some or modest savings," or "significant savings," or states could select the response "don't know." Twenty-two states indicated that they did not have sufficient information to estimate the impact and selected "don't know." The remaining responses were split with 14 states estimating none or insignificant savings and 14 states estimating some or modest savings. Only one state estimated that the savings would be significant.

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[34] A pharmacy lock-in program restricts a patient to filling all of his or her prescriptions at one pharmacy. The purpose of this program is to control duplicate and inappropriate drug therapies.

[35] Statement of Douglas Holtz-Eakin, Director of the Congressional Budget Office, before the United States Senate Special Committee on Aging, July 20, 2005, accessed at http://www.cbo.gov/ftpdocs/65xx/doc6564/07-20-MedicaidRx.pdf.

Future Ingredient Cost Formula Changes. Currently, states calculate reimbursement for brand name drugs by using drug pricing files published by national firms. States then take a discount from the reported "Average Wholesale Price" (AWP), or assign a mark-up to the reported "Wholesale Acquisition Cost" (WAC), and add a dispensing fee. As a result of litigation challenging the AWP calculations, two national drug pricing firms have announced their intention to eventually discontinue publishing AWPs. Several state survey responses indicated possible plans in FY 2008 to change the reimbursement policy for brand name drugs from an AWP-based methodology to some other pricing system due to the likely elimination of AWP in the market place. Three states noted definite plans to switch to a methodology based on "Average Manufacturer's Price" (AMP).

4. Care Management and Quality Initiatives

In recent years, considerable attention has been directed toward the objective of coordinating and managing care (especially for high cost populations), improving health care system performance, improving the quality of health care, and getting greater value for the money that is spent on medical care. State Medicaid programs are an important part of the system and increasingly have adopted policies intended to measure, monitor and improve the care that they pay for.
See Appendices A-7a and A-7b for more detail on care management and quality initiatives.

Managed Care Initiatives

States continue to expand and rely on managed care as the principal health care delivery system for Medicaid beneficiaries and use a variety of capitated and non-capitated models. CMS data indicate that all states except three (Alaska, Mississippi and Wyoming) had at least one form of managed care as of December 2006, and that the proportion of all Medicaid beneficiaries enrolled in some form of a managed care plan had reached a record level of 65 percent.[36] Of all Medicaid managed care enrollees, about two-thirds are in a prepaid, risk-based HMO or Health Insuring Organization that provides for a comprehensive array of services. About one-fourth of managed care enrollees are in a state operated "Primary Care Case Management" (PCCM) system. A PCCM typically is a fee-for-service system designed to assure a medical home with a primary care provider who guarantees access to primary and preventive care, and coordinates access to specialty care. Other managed care plans include prepaid inpatient or ambulatory plans, and those offering a limited set of benefits, such as for dental, vision or transportation.

In fiscal year 2007, states continued to expand the reach of managed care through expansions into new geographic service areas. A total of 15 states expanded the areas served by HMOs, including four states that achieved statewide coverage in 2007: Georgia and Ohio reached statewide MCO coverage and Kansas had one managed care organization (MCO) go statewide. Illinois implemented a statewide PCCM program with voluntary enrollment. Another dozen states expanded managed care to new coverage areas. At the same time, two states (North Carolina and North Dakota) ended capitated managed care, moving to full reliance on a PCCM service delivery model. Eight of the 15 states with expansions in 2007 planned further expansions in 2008. An

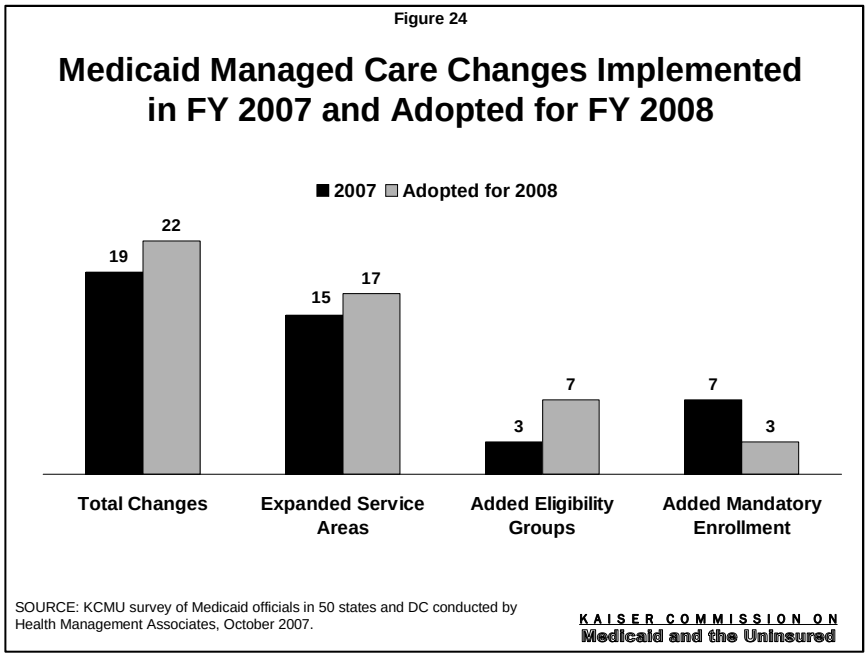
[36] CMS, "Medicaid Managed Care Enrollment as of December 31, 2006," Managed care is defined by CMS to include comprehensive capitated health plans, primary care case management systems and limited benefit capitated plans, such as for dental care. Accessed 5 September 2007 at:
http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcpr06.pdf

additional nine states plan to expand the reach of managed care in 2008, bringing the total number to 17 states with service area expansions in 2008. This total includes a pilot PCCM program to be implemented in Connecticut.

Medicaid programs also continue to move toward managed care for the aged, blind and disabled populations. In fiscal year 2007 three states implemented such policies.[37] Ohio expanded managed care to the aged blind and disabled (ABD) population in health plans, while North Carolina was doing so in its PCCM program. California began allowing enrollment of dual eligibles enrolled in a health plan under Medicare to enroll also under Medicaid in the same plan. In FY 2008, seven states expanded managed care to new eligibility groups, including five expanding to ABD groups, and two expanding for parents and non-disabled adults.

As managed care expands and beneficiaries have choices of plans, Medicaid programs are able to require that beneficiaries use managed care. In fiscal year 2007, seven states adopted mandatory enrollment in managed care for specific eligibility groups in specific geographic areas. In Florida, for example, managed care enrollment became mandatory for those counties in which Medicaid reform was being piloted. In New York, enrollment became mandatory for families in 14 counties, and for the SSI population in New York City. Other states that expanded mandatory enrollment include Illinois, New Jersey, Oregon, Texas and Wisconsin. Additional expansions of mandatory enrollment were planned for fiscal year 2008 in New Jersey, New York and Oregon (Figure 24).

Figure 24



[37] In 2007, Illinois excluded SSI children and HCBS participants from MCOs.

Disease and Case Management

State policy makers are increasingly aware of the opportunity to improve care and perhaps save money through programs that provide case management for Medicaid beneficiaries with chronic conditions. Among Medicaid populations, care management or disease management programs have been found to be beneficial for persons with chronic conditions such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) or hypertension. Other conditions include obesity, high-risk prenatal care, end stage renal disease (ESRD), mental health, and children with complex health care needs. Disease management is sometimes a part of the contract a state Medicaid agency has with an MCO, but in other states the programs are operated through contracts with specialized disease management organizations.

A total of 30 states indicated that they had a disease management program in place in FY 2006. In 2007, three additional states added new disease management initiatives, and eight states with existing programs made enhancements such as adding a new pilot site, adding conditions for which care management would be available, or using predictive modeling to better identify high-risk individuals eligible for care management.

For fiscal year 2008, seven additional states plan to begin new disease management programs, and eight states plan to enhance existing programs. Enhancements include a pilot to use telehealth in rural areas for diabetes, CHF and COPD, adding community-based nurses, and adding additional disease conditions, such as children with serious emotional disturbances (SED) in residential treatment centers. Based on already operational programs and state plans for the current year, a total of 35 states will have disease management programs in place by the end of fiscal year 2008.

Health Plan Quality Measures

It is difficult to measure quality in a fee-for-service delivery system other than quantifying services billed and reimbursed. Managed care, however, has allowed Medicaid to incorporate specific performance expectations and accountability into MCO contracts with managed care organizations. The contract specifications have included requirements to provide the data necessary to monitor care, as well as specific levels of performance. Performance measures have included guaranteed access to care as well as standards, processes and procedures designed to assure quality care. Medicaid has had the option to require accreditation by recognized national credentialing organizations, thereby assuring that providers meet quality requirements that extend beyond those required for state licensure. In many of these actions, Medicaid has followed the lead of other major purchasers. In other areas, Medicaid has taken the lead, particularly on issues that are of importance to Medicaid, such as care for pregnant women and young children.

Over the past decade, almost all states with MCOs and state-operated PCCM programs implemented initiatives related to quality measurement and improvement. Those with MCOs all use some form of performance measurement. The development of HEDIS® and CAHPS® by the National Committee on Quality Assurance (NCQA) provided Medicaid with nationally accepted, state-of-the-art measures that had credibility among providers and policy makers.[38]

[38] The National Committee for Quality Assurance (NCQA) sponsors and maintains HEDIS® data. HEDIS® (Health Plan Employer Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care

HEDIS® (Health Plan Employer Data and Information Set). In fiscal year 2006, a total of 42 states reported in this survey that they required MCOs to use and report on performance either using HEDIS® measures, a sub-set of HEDIS® measures, or state-defined measures that were similar to HEDIS® measures. This survey did not ask for the specific measures used, but many states described their approach, indicating, for example, that they "require a reporting schedule of HEDIS® and HEDIS®-like measures through our Quality Strategy." Some indicated that they required a specific number, such as the use of seven to 12 specified HEDIS® measures, or "the full set of HEDIS® measures," and that they had required reporting since a specific date, such as 1997.

For fiscal year 2007, two states indicated that they would begin using HEDIS® measures, bringing the total to 44 states. Among the 44 states, six states indicated they had enhanced their performance measurement by adding or changing their reporting requirements in 2007. As described by states in their survey responses, changes in 2007 were made based on a new contract year providing the opportunity to make updates, making reporting mandatory, and re-designing specific measures and new areas of emphasis. For fiscal year 2008, six states indicated that they were making further updates and enhancements to their performance measurement requirements.

CAPHS Surveys. CAHPS® is a companion measure of health plan performance based on a survey of patients to learn of their perception and satisfaction with the provision of health care they received. By fiscal year 2006, a total of 41 states reported using CAHPS® or a similar survey of patient experience. These surveys are often conducted periodically rather than annually, and are sometimes targeted to specific population groups, such as adults or children with special health care needs. Three states indicated they had last conducted a survey in 2004. Two of these states indicated the next survey would be in 2007, and a survey would then be conducted every two years. Other states indicated that the MCOs were required to conduct such surveys annually. In fiscal year 2007, four states indicated policy changes relating to CAHPS®. Two of these states were initiating the use of such surveys, one added the disabled population to its survey, and one other redesigned its survey. For fiscal year 2008, one state indicated that it was initiating the use of a survey, and six states indicated that they would be making changes in their patient surveys, using the survey with new populations or using the information for feedback to managed care plans and improvements in fee-for-service areas.

Accreditation. Some states have included in their quality assurance strategy a Medicaid contractual requirement that health plans be accredited by the NCQA or other national accrediting body such as JACHO or URAC. In 2006, a total of twelve states indicated such accreditation was a requirement, or (in one state) that Medicaid provided an incentive for MCOs to be accredited. Two states indicated accreditation was not a requirement, but that all Medicaid contracted plans were in fact NCQA accredited. In 2007, two additional states added the requirement for NCQA accreditation, and one state indicated it would add this requirement in 2008.

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plans. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

Public Reporting of Provider Performance

With increased availability of performance data, many state Medicaid programs now publicly report the performance of health plans and providers. The information is intended, in part, to assist beneficiaries in their choice of health plans and providers and, in part, to provide an incentive for providers to improve their measured performance over time.

A total of 27 states indicated in this survey that they reported health plan performance information publicly in 2006. In almost all cases the information is posted on a web site, or published in a report card format. In one state the information was provided only to a state quality committee and to a managed care advisory committee, but in all states the information on provider performance is regarded as public information and is available to the public. Two states indicated they began publicly reporting health plan data in 2007, and another state is to begin in 2008. That brings the total to 30 states with public reporting for health plans in fiscal year 2008.

Medicaid public reporting for other provider groups is much less common than for MCOs. In many states, reporting on hospital performance is conducted across all patients, not just those whose care is paid for by specific insurers such as Medicaid. Six states noted that reporting of hospital performance was in place in 2006 or before but that it was not Medicaid specific. Reporting was to begin in fiscal year 2007 for hospitals in one state, and in 2008 for two additional states. Reporting on physician performance was indicated for two states with PCCM programs.

Pay for Performance

As a major purchaser of health care, states have realized that Medicaid can provide significant incentives for providers to achieve desired levels of performance by setting specific standards and rewarding or penalizing performance through Medicaid reimbursement policies. With managed care, Medicaid is able to use performance on specified HEDIS® or CAHPS® performance measures as contractual benchmarks for performance, and to spell out any incentives for various levels of performance. For this survey, states were asked to identify whether they had pay-for-performance quality incentives in place in fiscal year 2006 for managed care organizations, hospitals, physicians or nursing facilities, and then whether they had added pay-for performance policies in fiscal year 2007 or planned to implement such policies in 2008.

Managed care. Medicaid officials indicated that pay-for-performance incentives were most likely to be in place for MCOs. A total of 20 states indicated they had pay-for-performance programs for managed care in place in FY 2006. Typically, these took the form of bonus payments related to performance on specified HEDIS® measures, and were structured in some cases to reward both higher performance as well as improvement. One state provided incentives for EPSDT performance and also for accreditation.

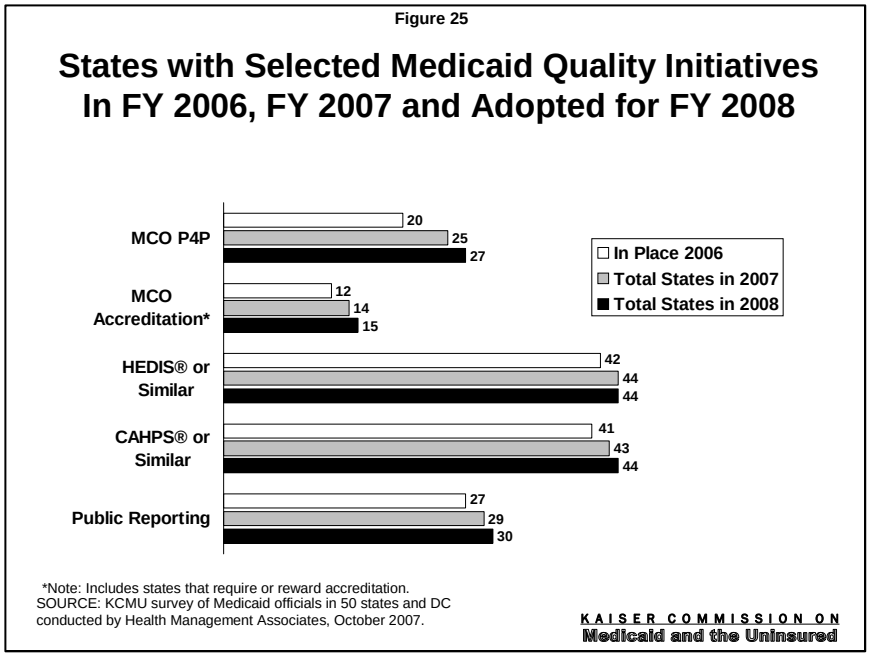
In fiscal year 2007, five additional states implemented pay-for-performance arrangements, and three states implemented new policies that incorporated additional measures. For example, in 2007 one state added incentives for lead screening and tobacco cessation programs. In fiscal year 2008, two additional states plan to implement pay-for-performance in its MCO contracts. Three states with ongoing programs plan to modify criteria for additional payment. One state will provide the opportunity to earn up to 2.5 percent in incentive payments, based on performance on twelve criteria, including eleven HEDIS® and one HEDIS®-like measures. The state intends to focus on

the health status of plan members rather than on utilization of services. Another state will use performance measures in the algorithm for auto-assignment of new enrollees.

Hospitals. Few states reported having pay-for-performance methodologies for hospitals. Two states (Vermont and Pennsylvania) indicated they had such plans prior to fiscal year 2007. Pennsylvania has a sophisticated hospital quality incentive pilot program that ties inpatient disproportionate share and medical education payments to performance measures such as readmission rates for asthma, diabetes, COPD and CHF. In addition, Pennsylvania has a hospital quality incentive grant program that awards $1 million annually to hospitals to improve performance on the quality incentive program. New programs were initiated in two states in fiscal year 2007, and no state indicated plans for such programs in 2008. Arkansas implemented a program that provides up to $50 per day based on quality measures. New York implemented four collaborative demonstrations for Medicaid and commercial populations.

Physicians. A limited number of states reported having pay-for-performance incentives for physicians. Most of those that do exist are part of state PCCM programs. Maine and Pennsylvania indicated having incentives prior to 2007 through their PCCM program. Pennsylvania developed a plan that provides a bonus of up to 5 percent for performance on measures such as well care visits, emergency department visits, prenatal visits, EPSDT screens and cancer screens. In 2007, Alabama and Louisiana implemented pay-for-performance for doctors in their PCCM programs, relating to reductions in emergency room usage, increased use of generic drugs and higher immunization rates. For 2008, three additional states plan to implement pay-for-performance for physicians using measures of EPSDT visits and diabetes, asthma and cardiac care. Figure 25 provides a summary of Medicaid quality initiatives in place in FY 2006, FY 2007 and planned for FY 2008.

Figure 25



Information Technology

As part of their efforts to improve quality, many states have embarked on a variety of initiatives involving new information technology. For FY 2006, only nine states indicated they had some kind of health information technology (HIT) related initiative, such as e-prescribing or an electronic health record. For 2007, a total of fourteen states (including five additional states) indicated they had initiatives underway, including pilot projects on health information exchange, e-prescribing and electronic records. For FY 2008, the number of states involved with such initiatives more than doubled to 31 states, including 17 states that indicated they had not been involved with HIT initiatives prior to 2008. These included public-private partnerships, e-prescribing initiatives, a new health information "transparency" website for data on quality and costs, and electronic medical or health records. Several states indicated that their initiatives were part of or had been sparked by their application for "DRA Medicaid Transformation Grants." These grants are designed to fund research, design and implement new systems to enhance quality and efficiency of care. The DRA included an appropriation of $150 million for Transformation grants. In January 2007, CMS awarded $103 million in grant awards to over half of the states. There will be a second round of grants for the remaining $47 million.

5. Section 1115 Medicaid Waivers

States design and operate their Medicaid programs within federal law and rules that set forth the terms and conditions that must be met for state expenditures to qualify for federal matching funds. Using authority provided under Section 1115 of the Social Security Act, the Secretary of Health and Human Services can waive statutory and regulatory provisions of Medicaid for "research and demonstration" projects that "further the objectives" of the program and still maintain federal matching funds for states. Section 1115 waivers have been used throughout the history of the Medicaid program to test new ways to provide coverage and deliver services to low-income populations. States also use Section 1115 waiver authority to establish single benefit Medicaid coverage, such as for family planning or prescription drug coverage for specific population groups.

While some states are still moving forward with comprehensive reform plans that rely on waivers (like Florida), several states reported last year that they changed their plans to move forward with an 1115 waiver proposal after the DRA allowed more flexibility to change benefits and cost sharing using state plan amendments. This year, several states reported that they were using waiver authority to offer a more limited benefit package with cost sharing requirements to a new expansion population. While these are expansions to individuals who might not otherwise have coverage, some of the initiatives (like in Indiana) would require substantial cost sharing for expanding coverage to very low-income individuals.

Arkansas used Section 1115 waiver authority to implement ARHealthnet in FY 2007 which offers a limited "bare bones" benefit package with deductible and co-insurance requirements. Benefits include seven inpatient days per year, two major outpatient services per year (including emergency room and major services performed in the office), six physician office visits per year, and two prescriptions per month. The cost-sharing requirements include a $100 annual deductible (that does not apply to office visits or drugs), a 15 percent co-insurance after the deductible is met, drug copayments ($5 for generics, $15 for brands and $30 for non-formulary brands), a $1,000 maximum out of pocket liability annually, including deductible, and a maximum annual benefit of $100,000.

California used Section 1115 waiver authority to implement a county-based, county-administered eligibility expansion for non-categorical adults aged 19 to 69 in ten counties in FY 2007. Covered services include inpatient and outpatient hospital, clinic, physician and home health. Cost-sharing varies by county and some counties may require no cost-sharing.

Maryland used Section 1115 waiver authority to implement its Primary Adult Care (PAC) Program in FY 2007 offering primary care, pharmacy, and outpatient mental health services to expansion adults.

Indiana is seeking Section 1115 waiver authority to expand eligibility for adults in FY 2008 using a package modeled on a state employee plan with optional dental and vision coverage for additional cost-sharing. Beneficiaries will receive $500 annually in preventive care coverage (at no cost to the individual), a high deductible managed care plan and a $1,100 health savings account (called a "Power Account") funded by a combination of individual and state contributions. Cost-sharing will be limited to 4.5 percent of income up to a maximum $1,100 that will be applied the Power Account (HSA). An employer can defray up to 50 percent of the beneficiary's cost-sharing amount. After a beneficiary's HSA is exhausted, only emergency room cost-sharing will be applied.

Florida implemented a Medicaid reform initiative in 2007 using Section 1115 Waiver authority in Broward and Dade Counties. The plan allows health plans contracting with the state to customize their benefit packages and limit the amount, duration and scope of benefits, subject to state approval based on actuarial equivalence and sufficiency tests. Further, plans are allowed to waive or reduce – but not increase – cost sharing. Children remain entitled to EPSDT coverage. Beneficiaries choose among the different managed care plans available in their area or can "opt-out" and have the premium go toward the purchase of employer-sponsored or individual coverage. Plans may also choose to cover non-traditional services. Beneficiaries may earn "enhanced benefits" as a reward for healthy behavior of up to $125 per year of credits that can be used to purchase health-related products and supplies.

Enrollment in the Florida waiver started on a pilot basis in 2 counties in September 2006 and was expanded to three additional counties (Baker, Clay and Nassau) in July 2007. Thus far, all of the Medicaid reform plans have chosen to enhance benefits and waive or reduce cost-sharing requirements to attract enrollment. In particular, the state reports that a number of plans are offering full adult dental benefits and enhanced coverage for DME, home health services and over-the-counter drugs. None of the plans has chosen to impose any benefit restrictions.

Finally, Florida is convening a legislative special session in October 2007 to adjust the state budget due to state revenue decreases driven in part by a slump in the state's housing market. A limited number of Medicaid reductions are under consideration including possible provider and MCO rate decreases. Final decisions had not been made and therefore these potential reductions have not been included in this report.

6. Provider Taxes

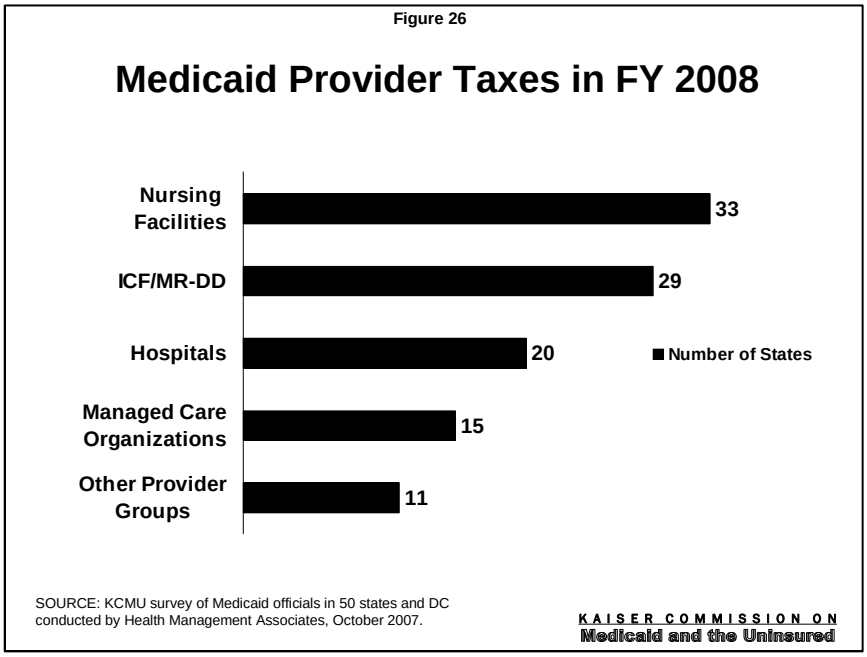
States are continuing the use of provider taxes to generate revenue to support their Medicaid programs. However many states have been affected by a new federal limit on Medicaid provider taxes that effectively reduces the ceiling on allowable Medicaid provider taxes from six percent of

provider revenues to 5.5 percent of provider revenues as of January 1, 2008.[39] At the end of fiscal year 2006 there were 43 states that had a Medicaid tax for at least one category of providers. Thirty of these states taxed more than one category of providers.

Last year we reported that the number of states implementing new provider taxes in 2006 (eleven states) was significantly smaller than the number that had previously indicated plans for new provider taxes that year. For FY 2007, no provider taxes were discontinued, and there were only two new provider taxes – a tax on nursing facilities in the District of Columbia and a tax on intermediate care facilities for the developmentally disabled (ICF/MR-DD) in Massachusetts. The level or size of these provider taxes also did not change much in FY 2007: one tax on hospitals was reduced and six tax rates were increased (two for inpatient hospitals, one for ICF/MR-DD facilities, two for nursing facilities and one for managed care organizations). By the end of FY 2007, 44 states had at least one Medicaid provider tax including 33 nursing facility taxes, 28 ICF/MR-DD taxes, 20 hospital taxes, and 15 MCO taxes.

For FY 2008, two states (South Dakota and the District of Columbia) are implementing new ICF/MR-DD taxes but one state (Rhode Island) is eliminating its ICF/MR-DD tax. Similarly one state (Maryland) is implementing a new nursing facility tax for FY 2008, but one state (Washington) is discontinuing its nursing facility tax for FY 2008. Figure 26 shows the distribution of Medicaid provider taxes for FY 2008 among the various types of providers.

Figure 26



[39] Any provider tax in excess of six percent of provider revenues is subject to additional testing that the state's Medicaid payments and other state payments do not "hold harmless" the providers that pay the taxes. Federal regulations at 433.68(f) indicate "When the tax or taxes are applied at a rate that produces revenues in excess of 6 percent of the revenue received by the taxpayer, (CMS) will consider a hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments." According to the new statute (PL 109-432), from January 1, 2008 through September 30, 2011, the safe harbor provider tax rate that ensures that a state does not violate the indirect guarantee component of the hold harmless provision will be temporarily reduced to 5.5 percent. On October 1, 2011, the cap on tax rates is scheduled to revert back to 6 percent.

While nine of the provider taxes are being increased in 2008 (four hospital taxes, four nursing facility taxes and one ICF/MR-DD tax), 30 provider taxes in 19 states are being reduced. All but one of the reductions (hospital tax in New York) is due to the implementation of the new federal "hold harmless" limits. The federally mandated reductions affect 2 hospital taxes, 10 ICF/MR-DD taxes, 9 nursing facility taxes, 6 managed care organization taxes, and 2 taxes on other provider groups. (See Appendix A-8)

7. Program Integrity and the Fiscal Impact of Federal Oversight Activities

Every state has a system in place to address potential Medicaid fraud and abuse – a fundamental requirement of Medicaid administration. Assuring program and fiscal integrity is necessary for public confidence and ongoing support for the program and the government organizations that administer it. States continue to take advantage of new tools and technologies to prevent and detect fraud and abuse. In FY 2007, in addition to the ongoing efforts to address fraud and abuse, a total of 18 states reported implementing specific measures designed to enhance their efforts. These actions included adding new staff, creating new organizational units to provide centralized control and coordination, hiring a new contractor, and issuing new policies. Medicaid officials in 17 states indicated that they plan to take specific actions to enhance their fraud and abuse control activities in FY 2008. The actions for 2008 will be similar to those undertaken in 2007. Notably, Kansas and New York State each created a new position of Medicaid Inspector General, emphasizing the importance of the issue in those states.

Over the last decade, however, the United States Government Accountability Office (GAO) has raised concerns regarding federal oversight of state's claims for Medicaid reimbursement and CMS's efforts to detect and reduce improper payments in the Medicaid program. In 2003, the GAO added Medicaid to its list of high-risk federal programs[40] because the program's size, growth, and diversity put it in danger of waste, abuse, and exploitation. In recent years, CMS has taken a number of steps to improve federal oversight including:

- The hiring of 90 funding specialists to examine high-risk state funding practices and work with states to eliminate them;
- The creation of a new unit – the Division of Reimbursement and State Financing (DRSF) – charged with reviewing state plan amendments for reimbursement to identify and work with states to eliminate payment methodologies that could result in higher federal costs;
- The continued use of focused financial reviews and OIG audits to identify inappropriate state claims for federal reimbursement and recommend changes to states' internal control practices;
- Implementation of the Medicare-Medicaid ("Medi-Medi") data match project that matches Medicare and Medicaid claims information on providers and beneficiaries to identify improper billing and utilization patterns which could indicate fraudulent schemes; and

[40] GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).

- Implementation of the Payment Error Rate Measurement (PERM) project where states use a CMS-developed methodology to measure state Medicaid payment errors.[41]

The DRA also included a new Medicaid Integrity Program to increase the government's capacity to prevent, detect, and address fraud and abuse in Medicaid.

In recognition of the increased federal scrutiny of state Medicaid programs, the 2007 survey asked respondents to describe the fiscal costs incurred by the state to comply with federal oversight activities (including the PERM initiative, federal audits or reviews, enhanced scrutiny of special financing arrangements, or DRA Medicaid Program Integrity requirements). Twenty-six states described the fiscal impact as "significant," 23 states described the costs as "some or modest" and only one state described the cost as "insignificant."[42]

Many state responders stressed the administrative burden of compliance and the need to divert staff from other agency priorities. Others noted the lack of consistency in how standards are applied from state to state. One responder noted that State Plan Amendments were "stacking up" unresolved and that in her state, they were even now seeing federal OIG auditors auditing the PERM auditors. Other states expressed concern about the impact on providers that may have already been audited once by state staff being asked to reopen previously resolved claims. One responder stated "this could be the straw that breaks the camel's back" referring to provider participation. Finally, some responders stated that the PERM initiative had not produced any meaningful results. One stated that the "concept" was not the problem, "it's the execution. It could be so much better."

State Officials regarding fraud and abuse and federal oversight:

"The most significant issue we face is continually assuring the legislature that whatever program they decide we should have, that we are running it well."

"We've found the requirements and oversight way too extensive…It is a lot of money when we are trying to reduce our administrative costs."

"We'll be a PERM state this year. We're concerned about the cost to a small state. My concern is that I won't get any new resources, so it takes staff away from other priorities."

8. Impact of the Medicare Part D Prescription Drug Benefit

On January 1, 2006, Medicaid drug coverage ended for over six million beneficiaries eligible for both Medicare and Medicaid ("dual eligibles"). These individuals were transitioned to newly implemented Medicare "Part D" prescription drug coverage. The FY 2007 survey asked states about whether there had been a Part D-related Medicaid enrollment impact on populations that "spend down" to meet an income eligibility threshold (e.g., the Medically Needy eligibility group) and about state actions regarding "wrap-around" coverage.

[41] GAO, Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts, GAO-06-705 (Washington, D.C., June 2006).
[42] Mississippi did not respond.

Enrollment Impact. Prior to the implementation of Part D, some states were concerned that dual eligibles using drug expenses to meet their spend-down requirement would no longer be able to attain Medicaid eligibility once drug coverage was provided under Part D. Ten states reported no decrease, 19 states reported that the state did not know whether a decrease had occurred and 11 reported that a decrease had occurred. (Nine states responded that their state did not have a spend-down eligibility program.)[43] Of the 11 states reporting a decrease, some noted only a small reduction, while others noted a somewhat more significant effect. For example, Montana and Washington noted a decrease of about 15-16 percent in the Medically Needy Aged. Other states indicated that they lacked sufficient data to measure such changes. Finally, Ohio noted seeing a shift in eligibility for aged beneficiaries from eligibility for full Medicaid benefits to eligibility under the "Qualified Medicare Beneficiaries" (QMBs) and "Specified Low-income Medicare Beneficiaries" (SLMBs) categories which only provide coverage for all or some Medicare cost-sharing requirements.

Part D Wrap-around Coverage. In 2007, Part D imposes copayments of $1 to $5.35 for non-institutionalized dual eligibles. These amounts are higher than those imposed by some states. The MMA, however, does not allow states to receive federal Medicaid matching funds if a state chooses to cover Part D copayment obligations. Despite this funding prohibition, 14 states reported providing wrap-around coverage for Part D copayment obligations for dual eligibles. The survey also asked whether states provided coverage for any Part D *excluded* drugs (e.g., over-the-counter drugs, benzodiazepines, and barbiturates). States do receive federal Medicaid matching funds for providing this type of wrap-around coverage and 47 states reported doing so. Finally, the survey asked states whether they provided wrap-around coverage for any *covered* Part D drugs that may not be included on a particular Part D plan's formulary. Federal match is not available for this coverage and only five states (Connecticut, Massachusetts, Maine, New Jersey and New York) reported offering such coverage in some circumstances. In FY 2007, New York reduced state-funded wrap-around coverage of non-formulary or restricted Medicare Part D covered drugs for dual eligibles to only four drug classes.[44]

[43] Two states (Mississippi and New Hampshire) did not respond.
[44] The four classes are antipsychotics, antidepressants, antiretrovirals and transplant drugs.

9. Medicaid and SCHIP Reauthorization

The 2007 survey of Medicaid officials was conducted in the midst of the debate in Congress on the issue of SCHIP reauthorization. Even though Medicaid directors could not know at the time of the survey how the reauthorization debate might be decided, the survey asked them about the potential impact of SCHIP reauthorization, and the extent Medicaid would be affected if the reauthorization resulted in insufficient funding for state programs.[45] Medicaid officials were clearly concerned about the outcome of the SCHIP reauthorization and the potential impact on Medicaid.

Several states indicated they could not assess the impact until federal SCHIP reauthorization was approved and the specific program changes were known. Nevertheless, over two-thirds of states responded to the question. Among responding states, all expected a fiscal impact on Medicaid if SCHIP funding were to be insufficient to continue the program at current levels, and that the fiscal impact would range from moderate to significant. In part, officials based this assessment on a presumption that the state would maintain coverage for currently enrolled children. This would require either shifting children from SCHIP coverage to Medicaid coverage, or shifting the funding source from Title XXI (SCHIP) to Title XIX (Medicaid). Because the federal matching rate is lower for Medicaid, state costs would increase. About half of responding states indicated that they would expect a moderate to significant impact on Medicaid caseloads, as some states might be compelled to limit enrollment in SCHIP. Some states indicated that some children would likely transfer to Medicaid under the medically needy category.

10. Medicaid and Health Care Reform

Driven largely by declines in employer-sponsored coverage, the number of uninsured residents in the United States grew in 2006 by 2.2 million to 47 million, up from 44.8 million in 2005. In the absence of a federal solution, many states have responded with initiatives to expand coverage. The 2007 survey asked states whether they were planning to implement a plan to reduce the number of uninsured in FY 2008 or FY 2009. Forty-two states answered "yes" and three states indicated that discussions were underway but that it was unclear whether or not the state would actually move forward with a plan. Six states answered "no."

States answering "yes" were asked to describe the significance of the Medicaid program's role in the financing of coverage under the plan and were also asked to describe the significance of new proposed Medicaid enrollments under the plan. Regarding the financing of coverage, 22 states reported that Medicaid would play a "significant" role and 16 states reported that Medicaid would play "some" or a "modest" role. Only three states stated that Medicaid's role would be "none" or "insignificant." Regarding enrollment, 18 states reported that Medicaid would play a "significant"

[45] Almost all survey responses were received prior to CMS' August 17, 2007 issuance of a State Health Official letter on crowd-out in SCHIP. Thus, the survey results do not reflect state reactions to these new restrictions. Among other things, the new standards require states to demonstrate that they have enrolled at least 95 percent of children in the state below 200 percent of the FPL who are eligible for Medicaid or SCHIP before expanding eligibility to children in families with incomes greater than 250 percent of the FPL. States seeking to expand SCHIP eligibility also must establish a minimum of a one-year period of uninsurance for individuals in families with incomes greater than 250 percent of the FPL to prevent them from switching from a private insurance plan to a public program. Further, states that insure children in families with annual incomes greater than 250 percent of the FPL must prove that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five-year period.

role and 16 states reported that Medicaid would play "some" or a "modest" role. Only six states stated that Medicaid's role would be "none" or "insignificant." While the survey did not attempt to inventory the components of states' plans, respondents reported a wide range of initiatives underway or planned including outreach efforts, Medicaid and SCHIP eligibility expansions, strategies to promote private sector coverage, and coverage plans based on the MassHealth model.

11. Outlook

The difficult fiscal challenges that states faced only a few years ago have become much less severe, but they are far from a faded memory for Medicaid officials. When asked in an open-ended question to name the most significant issues their Medicaid programs would face over the next year or two, one of the top issues remained the ongoing pressure to control costs so they don't grow faster than state revenues and other state programs. In a variation on this theme, two states noted the need to increase the "value" of Medicaid services by improving quality and bringing down costs. States also discussed a variety of other issues including: balancing the long-term care system toward community services; the aging population; coordination with mental health programs; the growing disparity between Medicaid and commercial insurance payment rates; access to care; concern about federal oversight activities; use of health information technology; the impact of the citizenship documentation requirements; the outcome of SCHIP reauthorization; and implementation of health reform efforts as critical issues for their programs in the next few years. Keeping up with on-going changes continues to be a challenge for Medicaid directors. As states look into the future, the current set of issues is more focused on program improvement and accomplishing positive goals through Medicaid, still within the fiscal constraints and within a context of increased federal oversight.

Conclusion

Improved state revenues and modest enrollment growth have given states a window to address program improvements that have not been possible for a number of years. As indicated in this survey, more states than ever are working on initiatives to expand eligibility, increase provider reimbursement, improve benefits, enhance quality and balance long-term care delivery systems. At the same time, states remain under pressure to control Medicaid costs and to obtain better value and quality for the dollars spent on the program. The survey reflects continued efforts to move forward with initiatives to improve quality and coordinate care as well as efforts to strengthen some effective cost controls that states had in place, especially for prescription drugs. While there was a clear focus on program improvements, Medicaid Directors also highlighted on-going challenges in administering the program including the implementation of Medicare Part D and various provisions in the DRA as well as heightened federal oversight activities.

Despite a host of recent challenges, the resilience of the Medicaid program proved strong as forty-two states reported that they were moving forward with efforts to expand access to health coverage, in most cases using Medicaid as a vehicle for coverage and financing. The future direction of state revenues as well as the final outcome of the SCHIP reauthorization debate will have near-term implications for Medicaid and for states ability to move forward to reach more uninsured. Given its fundamental role in the health care system, Medicaid is likely to stay at the forefront of the policy debate as the larger discussions around health care reform including the issues of coverage, costs, quality and long-term care continue to play out at both the state and national level into the 2008 election cycle.

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Appendix A: State Survey Responses

Appendix A-1a: Cost Containment Actions Taken in the 50 States and District of Columbia FY 2007

States	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Changes to Application and Renewal	Copays	LTC
Alabama		X					
Alaska		X					X
Arizona							
Arkansas	X	X					
California							
Colorado		X					
Connecticut		X		X			
Delaware	X						
District of Columbia	X	X					
Florida							X
Georgia	X	X	X				
Hawaii							
Idaho	X	X	X		X	X	
Illinois	X	X					
Indiana	X	X					X
Iowa		X					
Kansas							
Kentucky	X		X			X	
Louisiana		X					X
Maine							
Maryland							
Massachusetts		X					
Michigan	X						X
Minnesota							
Mississippi							
Missouri	X						
Montana		X					
Nebraska		X					
Nevada	X						X
New Hampshire	X						X
New Jersey	X	X					
New Mexico							
New York		X	X				
North Carolina	X	X					
North Dakota		X					
Ohio	X						X
Oklahoma		X					
Oregon	X						
Pennsylvania		X			X		
Rhode Island		X					
South Carolina	X			X			X
South Dakota		X					
Tennessee		X					
Texas	X	X					
Utah			X				
Vermont	X						
Virginia		X					X
Washington		X					
West Virginia		X	X				
Wisconsin	X	X					
Wyoming		X					
Total	**20**	**30**	**6**	**2**	**2**	**2**	**10**

Appendix A-1b: Cost Containment Actions Taken in the 50 States and District of Columbia FY 2008

States	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Changes to Application and Renewal	Copays	LTC
Alabama	X	X					
Alaska		X					
Arizona							
Arkansas	X	X					
California							
Colorado		X					
Connecticut							X
Delaware	X						
District of Columbia	X						
Florida							X
Georgia	X	X			X		
Hawaii							
Idaho	X						
Illinois	X						
Indiana	X	X					X
Iowa	X						
Kansas	X						
Kentucky	X						
Louisiana							X
Maine		X				X	
Maryland							
Massachusetts		X		X			X
Michigan	X						
Minnesota	X						
Mississippi							
Missouri	X						
Montana		X					
Nebraska		X					
Nevada	X	X					X
New Hampshire	X						
New Jersey							
New Mexico							
New York		X					
North Carolina							
North Dakota		X					
Ohio							
Oklahoma		X					
Oregon	X	X					
Pennsylvania		X					
Rhode Island		X				X	
South Carolina							X
South Dakota		X					
Tennessee	X				X		
Texas	X	X			X		X
Utah		X					
Vermont	X						
Virginia	X	X					X
Washington		X					
West Virginia							
Wisconsin		X				X	
Wyoming		X					
Total	**21**	**24**	**0**	**1**	**3**	**3**	**9**

Appendix A-2a: Positive Policy Actions Taken in the 50 States and District of Columbia FY 2007

States	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Simplification to Application/ Renewal	Long Term Care Expansions
Alabama	X				
Alaska	X	X			X
Arizona	X	X		X	
Arkansas	X		X		
California	X			X	X
Colorado	X	X	X		X
Connecticut	X	X		X	X
Delaware	X				
District of Columbia	X	X	X		X
Florida	X	X		X	X
Georgia	X				X
Hawaii	X				
Idaho	X	X	X		X
Illinois	X		X	X	X
Indiana	X		X		X
Iowa	X	X	X		X
Kansas	X			X	
Kentucky	X				X
Louisiana	X	x	X	X	X
Maine	X		X		
Maryland	X		X	X	X
Massachusetts	X	X	X		X
Michigan	X				X
Minnesota	X	X			
Mississippi	X				X
Missouri	X	X			X
Montana	X		X		X
Nebraska	X				X
Nevada	X		X	X	X
New Hampshire	X				
New Jersey	X				
New Mexico	X	X	X	X	X
New York	X		X		X
North Carolina	X				
North Dakota	X				X
Ohio	X				X
Oklahoma	X	X	X		
Oregon	X				
Pennsylvania	X	X		X	X
Rhode Island	X				
South Carolina	X				X
South Dakota	X				
Tennessee	X	X			X
Texas	X		X		X
Utah	X		X		X
Vermont	X				X
Virginia	X		X		X
Washington	X				X
West Virginia	X				
Wisconsin	X		X	X	X
Wyoming	X				X
Total	**51**	**16**	**20**	**12**	**35**

Appendix A-2b: Positive Policy Actions Taken in the 50 States and District of Columbia FY 2008

States	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Simplification to Application/ Renewal	Long Term Care Expansions
Alabama	X				X
Alaska	X		X	X	X
Arizona	X	X	X	X	X
Arkansas	X				X
California	X	X		X	X
Colorado	X		X	X	X
Connecticut	X	X	X	X	X
Delaware	X		X		X
District of Columbia	X		X		X
Florida	X				X
Georgia	X		X		X
Hawaii	X		X		
Idaho	X			X	X
Illinois					X
Indiana	X		X		X
Iowa	X	X	X	X	X
Kansas	X	X	X	X	X
Kentucky	X				X
Louisiana	X	X	X	X	X
Maine	X				
Maryland	X				X
Massachusetts	X		X		X
Michigan	X				X
Minnesota	X		X	X	X
Mississippi	X				X
Missouri	X		X		X
Montana	X		X		X
Nebraska	X				X
Nevada	X		X		X
New Hampshire	X	X			
New Jersey	X			X	X
New Mexico	X	X	X	X	X
New York	X		X	X	X
North Carolina	X		X		X
North Dakota	X		X	X	X
Ohio	X	X	X		X
Oklahoma	X		X	X	X
Oregon	X				X
Pennsylvania	X		X		X
Rhode Island	X				X
South Carolina	X				X
South Dakota	X				
Tennessee			X		
Texas	X	X			X
Utah	X	X			X
Vermont	X		X		X
Virginia	X	X			X
Washington	X		X	X	X
West Virginia	X				X
Wisconsin	X		X	X	X
Wyoming	X	X			X
Total	**49**	**13**	**28**	**17**	**46**

Appendix A-3a: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2007

State	Eligibility, Premium and Application Changes
Alabama	
Alaska	
Arizona	**Application:** Completed a total revision of the multi-program application for clarity, language level, and efficiency. Piloted a change from a face-to-face interview requirement to a customer contact by telephone, mail, or electronic medium. Implemented a paperless renewal process for the Aged, Blind, and Disabled populations.
Arkansas	**Parents & Adults without Children:** Through an 1115 waiver, Medicaid funds support ARHealthNet, an insurance program designed to help qualified small businesses, with low income workers, provide an affordable package of health care benefits to their employees. ARHealthNet is available to businesses with 2 to 500 employees that have not offered a group health plan in the past 12 months or longer.
California	**Application:** Replaced two-month Healthy Families to Medi-Cal Bridge with Title XIX Presumptive Eligibility coverage continuing until Medi-Cal determination. (7/1/07)
Colorado	**Children:** Removed Medicaid Asset test to shift clients from CHP to Medicaid. (25,000, 6/1/07) **Parents:** Removed Medicaid Asset Test. (7,000, 6/1/07) Increased income threshold for parents from 31% to 60% of FPL. (4,974, 6/1/07)
Connecticut	**Parents:** Reduced Transitional Medical Assistance from 24 to 12 months. (7/1/06) **Application:** Implemented self-declaration of income and Presumptive Eligibility for pregnant women & children. (7/1/06)
Delaware	
District of Columbia	**Children:** Added 19-20 year olds to Medicaid through State Plan Amendment. (1,000, 10/1/06)
Florida	**Application:** Discontinued requirement for an application when an individual goes from Medically Needy enrollment to full Medicaid eligibility.
Georgia	
Hawaii	
Idaho	**Children:** Eliminated asset test for children. (130,000, 7/1/06) **Aged & Disabled:** Implemented Medicaid for Workers with Disabilities (TWWIIA). (200; 1/1/07) **Application:** Application forms became more complex. **Premiums:** Implemented new $10 pmpm premium for kids in families with income from 133-150% FPL. **Premiums:** Implemented new buy-in for aged and disabled workers with income up to 250% FPL.
Illinois	**Family Planning Waiver:** Expanded Illinois Healthy Women program to 200% of FPL. (5/1/07) **Application:** Implemented a web-based (Internet) application for medical benefits, available for the aged, blind, and disabled as well as parents/caretaker relatives, children and pregnant women (which were already in place). The applicant must still sign and mail a signature page along with necessary verifications. (6/25/07)
Indiana	**Aged & Disabled:** Increased income threshold for HCBS to 300% of SSI.
Iowa	**Children:** Expanded coverage to children aging out of foster care. (550, 7/1/06) **Aged & Disabled:** Increased personal needs allowance for nursing facility residents from $30 to $50 per month. (7/1/06)
Kansas	**Application:** Implemented three-county pilot of Presumptive Eligibility for children & pregnant women eligible for managed care and presumptive disability determination for SSI. (9/06)
Kentucky	
Louisiana	**Children:** Implemented policy allowing "unaccompanied minors" to apply for coverage. (less than 250, 4/1/07) **Aged & Disabled:** Implemented optional coverage of disabled individuals. (6,125; 4/20/07) **Other:** Implemented Family Planning Waiver Services. (75,000, 10/06) **Application:** Began pilot of "Administrative Renewals" to shorten processing times.
Maine	**Aged & Disabled:** Maine has expanded its Medicare Buy-in program to include persons with

State	Eligibility, Premium and Application Changes
	income to 185% of poverty using a state plan amendment under the 1902(r)(2) provisions. **Adults without Children:** The state has capped and maintains enrollment in this category at around 20,000.
Maryland	**Aged & Disabled:** Employed Individuals with Disabilities included in waiver. (1,500) **Adults:** Implemented Maryland Primary Adult Care program for adults up to 116% of FPL who are ineligible for Medicaid and Medicare. (July 2006) **Application:** Online application process (SAIL) was implemented in September 2006.
Massachusetts	**Children:** Cover youths who were in DSS foster care on their 18th birthday until they reach age 21. (6/07) **Other:** Implemented Insurance Partnership Expansion. (32,800, 7/1/06)
Michigan	
Minnesota	**Premiums:** Implemented one-year exemption for returning military. **Premiums:** Repealed 8% premium increase enacted in a prior year.
Mississippi	
Missouri	
Montana	**Children:** Increased asset test from $3,000 to $15,000. (3,000, 7/1/06)
Nebraska	
Nevada	**Pregnant women:** HIFA: Income limit changed from 133% to 185% awaiting CMS approval. (2,000, 12/06) **Parents:** Increased income disregards, effectively increasing income standard for TANF groups to 130% of FPL. (2/1/07) **Other:** HIFA: Implemented ESI expansion - premium assistance to 200% for parents. (8,000, 12/06) **Application:** Simplified application forms**.**
New Hampshire	
New Jersey	
New Mexico	**Children:** Increased earnings disregards for children ages 0 to 5. (7/1/06) **Pregnant Women:** Increased income disregards for pregnant women while maintaining eligibility standards. (10/1/06) **Family Planning Waiver:** Expanded eligible age group. (6/1/07) **Application:** Medicaid recipients also on other assistance programs (Food Stamp, TANF, etc.) may recertify for all programs at the same time using one application; forms were simplified; changed six-month recertification back to twelve months. Implemented a data matching process for Presumptive Eligibility and MOSA (Medicaid on-site assistance).
New York	**Aged & Disabled:** Implemented a new working disabled buy-in programs. **Premiums:** for new working disabled buy-in program.
North Carolina	
North Dakota	
Ohio	
Oklahoma	**Children, Parents:** Implemented twelve-month eligibility (up from six). (400,000, 8/06) **Other:** Expanded employer size for Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program to 50 employees.[46](38,000; 8/06)
Oregon	
Pennsylvania	**Application:** Implemented centralized automated renewal process where all forms needed for renewal are mailed centrally rather than by individual workers at local County Assistance Offices, to reduce workload for caseworkers and standardize the types of forms sent to clients. (Pilot 01/07, statewide summer 2007) Eliminated self-declaration of child and parent income for disabled children. (37,122, 1/16/2007).
Rhode Island	
South Carolina	**Children, Parents:** Added asset test (7/1/06)
South Dakota	
Tennessee	

[46] O-EPIC provides funds to match employer and employee contributions for adults who work for small employers and have incomes above Medicaid Standards but below 185% of FPL.

State	Eligibility, Premium and Application Changes
Texas	**Aged & Disabled:** Adopted TWWIIA Working Disabled Option. (minimal enrollment, 91/06) **Family Planning Waiver:** Implemented program. (1/1/07) **Premiums:** New TWWIIA buy-in program implemented with sliding scale premiums.
Utah	**Children:** Expanded program to cover 19 to21 year olds aging out of foster care. (500, 7/1/06) **Parents**: Implemented Utah Premium Partnership (UPP). (200, 7/01/2006)
Vermont	**Premiums:** Vermont pharmacy premiums increased to $20 for VScript and $42 for VScript-Expanded. (7/1/06)
Virginia	**Aged & Disabled:** Implemented a Medicaid buy-in program under TWWIIA. (200; 1/1/07)
Washington	
West Virginia	
Wisconsin	**Medically Needy:** Increased community spousal allowances and shelter amounts. (12/06) **Application:** Changed policy to permit changes in earned income to be reported via the web (ACCESS) for Medicaid. (09/05/06) Functionality added to ACCESS for Presumptive Eligibility for Family Planning Waiver and Newborns via the web.
Wyoming	

Appendix A-3b: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2008

State	Eligibility, Premium and Application Changes
Alabama	
Alaska	**Pregnant Women:** Increased income standard to 175% of FPL for Alaska. (218, 7/1/07) **Application:** Application revised to make it more 'user friendly'.
Arizona	**Pregnant Women:** Increased SOBRA pregnant women and family planning income limit to 150% of FPL from 133%. (676, assuming 60% participation, 10/1/07) **Application:** Change in face-to-face interview requirement rolls out statewide 10/07. Medicaid only application revisions for clarity scheduled for FY 2008.
Arkansas	
California	**Application**: Implement continuing Presumptive Eligibility coverage until Healthy Families determination to replace one month Medi-Cal to Healthy Families Bridge (Title XXI) and when Medi-Cal application is screened to exceed Medi-Cal income/resource requirements (replaces Accelerated Eligibility--Title XXI). (Early 2008)
Colorado	**Children:** Expand eligibility through age 20 for Title IV E eligible foster care and adoption assistance. (+1,266) **Application:** Created a single purpose application (Medicaid and Financial), available on the Internet, that clarified benefits for estate recovery and lowered reading level. Implement Medicaid presumptive eligibility for children. (no estimate)
Connecticut	**Parents:** Increased parent eligibility from 150% to 185% of FPL. (20,000, 7/1/07) **Pregnant Women:** Increased eligibility from 185% to 250% of FPL. (10/1/07) **Medically Needy:** Increased income level for medically needy consistent with increase in TANF cash standard. **Application:** Assistance to be provided with application and recertification processes for persons with disabilities as required by settlement of Raymond v. Rowland.
Delaware	**Aged and Disabled:** Implement new TWWIIA Medicaid buy-in program. (120; 4/1/08) **Premiums:** New Ticket to Work program has premiums.
District of Columbia	**Children:** Expanding income level for 19-20 year olds from 50% to 200% of FPL (1,500; 10/1/07)
Florida	
Georgia	**Aged & Disabled:** Implement TWWIIA Medicaid buy-in program under DRA state plan option. (<500; 1/08) **Application:** Add external data validation vendor for assets and income. (credit reports etc). **Premiums:** New TWWIIA buy-in program has premiums.
Hawaii	**Adults:** Implementing Quest-Ace: a limited benefit package for childless adults with income up to 100% of FPL who meet the Medicaid asset limits but are unable to enroll in Quest due to enrollment cap. (4,500, September or October 2007) **Premiums:** Eliminated premiums for adults between 100% and 200% of FPL.
Idaho	**Application:** Efforts underway to simplify children-only application.
Illinois	**Parents:** Shifting coverage of parents with income at or below 185% of FPL from SCHIP (under HIFA 1115 waiver) to Medicaid. Coverage is subject to cost sharing and monthly premiums. (8/1/07) **Aged & Disabled & Medically Needy:** Institution Diversion Pilot – expands income and asset limits to 200% of FPL and $10,000 respectively for persons with disabilities. (50, unknown date)
Indiana	**Pregnant Women:** Increased pregnancy coverage to 200% FPL from 150% FPL. (1,900, 7/1/07) **Parents & Adults Without Children:** Awaiting CMS approval of waiver authority to cover parents and adults to 200% of FPL. (21,000 & 41,000, 4/1/08) **Application:** Eligibility outsourcing to be phased in during 2008.
Iowa	**Parents:** Increased earned income disregard for parents (effectively expanding eligibility to 50% of FPL). (6,000) **Aged & Disabled:** Increased personal needs allowance for residents of all medical facilities from $30 to $50 per month. **Application:** The state is going from 6-month premium reviews to annual reviews for the MEPD program. Eliminated face-to-face interview requirement. (8/1/07) **Premiums:** IowaCare premiums eliminated for persons with income at or below 100% of FPL.

State	Eligibility, Premium and Application Changes
	Premiums for Medicaid Employed Persons with Disabilities (MEPD) now reviewed annually rather than every six months.
Kansas	**Aged & Disabled:** Long-term care personal needs allowance increased from $30 to $50. (9,500; 7/1/07) **Application:** Special pre-release application process implemented for inmates. (07/07) Multi-program applications implemented. (09/07) On-line application process under development for future implementation.
Kentucky	
Louisiana	**Children:** Implement Family Opportunity Act (200% to 300% of FPL). (404, 10/1/07) **Parents:** Implement earned income disregards to cover parents up to 200% of poverty in Hurricane Katrina/Rita affected areas (awaiting CMS approval). (35,000 1/1/08) **Application:** Implement 'administrative' renewals statewide. **Premiums:** New Family Opportunity Act buy-in program.
Maine	
Maryland	
Massachusetts	**Aged and Disabled:** Increased PNA from $60 to $72.80. (7/1/07) **Other: Insurance Partnership:** Eliminate self-employed subsidy; Continue Commonwealth Care expansion. (-8,000; 7/1/07) **Premiums:** Eliminate premiums for: Insurance Partnership (133% of FPL), Breast and Cervical Cancer Treatment program (133% to 150% of FPL) Children (133% to 150% of FPL) HIV program (133% to 150% of FPL).
Michigan	**Application:** New system pilot program includes automatic case closures to provide worker relief; will not make things simpler for beneficiaries.
Minnesota	**Children and Parents:** Eliminated add-back of depreciation and eliminated workers' comp settlements as countable assets. (7/07) **Children:** Repealed insurance barrier for college students under age 21 in MinnesotaCare. (7/07) **Application:** MinnesotaCare - eliminate six-month renewal if no change reported.
Mississippi	**Application:** Long-Term Care Preadmission Screening Tool for level of care certification for nursing home and majority of, but not all, 1915(c) HCBS waivers.
Missouri	**Children:** Expanded coverage for children aging out of foster care, up to age 21 (970, 7/1/07). **Aged & Disabled:** Implemented Ticket to Work Medicaid category; sheltered workshop income disregarded. (9/1/07) **Premiums:** New Ticket to Work program.
Montana	**Pregnant Women:** Increased pregnant women income limit to 150% of FPL. (7/1/07) **Aged & Disabled:** Increased personal needs allowance from $40 to $50. (7/1/07) **Medically Needy:** Added a $50 general income deduction. (8/1/07)
Nebraska	
Nevada	**Aged & Disabled:** Eliminate unearned income limit for TWWIIA. (10/1/07)
New Hampshire	
New Jersey	**Application:** Revising application for aged, blind, and disabled population to assist applicants by asking questions differently and to reduce the need for additional information.
New Mexico	**Parents:** Expanded coverage for parents up to 100% of FPL. (8/1/07) **Adults Without Children:** Expanded coverage for adults to 100% of FPL. (8/1/07) **Application:** Implement telephone re-certifications for low-income families and children.
New York	**Parents:** Implement Employer Sponsored Insurance Initiative. (1,000; 1/1/08) **Adults without Children:** Implement Employer Sponsored Insurance Initiative. (2,000; 1/1/08) **Application:** Eliminate documentation of income and residency and implement 12 months continuous coverage (awaiting CMS approval).
North Carolina	**Children:** Expanding coverage for children aging out of foster care, up to age 21. (1200, 10/1/07)
North Dakota	**Children:** Implement 12-month continuous Medicaid eligibility for children. (11,000; 2008) **Children:** Implement Family Opportunity Act – Buy in for children. (400, 2008) **Application:** Revise Medicaid application for children and families and create shortened application for aged, blind and disabled. **Premiums:** New Family Opportunity Act buy-in program.

State	Eligibility, Premium and Application Changes
Ohio	**Children:** Expand coverage for uninsured children up to 300% of FPL. (30,000, targeted for 1/1/08) **Children:** Expand coverage for uninsured children over 300% of FPL. (4,000, targeted for 1/1/08) **Children:** Medicaid coverage for young adults (aged 19-20) who have been in foster care. **Pregnant Women:** Expand coverage from 150% of FPL to 200% of FPL. (3,700; 1/1/08) **Aged & Disabled:** Implement coverage for working people with disabilities up to 250% of FPL. (TWWIIA) (7,000; 1/1/08)
Oklahoma	**Children:** Expand coverage for children up to 300% of FPL. (42,000, spring 2008) **Other:** Expand coverage under O-EPIC to 200% FPL for college students. (3,000; 11/07) **Other:** Expand O-EPIC to 250% of FPL for businesses with 250 employees. (13,000; 11/07) **Application:** Implement electronic application for newborns. **Premiums:** Increase premiums for Oklahoma Employee/Employer Partnership for Insurance Coverage (O-EPIC) program.
Oregon	
Pennsylvania	**Family Planning Waiver:** Implement PlanSmart for Women. (100,000+; 2/1/08)
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**Medically Needy:** Opened enrollment in a new Standard Spend Down category. (100,000; summer/fall 2007) **Application:** Application revised and lengthened to collect more financial information regarding income, resources, and assets to fully comply with all federal regulations.
Texas	**Application:** Face-to-face interview required as of 10/1/07. Application reworded to collect information regarding migrant status, household members serving in armed forces and other absent parent information.
Utah	
Vermont	**Adults (parents and adults without children):** Increase income limit from 150% to 200% of FPL. (1,423; 10/1/07) **Premiums:** Premiums for children with household income greater than 185% of FPL reduced 50%; premiums for pregnant women with household income greater than 185% of FPL reduced 35%.
Virginia	
Washington	**Children:** Expanded coverage for children aging out of state or tribal foster care. (300 per year, 7/22/07) **Application:** Application and related eligibility review forms being revised for clarity, ease of use, and to reduce barriers for applicants and recipients.
West Virginia	
Wisconsin	**Children:** Expand coverage to all uninsured children under age 19, youth exiting out-of-home care, and presumptive eligibility for children under age 19 with income at or below 150% of FPL. (3,144, 1/1/08) **Children:** Implement changes in calculation of income: change filing unit for income calculations and elimination of income deductions ($90 work disregard, $30 and 1/3) **Parents:** Expand coverage to parents and caretaker relatives to 200% of FPL; child welfare parents (3,589 including pregnant women (below);1/1/08) **Pregnant Women:** Expand coverage to 300% of FPL with spend down feature to 300%. (1/1/08) **Application:** Simplified and automated process for submitting and accessing disability applications with use of scanning capabilities. **BadgerCare Plus:** Implement automation improvements to support BadgerCare Plus policy changes. (12/07) Re-engineer client notices to meet the goals of user readability, user understandability, to meet policy/legal requirements, reduce phone calls placed to local agencies, and to reduce extraneous notices. New software will be utilized to meet these needs. The new notices will be accessed via CWW. (12/07) Implement an automated process for providers to determine presumptive eligibility for pregnant women and children with incomes below 150% of FPL (1/08). **Premiums:** New premiums for adults between 150-200% of FPL, and children above 200% of FPL
Wyoming	

Appendix A-4a: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2007

State	Benefit Change
Alabama	
Alaska	**All adults:** Expanded dental benefits to include a capped preventative & restorative services; benefit sunsets after 3 years.
Arizona	**Children**: Added Human Papillomavirus vaccine to EPSDT benefit.
Arkansas	**Expansion Adults:** Beneficiaries enrolled in ARHealthNet receive a limited benefit package that includes 7 inpatient days per year, 2 major outpatient services per year (including emergency room and major services performed in the office), 6 physician office visits per year, 2 prescriptions per month and a maximum annual benefit of $100,000.
California	**Expansion Adults:** used Section 1115 waiver authority to implement a county-based, county-administered eligibility expansion for non-categorical adults aged 19 to 69 in ten counties in FY 2007. Covered services include inpatient and outpatient hospital, clinic, physician and home health. Cost-sharing varies by county and some counties may require no cost-sharing.
Colorado	**Pregnant Women**: Substance abuse treatment services for post partum women were expanded to include months 3-12 post partum. **Other**: Outpatient substance abuse services added
Connecticut	**Children**: Added coverage for Child and Adolescent Rapid Emergency Stabilization Services (to treat psychiatric and substance abuse problems).
Delaware	
District of Columbia	**Adults:** Added comprehensive dental benefits for adults.
Florida	**All adults:** Added coverage for partial dentures. **Other:** Benefit flexibility (enhanced benefits) allowed through Medicaid Reform plans.
Georgia	**Children**: Added pre-certification process for hospital admits and therapy visits over 8. **All**: Added pre-approval requirement for outpatient procedures to divert to ASCs where appropriate.
Hawaii	
Idaho	**All:** Used DRA authority to create the "Basic" plan for healthy low-income children and adults, the "Enhanced" plan for individuals with disabilities and special health care needs, and the "Coordinated" plan for dual eligibles that will enhance Medicaid and Medicare integration. The plans also include some enhanced wellness and prevention benefits. Participation is voluntary – beneficiaries may "opt-out" if they wish to retain standard Medicaid. However, the standard Medicaid benefit was amended in FY 2007 to eliminate all optional services. The Basic plan excludes long-term care benefits, limits mental health services, and restricts some provider specialties (such as rehab mental health services, speech and hearing clinics, independent practical and registered nurse services, mental health and personal care case management) to diagnostic and evaluation services only.
Illinois	
Indiana	
Iowa	**All:** Added coverage for smoking cessation prescription drugs, over-the-counter nicotine replacement and cessation counseling.
Kansas	
Kentucky	**All**: Implemented four redesigned benefit packages (under DRA authority) with new "soft" service limits that vary by package including limits on audiometric services, chiropractic services, dental services, home health, occupational and physical and speech therapies and ultrasound services. New dollar limits apply to hearing aids, prosthetic devices and vision hardware.
Louisiana	**All Adults:** Added coverage for adult preventive visits and inpatient concurrent care (physician reimbursement for visits concurrent with hospital stays).
Maine	
Maryland	**Expansion Adults:** Implemented Primary Adult Care (PAC) Program offering primary care, pharmacy, and outpatient mental health services to adults with incomes below 116% FPL (100% for families of 2 or more) and assets below $4,000 ($6,000 for families of 2 or more).
Massachusetts	**All Adults**: Restored dental, vision, and chiropractic services, orthotics and prosthetics. Added coverage for Level III-B and Level III-C 24-hour post-medical detoxification services. Added coverage for tobacco cessation services. (Exception: MassHealth Essential adults do not receive coverage for vision, chiropractic or orthodontic services.)
Michigan	

State	Benefit Change
Minnesota	**All**: Added coverage for community health worker services, physician-directed care management, direct payment for sign language interpreters, lead risk assessments and mental health certified peer specialist services.
Mississippi	
Missouri	**All adults:** Coverage restored for wheelchair accessories and batteries, and eyeglasses for adults.
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	**Children, Aged & Disabled:** Expand comprehensive dental exams to 2 times per year. **Other**: Added treatment for sexually transmitted diseases for Family Planning Waiver participants.
New York	**Aged & Disabled:** Reduced Part D wrap-around coverage for dual eligibles.
North Carolina	
North Dakota	
Ohio	
Oklahoma	**Children:** Added coverage for donor expenses for organ transplants, coverage of certain Over-The-Counter products and established criteria for coverage of bariatric surgery. **Pregnant Women:** Added perinatal dental program and coverage for first trimester ultrasound and additional ultrasounds in high risk pregnancies. **Adults:** Established criteria for coverage of bariatric surgery and added coverage for donor expenses for organ transplants for SoonerCare members**.** Added coverage for adult immunizations per ACIP guidelines and coverage of external breast prosthesis and support garments for women who have had a mastectomy.
Oregon	
Pennsylvania	**All Adults**: Added coverage of Peer Support services for persons over age 18 and added coverage for mobile mental health services.
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**All Adults:** Changed five prescription limit from a “hard” limit to a “soft limit” that can be over-ridden through the prior authorization process.
Texas	
Utah	**All Adults:** eliminated dental benefits and eliminated vision benefits for non-pregnant adults.
Vermont	
Virginia	
Washington	
West Virginia	**Children and Parents:** Implemented (in three counties) an alternative benefit package (under DRA authority) for healthy adults and children that restricts benefits for persons that do not sign or fail to comply with a Member Medicaid Agreement. Benefits restricted or excluded include diabetes care, mental health care, podiatry, and chiropractic services. Also includes a four script per month limit.
Wisconsin	
Wyoming	

Appendix A-4b: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2008

State	Benefit Change
Alabama	
Alaska	
Arizona	**Aged & Disabled**: Added a $1000 dental benefit for LTC beneficiaries (previously only emergency service covered). Added hospice coverage.
Arkansas	
California	**All**: Added coverage for Human Papillomavirus Vaccine and home infusion therapy with tocolytic agents to control preterm labor and allowed all certified nurse practitioners to bill Medi-Cal independently.
Colorado	
Connecticut	**Children and Adults**: Premium assistance option added for existing eligibility groups in HuskyCare that have access to employer-sponsored insurance with wrap-around coverage provided by Medicaid.
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	
Illinois	
Indiana	**Expansion Adults**: Implemented benefit package modeled on state employee plan with optional dental and vision coverage for additional cost-sharing. Beneficiaries will receive $500 annually in preventative care coverage (at no cost to the individual), a high deductible managed care plan and a $1,100 health savings account (called a "Power Account") funded by a combination of individual and state contributions.
Iowa	**All:** Added coverage for preventive medical exams and for comprehensive physical exam and health risk assessments.
Kansas	**Aged & Disabled:** Added personal assistance and related services for participant's in "Working Healthy," the state's TWWIAA Medicaid buy-in program.
Kentucky	
Louisiana	**Pregnant Women:** Added coverage for gestational diabetes education. **All Adults:** Added coverage for adult immunizations.
Maine	
Maryland	
Massachusetts	
Michigan	
Minnesota	
Mississippi	
Missouri	
Montana	
Nebraska	
Nevada	
New Hampshire	**All Adults:** Added coverage for incontinence supplies.
New Jersey	
New Mexico	**Pregnant Women:** Added dental services. **All Non-Pregnant Adults and Children:** Added coverage for Multisystemic Therapy and Comprehensive Community Support Services. **All**: Added coverage for Telehealth Services.
New York	

State	Benefit Change
North Carolina	
North Dakota	
Ohio	**All Adults**: Restored chiropractic services, independent psychologist services and dental services.
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	**Other:** Implementing 2 one-county pilots each limited to 1000 beneficiaries: a voluntary DRA Health Opportunity Account Demonstration for healthy adults and children and a voluntary "Health Savings Account" plan using the State Employee High Deductible Health plan as the benchmark plan (done under DRA Benchmark plan authority and open to all beneficiaries except duals, foster care and persons in institutions).
South Dakota	
Tennessee	
Texas	**Children:** Enhanced personal care services.
Utah	**Other:** Implemented a pain management program.
Vermont	
Virginia	**Children and Non-Pregnant Adults:** Adding coverage for substance abuse services (already covered previously for pregnant women).
Washington	
West Virginia	
Wisconsin	**Other:** Implementing BadgerCare Plus expansion with a comprehensive benchmark plan adapted from Wisconsin's largest commercial, low-cost health care plan which is provided by United Healthcare. The benchmark plan will be available to children and pregnant women with incomes above 200 percent of the FPL. Certain farmers and other self-employed parents will also be enrolled in the Benchmark Plan.
Wyoming	**Adults:** Increased dental benefits.

Appendix A-5: DRA Options

States	LTC Partnership Program (a)	PRTF Demo Grants (b)	Money Follows the Person (b)	HCBS State Plan Option	Self-Directed Personal Assistance Services	Family Opportunity Act	Medicaid Transformation Grants (b)	HOA Demo Grants	Benefit Changes
Alabama	X				X		X		
Alaska		X							
Arizona							X		
Arkansas	X		X		X		X		
California			X						
Colorado	X			X	X				
Connecticut			X				X		
Delaware			X						
Columbia	X		X				X		
Florida	X	X					X		
Georgia	X	X	X						
Hawaii			X				X		
Idaho	X			X					X
Illinois	X		X				X		
Indiana		X	X				X		
Iowa			X	X					
Kansas	X	X	X				X		X
Kentucky (c)			X		X		X		X
Louisiana	X		X		X	X			
Maine									
Maryland	X	X	X				X		
Massachusetts							X		
Michigan	X		X				X		
Minnesota	X						X		
Mississippi		X					X		
Missouri	X		X						
Montana	X	X					X		
Nebraska	X		X						
Nevada	X			X	X				
New Hampshire			X		X				
New Jersey	X		X	X			X		
New Mexico	X						X		
New York			X						
North Carolina	X		X						
North Dakota	X		X			X	X		
Ohio	X		X						
Oklahoma	X		X						
Oregon	X		X						
Pennsylvania	X		X						
Rhode Island							X		
South Carolina	X	X	X					X	X
South Dakota	X								
Tennessee							X		
Texas			X				X		
Utah							X		
Vermont									
Virginia	X	X	X						X
Washington	X		X	X					X
West Virginia							X		X
Wisconsin			X		X		X		X
Wyoming									
Total	**29**	**10**	**31**	**6**	**8**	**2**	**26**	**1**	**8**

(a) California, Connecticut, Indiana and New York had LTC Partneship model programs in place prior to the DRA.
(b) SOURCE: CMS. PRFT: http://www.cms.hhs.gov/DeficitReductionAct/20_PRTF.asp#TopOfPage
MFP: http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp#TopOfPage
Transformation Grant: http://www.cms.hhs.gov/MedicaidTransGrants/
(c) Kentucky is the only state that has adopted the measure to make copayments enforceable

Appendix A-6a: Pharmacy Cost Containment Actions in Place in the 50 States and District of Columbia in FY 2007

States	Preferred Drug List	Prior Authorization Program	Supplemental Rebates	Multi-State Purchasing Coalition	Script Limits	State MAC Progam
Alabama	X	X	X		X	X
Alaska	X	X	X	X		
Arizona						
Arkansas	X	X	X		X	X
California	X		X		X	
Colorado		X				X
Connecticut	X	X	X			X
Delaware	X	X	X	X		X
District of Columbia		X		X		
Florida	X	X	X			X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X		X
Idaho	X		X	X		
Illinois	X	X	X		X	X
Indiana	X	X	X			X
Iowa	X		X	X		X
Kansas	X	X	X			X
Kentucky	X	X	X	X	X	
Louisiana	X	X	X	X	X	X
Maine	X	X	X	X	X	X
Maryland	X	X	X	X		X
Masschusetts	X	X	X			X
Michigan	X		X	X		X
Minnesota	X		X	X	X	X
Mississippi	X		X		X	X
Missouri	X		X			X
Montana	X	X	X	X		
Nebraska		X				X
Nevada	X	X	X	X		X
New Hampshire	X		X	X		
New Jersey		X				
New Mexico	X		X			X
New York	X	X	X	X		X
North Carolina		X			X	X
North Dakota		X				X
Ohio	X	X	X			X
Oklahoma	X	X	X		X	X
Oregon	X	X	X			X
Pennsylvania	X	X	X	X		X
Rhode Island	X		X			
South Carolina	X	X	X		X	X
South Dakota		X				X
Tennesee	X	X	X	X	X	X
Texas	X	X	X		X	X
Utah		X			X	X
Vermont	X	X	X	X		X
Virginia	X	X	X			X
Washington	X	X	X		X	X
West Virginia	X	X	X	X		X
Wisconsin	X	X	X	X		X
Wyoming	X	X	X			X
Total	**42**	**40**	**42**	**22**	**17**	**41**

Appendix A-6b: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia FY 2007 and FY 2008

States	Impose Script Limits		Reduce Ingredient Cost		Preferred Drug List		More Drugs/Prior Authorization		Suplemental Rebates		Multi-State Purchasing Coalition		New/Lower State MAC		Other Actions	
	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008
Alabama							X	X								
Alaska					X	X	X	X								
Arizona																
Arkansas							X	X	X	X			X	X		
California																
Colorado						X	X			X						
Connecticut					X											
Delaware																
District of Columbia					X				X		X		X			
Florida																
Georgia					X	X			X		X		X			
Hawaii																
Idaho					X				X		X					
Illinois	X				X								X			
Indiana					X	X	X	X	X	X						
Iowa															X	
Kansas																
Kentucky																
Louisiana													X			
Maine		X						X								
Maryland																
Massachusetts					X	X	X	X					X			
Michigan																
Minnesota																
Mississippi																
Missouri																
Montana					X	X	X	X								
Nebraska							X	X								
Nevada								X								
New Hampshire																
New Jersey															X	
New Mexico																
New York			X	X	X	X			X	X	X		X		X	
North Carolina							X									
North Dakota							X	X								
Ohio																
Oklahoma							X	X								
Oregon								X								X
Pennsylvania							X	X			X				X	X
Rhode Island			X		X			X	X							
South Carolina																
South Dakota							X	X								
Tennessee							X									
Texas							X	X					X	X		
Utah						X				X		X				
Vermont																
Virginia															X	X
Washington					X	X	X	X	X	X			X	X		
West Virginia	X				X		X									
Wisconsin					X	X		X	X	X						
Wyoming					X	X	X	X	X	X				X		X
Total	**2**	**1**	**2**	**1**	**15**	**11**	**18**	**19**	**10**	**8**	**5**	**1**	**9**	**4**	**5**	**4**

*Maine has an additional other provider tax in both 2007 and 2008

Appendix A-7a: Medicaid Care Management and Program Integrity Actions Taken in the 50 States and District of Columbia FY 2007 and 2008

States	Managed Care		Disease Management / Case Management		New Program Integrity Initiatives	
	2007	2008	2007	2008	2007	2008
Alabama				X	X	X
Alaska						
Arizona						
Arkansas			X	X	X	X
California	X	X	X		X	
Colorado				X	X	X
Connecticut		X		X		
Delaware	X		X		X	X
District of Columbia						
Florida	X	X	X	X	X	X
Georgia	X				X	X
Hawaii						
Idaho			X			
Illinois	X	X	X		X	
Indiana		X		X	X	X
Iowa		X				
Kansas	X					X
Kentucky						
Louisiana				X		
Maine				X		X
Maryland						
Massachusetts	X				X	
Michigan						
Minnesota	X	X			X	X
Mississippi						
Missouri		X				X
Montana			X			
Nebraska				X		
Nevada				X		X
New Hampshire						
New Jersey	X	X			X	X
New Mexico		X				
New York	X	X	X	X	X	X
North Carolina	X					
North Dakota	X			X		
Ohio	X				X	X
Oklahoma		X				
Oregon	X	X			X	
Pennsylvania	X	X		X		
Rhode Island		X	X		X	
South Carolina	X	X			X	
South Dakota					X	
Tennessee		X				
Texas	X	X				
Utah						
Vermont				X		X
Virginia	X	X		X	X	X
Washington		X	X			
West Virginia		X			X	X
Wisconsin	X	X	X			
Wyoming					X	X
Total	**19**	**22**	**11**	**15**	**21**	**19**

Appendix A-7b: Medicaid Quality Measures in Place in the 50 States and District of Columbia FY 2007 and 2008

States	Requires or Incentives for Accreditation		Use of HEDIS® or Similar Performance Measures		Use of CAHPS® or Similar Patient Surveys		Pay for Performance for MCOs		Public Reporting of MCO Performance	
	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008
Alabama										
Alaska			X	X	X	X				
Arizona			X	X	X	X			X	X
Arkansas			X	X	X	X				
California			X	X	X	X			X	X
Colorado	X	X	X	X	X	X	X	X	X	X
Connecticut			X	X	X	X			X	X
Delaware			X	X	X	X	X	X	X	X
District of Columbia	X	X	X	X	X	X		X		X
Florida	X	X	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X		
Hawaii		X	X	X	X	X		X	X	X
Idaho										
Illinois			X	X	X	X	X	X	X	X
Indiana			X	X	X	X			X	X
Iowa	X	X	X	X	X	X	X	X	X	X
Kansas			X	X	X	X	X	X		
Kentucky			X	X	X	X	X	X	X	X
Louisiana			x	x	X	X				
Maine			X	X	X	X				
Maryland			X	X	X	X	X	X	X	X
Massachusetts			X	X	X	X	X	X	X	X
Michigan	X	X	X	X	X	X	X	X	X	X
Minnesota			X	X	X	X	X	X	X	X
Mississippi										
Missouri			X	X	X	X	X	X	X	X
Montana			X	X	X	X				
Nebraska	X	X	X	X	X	X	X	X		
Nevada			X	X	X	X	X	X		
New Hampshire						X				
New Jersey			X	X	X	X			X	X
New Mexico	X	X	X	X	X	X	X	X	X	X
New York			X	X	X	X	X	X	X	X
North Carolina										
North Dakota										
Ohio			X	X	X	X	X	X	X	X
Oklahoma			X	X	X	X				
Oregon			X	X	X	X			X	X
Pennsylvania	X	X	X	X	X	X	X	X	X	X
Rhode Island	X	X	X	X					X	X
South Carolina	X	X	X	X	X	X			X	X
South Dakota										
Tennessee	X	X	X	X	X	X	X	X	X	X
Texas			X	X	X	X	X	X	X	X
Utah			X	X	X	X	X	X	X	X
Vermont			X	X	X	X	X	X		
Virginia	X	X	X	X	X	X				
Washington			X	X	X	X	X	X	X	X
West Virginia			X	X	X	X				
Wisconsin	X	X	X	X	X	X	X	X	X	X
Wyoming			X	X	X	X				
Total	**14**	**15**	**44**	**44**	**43**	**44**	**25**	**27**	**29**	**30**

Appendix A-8: Provider Taxes in Place in the 50 States and District of Columbia FY 2007 and FY 2008

States	Hospitals		ICF/MR-DD		Nursing Facilities		Managed Care Organizations		"Other"	
	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008
Alabama					X	X			X	X
Alaska										
Arizona							X	X		
Arkansas					X	X				
California			X	X	X	X	X	X		
Colorado			X	X						
Connecticut					X	X				
Delaware										
District of Columbia				X	X	X				
Florida	X	X								
Georgia					X	X	X	X		
Hawaii										
Idaho										
Illinois	X	X	X	X	X	X				
Indiana			X	X	X	X				
Iowa			X	X						
Kansas	X	X								
Kentucky	X	X	X	X	X	X	X	X	X	X
Louisiana			X	X	X	X			X	X
Maine	X	X	X	X	X	X			X	X
Maryland			X	X		X	X	X		
Massachusetts	X	X	X	X	X	X				
Michigan	X	X			X	X	X	X	X	X
Minnesota	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X				
Missouri	X	X			X	X	X	X	X	X
Montana	X	X	X	X	X	X				
Nebraska			X	X						
Nevada					X	X				
New Hampshire	X	X			X	X				
New Jersey			X	X	X	X	X	X		
New Mexico							X	X		
New York	X	X	X	X	X	X			X	X
North Carolina			X	X	X	X				
North Dakota			X	X						
Ohio	X	X	X	X	X	X	X	X		
Oklahoma					X	X				
Oregon	X	X			X	X	X	X		
Pennsylvania			X	X	X	X	X	X		
Rhode Island	X	X	X		X	X			X	X
South Carolina	X	X	X	X						
South Dakota				X						
Tennessee			X	X	X	X	X	X		
Texas			X	X			X	X		
Utah			X	X	X	X				
Vermont	X	X	X	X	X	X			X	X
Virginia										
Washington					X					
West Virginia	X	X	X	X	X	X			X	X
Wisconsin	X	X	X	X	X	X				
Wyoming										
Total	**20**	**20**	**28**	**29**	**33**	**33**	**15**	**15**	**11**	**11**

*Maine has an additional other provider tax in both 2007 and 2008

Appendix B: Profiles of Selected State Medicaid Policy Changes:

- **Indiana**
- **Massachusetts**
- **Pennsylvania**

Profile of Medicaid Policy Changes: Indiana

With a net loss of approximately 100,000 jobs in the first half of the decade, Indiana did not see the economic growth that was experienced in some parts of the country. Even with strong revenue growth in 2003, 2004 and 2005, budget woes continued to plague Indiana's state government. The depths of the 2001 recession combined with costly property tax relief packages were primary contributors to Indiana's structural deficit of over $800 million at the end of 2004. State payment delays to local governments, schools and higher education institutions in FY 2002, helped to balance the books, but also created a lingering liability of over $700 million dollars for the state.

Governor Mitch Daniels took office in January 2005 marking the first Republican administration in sixteen years. Promising bold and real changes and "a new era of financial responsibility," his tenure began with the immediate task of partnering with a favorable Republican-dominated General Assembly in crafting a biennial budget for FY 2006 and FY 2007. Despite opposition from House Democrats, much of the Governor's legislative proposals, centering primarily on economic development reforms, found ultimate success. "What time is it in Indiana?" was the heretofore complicated question one of the Governor's economic reforms attempted to answer for those seeking to do business in Indiana. The Governor's contentious Daylight Savings Time proposal dominated political discussions as well as the headlines.

The Administration's budget-balancing approach for FYs 2006 and 2007 combined tight spending controls with reorganizing and reforming state government functions to reduce abuse and waste. For Indiana Medicaid, spending controls meant holding the line on growth to no more than 5 percent in each of the two years, in spite of the forecasted increases of 5.4 percent for FY 2006 and 8.2 percent for FY 2007. On the revenue side, a successful tax amnesty program, generating $244.6 million in delinquent tax revenue, exceeded expectations. Further, a contentious bill to allow for the 75 year leasing of the Indiana Toll Road that passed during the short, mid-budget session of the General Assembly in 2006, added revenue that supported additional spending, primarily on transportation projects, but also for economic development, education and other initiatives in the second year of the budget cycle.

Controversy over the change to Daylight Savings Time and the leasing of the Indiana Toll Road contributed to a Democratic take over of the House of Representatives in the November 2006 elections. A bipartisan approach was therefore needed to craft the biennial budget for FYs 2008 and 2009 during the 2007 legislative session. Tight spending controls, however, were a shared priority and there was also general agreement among the parties that a healthcare reform package was needed to address the lack of affordable health insurance for lower income citizens and small businesses. The Healthy Indiana Plan (HIP), funded in part by a 44 cent increase in the cigarette tax, was signed into law May 10, 2007. Touted as a plan encompassing both personal and public responsibility, HIP combined affordable commercial insurance with an emphasis on preventive care along with a health savings account for low-income, uninsured Hoosiers. The HIP plan provides for non-entitlement insurance to the parents of Medicaid and SCHIP kids with family incomes at 22 percent to 200 percent of the FPL and childless adults with incomes up to 200 percent of the FPL, who have been uninsured for 6 months or more and who did not have access to employer insurance. An estimated 562,235 Hoosiers would be eligible for services under these parameters. Other key aspects of the plan include:

- $500 free age- and gender-appropriate preventive care;
- a $1,100 "Power Account" combing individual contributions (on sliding scale up to 4.5 percent of gross income) and state contributions, to cover initial out-of-pocket medical expenses;
- an additional $300,000 per year ($1,000,000/lifetime) basic insurance coverage to include physician services, prescriptions, diagnostic exams, home health services, outpatient hospital, inpatient hospital, hospice, preventive services, family planning, mental health services, and case and disease management; dental and vision coverage may be purchased as an optional rider, and
- a buy-in option for those on the HIP waiting list, those above 200 percent of the FPL, and small businesses and local units of government.

The number of persons served through HIP will be dependent on the resources available, but is expected to total between 120,000 and 150,000 people. Aside from the funding for HIP, portions of the cigarette tax increase have been designated to fund other health initiatives including immunizations for all children up to age 2, smoking cessation programs through the Indiana Tobacco and Prevention Cessation Trust Fund (ITPC), and physician and dental reimbursement increases under Medicaid. Pending approval of the state's Section 1115 waiver request, the expected implementation date is January 1, 2008. (Refer to http://www.in.gov/fssa/hip/2269.htm for more information)

The close of Indiana's 2006 and 2007 fiscal years brought good state budget news. Revenues in excess of forecasted levels and historically small expenditure increases over the previous four years (4.3% in 2004, 2.5% in 2005, 3.3% in 2006, and estimated at 2.8% in 2007), resulted in the elimination of the structural budget deficit and allowed for the full reversal of the payment delays owed to local governments, schools and universities.

To limit the rate of growth in Medicaid expenditures, Indiana's Family and Social Services Administration employed a number of cost containment strategies and made fundamental changes to the way they conducted business. In FY 2006, general strategies included shifting additional recipients to managed care, implementing a central accounting system, auditing operations and financial processes, reducing Medicaid error rates, creating a team to review high-cost patient cases, and privatizing services and administrative processes. The chart below outlines specific cost containment measures taken in FY 2007, proposed cost containment measures for FY 2008 as well as some positive policy actions taken by the state during this same timeframe.

Provider Rates:

• In FY 2007:
  o Increased reimbursement rates for physicians and HCBS waiver providers. Also, while nursing home rates increased, growth was limited to 5 percent.
• In FY 2008:
  o Increased reimbursement rates for physicians, dental services, nursing homes, home health services and HCBS waiver providers.

Eligibility Changes:

• In FY 2007:
  o Increased income eligibility standard for HCBS waiver to 300 percent of SSI.
  o Extended coverage for children in foster care to age 21 for those with incomes at

or below 200 percent of the FPL with no asset test.

- In FY 2008:
  - Provided continuous 12-month eligibility for children from birth through age 3.
  - Expanded eligibility of pregnant women from 150 percent to 200 percent of the FPL.
  - Added presumptive eligibility for pregnant women.
  - Planning to cover parents and childless adult with incomes up to 200 percent of the FPL under Section 1115 waiver authority.

Application/Renewal changes:

- In FY 2008:
  - Implementing the Eligibility Modernization Initiative by phasing it in across four regions of the state between October 2007 and April 2008. The initiative includes the outsourcing of certain administrative functions relating to Medicaid, Food Stamps and TANF eligibility determination processes to an IBM-led coalition.
  - Creation of a Voluntary Community Assistance Network (V-CAN) of community agencies serving families who might need public assistance to provide connector services either through application assistance or information and referral.

Benefit and Cost-Sharing Changes:

For new waiver expansion group in FY 2008, implementing a benefit package modeled on the state employee plan with optional dental and vision coverage for additional cost-sharing. Beneficiaries will receive $500 annually in preventative care coverage (at no cost to the individual), a high deductible managed care plan and a $1,100 health savings account (called a "Power Account") funded by a combination of individual and state contributions. Cost-sharing is limited to 4.5 percent of income up to a maximum $1,100 that will be applied the Power Account. An employer can defray up to 50 percent of the beneficiary's cost-sharing amount. After a beneficiary's HSA is exhausted, only emergency room cost-sharing will be applied.

Long-Term Care Changes:

- In FY 2007:
  - Increased A&D waiver slots from 6,000 to 9,500 with priority criteria for filling, including waiting lists, risk of NF placement, transition from NF, and transition from state-funded CHOICE.
  - Implemented Options program that supports a full range of long-term care alternatives including Adult Foster Care, Assisted Living, Adult Day Services and Self-Directed Attendant Care options for seniors.
  - Reduced HCBS Medicaid Waiver waiting list for persons with developmental disabilities by 650 persons (500 for Support Services Waiver, 100 for Developmental Disabilities Waiver, and 50 for Autism Waiver).
  - Estate Recovery efforts were enhanced.
  - Closed Fort Wayne State Development Center transitioning clients to community-based service settings.
- In FY 2008:
  - The Money Follows the Person initiative will continue and will allow nursing facility residents to transition to HCBS services.
  - The nursing facility bed moratorium was extended through March 30, 2008.
  - Released additional HCBS Medicaid Waiver waiting list slots for persons with developmental disabilities, with priority given to young adults 18-24 leaving school, caregivers age 80 and older and emergency cases.

Prescription Drug Controls:

- In FY 2007:
  - Expanding the number of classes reviewed and making related changes to the Preferred Drug List (PDL) and the Supplemental Rebate program.
  - Continued implementation of Mental Health Quality Advisory Committee's (MHQAC) recommended utilization edits for mental health medications requiring prior authorization for prescribing situations inconsistent with established pharmacokinetic principles and clinical practice guidelines; applies to all risk-based managed care and traditional fee-for-service programs.
  - Eliminated the Federal Upper Limit (FUL) from the ingredient cost reimbursement methodology relying instead on State Maximum Allowable Cost amounts and an aggregate upper limit analysis/test.
- In FY 2008:
  - Expanding the number of classes reviewed and making related changes to the Preferred Drug List (PDL) and the Supplemental Rebate program.
  - Continued implementation of Mental Health Quality Advisory Committee's (MHQAC) recommended utilization edits for mental health medications.

Managed Care Changes:

- In FY 2007:
  - Enhanced risk-based managed care services through Hoosier Healthwise under three new statewide managed care contracts and the incorporation of performance based incentives; effective January 1, 2007.
  - Eliminated MCO carve-out for behavioral health services (except for MRO and PRTF services); effective January 1, 2007
- In FY 2008:
  - Implementing "Care Select" enhanced care management program following disease management/PCCM care model, for all Aged, Blind and Disabled (ABD) populations (except dual eligibles); phased-in implementation to begin in November 2007 and be operational throughout the State no later than 2009.

Other Cost Containment and Policy Changes:

Enhanced fraud and abuse controls in FY 2007 and in FY 2008.

Profile of Medicaid Policy Changes: Massachusetts

On April 12, 2006, former Governor Mitt Romney signed into law comprehensive health care reform legislation designed to achieve nearly universal coverage for Massachusetts residents. The sweeping legislation expands coverage through a variety of mechanisms including a Medicaid expansion, subsidized private insurance, a personal responsibility mandate, and insurance reform. Specific components of the reform plan include the following:

- A MassHealth eligibility expansion for children up to 300 percent of the FPL and a lifting of the enrollment caps for Medicaid adult expansion populations;
- Restoration of previous adult Medicaid benefit cuts;
- Creation of the Commonwealth Care Health Insurance Program (CCHIP) to provide sliding scale premium subsidies for uninsured adults earning below 300 percent of the FPL;
- Insurance market reforms to promote lower-cost insurance products;
- Mandates for all adults to have health insurance coverage or face tax penalties;
- Requirement that employers with over 11 employees contribute a "fair share" to their employees' health insurance or pay up to $295 annually per employee;
- Requirement that employers establish Section 125 cafeteria plans through the IRS so workers may obtain coverage with pre-tax dollars;
- Imposition of a "Free Rider Surcharge" for employers whose uninsured workers accumulate more than $50,000 in costs against the Uncompensated Care Pool in a year; and
- Creation of a quasi-public agency ("the Connector") charged with assuring access to affordable health insurance through combining individual and small business markets, using pre-tax instruments, increasing portability, and managing the CCHIP subsidy program.

At the same time, the state increased Medicaid provider reimbursement rates over three years (FYs 2007, 2008 and 2009) to address the concern that unreimbursed Medicaid costs were being shifted to private-sector payers. Beginning in October 2007, hospital rate increases will be tied to quality standards and the achievement of performance benchmarks. Finally, the health reform legislation also addressed access and racial equity questions, funded outreach activities, established public health and prevention programs, and restructured safety-net funding.

As of the end of March 2007, MassHealth enrollment had increased by 53,000 as a result of the health care reform expansions. Also, as of June 1, 2007, 80,000 low-income adults had enrolled in Commonwealth Care Plans.

In February 2007, recently inaugurated Governor Deval Patrick was challenged to propose a state budget for FY 2008 that would continue to fund the Massachusetts health care reform plan but also address a $1.3 billion structural budget deficit due, in large part, to markedly lower state revenue growth projections compared to FY 2006. Governor Patrick's budget plan included full funding of the reform law's eligibility expansions, benefit restorations and rate increases. To close the budget gap, however, the plan closed a corporate tax "loophole," tapped one-time revenue, and made a

number of other "savings and efficiencies," including $179 million in proposed Medicaid reductions.

The final enacted FY 2008 budget cut very little on the spending side and instead relied on over $600 million of reserve funds and non-recurring revenues to close the budget gap. A number of Governor Patrick's priorities were funded including increases for full-day Kindergarten, funding for the Universal Immunization Program (including coverage for two new vaccines) and over $1.8 billion to fund the state's historic health care reform law.

The FY 2008 budget also provides funding to improve access to healthcare services for Medicaid beneficiaries including $3.5 million for enrollment and outreach grants and $200,000 for a new Health Care Reform Outreach and Education Unit. Also, the budget requires the Executive Office of Health and Human Services to assist persons born in Massachusetts in obtaining birth certificates, at no cost, for the purpose of establishing Medicaid eligibility and to also provide (as yet undetermined) assistance to persons born outside the state. The chart below outlines specific Medicaid policy initiatives taken in FY 2007 and planned for FY 2008.

Provider Rates:

- In FY 2007:
  - Rate increase, partially mandated by reform legislation, provided for inpatient hospital (10.1%), outpatient hospital (4.4%), physicians (5.5%), and nursing homes (2%).
  - Other rate increases provided for managed care organizations (10%), home health (3.68%), continuous nursing (9.76%), hospice (2%), and DME (1.6%).
  - EPSDT-related dental rates increased (11.64%) (related to litigation).
- In FY 2008:
  - Rate increase, partially mandated by reform legislation, provided for inpatient hospital (7.91%), outpatient hospital (3.6%), physicians (5.5%), and nursing homes (4%).
  - Other rate increases provided for managed care organizations (10%), and hospice (6-7%). (DME rate increases still under consideration).
  - EPSDT-related dental rates increased 1.02% (related to litigation) and adult dental rates increased (8.4%).

Eligibility and Premium Changes:

- In FY 2007:
  - Increased the income eligibility level for the MassHealth Insurance Partnership[47] waiver expansion group to 300 percent of the FPL and added a requirement that the beneficiary not have been offered employer-sponsored coverage in the previous six months.
  - Enrollment cap eliminated on the MassHealth adult expansion population.
  - Implemented Commonwealth Care subsidized insurance coverage up to 300 percent of the FPL.
  - Extended MassHealth coverage for foster care adolescents up to age 21.

[47] The MassHealth Insurance Partnership helps small business owners provide health insurance for their uninsured employees. Self-employed workers are also eligible. The Partnership pays part of the employer share of health insurance costs and also pays part of the employee monthly premiums.

- In FY 2008,
  - Eliminated Insurance Partnership employer subsidies to self-employed persons, allowing them to qualify for the employee subsidies only.
  - Eliminated premium requirements for those with incomes under 150 percent of the FPL (impacting children, beneficiaries in the Breast and Cervical Cancer Treatment Program, the HIV program and the Insurance Partnership).
  - Increased the Personal Needs Allowance for residents of long-term care facilities from $60 to $72.80.

Benefit and Cost-Sharing Changes:

- In FY 2007:
  - Restored coverage for dental, vision, chiropractic services, orthotics, prosthetics, and Level IIIB and Level IIIC detoxification substance abuse treatment services for MassHealth adults (except MassHealth "Essential" adults who do not receive coverage for vision, chiropractic or orthotic services).
  - Coverage added for tobacco cessation services for all MassHealth beneficiaries.
  - Effective January 1, 2007, eliminated the copayment requirement on emergency screening that acute care hospitals were previously allowed to collect when delivering non-emergency services in the emergency department.

Long-Term Care Changes:

- In FY 2007, implemented the Geriatric Mental Health Services program to deinstitutionalize and divert elders with serious and persistent mental illness from institutionalized settings.
- In FY 2008:
  - Launching a three-year pilot program offering expanded HCBS waiver services for children under age nine with autism.
  - Implementing preadmission counseling to reduce institutionalizations.

Prescription Drug Controls:

- In FY 2007:
  - Continued to refine PDL.
  - Subjected more drugs to prior authorization.
  - Updated State MAC weekly instead of monthly.
- In FY 2008:
  - Continuing to refine PDL.
  - Subjecting more drugs to prior authorization.
  - Additional supplemental rebates being contemplated.

Managed Care Changes:

- In FY 2007:
  - MassHealth MCOs expanded into new service areas.
- In FY 2008:
  - Anticipate further MCO expansion into new service areas.
  - MassHealth allowing MCOs to propose voluntary mail order pharmacy programs.

Other Policy Changes:

- In FY 2007:
  - Imposed a new ICF/MR provider assessment.
  - Implemented significant outreach efforts including large-scale public relations campaign connected to health care reform law implementation.
  - Enhanced fraud and abuse controls.

Profile of Medicaid Policy Changes: Pennsylvania

On January 17, 2007 – two and a half months after signing into law the "Cover All Kids" program that allows families with incomes exceeding 200 percent of the FPL to buy into the state's SCHIP program – Democratic Governor Ed Rendell announced the "Prescription for Pennsylvania" initiative intended to reduce health care costs and expand access to coverage for all Pennsylvanians. The initiative would expand coverage for the uninsured by implementing a three percent payroll tax on employers that do not offer employee health coverage, with funds going to subsidize coverage for the uninsured. Other aspects of the initiative would lower costs by:

- Requiring hospitals to adopt measure to reduce hospital infection rates;
- Eliminating reimbursement for extended hospitals stays caused by medical errors and preventable infections;
- Regulating hospital expenditures for new construction and equipment;
- Providing incentives to health care providers who encourage healthy behaviors and pay closer attention to medications to reduce the hospitalizations for patients with chronic diseases;
- Expanding the scope of practice for nurses and physician's assistants;
- Prohibiting insurers from considering pre-existing medical conditions when setting their premium rates;
- Requiring that at least 85 percent of health insurance premiums be spent on health care costs; and
- Prohibiting smoking in public places.

Three weeks later in his Executive Budget Address, Governor Rendell proposed several additional significant budget initiatives including a property tax relief measure, new mass transit and infrastructure investments, a new "Energy Independence Fund" that would invest in Pennsylvania companies bringing new energy products and technologies to market and a new "Jonas Salk Legacy Fund" that would fund investments in biomedical research. To fund these initiatives and also close a state budget funding gap, the Governor proposed several revenue raising measures including an increase in the state sales tax (from six percent to seven percent), an expanded and increased tobacco tax, a tax on oil company profits generated by business activity within Pennsylvania, leasing the Pennsylvania Turnpike to the private sector and securitizing a portion of Pennsylvania's Tobacco Settlement Funds.

Opposition to the proposed tax increases by the Republican-controlled Senate led to a budget impasse that resulted in a partial government shut-down when the end of the state fiscal year passed without the adoption of a new budget for FY 2008. A new state budget was finally passed on July 16, 2007, but without all of the new initiatives that the Governor had sought. Also, an improvement in state revenue collections at the end of FY 2007 eliminated the need for a broad-based sales tax increase.

Nevertheless, the legislature did adopt sizable budget increases for education (6.3 percent for pre-kindergarten through twelfth grade and 3.5 percent for state universities) and a significant transportation overhaul that included new infrastructure funding ($750 in FY 2008 and an average of $946 million per year for the next ten years) for highways, bridges and mass transit systems to be funded through higher tolls on the Pennsylvania Turnpike and new tolls on I-80. The legislature also adopted two important components of the Governor's Prescription for Pennsylvania initiative:

- An expansion of the scope of practice for nurse practitioners, certified midwives, dental hygienists and others, and
- A requirement that hospitals, nursing homes and ambulatory surgical facilities develop and carry out infection control plans. If by January 1, 2009 a facility has reduced infections by ten percent, it will be eligible for a quality improvement payment.

The FY 2008 state budget also included new or increased funding:

- To provide home and community-based waiver services to more than 3,400 people with mental retardation – the largest increase in nearly a decade;
- For an Autism Capitated Assistance Program – a prepaid inpatient health plan – and for other state autism service enhancements including a new autism home and community-based services Medicaid waiver; and
- For community-based services for persons with mental illness and respite services for children with serious emotional disturbances.

In addition to the efforts described above, Pennsylvania has implemented or plans to implement the policy changes noted below:

Provider Rates:
• In FY 2007, increased rates by 4% for inpatient hospital services, nursing facilities and managed care organizations. • In FY 2008, increased rates for inpatient hospital (2%), nursing homes (3%), and managed care organizations (3%). Fee increases are also planned for physicians and dentists. • Rates for home and community-based waiver providers are set at the local level but generally experienced increases in both FY 2007 and FY 2008.
Eligibility Changes:
• In FY 2008, implementing a Family Planning waiver to provide family planning services to uninsured women, ages 18 to 44 with income at or below 185 percent of the FPL who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, or Medicare.
Benefit/Service Changes:
• In FY 2007, "Peer Support" mental health services added for all beneficiaries age 18 and older. Also, mobile mental health services added for all adult beneficiaries. • Effective October 1, 2007, eliminated copayment requirements for tobacco cessation counseling for all non-exempt populations. Also, (under DRA authority) will eliminate copayments for all Medicaid services for residents of personal care homes or domiciliary care homes.
Prescription Drug Controls and Limits:
• In FY 2007: o Implemented clinical prior authorization for Tysabi and Toradol injections. o Implemented a behavioral pharmacy management and care coordination program. o Joined a multi-state purchasing coalition. • In FY 2008: o Clinical prior authorization will be implemented to ensure appropriate uses for new drugs coming to market that are high cost or have the potential for abuse. o Implementing a Specialty Pharmacy Drug Program:

- Using selective contracting to offer beneficiaries a choice of two specialty pharmacy preferred providers.
- To provide a reliable and convenient dispensing and delivery system that facilitates care in clinically appropriate settings.
- To provide a clinical support system designed to optimize therapy management, care coordination, and patient compliance.

Long-Term Care Policy Changes:

- In FY 2007, added one PACE site and added 1,444 waiver slots as an alternative to nursing facility care for persons with disabilities.
- In FY 2008:
  - Will add 7 PACE sites, 2,000 slots to the PDA 60+ Waiver (for persons aged 60 and over) and 882 slots to the waiver for persons with disabilities.
  - Implementing a Long-Term Care Partnership Program.

Managed Care Policy Changes:

- In FY 2007, mandatory behavioral health managed care was expanded into 4 additional counties for a total service area of 25 counties.
- Effective July 1, 2007, mandatory behavioral health managed care was expanded statewide for a total service area of 67 counties.

Other Quality and Program Improvement Initiatives

- In FY 2007:
  - Using HEDIS data to identify gaps in care due to racial or ethnic disparities.
  - Developed physical and behavioral health coordination measure and project in conjunction with the Office of Mental Health and Substance Abuse Services.
- In FY 2008:
  - MCO contracts will include a base increase of 3 percent and an opportunity to earn up to 2.5 percent through incentives. Contract incentives focus on improving health status of members (not utilization controls), rewarding plans that improve 11 defined HEDIS measures and one HEDIS-like measure. MCOs will also be eligible for additional funds for provider incentives.
  - Will increase pay for performance rates for physicians.
  - Will expand the nursing home provider tax to include county homes and use a portion of the proceeds to increase "Day One Incentive Payments" designed to encourage county nursing facilities to admit Medicaid eligibles on the day of admission.
  - The ACCESS Plus Disease Management Program will add 16 community-based nurses to increase outreach to both consumers and providers.
  - Requiring managed care plans to submit quality improvement plans to address racial disparity if identified in their population.
  - Targeted reviews and/or technical assistance to managed care plans to improve medical management.
  - Implementing performance measures for Perinatal Depression Screening.
  - Implementing physical/behavioral health coordination project.
  - Implementing Consumer Engagement Program: smoking cessation counseling, nutritional counseling for overweight, and filling prescriptions for medications.
  - Implementing payment for childhood obesity management.
  - Working with hospitals to better define the occurrence of "Never Events".

Appendix C: Survey Instrument

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2006, 2007 AND 2008

State _____ **Name** _____

Phone _____ **Email** _____ **Date** _____

This survey is being conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. The report, based on this survey of all 50 states and D.C., will be sent to you as soon as it is available. If you have any questions, please call Vern Smith at (517) 318-4819.

Return Completed Survey:

Email preferred: Vsmith@healthmanagement.com

Or mail or FAX to: Vernon K. Smith, Ph.D.
Health Management Associates
120 N. Washington Square, Suite 705
Lansing, MI 48933
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Section I. Medicaid Expenditure Growth: State Fiscal Years 2006, 2007 and 2008

A. For each year shown below, please indicate the annual percentage change in total Medicaid expenditures (excluding administration), and the annual percentage change for each source of funds.

	Percent Change for Each Fund Source			
	State	Local or Other	Federal	All Fund Sources
FY 2006 1. Percentage change: FY 2006 Medicaid Expenditures over FY 2005 Expenditures	%	%	%	%
FY 2007 2. Percentage Change: Estimated FY 2007 Medicaid Expenditures over FY 2006 Expenditures	%	%	%	%
FY 2008 3. Estimated Percentage Change: FY 2008 Medicaid Appropriations over FY 2007 Expenditures	%	%	%	%

Comments: _____

B. Do the percentages reflected in the table above include your state's Medicare Part D clawback payments to the federal government? ☐ Yes ☐ No

C. If you answered "Yes" to question B above, what would the percentage growth in state and total expenditures be without the clawback:

	FY 2006	FY 2007	FY 2008
State	%	%	%
Total	%	%	%

D. Was FY 2007 spending greater than the *original* appropriation? ☐ Yes ☐ No

E. Has your legislature enacted the Medicaid budget for FY 2008? ☐ Yes ☐ No

F. Potential FY 2008 Medicaid Budget Shortfall: When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2008 for Medicaid, how likely would you say it is that your state will experience a Medicaid budget shortfall in FY 2008 (check one)?

☐ Almost Certain to be No Shortfall ☐ Not Likely ☐ 50-50 ☐ Likely ☐ Almost Certain to be a shortfall

Section II. Medicaid in State Fiscal Year 2007 and 2008

1. **Factors Driving Expenditure Changes:** What would you consider to have been *the most significant factors* contributing to increases and/or decreases in your Medicaid spending in FY 2007 and what factors do you expect to be the principal drivers in FY 2008 (e.g., enrollment, healthcare inflation, utilization, etc.)?

	FY 2007	FY 2008
a. Most significant factor driving expenditures ***up***?		
b. Other significant factors driving expenditures ***up***?		
c. Most significant factor driving expenditures ***down***?		
d. Other significant factors driving expenditures ***down***?		

2. **Medicaid Enrollment Changes**:
   a. Overall % enrollment growth/decline (+/–), FY 2007 over FY 2006: _____%
   b. Overall % enrollment growth/decline (+/–), projected for FY 2008 over FY 2007: _____%
   c. What do you believe are the *key factors* that contributed to increases or decreases in enrollment in FY 2007, and will do so in FY 2008 (e.g., eligibility expansions or cuts, the economy, changes in the application or redetermination process, etc.)?

	FY 2007	FY 2008
A. Most significant factor driving enrollments ***up***?		
B. Other significant factors driving enrollments ***up***?		
C. Most significant factor driving enrollments ***down***?		
D. Other significant factors driving enrollments ***down***?		

3. **Provider Payment Rates**: For each provider type and as compared to the prior year, please indicate any rate increases (including COLA or inflationary increases) or decreases implemented in FY 2007 or to be implemented in FY 2008. Please indicate "+" for an increase, " – " for a decrease and "0" for no change. If available, please indicate actual percentage change as well.

Provider Type	FY 2007	FY 2008
a. Inpatient hospital		
b. Outpatient hospital		
c. Doctors		
d. Dentists		
e. Managed care organizations		
f. Nursing homes		
g. Home health		
h. Home and community-based waiver providers		

Comments (e.g., indicate whether rate changes were court-ordered/litigation-related):

_____

4. **Provider Taxes/Assessments**: Please list any provider taxes and indicate for each if it was or will be new in FY 2007 or 2008, or if changes were made or will be made to existing provider taxes in FY 2007 or 2008.

Provider Group Subject to Tax	In Place in FY 2006?	New		Discont'd		Increased, Decreased or No Change (+, -, or 0)		Change Federally Mandated?
		In FY '07?	In FY '08?	In FY '07?	In FY '08?	In FY '07?	In FY '08?	
a. Hospitals	☐	☐	☐	☐	☐			☐
b. ICF/MR-DD	☐	☐	☐	☐	☐			☐
c. Nursing Facilities	☐	☐	☐	☐	☐			☐
d. Managed Care Organizations	☐	☐	☐	☐	☐			☐
e. Other:	☐	☐	☐	☐	☐			☐
f. Other:	☐	☐	☐	☐	☐			☐

5. **Changes in Medicaid Eligibility Standards:** Please describe any expansion, reduction, restriction, restoration or other change in *eligibility standards* [1] implemented during FY 2007 or to be implemented in FY 2008. (Do not include SCHIP funded changes or DRA mandated changes related to long term care eligibility.)

Eligibility Category	Fiscal Year	Nature of Eligibility Change*	Effective Date	Estimated Number of People Affected	Under Waiver Authority?
a. Children	'07				☐
	'08				☐
b. Parents/ Pregnant Women	'07				☐
	'08				☐
c. Aged/ Disabled (incl. duals)	'07				☐
	'08				☐
d. Medically Needy	'07				☐
	'08				☐
e. Adults Without Children	'07				☐
	'08				☐
f. Other:	'07				☐
	'08				☐

[1] "Eligibility standards" may include income standards, asset tests, retroactivity, treatment of asset transfer or income, enrollment caps or buy-in options (including buy-in options provided under the Ticket to Work and Work Incentive Improvement Act or the DRA Family Opportunity Act).

6. DRA Citizenship Documentation Requirement:

a. **Administrative Impact:** Please describe the new administrative costs your state has incurred to comply with the new DRA citizenship documentation requirements (check one):
☐ None/Insignificant ☐ Some or modest ☐ Significant

b. **Enrollment:** Please describe the impact of the new documentation requirements on Medicaid enrollment in your state. (check one)
☐ None/Insignificant ☐ Some or modest ☐ Significant

c. **Application/Renewal Process:** As a result of the new documentation requirements, have application processing times in your state (check one):
☐ Increased ☐ Decreased ☐ Remained about the same?

d. **Vital Records:** Has your state implemented a vital records data matching process to facilitate citizenship documentation? ☐ Yes ☐ No

Comments: _____

7. Changes in Application/ Renewal Process: Did your state make any changes to the ***application or renewal process*** (e.g., changes in forms, verification or face to face interview requirements, etc.)? (Do *not* include DRA mandated changes regarding citizenship documentation.)

a. In FY 2007? ☐ Yes ☐ No If "Yes," please describe those changes:

_____

b. In FY 2008? ☐ Yes ☐ No If "Yes," please describe those changes:

_____

8. Changes in Benefits: Please describe below any expansion, reduction, restriction, restoration or other change in benefits or services *implemented* during FY 2007 or to be implemented in FY 2008.

Populations Affected	Fiscal Year	Nature of Benefit Change	Effective Date	Under DRA Authority?	Under Waiver Authority?
a. Children	'07			☐	☐
	'08			☐	☐
b. Parents/ Pregnant Women	'07			☐	☐
	'08			☐	☐
c. Aged/ Disabled (incl. duals)	'07			☐	☐
	'08			☐	☐
d. Medically Needy	'07			☐	☐
	'08			☐	☐
e. Adults Without Children	'07			☐	☐
	'08			☐	☐
f. Other:	'07			☐	☐
	'08			☐	☐

9. Changes in Cost Sharing:

a. Does your state charge copays (c*heck one*)? ☐ Yes ☐ Yes, but only for drugs ☐ No

b. Are copayments enforceable for any eligibility group as allowed by the DRA (c*heck one)*? ☐ Yes ☐ No ☐ Plan to implement in FY 2008 ☐ N/A

c. Please describe any changes in beneficiary cost sharing in FY 2007 and FY 2008 and indicate whether the cost sharing was *newly implemented*, *increased* or *decreased.*

Populations Affected	Fiscal Year	New, Higher or Lower Copays by Service (e.g., for drugs, ER, inpatient hospital, etc.)	Under DRA Authority?	Under Waiver Authority?
A. Children	'07		☐	☐
	'08		☐	☐
B. Parents/ Pregnant Women	'07		☐	☐
	'08		☐	☐
C. Aged/ Disabled (incl. duals)	'07		☐	☐
	'08		☐	☐
D. Medically Needy	'07		☐	☐
	'08		☐	☐
E. Adults without Children	'07		☐	☐
	'08		☐	☐
F. Other:	'07		☐	☐
	'08		☐	☐

10. Premiums: Please list any Medicaid eligibility group subject to a premium requirement and whether changes were made in FY 2007 or will be made in FY 2008.

Eligibility Group Subject to a Premium Requirement	In Place in FY 2006?	New, Increased, Decreased, Eliminated or No Change (New,+, -, Elim., or 0)		Under DRA Authority?	Under Waiver Authority?
		FY '07?	FY '08?		
a.	☐			☐	☐
b.	☐			☐	☐
c.	☐			☐	☐
d.	☐			☐	☐
f.	☐			☐	☐

11. DRA Long Term Care Changes:

a. How would you estimate the impact of the mandatory DRA long term care eligibility changes (e.g., to asset transfer rules, treatment of home equity, application of penalty periods, etc.):

i. On Medicaid costs? *(check one)* ☐ Insignificant ☐ Moderate ☐ Significant

ii. For beneficiaries? *(check one)* ☐ Insignificant ☐ Moderate ☐ Significant

b. Has your state implemented or does it plan to implement any of the following DRA options:

	FY 2007		FY 2008	
A. Long Term Care Partnership Program	☐ Yes	☐ No	☐ Yes	☐ No
B. HCBS State Plan Option	☐ Yes	☐ No	☐ Yes	☐ No
C. Self-Directed Personal Assistance Service Options (Cash & Counseling)	☐ Yes	☐ No	☐ Yes	☐ No

c. If you answered "No" to the options in question 11b above, do you have any comments as to why your state is not considering these DRA options?

_____

12. Long Term Care Policy Changes: Briefly identify the long term care reductions, restrictions or expansions (described below) that were implemented during FY 2007 or will be implemented in FY 2008. (Please *exclude* rate and tax changes reported under questions 3 and 4). Where applicable, please indicate if the change was made possible by the DRA.

Program or Policy Actions	Actions Implemented in FY 2007	Actions to be implemented in FY 2008
a. Community Service Restrictions [1]		
b. Community Service Expansions [2]		
c. Institutional reductions [3]		
d. Institutional expansions/ increases [4]		
e. Estate Recovery Initiative		
f. LTC Managed Care Initiative		
g. Other:		

[1] Including restrictions on waiver slots, waiver services, state plan personal care services, etc.
[2] Including adding or expanding waiver slots, waiver services, state plan personal care services, PACE sites, or nursing home diversion/transition programs, and liberalization of level of care requirements, etc.
[3] Including bed-hold policy changes, reduction of Medicare cross-over payments, bed moratoriums, tightening of level of care requirements, etc.
[4] Including repeal of a bed moratorium, quality enhancement initiatives, etc.

13. Prescription Drug Policy Changes:

a. **Impact of DRA FUL Changes:** The DRA made changes to the Federal Upper Limit (FUL) program to reduce Medicaid payments for certain multi-source drugs. For your state in FY 2008, do you expect these changes to produce (check one):

☐ None/insignificant savings ☐ Some/modest savings ☐ Significant savings ☐ Don't know

b. **Program or Policy Actions:** What *new prescription drug policies* were *implemented* during FY 2007? What *new* actions will be implemented for FY 2008? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2007	Actions to be Implemented in FY 2008	Was policy in place in FY 2007? (check all that apply)
A. Change in dispensing fees			
B. Change ingredient cost (i.e., AWP – x%; ASP, WAC or AMP + x%)			
C. Preferred Drug List (PDL)			☐
D. More/fewer drugs subject to prior authorization w/out PDL			☐
E. Supplemental rebates			☐
F. Multi-state purchasing coalition			☐
G. Limits on number of Rx per month imposed or lifted			☐
H. Changes to State MACs (update frequency, lower rates, new contract administrator, etc.)			☐
I. Other:			

14. Medicare Prescription Drug Benefit:

a. **Medically Needy/Spend-down Enrollment:** Has your state experienced a decrease in Medicaid enrollments in eligibility categories where individuals "spend-down" to meet an income eligibility threshold that you believe has resulted from the implementation of the Part D benefit? ☐ Yes ☐ No ☐ Don't Know

Comments:_____

b. **Wrap-around Coverage:** In FY 2008, will your state provide ***dual eligibles*** with:

i. Wrap-around coverage for Part D copay requirements? ☐ Yes ☐ No

ii. Coverage for any Part D *excluded* drugs (e.g., OTCs, benzodiazepines, barbiturates, etc.)? ☐ Yes ☐ No

iii. Coverage for *covered* Part D drugs that are not included on a particular Part D plan's formulary? ☐ Yes ☐ No

15. Quality and Program Improvement Initiatives: What quality initiatives or incentives were in place before 2007, implemented during FY 2007 or are planned to be implemented in FY 2008? Please briefly describe those that apply.

Program or Policy Actions	Actions In Place before FY 2007	Actions Implemented During FY 2007	Actions to be Implemented in FY 2008
a. Health plans required to be NCQA Accredited			
b. Use HEDIS (or similar) measures			
c. Conduct CAHPS (or similar) consumer survey			
d. Pay for performance with financial incentives (direct/indirect) for:			
1. MCOs			
2. Hospitals			
3. Physicians			
4. Nursing Facilities			
5. Other:			
e. Public reporting of quality measures for:			
1. MCOs			
2. Hospitals			
3. Physicians			
4. Nursing Facilities			
5. Other:			
f. E-Prescribing, electronic health record or other health information technology initiative			
g. Other pharmacy quality initiative			
h. Other LTC quality initiative			
i. Provider profiling initiative			
j. Other Program Improvement Initiative			
1. Disease management or case management (specify disease states or approaches)			
2. Enhanced Fraud and Abuse Controls/Program Integrity efforts			
3. Medicaid Transformation Grant Initiative			
4. Other actions:			

16. Managed Care Changes: What managed care program or policy actions were *implemented* during FY 2007, or will be implemented in FY 2008? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented in FY 2007	Actions to be implemented in FY 2008
a. Expand/contract PCCM or MCO service areas		
b. Enroll new eligibility groups (please specify)		
c. Change from voluntary to mandatory enrollment (specify by eligibility category)		
d. New benefit carve-out (i.e., drugs, behavioral health) or elimination of a carve-out		
e. Other actions:		

Comments: _____

17. Fiscal Impact of Federal Oversight Activities: How would you describe the fiscal costs your state has incurred to comply with federal oversight activities including the Payment Error Rate Measurement (PERM) initiative, federal audits or reviews, enhanced scrutiny of special financing arrangements, or DRA Medicaid Program Integrity requirements? (*Check one*):

☐ None/Insignificant ☐ Some or modest ☐ Significant

Comments: _____

18. Medicaid and SCHIP Reauthorization

a. Do you anticipate Medicaid implications as a result of SCHIP reauthorization if federal funding is insufficient to meet your states SCHIP obligations going forward?

☐ Yes ☐ No ☐ Don't Know

b. If you answered "Yes", please describe the anticipated:

i. Medicaid fiscal impact (check one): ☐ Insignificant ☐ Moderate ☐ Significant

ii. Medicaid enrollment impact (check one): ☐ Insignificant ☐ Moderate ☐ Significant

Comments: _____

19. Medicaid and Health Care Reform

a. Is your state planning to implement a plan to reduce the number of uninsured in your state in FY 2008 or FY 2009? ☐ Yes ☐ No

b. If you answered "Yes" to question 18a above,

i. Describe the significance of the Medicaid program's role in the financing of coverage under the plan: ☐ None/Insignificant ☐ Some or modest ☐ Significant

ii. Describe the significance of new proposed Medicaid enrollments under the plan: ☐ None/Insignificant ☐ Some or modest ☐ Significant

Comments: _____

20. Outlook: What do you see as the most significant issues Medicaid will face over the next one or two years?_____

This completes the survey. Thank you very much.

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