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The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010

Prepared by
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Kaiser Family Foundation

September 2009

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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We thank the Medicaid directors and their staff in all 50 states and the District of Columbia, who took the time to complete the survey on which this study is based. Officials in every state provided information about their programs and their plans for the future, participated in structured interviews and responded to our follow-up questions. Without their help the study could not be done, and we truly appreciate their assistance.

We offer special thanks Dennis Roberts at Health Management Associates who developed and managed the data base. His work as usual was excellent and invaluable. Jenna Walls and Donna Marks from Health Management Associates assisted with the case studies and we thank them for their excellent work.

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Executive Summary

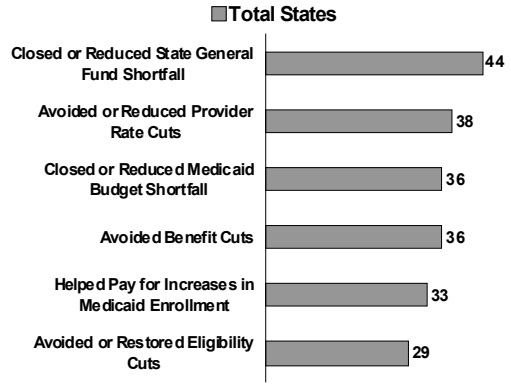
The recession was the dominant driver of Medicaid spending and enrollment growth as well as changes in policy for state fiscal years 2009 and 2010. Rising unemployment, sharp declines in state revenues and higher demands for public programs including Medicaid left states with severe budget gaps. The impact of the temporary Medicaid fiscal relief provided through the American Recovery and Reinvestment Act (ARRA) proved to be critical in helping states balance their budgets and protect their Medicaid programs, but states still felt pressure to control Medicaid spending growth. In addition to the issues related to the recession, states were also considering the effect of federal health reform proposals that would include a greater role for Medicaid. Today, Medicaid provides affordable and comprehensive health coverage and long-term care support services to 60 million individuals. The program is administered by the states within broad federal guidelines, but financing is shared by the states and the federal government.

For the ninth 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 also includes background on the Medicaid program, as well as current issues facing the program. Findings are presented for state fiscal years (FYs) 2009 and 2010.

Facing severe state budget shortfalls in FY 2009 and FY 2010, the Medicaid fiscal relief funds in ARRA helped states to address budget shortfalls, preserve Medicaid eligibility and avoid or soften program cuts (Figure 1). At the end of state FY 2009 and headed into FY 2010, states were facing severe fiscal pressures from the recession. The national unemployment rate hit 9.7 percent in August 2009, up from 4.9 percent at the start of the recession in December 2007. States experienced the sharpest decline in revenue on record, projected budget shortfalls of at least $350 billion through 2011, and saw accelerating Medicaid caseload growth. Nearly all states had taken actions to cut program spending and cut spending for state employees. The ARRA provides an estimated $87 billion in relief to all states through enhanced federal Medicaid matching funds from October 1, 2008 through December 31, 2010. These funds were able to reach states quickly and were used to address both overall state budget and Medicaid budget shortfalls; avoid cuts to providers, benefits and eligibility, and help support increased Medicaid enrollment. Many states reported multiple uses for the ARRA funds meaning that a range of restrictions would have likely occurred without the additional federal funds.

ES Figure 1

How States Used ARRA Enhanced Medicaid Funding in FY 2009

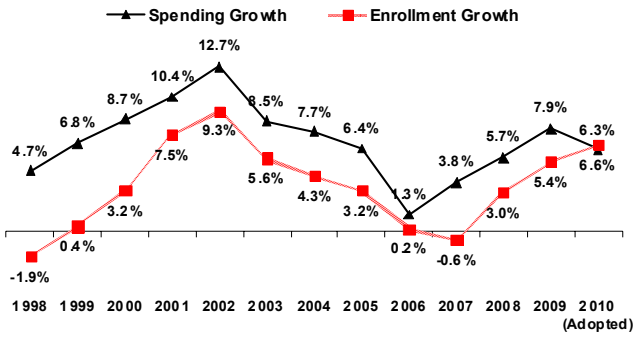


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

As a result of the recession, Medicaid spending and enrollment growth accelerated in FY 2009 well above original projections and higher enrollment growth is expected again in FY 2010 (Figure 2). Total Medicaid spending growth averaged 7.9 percent across all states in FY 2009, the highest rate of growth in six years and higher than the original projections of 5.8 percent growth. Medicaid Directors overwhelmingly attributed the growth to higher than expected increases in caseload due to the recession. Enrollment growth averaged 5.4 percent in FY 2009, significantly higher than the 3.6 percent enrollment growth projected at the start of FY 2009. For FY 2010, states projected that Medicaid enrollment growth would continue to accelerate, increasing on average by 6.6 percent above FY 2009 levels. For FY 2010 spending, initial legislative appropriations authorized total spending growth that would average 6.3 percent above FY 2009 spending, lower than enrollment growth. However, Medicaid officials in three-fourths of the states believed there was at least a 50-50 chance that initial FY 2010 legislative appropriations would be insufficient, including a dozen states where a Medicaid budget shortfall was regarded as almost certain. Thus, the FY 2010 growth rate for total Medicaid spending is expected to be higher than 6.3 percent. Due to the enhanced FMAP from ARRA, state general fund spending for Medicaid declined by an average of 6.3 percent. Legislatures appropriated further reductions in state general funds that averaged 5.6 percent for FY 2010. These declines in state spending are the first in the program's history.

ES Figure 2

Percent Change in Total Medicaid Spending and Enrollment, FY 1998- FY 2010



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

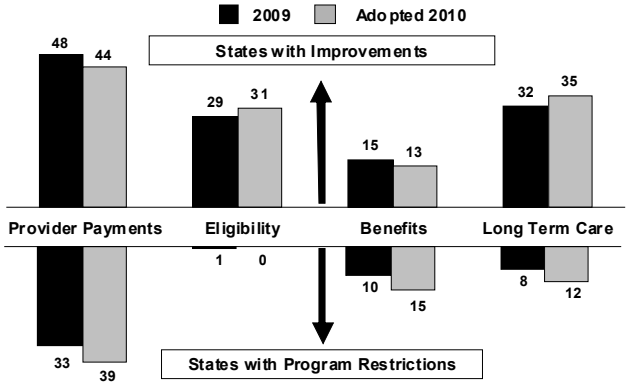
SOURCE: Enrollment Data for 1998-2008: *Medicaid Enrollment in 50 States*, KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2009 and FY 2010 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

Even with the relief from ARRA, nearly every state implemented at least one new Medicaid policy to control spending in FYs 2009 and 2010 with more states implementing provider cuts and benefit restrictions than in the previous few years (Figure 3). Some states reported program reductions in multiple areas and also reported that mid-year budget reductions were possible. While most states mentioned that ARRA helped to avoid or mitigate provider rate cuts, many more states cut or froze rates in FY 2009 than planned (33 versus 22 states) and even more states are cutting or freezing rates for FY 2010 (39 states). Several states are considering additional provider rate cuts that have not yet been implemented. More than any other policy area, provider payment rate changes have served as a barometer of fiscal conditions. All states cut provider rates during the last economic downturn from 2001 to 2004, but then worked to restore these cuts as the economy improved in 2005 to 2008, and now

states are once again turning to rate restrictions to generate program savings. Rate cuts can jeopardize provider participation and therefore access to needed care. ARRA also helped states avoid or mitigate the severity of Medicaid benefit cuts in FY 2009; however, the number of states reporting benefit restrictions for FY 2009 (10 states) or FY 2010 (15 states) increased significantly from FY 2008. These benefit cuts include the elimination of covered benefits, the application of utilization controls or limits for existing benefits. In California, Michigan and Utah, however, the benefit cuts were more extensive with multiple benefits eliminated.

ES Figure 3

State Policy Actions, FY 2009 – FY 2010



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. Eligibility includes eligibility and application expansions/restrictions.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

ARRA helped to protect Medicaid eligibility. To be eligible for the enhanced federal matching funds in ARRA, states could not restrict their Medicaid eligibility standards, methodologies or procedures more than those in place on July 1, 2008. States that had implemented restrictions had to reverse the restrictions to come into compliance with the ARRA maintenance of eligibility requirements. According to this survey, ARRA requirements resulted in 14 states reversing and 5 states abandoning planned restrictions to eligibility. Separate from these eligibility changes tied to ARRA, 29 states in FY 2009 and 31 states in FY 2010 reported positive eligibility changes to increase eligibility standards or initiatives to streamline application processes despite worsening fiscal conditions. Some of the efforts to streamline enrollment could help states qualify for performance bonus payments related to increased Medicaid enrollment that were enacted as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA). Many eligibility changes are expected to affect only a small number of beneficiaries, but Colorado, Maryland, New York, Oklahoma, and Wisconsin are implementing broader reforms and eligibility expansions.

While the majority of states continue to expand and improve options for community based long-term care, there are fewer states adopting these policies compared to FY 2008. In FY 2009, 32 states took actions that expanded LTC services (primarily expanding home and community based services (HCBS) programs, and 35 states planned expansions for FY 2010 compared to 42 states in FY 2008. However, states reporting long-term care reductions (eight states in FY 2009 and 12 in FY 2010) tended to be more focused on HCBS services (rather than institutional services) than in the

past. Most states already have limits in place for HCBS such as coverage limits, enrollment caps, and waiting lists for services, but states' ability to impose certain eligibility HCBS restrictions is currently limited by the ARRA maintenance of eligibility (MOE) requirements. For example, states are prohibited from increasing stringency in institutional level of care determination processes or from reducing waiver capacity as of July 1, 2008.

States continue to adopt policies to manage and coordinate care, to improve quality and to expand the use of health information technology. Nineteen states in FY 2009 and 20 states in FY 2010 have implemented or plan to expand managed care by expanding service areas, adding eligibility groups to managed care, requiring enrollment into managed care or implementing managed long-term care initiatives. Specifically, six states in FY 2009 and eight states in FY 2010 have been applying the principles of managed care in the long-term care area. Twelve states in FY 2009 and 14 states in FY 2010 are implementing new or expanded disease management programs. In FY 2010, there was a dramatic uptick in Medicaid health information technology (HIT) initiatives, such as e-prescribing or electronic health records, driven, in part, by federal funding made available to states from the DRA Medicaid Transformation Grants and the HIT funding included in ARRA.

Looking forward, states struggle with the major uncertainties related to the economy and the outcome of national health reform. As states look ahead to FY 2011, considerable uncertainty remains regarding the prospects for improved economic conditions. While the recession may have officially ended by then, improvements in state revenues and slower enrollment growth are expected to lag behind other economic recovery indicators. With few options left to achieve significant additional Medicaid cost reductions, and faced with the expiration of the ARRA enhanced FMAP in December 2010, many states believe they may be pressured to consider previously unthinkable eligibility and benefit reductions. Another enormous "unknown" for states as they plan for the future is the outcome of health care reform discussions currently underway at the federal level. While Medicaid Directors generally support the principles underpinning federal reform, these changes could bring dramatic changes to state Medicaid programs. It is highly likely that federal health care reform, if successful, will build on existing state Medicaid programs potentially resulting in new fiscal and administrative challenges for states. Along with these challenges, however, is the potential opportunity to address the long desired goals of better managing high need populations (including the dual eligibles), simplifying Medicaid eligibility rules, streamlining the enrollment process, and closing the gaps in the current health care social safety net.

Introduction

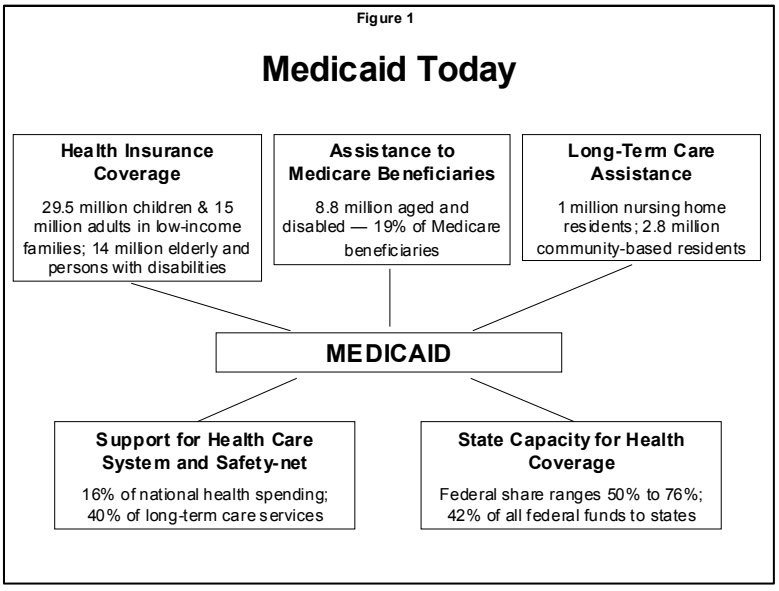
Most states endured severe fiscal challenges throughout 2009. Rising unemployment, sharp declines in state revenues and higher demands for public programs including Medicaid left states struggling to meet balanced budget requirements. These pressures continued and worsened as states adopted budgets for 2010. Federal fiscal relief through Medicaid proved to be critical in helping states address many budget gaps. In addition to the issues related to the recession, states were also considering the effect of federal health reform proposals that would include a greater role for Medicaid.

For the ninth 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 also includes background on the Medicaid program, as well as current issues facing the program. Findings are presented for state fiscal years (FYs) 2009 and 2010.

1. Medicaid Today

Medicaid serves multiple roles in the health care system. Medicaid provides health coverage and long-term care services and supports for 60 million low-income American including nearly 30 million low-income children, 15 million adults and 14 million elderly and people with disabilities. The program also provides assistance to 8.8 million low-income Medicare beneficiaries (dual eligibles) who rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care. 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., nearly half of all nursing home care, and critical funding for a range of safety-net providers. Finally, Medicaid represents the largest source of federal revenue to states, which provides a significant support for state capacity to finance health coverage (Figure 1).

Figure 1

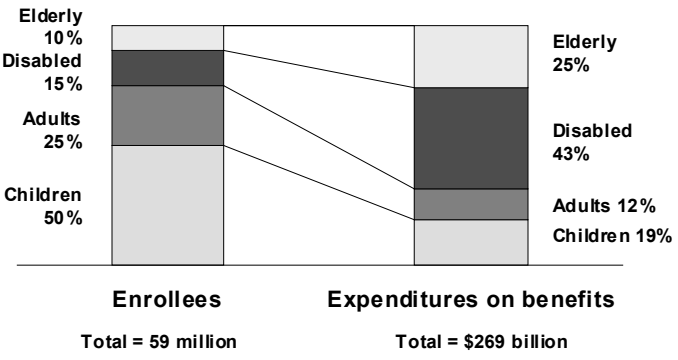


Most Medicaid spending is for the elderly and people with disabilities. About three-quarters of the beneficiaries served by the program are children and non-disabled adults, mostly parents. The elderly and people with disabilities represent just one-fourth of the share of program enrollees, but account for 70 percent of program spending because these groups tend to have higher utilization of acute and long-term care services (Figure 2). In fact, Medicaid data show that just 5 percent of Medicaid enrollees account for more than half (57%) of program spending.[1]

[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on MSIS 2004.

Figure 2

Medicaid Enrollees and Expenditures by Enrollment Group, 2006

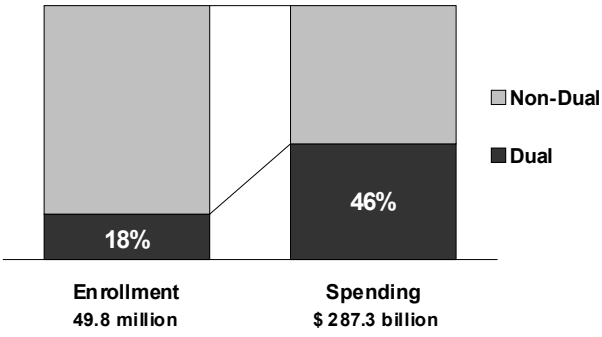


SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2006 MSIS data.

Dual eligibles represent a small portion of Medicaid enrollees, but a high percentage of costs. Nearly 9 million elderly and persons with disabilities rely on both the Medicare and Medicaid programs to obtain needed health and long-term services. These "dual eligibles," accounted for only 18 percent of Medicaid enrollment, but 46 percent of Medicaid expenditures in 2005, prior to the transfer of prescription drugs to Medicare (Figure 3). These same individuals accounted for 20 percent of Medicare enrollment and over 28 percent of Medicare spending. 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 from Medicaid to the Medicare Part D program on January 1, 2006, but states are required to finance a portion of this coverage through a payment to the federal government, often referred to as the "Clawback." States have called for better coordination between Medicare and Medicaid and across acute and long-term care services that will result in savings and better quality for beneficiaries.

Figure 3

Dual Eligibles' Share of Medicaid Enrollment and Spending, FFY 2005

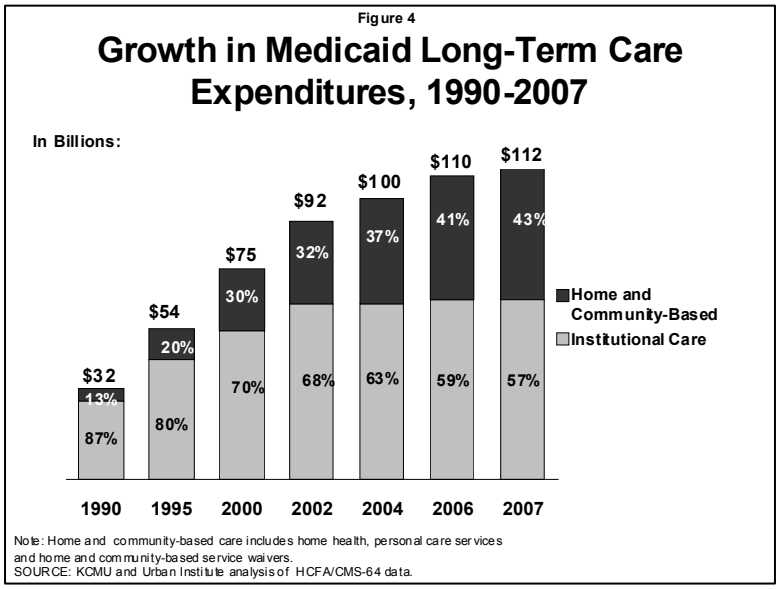


SOURCE: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2008.

Medicaid is the dominant source of coverage and financing for long-term services and supports. Medicaid plays a critical role for low-income people of all ages with long-term care needs. Persons 65 and older constitute over half (55%) of those who use Medicaid long-term care services, but roughly one-third (34%) are individuals under age 65 with a disability and another 11 percent are adults and children with long-term care needs. Unlike Medicare, which primarily covers physician

and hospital-based acute care services, Medicaid covers long-term services needed by people to live independently in the community such as home health care and personal care, as well as services provided in institutions such as nursing homes. Spending on long-term care services represents over a third of total Medicaid spending. Medicaid has evolved to become the primary payer for long-term services and supports to low-income individuals. Over the past two decades spending on Medicaid home and community-based services has been growing as more states attempt to reorient their long-term care programs by increasing access to home and community-based service options. In 2007, spending on home and community-based services accounted for 43 percent of total Medicaid long-term care spending, up from 13 percent in 1990 (Figure 4).

Figure 4

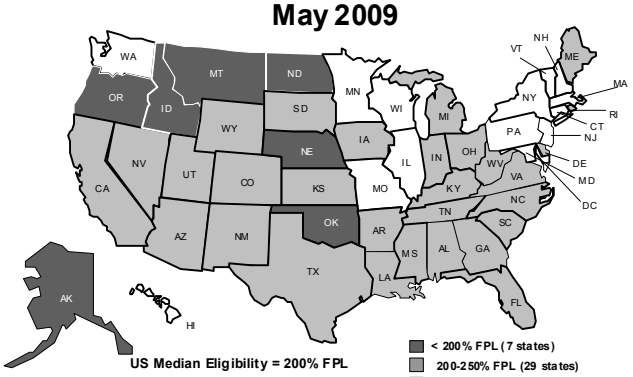


States administer Medicaid within broad federal guidelines. Within the federal guidelines, each state decides who qualifies for coverage, what medical benefits to cover, how much to pay medical providers who serve enrolled individuals, whether to use managed care or another delivery system, how the program is organized and administered, and how to use Medicaid to address state policy priorities such as covering uninsured children and adults.

Eligibility levels vary significantly across states. To be eligible for Medicaid, individuals must meet income and resource requirements and also fall into one of the categories of eligible populations. The federal government sets minimum eligibility levels for coverage and then states have the option to expand eligibility to higher incomes. Today, 44 states have set the Medicaid/CHIP income-eligibility level for children at or above 200 percent of the federal poverty level, but Medicaid coverage for parents is more limited with only 18 states above 100 percent of the federal poverty level and 33 states setting levels below 100 percent of the federal poverty level (Figures 5 and 6). Median coverage for the elderly and people with disabilities is about 74 percent of poverty (tied to the levels for Supplemental Security Income or SSI). Under federal law, states cannot cover adults without dependent children under Medicaid without a federal waiver. Low-income and high-need individuals covered by Medicaid generally do not have access to employer based or other private coverage.

Figure 5

Children's Eligibility for Medicaid/CHIP by Income, May 2009

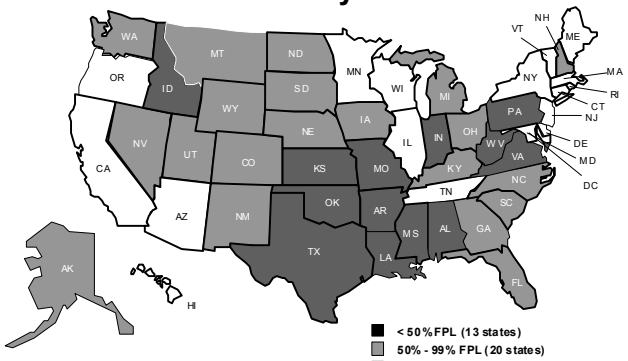


Note: 200% of the Federal Poverty Line (FPL) for a family of three was $35,200 per year in 2008. IL uses state funds to cover children above 200% FPL; MA uses state funds to cover children above 300% FPL; NY uses state funds to cover children from 250% to 400% FPL; WI uses state funds to cover children from 250% to 300% FPL.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Center on Budget and Policy Priorities, *Challenges of Providing Health Coverage for Children and Parents in a Recession*, 2009.

Figure 6

Medicaid Eligibility for Working Parents by Income, January 2009



*The Federal Poverty Line (FPL) for a family of three in 2008 is $17,600 per year.

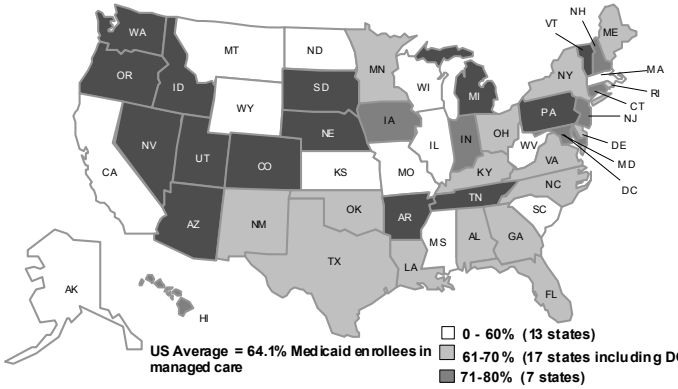
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2009.

Medicaid provides affordable and comprehensive benefits reflecting the health and long-term care needs of the population it serves. Medicaid provides a comprehensive benefits package of acute and long-term care services that has been designed to meet the needs of low-income and high-need populations served by the program, many of which have more serious health needs than the general population. For example, Medicaid covers an array of supportive and enabling services for high-need populations such as transportation, durable medical equipment, case management, and habilitation services, that are often not covered by private insurance plans. Medicaid also provides protections against high out-of-pocket expenses by prohibiting or limiting premiums and cost-sharing requirements.

Most Medicaid enrollees receive care through private managed care plans. The majority of low-income families on Medicaid receive their health coverage through private managed care organizations under contract with the state to provide comprehensive services and a provider network for beneficiaries (Figure 7). Through managed care arrangements and primary care case management, states have moved to both secure better access to primary care services and restrain costs. Many states have used managed care and pay-for-performance programs as a vehicle to improve the quality of services provided to Medicaid beneficiaries.

Figure 7

Over 60 Percent of Medicaid Beneficiaries Enrolled in Managed Care



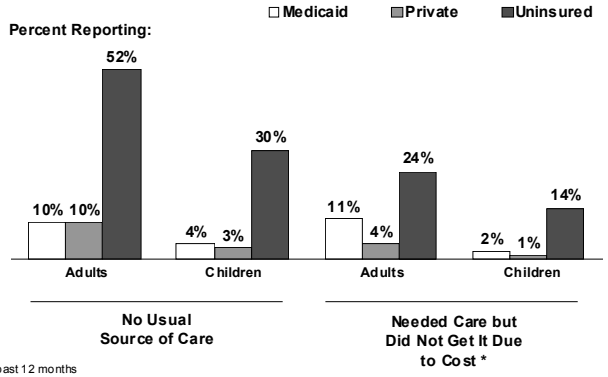
Note: Managed care includes individuals enrolled in managed care organizations (MCOs) and primary care case management (PCCM) arrangements.

SOURCE: Medicaid Managed Care Penetration Rates by State as of June 30, 2007, CMS, U.S. Department of Health and Human Services.

Medicaid compares favorably to private insurance in terms of access and cost. Medicaid enrollees fare as well as the privately insured populations on important measures of access to primary care, even though they are sicker and more disabled. Accounting for the health needs of its beneficiaries, Medicaid is a low-cost program with lower per capita spending than private insurance (Figures 8 and 9).

Figure 8

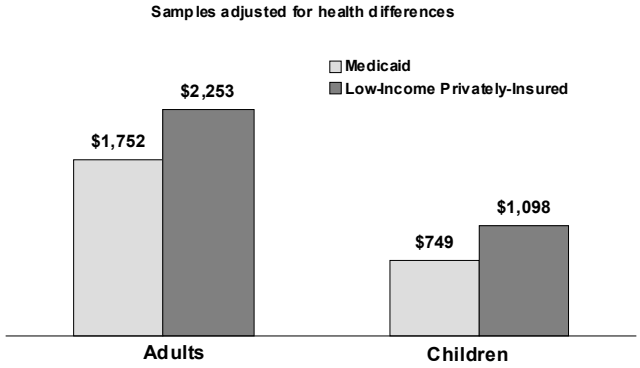
Access to Care: Medicaid Comparable to Private Insurance



* In the past 12 months
NOTE: Respondents who said usual source of care was the emergency room were included among those not having a usual source of care
SOURCE: KCMU analysis of 2008 NHIS data

Figure 9

Per Capita Spending For Medicaid Enrollees vs. Low-Income Privately-Insured

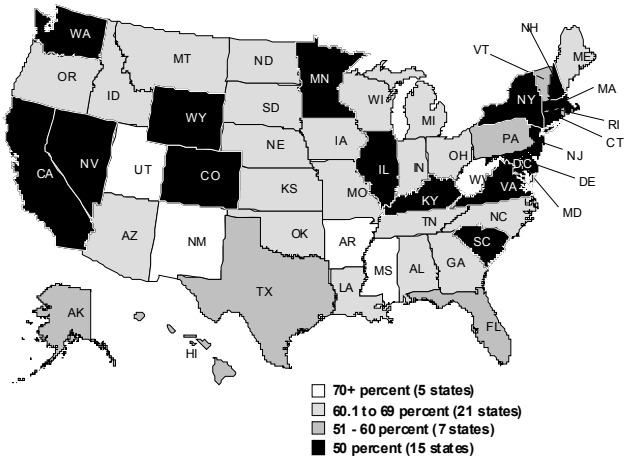


SOURCE: Hadley and Holahan, "*Is Health Care Spending Higher under Medicaid or Private Insurance?*" Inquiry, Winter 2003/2004.

Medicaid is financed by states and the federal government. The Medicaid program is jointly funded by states and the federal government. In 2006, total Medicaid expenditures exceeded $300 billion. The federal government guarantees matching funds to states for qualifying Medicaid expenditures, which includes payments states make for covered Medicaid services provided by qualified providers to eligible Medicaid enrollees. The federal matching percentage for each state (officially known as the Federal Medical Assistance Percentage, or FMAP) is calculated annually using a formula set forth in the Social Security Act. 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 used for FY 2010 is from the three years of 2005 to 2007 (Figure 10). According to the statutory formula, for 2010, the FMAP varies across states from a floor of 50 percent to a high of 76 percent[2]; however, states are receiving an

Figure 10

Federal Medical Assistance Percentages (FMAP), FY 2010



SOURCE: http://aspe.hhs.gov/health/fmap10.htm

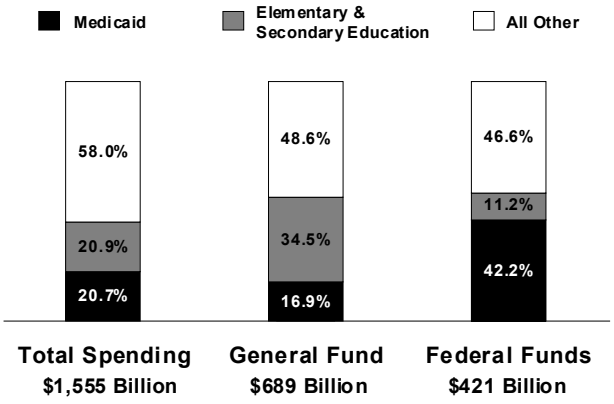
[2] In FY 2010, 11 states had an FMAP at the statutory minimum of 50.0 percent: CA, CO, CT, MD, MA, MN, NH, NJ, NY, VA and WY. The FMAP for WA is 50.12, NV is 50.16 and IL is 50.17 and DE is 50.21. In addition, the FMAP is set in statute for the territories at 50 percent, with a cap on federal matching funds.

enhanced FMAP as a result of the American Recovery and Reinvestment Act (ARRA), which increased the range of FMAPs from 56.2 percent to just above 80 percent, which is discussed later in the report. Each state receives the federal Medicaid funds after a state has first paid Medicaid providers for services that qualify for federal Medicaid matching funds and then has submitted a claim to the federal government for the funds.

Medicaid provides financing for a range of health care providers within communities across the country, supporting jobs, income and economic activity. The economic impact of Medicaid is magnified by the matching formula. At a minimum, states draw down $1.00 of federal money for every dollar of state funds spent on Medicaid; while on the flip side, states must cut at least $2 in program spending to save $1 in state funds. Federal Medicaid dollars represent the single largest source of federal grant support to states, accounting for an estimated 42 percent of all federal grants to states in 2008. On average, states spend about 17 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 2008 (Figure 11).

Figure 11

Distribution of Spending In the States, 2008



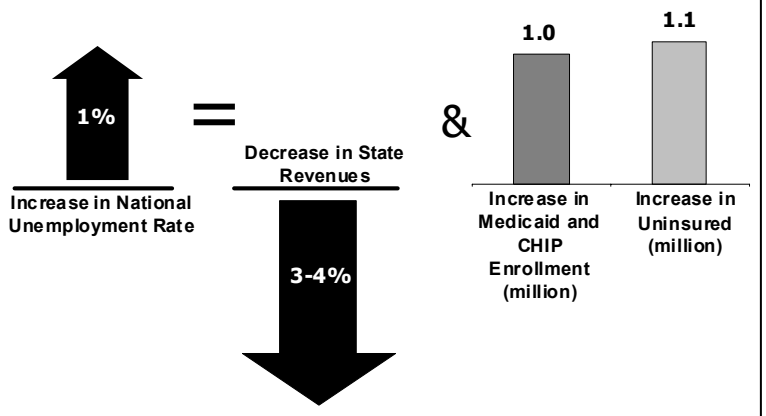
SOURCE: National Association of State Budget Officers, 2007 State Expenditure Report, Dec. 2008

2. Medicaid and the Economy

Headed into state fiscal year 2010, the national unemployment rate hit 9.7 percent in August 2009, state revenues were plummeting and states were facing budget shortfalls of at least $350 billion for FY 2010 through 2011. During an economic downturn, unemployment rises and puts upward pressure on Medicaid. As individuals lose employer sponsored insurance and incomes decline, Medicaid enrollment and therefore spending increase. At the same time, increases in unemployment have a negative impact on revenues making it even more difficult for states to pay their share of Medicaid spending increases. Specifically, a 1 percentage point increase in unemployment is expected to result in 1 million more Medicaid and CHIP enrollees and an additional 1.1 million uninsured, while state revenues are projected to fall by 3 to 4 percent (Figure 12). Increases in the national unemployment rate since the start of the recession are expected to result in about 4.5 million more Medicaid and CHIP enrollees and an additional 5 million uninsured.

Figure 12

Effect of a 1% Point Increase in Unemployment



SOURCE: *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses*, Kaiser Commission on Medicaid and the Uninsured, April 2008

3. Recent Legislative Action

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA was one of the first pieces of legislation passed by the 111th Congress and signed by President Obama on February 4, 2009. Many of the provisions in CHIPRA have direct implications for state Medicaid programs. The Act extends and expands the State Children's Health Insurance Program (now referred to as CHIP, not SCHIP) which was enacted as part of the Balanced Budget Act of 1997 (BBA). CHIPRA adds $33 billion in federal funds for children's coverage in Medicaid and CHIP over the next four and half years, and is expected to provide coverage to 4.1 million children who otherwise would have been uninsured by 2013.

CHIPRA provides fiscal incentives, new tools, and outreach funding for states to enroll children who are eligible but not enrolled in Medicaid and CHIP programs. The legislation includes some new coverage options for states including allowing the use of Medicaid and CHIP to cover legal immigrant children and pregnant women during their first five years in the country. This 5 year ban was originally imposed in 1996 as part welfare reform. CHIPRA phases out coverage for some adults currently covered by CHIP, and states have the option to transition these adults to Medicaid. CHIP funding for existing coverage of childless adults expires on December 31, 2009. Additionally, CHIPRA focuses on access and quality by adding a new Commission to focus on access and payment policies in Medicaid and CHIP and funding for quality initiatives and demonstrations related to quality measures and electronic health records.

American Recovery and Reinvestment Act (ARRA). In an effort to boost an ailing economy, Congress enacted and President Obama signed the ARRA on February 17, 2009. The overall package, expected to cost $787 billion, included significant funding for health care and state fiscal relief. Specifically, the Act included an estimated $87 billion for a temporary increase in the federal share of Medicaid costs from October 2008 through December 2010. This was the single most significant source of fiscal relief to states in the ARRA. Similar to relief provided in 2003 during the last economic downturn, these funds are designed to help support state Medicaid programs during a time of increased demand and when states are least able to afford their share of the program. The FMAP increase included a hold-harmless, a base FMAP rate increase, and then additional funding for states with significant increases in unemployment.

Other Legislation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided for an increase to the asset limits for Medicare Savings Programs (MSP), Medicaid QMB, SLMB and QI recipients. Currently the asset limits are $4,000 for an individual and $6,000 for a couple and are not indexed to inflation. Although states have the flexibility under Medicaid to use more generous asset rules, most states use the federal limits. MIPPA increases the MSP asset limits beginning January 1, 2010, to the same level as those used for the full Medicare Part D Low Income Subsidy (LIS), and indexes the limits to inflation thereafter. The full Part D LIS asset limit in 2009 is $8,100 for individuals and $12,910 for couples. Asset limits for 2010 are yet to be reported.

The Consolidated Appropriations Act, 2008, provided Afghans with refugee (similar to status given to Iraqi special immigrants) status for 6 months. This refugee status was extended to eight months in the Omnibus Appropriations Act of 2009, enacted on March 11, 2009.

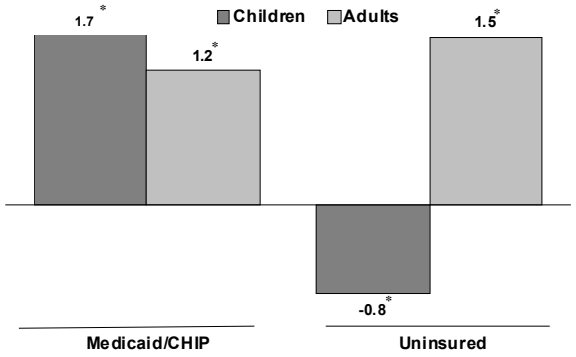
4. National Health Reform

Federal policy makers are engaged in a vigorous debate about how to reform the nation's health care system as health care costs, the uninsured, and national poverty continue to increase. Recent Census numbers show that from 2007 to 2008 the number of people in poverty increased by 2.6 million (from 12.5 to 13.2 percent) and the number of uninsured climbed to 46.3 million. The number of those in poverty and the uninsured is likely even greater now given the toll of the recession and that job loss has continued and was not accounted for by the 2008 Census data. The 2008 data show an increase of over 600,000 uninsured from 2007, which was moderated by the substantial increase in public coverage for children. The uninsured numbers this year show the tremendous impact of public program coverage (Medicaid and CHIP) as a safety net for children, with the number of uninsured children decreasing from 8.2 million in 2007 to 7.3 million in 2008 (800,000 fewer uninsured children) (Figure 13).

Figure 13

Change in Coverage for Nonelderly, 2007 – 2008

(Millions of Americans)



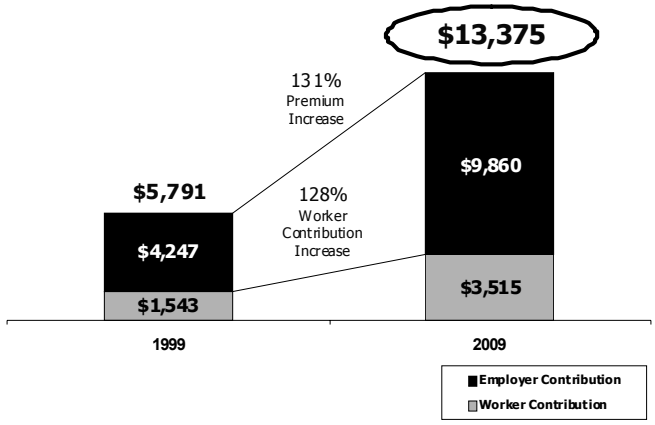
*Indicates change in percent of people is statistically significant (at the 95% confidence level).

SOURCE: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS.

While the growth in the cost of health insurance premiums has moderated somewhat in recent years, premiums for employer-sponsored health insurance rose to $13,375 annually for family coverage in 2009 (Figure 14). Family premiums rose about 5 percent this year while workers wages went up 3.1 percent and general inflation fell by 0.7 percent during the same period. Since 1999, premiums have gone up a total of 131 percent, far more rapidly than workers' wages (38 percent) or inflation (28 percent). The result has been an increasing problem of affordability for health care coverage particularly for low-income workers. Rising costs, increases in the uninsured, further losses in employer coverage and additional pressures on public health programs are all key factors contributing to the health care reform debate.

Figure 14

Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009



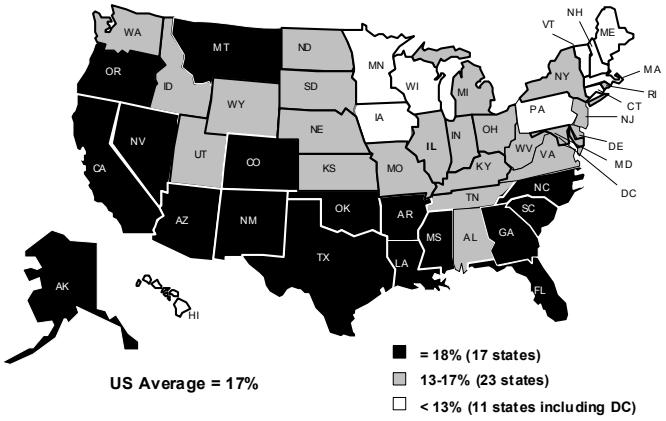
Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

A number of leading health reform proposals rely on a combination of public and private approaches to achieve broader coverage with shared responsibilities across employees, employers, government, consumers and insurance markets. Policy makers will debate the right mix of public and private coverage and how to integrate these systems. Given Medicaid's role in serving low-income and high-need populations and the statistics that two-thirds of the 46 million uninsured have incomes below twice the rate of poverty ($36,620 for a family of three in 2009) and many have significant health needs, Medicaid is a logical platform to extend coverage to more uninsured

The House Tri-Committee bill and the Senate Finance proposal would expand Medicaid to all individuals up to 133 percent FPL. The proposals would also simplify enrollment processes and coordinate eligibility determinations with a newly created health insurance exchange. Key issues for states about Medicaid expansions are related to additional financial responsibilities (especially during the recession), administrative and provider capacity and maintenance of eligibility requirements. Given variation in current state coverage levels and the rates of the uninsured, any Medicaid changes will affect states differently. States in the South and West have the highest uninsured rates but the fewest resources (Figure 15).

Figure 15

Uninsured Rates Among the Nonelderly, by State, 2007-2008



SOURCE: Urban Institute and KCMU analysis of the March 2008 and 2009 Current Population Survey. Two-year pooled estimates for states and the US (2007-2008).

Methodology

The Kaiser Commission on Medicaid and the Uninsured (KCMU) commissioned Health Management Associates (HMA) to survey Medicaid directors in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy making. This report is based on the 2009 survey and discussions with Medicaid directors and staff based on each state's response to the survey.

This is the thirteenth KCMU/HMA survey of Medicaid officials to address these issues, including nine surveys conducted at the beginning of state fiscal years 2002 through 2010, and four mid-year surveys conducted during times of economic downturn in fiscal years 2002, 2003, 2004 and 2009 when many states made mid-year Medicaid policy changes due to shortfalls in state revenues.[3]

The KCMU/HMA Medicaid survey on which this report is based was conducted in July and August 2009. The survey was designed to document the policy actions states had taken in the previous year, state FY 2009, and new policy initiatives that they had implemented or expected to implement in state FY 2010, which for most states had begun on July 1, 2009.[4] At the time each state survey was finalized, the FY 2010 Medicaid budget had been adopted by the Legislature in all states except Michigan, where the state fiscal year begins October 1st. The Michigan survey responses reflected the proposed Executive budget as of August 2009; responses were re-confirmed on September 21, 2009, but remained subject to change pending the outcome of final legislative budget decisions.

The 2009 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: the overall state economic and budget situation, issues related to the enhanced Medicaid funding provided through the American Recovery and Reinvestment Act of 2009 ("ARRA"), and pending federal health reform discussions.[5]

The data for this report 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 June 2009. Personal telephone interviews occurred in July and August 2009. The telephone discussions 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 and ensure complete responses and to record the nuances of state actions. For most states, the interview included the Medicaid director along with Medicaid policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid policy or budget official. Survey responses were received from all 50 states and the District of Columbia.

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[3] 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; http://www.kff.org/medicaid/7699.cfm. The previous annual report issued September 2009 is at: http://www.kff.org/medicaid/7815.cfm . The mid-fiscal year 2009 report issued January 2009 is at: http://www.kff.org/medicaid/7848.cfm .

[4] 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.

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

Each annual survey focuses on policy directions, policy changes and new initiatives. The survey does not attempt to catalog all current policies. This survey asked state officials to describe policy changes that occurred in FY 2009, the previous fiscal year, and new policy changes that were implemented or would be implemented in FY 2010. The survey includes only policy changes already implemented in FY 2009 or FY 2010, or for which there was a definite decision to implement in FY 2010. Policy changes under consideration but for which a definite decision has not yet occurred are not included, even though they may be implemented during FY 2010. At the same time, previous surveys have documented that some actions listed at the time of the survey as definitely planned for implementation might not be implemented in the upcoming year. Medicaid policy initiatives often involve complex administrative changes, computer system updates, specific advance notice requirements and various political, legal and fiscal considerations. As a result, adopted policy changes sometimes are delayed or reconsidered.

This report also includes case studies of four states (Connecticut, Nevada, Washington and Wisconsin.) These state profiles provide specific examples of policy changes states are making, including program expansions and improvements, as well as cutbacks, as they deal with the fiscal challenges common across states in FY 2009 and FY 2010. The four state case studies are included as Appendix B in the report.

Where possible, the results from previous surveys are referenced to provide context and perspective for the results of this survey and to illustrate trends. For example, Medicaid cost containment actions in FY 2009 and FY 2010 are compared to information from previous surveys to show the number of states adopting specific cost containment actions over the period from FY 2004 to 2010.

Annual rates of growth for Medicaid spending and enrollment are calculated as weighted averages across all states. For FY 2009 and FY 2010, average annual Medicaid spending growth was calculated using weights based on the most recent available state Medicaid expenditure data, as reported by the National Association of State Budget Officers (NASBO) *State Expenditure Report*, December 2008. Average annual Medicaid enrollment growth is calculated using weights based on state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2008. For years prior to the periods covered by the KCMU/HMA surveys, Medicaid spending and enrollment data are based on estimates prepared for KCMU by the Urban Institute using data from Medicaid financial management reports (CMS Form 64), adjusted for state fiscal years.

Survey Results for Fiscal Years 2009 and 2010

1. State Fiscal Conditions and Overall Impact of ARRA

Key Section Findings:

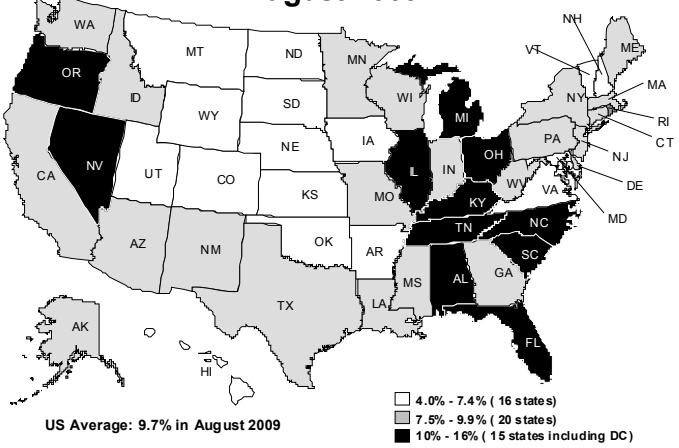
- States endured severe fiscal challenges in FY 2009 and into FY 2010 with unemployment rising, revenues declining and demand for public programs growing.
- ARRA funds were used to address both overall state budget and Medicaid budget shortfalls, avoid cuts to providers, benefits and eligibility, and to help support increased Medicaid enrollment. Many states reported multiple uses for the ARRA funds meaning that in these states a range of restrictions would have likely occurred without these additional funds.

A. State Fiscal Conditions

The national unemployment rate climbed to 9.7 percent in August 2009, up from 4.9 percent in December 2007 at the start of the recession. In August 2009, 15 states (including the District of Columbia) had unemployment rates at or above 10 percent (Figure 16). Since the start of the recession, over 7.4 million individuals have lost their jobs and there are an estimated 14.9 million unemployed. Among those working, 9 million want to work full-time but have had to settle for part-time employment and 2.3 million individuals wanted to work and had looked for work in the past year, but are no longer counted in the labor force because they had not looked for work in the past four weeks.

Figure 16

States with Unemployment Rates at Various Levels, August 2009



SOURCE: State and territory figures from the Table 3, *Regional and State Employment and Unemployment: September 2009*, Bureau of Labor Statistics.

States were experiencing major fiscal challenges heading into fiscal year 2010, which began for most states on July 1, 2009. Forty-eight states are projecting budget shortfalls that could total $163 billion in 2010, and at least $350 billion through 2011.[6] Data for the first quarter of 2009 (January through March) show state tax revenue went down in 44 states by 11.8 percent from the same period in 2008, the sharpest decline on record. Real per capita revenues dropped by over 10 percent in eight states (Arizona, California, Florida, Georgia, Nevada, South Carolina, Utah and Virginia).[7]

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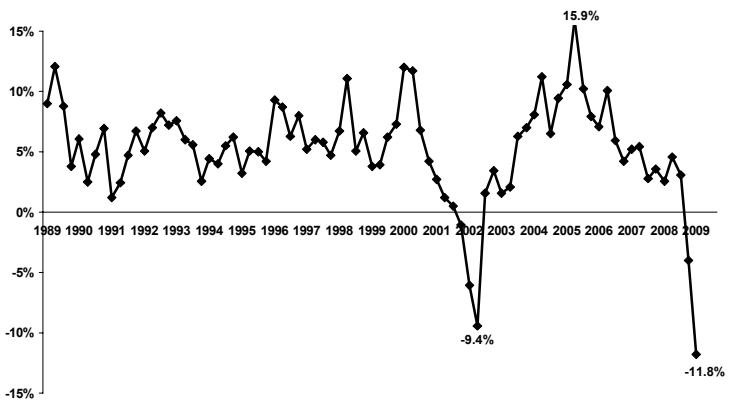
[6] Elizabeth McNichol and Iris Lav, "New Fiscal Year Brings Relief from Unprecedented State Budget Problems" CBPP, September 3, 2009.

[7] Donald J. Boyd, "Coping with Effects of Recession in the States," The Rockefeller Institute of Government, Presentation for Governmental Research Association Annual Conference, Washington, DC, July 27, 2009. www.rockinst.org

Personal income taxes dropped by 17.6 percent, corporate net income by 19.9 percent and general sales tax by 8.3 percent (Figure 17).

Figure 17

State Tax Revenue, 1999-2009



SOURCE: Percent change in quarterly state tax revenue, US Census Bureau

Unlike the federal government, states are legally required to balance their budgets. States can use reserves or rainy day funds, increase taxes or cut spending to achieve a balanced budget during periods of economic stress. Nearly all states have reduced program spending to balance their budgets and in the large majority of states some actions are expected to impact vulnerable residents. A recent report shows that 41 states and the District of Columbia are enacting cuts in all major program areas from health care, to K-12 education, higher education, and services for the elderly and disabled.[8] At least 42 states and DC have made cuts to state employees by reducing wages, layoffs, furlough days, and hiring freezes.[9] These cuts to the state work force affect Medicaid making it more challenging to administer the program and process applications.

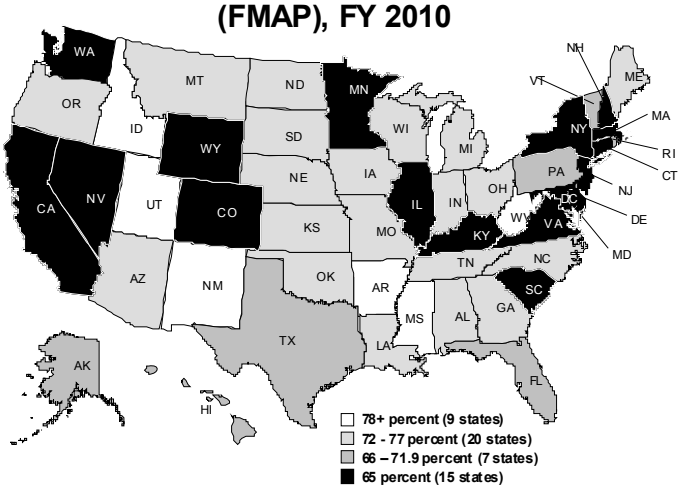
B. Impact of ARRA

Recognizing that states were facing a fiscal emergency that would make it difficult to maintain essential services, including Medicaid, Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA), which the President signed into law on February 17, 2009. The largest component of state fiscal relief was provided through a temporary increase in the FMAP for states. Under ARRA, there are three factors used to calculate a state's FMAP increase: First, the legislation would provide a "hold-harmless" to prevent states from receiving a formula-driven reduction in their FMAP. Second, all states would receive a 6.2 percent base increase in their FMAP. Third, states with significant increases in unemployment over a base rate would receive a 5.5 percent, 8.5 percent or 11.5 percent reduction in their state share of Medicaid costs. The base rate is the lowest three month average state unemployment rate since January 2006. ARRA increases the federal share of Medicaid, with over half of all states with FMAPs at 70 percent or greater (Figure 18).

[8] Nicholas Johnson, Phil Oliff and Erica Williams, "An Update on State Budget Cutes," CBPP. September 3, 2009
[9] Ibid

Figure 18

Enhanced Federal Medical Assistance Percentages (FMAP), FY 2010



SOURCE: http://aspe.hhs.gov/health/fmap10.htm

The ARRA provided immediate fiscal relief to states through Medicaid. Once the funds were earned through payments for qualified Medicaid expenditures to medical providers, the federal matching funds were available to use as determined by the state. As of June 19, 2009, 90 percent of the $29 billion in Recovery outlays from the Treasury for use by states and localities were tied to the increased Medicaid FMAP[10].

To be eligible for the enhanced federal financing, states must comply with provider prompt payment requirements and may not have eligibility standards, methods or procedures that are more restrictive than those effective on July 1, 2008. The increased FMAP does not apply to payments for eligibility expansions implemented on or after July 1, 2008. The ARRA extended emergency unemployment compensation benefits for workers from March 31, 2009 to December 31, 2009 and disregards the monthly equivalent of any additional compensation paid under these provisions in determining Medicaid and CHIP eligibility. States must also submit a report on how the increased FMAP funds were used by September 2011.

This survey addressed the question of how states used the ARRA funds that flowed through Medicaid. In general, it can be said that states used the ARRA enhanced Medicaid funding just as it was intended, which is to say in every possible way to address budget shortfalls in the states (Figure 19). The ARRA funds clearly assisted Medicaid and avoided or ameliorated program restrictions that would have occurred without the influx of these dollars. Without these funds, significant restrictions would almost certainly have been adopted that would have impacted Medicaid beneficiaries as well as providers. ARRA funds were used to address both overall state budget and Medicaid budget shortfalls; avoid cuts to providers, benefits and eligibility, and help support increased Medicaid enrollment. Almost half of states indicated that the ARRA funds were used in five or more of the six listed options, meaning that in these states a range of restrictions would have likely occurred without the additional federal funds.

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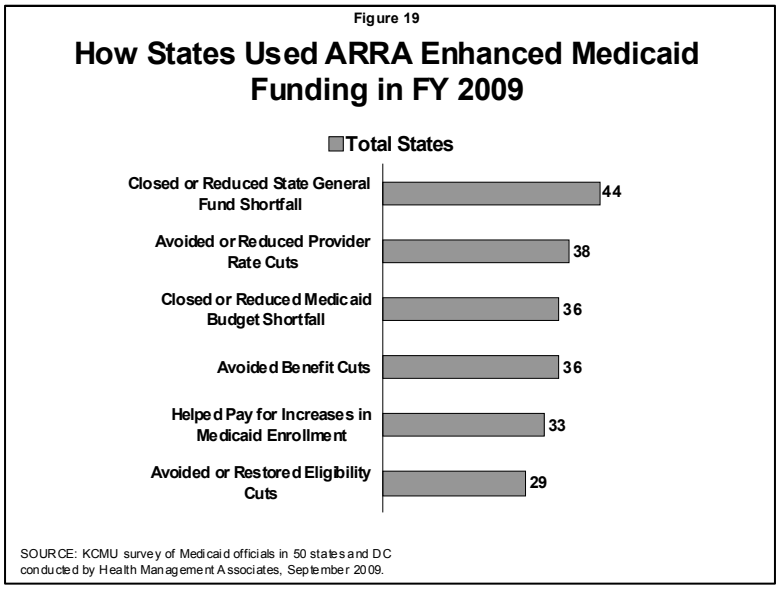
[10] "Recovery Act: States' and Localities' Current and Planned Uses of Funds While Facing Fiscal Stresses." GAO, July 2009.

Figure 19



As states begin to think about developing their 2011 budgets, few if any expect a full economic recovery. There is grave concern about the prospects of the end of the enhanced FMAP which is scheduled for December 31, 2010, the half-way point in fiscal year 2011 for most states. Medicaid officials believe that major program cuts will be considered, perhaps on a scale not ever seen in Medicaid. Many Medicaid directors expressed a hope that federal policymakers will find a way to extend the enhanced FMAP so as to avoid the need to consider such cuts that almost certainly would include restrictions on eligibility that have been prohibited by ARRA. One Medicaid director said, "It will be something between bad and real bad. It all depends on the economy." Another said "Without relief or replacement of lost funding, [our state] will not have a viable Medicaid program." Recovery in state revenues and employment tend to lag behind other indicators which will mean that the effects of the recession are likely to persist for states even as the economy starts to pick up.

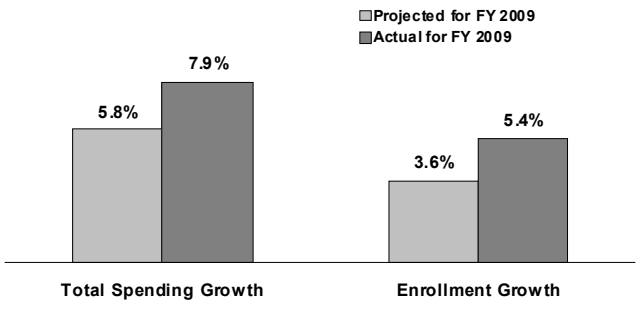
2. Medicaid Spending and Enrollment Growth Rates

Key Section Findings:

- Medicaid spending growth accelerated in FY 2009 averaging 7.9 percent across all states, the highest rate of growth in six years and higher than the 5.8 percent rate of growth originally projected. Medicaid Directors overwhelmingly attributed the growth primarily to higher than expected caseload growth related to the recession (Figure 20).
- For the first time in the program's history, state general fund spending declined on average by 6.3 percent in FY 2009 due to the ARRA enhanced FMAP applicable to nine months of FY 2009. Legislatures appropriated further reductions in state general funds that averaged 5.6 percent for FY 2010. States must still make Medicaid payments before drawing down their federal match.
- Enrollment growth averaged 5.4 percent in FY 2009, the highest rate in six years, reflecting the impact of the recession. This was significantly higher than the 3.6 percent enrollment growth projected at the start of FY 2009. For FY 2010, states projected that Medicaid enrollment growth would continue to accelerate, increasing on average by 6.6 percent above FY 2009 levels (Figure 21).
- For FY 2010 spending, initial legislative appropriations authorized total spending growth that would average 6.3 percent above FY 2009 spending, lower than enrollment growth. However, Medicaid officials in three-fourths of the states believed there was a 50-50 chance that initial FY 2010 legislative appropriations would be insufficient, including a dozen states where a Medicaid budget shortfall was regarded as almost certain. Thus, the FY 2010 growth rate for total Medicaid spending is expected to be higher than 6.3 percent.

Figure 20

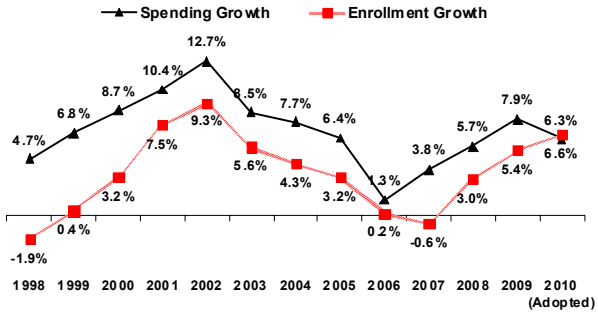
Projected and Actual Total Medicaid Spending and Enrollment Growth for FY 2009



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008 and September 2009.

Figure 21

Percent Change in Total Medicaid Spending and Enrollment, FY 1998- FY 2010



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

SOURCE: Enrollment Data for 1998-2008: *Medicaid Enrollment in 50 States*, KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2009 and FY 2010 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

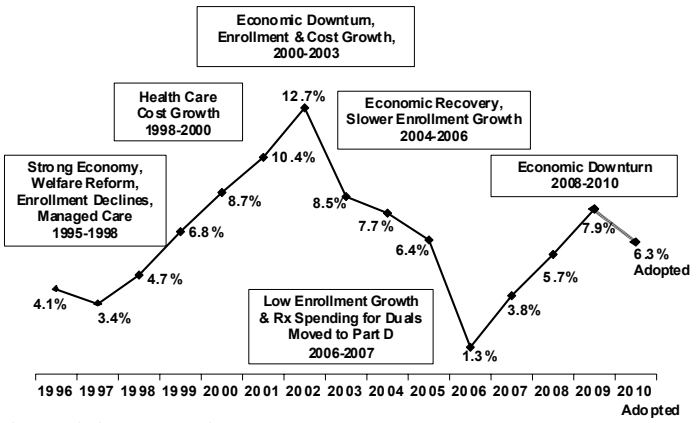
A. Total Medicaid Spending Growth

Total Medicaid spending includes all payments to Medicaid providers for covered Medicaid services for enrolled Medicaid beneficiaries. Within this definition also are "disproportionate share" (DSH) payments to hospitals that qualify for special payments to subsidize part of the costs of care for persons on Medicaid or that are uninsured. Total spending does not include state obligations to finance a portion of the Medicare Part D prescription drug benefit for dual Medicare - Medicaid enrollees (the Clawback).[11] Total Medicaid medical spending also excludes Medicaid administrative costs. The sources of financing for total Medicaid payments include federal and state funds, and in some states, also includes local funds.[12]

Total Medicaid Spending Growth in Fiscal Year 2009. In state fiscal year 2009, total Medicaid spending increased by 7.9 percent above spending in FY 2008.[13] This was considerably higher than the 5.6 percent growth that was originally adopted last year for 2009 and higher than the historic record low growth that occurred in FY 2006 and FY 2007. This also marked the highest annual rate of growth in six years, when Medicaid spending increased by 8.5 percent in FY 2003 during the last economic downturn (Figure 22).

Figure 22

Total Medicaid Spending Growth, 1996-2010



NOTE: Data for State Fiscal Years, for total Medicaid spending, including state, local and federal funds.

SOURCE: Historic Medicaid Growth Rates from KCMU Analysis of CMS Form 64 Data, FY 2008, 2009 and 2010 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2009.

Over time, Medicaid spending growth has been driven by overall growth in health care costs and changes in economic conditions. Medicaid growth hit record low rates in FY 2006 and FY 2007 due to two primary factors: lower enrollment growth due to an improving economy and the implementation of Medicare Part D on January 1, 2006, which transferred the costs of prescription drugs for dual Medicaid – Medicare enrollees from Medicaid to Medicare mid-way through the state fiscal year 2006. States continued to pay part of the cost of prescription drugs for dual enrollees through a payment to the federal government (the "Clawback"), but these costs are no longer classified as Medicaid expenditures. After the effects of

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[11] Medicare Part D transferred fiscal responsibility for prescription drugs for dual eligibles from Medicaid to Medicare, effective on January 1, 2006. Federal law required states to finance a portion of these costs through a payment to the federal government generally known as the "Clawback. By law the Clawback is a source of financing for Medicare and is not a Medicaid expenditure, although many states continue to budget the Clawback payment as a part of Medicaid. For this survey, Medicaid expenditures exclude state Clawback payments when calculating spending growth.

[12] For this and previous surveys, Medicaid agencies were asked to use a consistent definition of expenditures from year to year in their calculation of annual rates of growth of total Medicaid spending. The definition was determined by each state and varied across states. In some states, for example, Medicaid-financed spending under the control of another agency such as mental health or public health agency may be included, and in other states not included. The national rates of growth in Medicaid spending reported here are the weighted averages of growth rates reported by each state, with the weights based on actual expenditures for each state in FY 2007, the most recent year for which state-by-state national data were available.

[13] FY 2009 spending levels were preliminary at the time of the survey, pending the actual closing of the fiscal year books.

Medicare Part D were seen in 2006 and 2007, the economy began to slow, causing annual average Medicaid spending growth to rebound to 5.7 percent in FY 2008, and spending growth continued to accelerate to 7.9 percent in FY 2009.

Total Medicaid Spending Growth for Fiscal Year 2010. The Medicaid budgets for FY 2010 were adopted in the spring and early summer of 2009, a time of increasingly high rates of unemployment, high growth in Medicaid caseloads and in most states actual declines in state revenues. State revenues declined on average by 11.7 percent in the first calendar quarter of 2009, the largest year-over-year quarterly drop on record.[14] When making decisions on the FY 2010 Medicaid budget, state legislatures had to balance the real fiscal demands of the program with the real constraints in availability of state revenues. The initial legislatively-adopted budgets for FY 2010 authorized increases in overall Medicaid spending that averaged only 6.3 percent, a figure lower than growth in 2009 and lower than expected enrollment growth. Medicaid spending historically has grown faster than enrollment, due to health care inflation, provider rate increases, and increases in utilization and intensity of services. However, with state revenues dropping and severe constraints on state general fund spending, in many cases, legislatures adopted budgets that in all likelihood will need supplemental funding, or will require additional mid-year actions to reduce the pace of Medicaid spending.

Medicaid officials in three-fourths of states indicated that the likelihood of a Medicaid budget shortfall in FY 2010 was at least 50 – 50, including officials in one-fourth of states who said a shortfall was almost a certainty. This was the highest proportion of Medicaid officials to say the likelihood of a shortfall was at least 50 – 50 since FY 2003 in the midst of the last downturn. Therefore, actual Medicaid spending in FY 2010 may exceed the initial legislative appropriation in many states resulting in higher national spending growth.

Factors Contributing to Growth in Total Medicaid Spending in FY 2009 and FY 2010. A year ago, at the beginning of FY 2009, Medicaid directors had listed provider rate increases as the factor that would contribute most to growth in Medicaid spending in FY 2009, as nearly every state adopted rate increases in FY 2008 or FY 2009. In many cases, these rate increases were intended to help Medicaid rates catch up with the health care marketplace after many years when rates were frozen or actually cut due to state fiscal difficulties caused by the previous economic downturn that began in 2001. However, looking back on the past year, Medicaid officials listed provider rate increases as a distant second factor contributing to Medicaid spending growth in fiscal year 2009.

The most significant factor was enrollment growth. Almost three-fourths of states (36 states) mentioned increasing Medicaid caseloads due to the economic downturn as the number one factor driving growth in Medicaid spending, with seven of the remaining states listing it as a second factor. Provider rate increases and health care inflation (often reflected in higher payments to hospitals and nursing homes) were cited by seven states as the primary factor and by 17 states as a secondary contributor to Medicaid spending growth. Several states indicated that rate increases had been adopted specifically to improve access to providers. Other factors included waiver and other long-term care expansions and increases in utilization of services.

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[14] Donald J. Boyd and Lucy Dadayan, "State Tax Decline in Early 2009 Was the Sharpest on Record," State Revenue Report, the Rockefeller Institute, July 2009.

For FY 2010, a total of 42 states listed growth in enrollment tied to high unemployment as the most significant factor expected to drive growth in Medicaid spending. At the same time, directors also expected rate increases and pressure from health care inflation to be important factors.

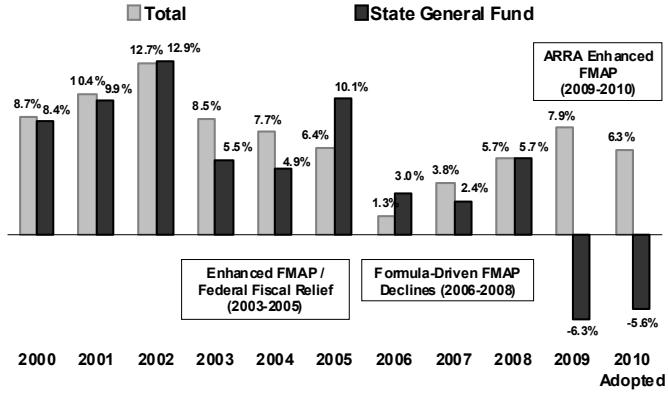
State officials also identified a number of factors that are constraining overall Medicaid spending growth. Primarily, these were specific policy changes related to provider rates, benefits, managed care, chronic care management and re-orienting the long-term care system. (These policy changes are described in detail later in this report.) In addition, state officials pointed to a number of administrative, information technology and program integrity initiatives, such as improvements in the Medicaid Management Information System that facilitated improved claims processing, better identification of other insurance that was primary to Medicaid, utilization management and improved fraud and abuse detection.

B. State General Fund Spending Growth for Medicaid and the Impact of ARRA

State and federal governments jointly pay for total Medicaid expenditures. State spending is matched with federal dollars at the federal matching rate (FMAP) which is determined by a statutory formula that relies on states' relative per capita income. State policy makers must consider how Medicaid spending affects state general fund dollars and federal revenues to states as a result of the match. Total Medicaid spending and state Medicaid spending typically grow at about the same pace; however, differences can result from changes in the FMAP, contributions from local governments, tobacco tax funding, special financing arrangements and provider tax revenues. For example, during the last economic downturn, federal fiscal relief in the form of an increased Medicaid match rate resulted in total Medicaid spending growth outpacing state general fund growth. Following that period, formula driven declines in the FMAP have resulted in the reverse. When the FMAP drops, states must pay more from state general fund dollars just to maintain their Medicaid program at the same level. Regardless of changes in the FMAP, states must make Medicaid payments before they draw their federal match.

Figure 23

Total and State Funds Medicaid Spending Growth FY 2000 - FY 2010



NOTE: State Fiscal Years. SOURCE: Historic Medicaid Growth Rates, KCMU Analysis of CMS Form 64 Data; FY 2008, 2009 and 2010, KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2009.

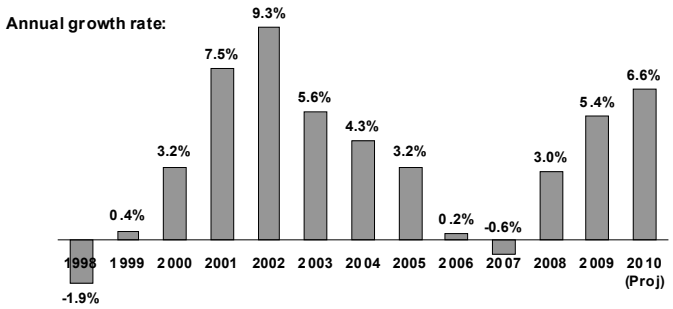
As a result of the enhanced FMAP from ARRA state general fund spending on Medicaid declined by 6.3 percent in FY 2009 and is expected to decline by 5.6 percent for FY 2010 compared to total spending growth increases of 7.9 percent in FY 2009 and 6.3 percent in FY 2010 (Figure 23). FY 2009 represented the first decline in state spending on Medicaid in the history of the program reflecting the infusion of almost $24 billion dollars in enhanced federal Medicaid matching funds to states over only a part of state fiscal year 2009 (the enhanced FMAP was in effect starting October 1, 2008, three months after the start of the FY 2009 fiscal year for most states). Negative growth in the state share of Medicaid funds did not occur during the last period of fiscal relief because the size of the federal funding was much smaller ($10 billion in 2003 and 2004) than the ARRA funds.

C. Medicaid Enrollment Growth

Medicaid enrollment trends are the primary driver of Medicaid costs. At the beginning of state fiscal year 2009, Medicaid officials had projected Medicaid enrollment to grow on average by 3.6 percent. However, the worsening economy contributed to increasing poverty and an average rate of growth of 5.4 percent about one and a half times faster than the original projections. In FY 2009, enrollment increased in every state and the District of Columbia. In eight states, the annual growth exceeded 10 percent. The 5.4 percent growth in FY 2009 was the highest rate of growth in Medicaid caseloads since 2003, and a significant departure from the experience of FY 2006 and FY 2007, when Medicaid enrollment nationally was essentially flat and about as many states had enrollment declines as increases (Figure 24).

Figure 24

Percent Change in U.S. Medicaid Enrollment, FY 1998- FY 2010



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

SOURCE: For 1998-2008: *Medicaid Enrollment in 50 States: June 2008 Data Update*, KCMU, August 2009. FY 2009 and FY 2010 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2009.

For FY 2010, Medicaid officials expect Medicaid enrollment growth to continue to accelerate. On average, the number of persons enrolled in Medicaid is projected to increase by 6.6 percent in FY 2010. This would be the highest annual rate of growth in the Medicaid caseload since the 9.3 percent annual increase that occurred in FY 2002 at the height of the last recession. Every state projects enrollment to increase in FY 2010, and two-thirds of states expect enrollment growth to exceed the pace they experienced in FY 2009. One-third of the states project enrollment growth of at least 8 percent, including four states projecting double-digit rates of growth.

In both FY 2009 and FY 2010, Medicaid officials indicated that most of the growth in enrollment was in the eligibility categories of children and families because these groups are more likely to be affected by the economy, by unemployment and by loss of health insurance. On the other hand, Medicaid enrollment of persons with disabilities and over age 65 is less affected by the economy and more so by demographic trends, including the aging of the population and the associated incidence of disability among persons who are older. Some Medicaid officials commented that the growth among children and families meant that the larger share of new enrollees was among categories for which costs tend to be lower.

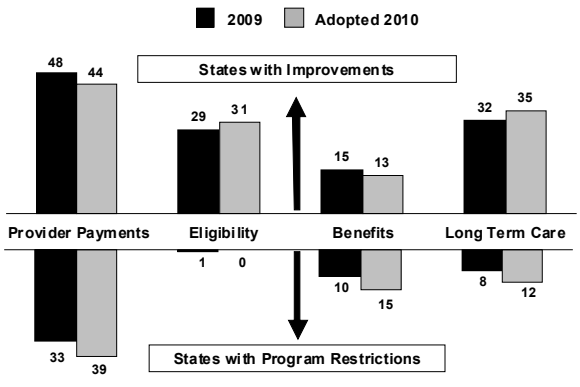
3. Medicaid Policy Initiatives for FY 2009 and FY 2010

Key Section Findings:

- In FY 2009, 46 states implemented at least one new Medicaid policy to control Medicaid costs and 47 states planned to do so in FY 2010. Some states reported program reductions in multiple areas and also reported that mid-year budget reductions were possible.
- While most states report ARRA helped to avoid or mitigate provider rate cuts, many more states cut or froze rates in FY 2009 than planned (33 versus 22 states) and even more states are cutting or freezing rates for FY 2010 (39 states). Additional provider rate cuts that have not yet been implemented are under consideration in several states (Figure 25).
- Despite worsening fiscal conditions, 29 states in FY 2009 and 31 states in FY 2010 improved eligibility (by making changes to eligibility standards or simplifying the eligibility and renewal process). Though not counted in these improvements, the ARRA maintenance of eligibility requirements protected eligibility standards and application / renewal procedures and resulted in 14 states reversing and 5 states abandoning restrictions (Figure 25).
- ARRA also helped states avoid or mitigate the severity of Medicaid benefit cuts in FY 2009; however, the number of state s reporting benefit reductions for FY 2009 or FY 2010 (10 and 15, respectively) increased significantly from FY 2008 (3) (Figure 25).
- In FY 2009, 32 states took actions that expanded LTC services (primarily expanding HCBS programs), and 35 states planned expansions for FY 2010. States reporting long term care reductions, tended to be more focused on HCBS services (rather than institutional services) than in the past (Figure 25).
- States continue to adopt policies to improve the quality of care provided to Medicaid beneficiaries. In FY 2010, there was a dramatic uptick in Medicaid health information technology (HIT) initiatives driven, in part, by federal funding made available to states from the DRA Medicaid Transformation Grants and the HIT funding included in ARRA.

Figure 25

State Policy Actions, FY 2009 – FY 2010



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. Eligibility includes eligibility and application expansions/restrictions.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

State by state policy actions including cost containment and program expansions are listed Appendices A-1 and A-2.

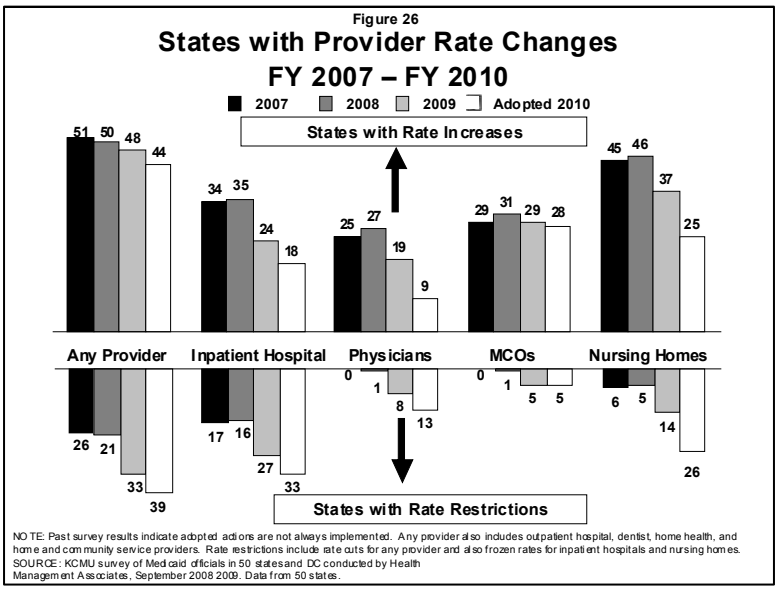
A. Changes in Provider Reimbursement

Rate Changes. In recent years, Medicaid provider payment rates have served as a barometer of state fiscal conditions as this policy area has been more directly affected than any other aspect of the Medicaid program. Every state froze or cut provider payment during the last downturn from 2001 to 2004, but starting in FY 2005, as the economy improved, states were less likely to cut and more likely to increase provider rates. This recession has seen renewed focus on cutting provider rates to control costs. Provider payment rates are an important determinant of provider participation and access to services for Medicaid beneficiaries. Medicaid typically pays providers less than Medicare or commercial insurance, and providers often cite low reimbursement rates as one of their primary reason for not participating in the program.

When Medicaid directors were surveyed in 2008, 22 states indicated that for FY 2009 they were either cutting provider rates or freezing rates to institutional providers (hospitals and/or nursing homes). However, even a few months into FY 2009, several states had already made previously unplanned provider rate cuts.[15] The enhanced FMAP available through ARRA mitigated some of the rate cuts that might have occurred. As noted in the discussion of the impact of ARRA, 38 states report that ARRA fund were used in part for provider payments – to avoid or reduce a provider rate cut. Even so, in FY 2009 there were 33 states that either cut rates to one or more categories of providers or froze rates to hospitals and/or nursing homes up from 22 states that had planned to cut or freeze these rates at the start of FY 2009.

Provider rates fared even worse in FY 2010 with a total of 39 states either cutting provider rates or freezing payments to hospitals and/or nursing homes for FY 2010 (Figure 26).[16] Across all major provider types, more states reported rate cuts or freezes than increases except for in managed care. While inpatient hospital services have historically received reimbursement based on costs or on Medicare rates, states are increasingly looking to this large component of the Medicaid program for rate cuts in challenging times. Hospitals are the most likely to have rates frozen or cut for FY 2010. MCOs are generally protected from cuts by the requirement that states pay actuarially sound rates, however, there are still five states cutting MCO rates in each of FY 2009 and FY 2010.

Figure 26



NOTE: Past survey results indicate adopted actions are not always implemented. Any provider also includes outpatient hospital, dentist, home health, and home and community service providers. Rate restrictions include rate cuts for any provider and also frozen rates for inpatient hospitals and nursing homes.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008 2009. Data from 50 states.

[15] Medicaid in a Crunch: A Mid-Year Update on State Medicaid Issues, January 2009, Kaiser Commission on Medicaid and the Uninsured. Available at http://www.kff.org/uninsured/upload/7848.pdf.

[16] As of September 2009, Michigan does not have a budget for FY 2010. Other states, such as Colorado, Maryland and Louisiana, have recently adopted reductions from the original rates proposed for FY 2010 and these changes are reflected in this report.

For FY 2009, 17 states actually reduced payment rates to hospitals, nursing homes, physicians or managed care organizations. At the start of FY 2009, there had only been five states that planned to cut rates to one or more of these groups during FY 2009. For FY 2010 there are 19 states that have already implemented rate cuts for one or more of these provider categories including: thirteen states will be cutting some or all physician rates and 12 states reducing hospital rates. Given that many states expect to see Medicaid budget shortfalls, additional rate cuts across provider groups can be expected.[17]

While the survey does not ask states the magnitude of the provider rate cuts or increases, several states making significant rate changes reported these statistics.

- ***California*** cut all provider rates but MCO rates by 10 percent in FY 2009;[18]
- ***New Hampshire*** cut inpatient hospital rates by 10 percent and outpatient rates by 33 percent in FY 2009;
- ***Utah*** cut hospital rates by 11.1 percent in FY 2010 and cut dental rates by 23.5 percent in 2010 after having cut them by 2.75 percent in FY 2009;
- ***Louisiana*** cut inpatient hospital rates by 3.5 percent in FY 2009 and an additional 6.3 percent in FY 2010, and also cut outpatient hospital rates by 3.5 percent and then an additional 5.65 percent;
- ***Maine*** cut both inpatient and outpatient hospital rates by 6.7 percent for FY 2010; and
- ***Nevada*** cut inpatient hospital rates by 5 percent in FY 2009.

48 states in FY 2009 and 44 states in FY 2010 increased or planned to increase rates for at least one provider group, slightly less than in previous years. Hospitals and nursing facilities (NFs) generally receive some form of cost-based reimbursement or are updated based on cost trends or inflation factors. As state economies improved in FY 2007 and FY 2008, all but five or six states increased NF rates each year and most states also increased hospital rates. For FY 2009 and FY 2010 there is a steep decline, with only 25 states expected to increase NF rates and 18 states expected to increase hospital rates. In recent years, many states experiencing declining physician participation used enhanced payment rates as part of their strategy to improve physician participation and patient access. States now find themselves unable to increase these rates. When surveyed in 2008, 27 states indicated plans to increase physician rates for FY 2009, but only 19 were able to do so. Now only nine states indicate any plans to increase physician rates for FY 2010.

A few notable rate increases occurred for dentists in Alaska (20% in FY 2009 and 11% in FY 2010), doctors in Alaska (8% in FY 2009), doctors in DC (moved to 100% of Medicare in FY 2009), doctors in Maine (7.5% in FY 2009 and 9.5% in FY 2010), doctors in Montana (6% in both FY 2009 and FY 2010), inpatient and outpatient hospitals in Ohio (5% in FY 2010), and dentists in South

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[17] States may face legal challenges to their rate cuts under the provisions of 42 USC §1396a(a)(30)(A) which requires state Medicaid programs to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

[18] All of the FY 2009 provider rate cuts, except for the 10% cut in payments to certain hospitals (mostly in rural areas) have been enjoined in federal court and therefore have not been implemented.

Dakota (8% in FY 2009). Additionally, New York, who has historically had low physician payment rates, raised its Medicaid physician fees substantially to bring them closer to the national average. In their FY 2009 – FY 2010 budget, the state dedicated $68 million to increasing reimbursement to these providers. When combined with last year's investment, New York's total investment in physician and other practitioner fees will reach $188 million.

Medicaid officials were asked an open-ended question whether provider rate changes in FY 2009 had an impact or were expected or intended to have an impact on provider access or participation. Sixteen states indicated that they had implemented rate increases in FY 2009 that were intended to improve access to care. Almost all of these were dental and/or physician rate increases. While these rate increases were intended to increase access, most states were unable to measure the change. However, Louisiana did report an 8 percent increase in the number of enrolled dentists. Some states indicated that it was too early to tell or that they would be studying the impact later this year (Maryland).

Impact of ARRA Prompt Payment Requirements

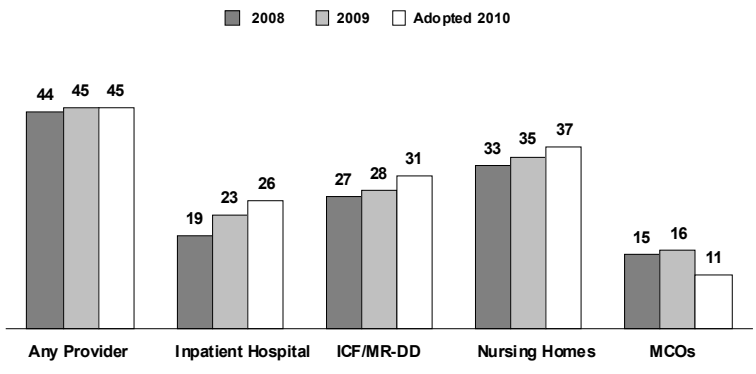
As a condition to receiving ARRA enhanced FMAP, states are required to meet prompt payment requirements and to report regularly to CMS on the timeliness of provider payments. Medicaid officials were asked to describe the impact, if any, of this requirement on their states. Some states questioned the value of daily reporting on the prompt payment information when many of them only pay providers on a weekly basis. The greatest fiscal impact may have been on Illinois which made supplemental provider payments and did short-term borrowing to come into compliance. Kentucky also experienced a change in cash flow as the time from receipt of claims to payment of claims was shortened to meet ARRA requirements. Pennsylvania also indicated that there was an increase in expenses associated with the shortened timeframe for claims payment.

Other responses were as follows: 23 states indicated that there was no impact from the new requirements; 13 states reported that there was significant work involved in developing the necessary reports to CMS, including the addition of staff in some states and six states indicated significant system issues. Some of these are states that are currently in the process of implementing new claims payment systems. Tennessee has already applied for a waiver of the prompt pay provisions while implementing a new statewide accounting and reporting system. Michigan and Wisconsin may also apply for waivers due to implementation of new claims payment systems. Six states indicated that the impact was unknown at this time.

Provider Taxes. In times of fiscal crisis, states frequently turn to provider taxes to raise non-federal dollars to support Medicaid programs. The number of states taxing at least one provider category reached 44 at the end of FY 2008, and increased to 45 states for FY 2009 and FY 2010. Thirty of these states taxed more than one category of providers in FY 2008, 33 states had more than one provider tax in FY 2009, and 36 states will have more than one provider tax in FY 2010 (Figure 27). (See Appendix A-10 for state-specific information on provider taxes.)

Figure 27

Medicaid Provider Taxes, FY 2008 – FY 2010



Note: ICF/MR-DD facilities are Intermediate Care Facilities for persons with mental retardation or developmental disabilities.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008 and September 2009.

Compared to FY 2008, an additional seven states are expected to have hospital taxes in FY 2010; four more states are expected to have taxes on nursing facilities and states with taxes on Intermediate Care Facilities for the Developmentally Disabled (ICF/MR-DD) will increase by four from the number in FY 2008. Federal Medicaid law was changed effective July 1, 2009 to restrict the use of Medicaid provider taxes on managed care organizations such as HMOs. As a result the number of states reporting a Medicaid provider tax on HMOs decreased from 16 states to 11 states for FY 2010. Several of those 11 states report that their HMO taxes were already broad-based taxes that were not limited to just Medicaid HMOs. Four states of the 11 states report that they are replacing taxes that applied only to Medicaid HMOs with new taxes that apply to all HMOs or they are removing provisions that previously exempted Medicaid HMOs from broad-based insurance or premium taxes.

In their effort to find additional revenue sources for Medicaid, states not only increased the number of provider groups that were taxed, but also increased the size of some of those taxes. For FY 2010 the rate of provider taxes are increased for seven nursing facility taxes, five hospital taxes, three ICF/MR-DD taxes and two MCO taxes. The only taxes being reduced in FY 2010 are two MCO taxes that are being reduced to meet the new federal limits.

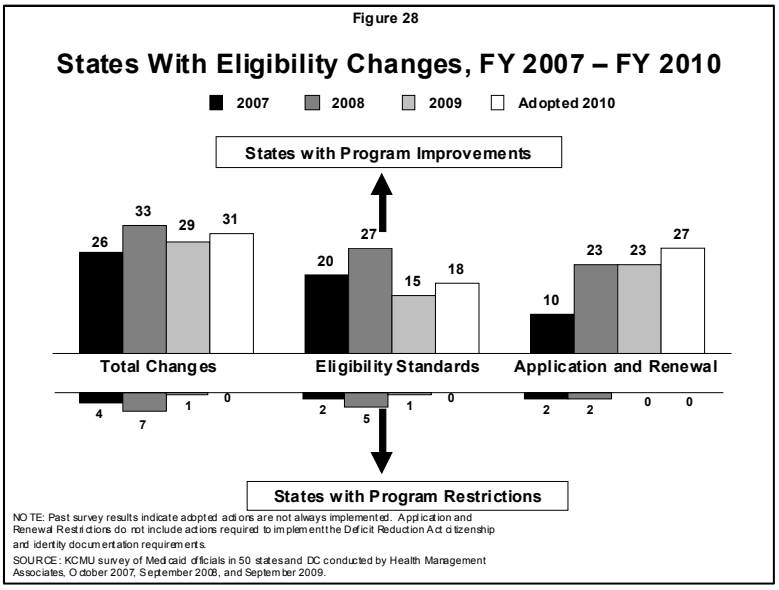
B. Eligibility and Enrollment Process Changes

Medicaid eligibility standards determine who can qualify for the program. The application and renewal process impacts how hard or easy it is to comply with program requirements, and therefore affects the likelihood that those who are eligible will apply or follow through on their application.

The general trend in Medicaid over time has been to expand the program to address the mounting uninsured problem and to simplify the application and renewal processes. Once in place it is very difficult to make eligibility cuts because they have direct implications for often vulnerable residents. However, during the last economic downturn, many states did make eligibility restrictions which were often changes to the application processes that had immediate effects on slowing caseload growth. Such changes include increases in the documentation requirements or increasing the frequency for eligibility determinations. Many of these types of changes were reversed as states emerged from the last downturn. In 2007 and 2008, several states implemented significant Medicaid coverage initiatives to help reduce the number of uninsured.

In general, ARRA protected eligibility from cuts and restrictions to the application and renewal processes for FY 2009 and FY 2010. In fact, several states had to reverse or abandon restrictions to be eligible for ARRA funds. For FY 2008, five states implemented eligibility cuts and three states indicated a year ago that they had adopted cuts for FY 2009. Only one state (Rhode Island) implemented a cut in eligibility standards in FY 2009.[19] Despite the downturn, 29 states made positive eligibility and application process changes in FY 2009 and 31 states had plans to do so in FY 2010 (Figure 28). New federal requirements and options enacted as part of ARRA, CHIPRA and other legislation are highlighted below.

Figure 28



NOTE: Past survey results indicate adopted actions are not always implemented. Application and Renewal Restrictions do not include actions required to implement the Deficit Reduction Act citizenship and identity documentation requirements.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007, September 2008, and September 2009.

[19] The ARRA MOE requirement requires that state eligibility standards, methodologies or procedures not be more restrictive than those in effect on July 1, 2008. The change Rhode Island made that reduced eligibility from 185% to 175% of FPL for parents and pregnant women did not occur until October 1, 2008. This restriction of eligibility was permitted under a special rule in ARRA for "a restriction that was directed to be made under state law as in effect on July 1, 2008, and would have been in effect as of such date, but for a delay in the effective date of a waiver under section 1115 of such Act with respect to such restrictions."

ARRA and Other Federal Changes Affecting Medicaid Eligibility and Enrollment

ARRA. As a condition of accepting substantial federal fiscal relief through the ARRA states are required to agree to maintenance of eligibility (MOE) provisions. Specifically, section 5001 of ARRA requires each state to ensure that the eligibility standards, methodologies, or procedures under its Medicaid State Plan, or under a waiver or demonstration program, are not more restrictive than those in effect on July 1, 2008. States were given until June 30, 2009 to reverse any known MOE violations and still access the enhanced FMAP effective (retroactively) to October 2008.[20]

In guidance provided to the states, CMS offers numerous examples of changes in state programs that would be considered "more restrictive" including: instituting or increasing premiums; restrictive adjustments to financial eligibility criteria of the Medicaid program or waiver (e.g., income or resource standards); elimination of any eligibility group or subgroup that was included under the approved State Plan or under an approved 1915(c) or demonstration waiver as of July 1, 2008, or increasing the frequency of eligibility redetermination, revoking or otherwise restricting a policy allowing self-declaration of income, or changing the way an individual applies for Medicaid from a mail-in application process to a face-to-face determination process. Other changes affect eligibility for long-term care and home and community based waivers discussed in a later section. ARRA also extended Transitional Medical Assistance (TMA), allowed states to extend TMA eligibility for an initial 12-month period (instead of 6) and reduced reporting requirements.

To qualify for ARRA funds, 14 states reported the following changes to eligibility standards or processes to come into compliance with the MOE requirements (some states had multiple changes): reversal of more restrictive treatment of income or assets (3 states); reversal of shortened timeframes for submission of documentation (3 states); reversal of more frequent re-determination cycles (2 states); reversal of new verification requirements (4 states); restored continuous eligibility (1 state); an eligibility group that had been eliminated was reinstated (1 state); passive renewal for adults was restored (1 state); the length of retroactive eligibility for aged and disabled applicants was restored from 30 days to 90 days (1 state); Medicaid for individuals losing Supplemental Security Income due to a cut in state supplemental payments will be retained (1 state); HCBS waiver slots released (1 state); and abandoned planned premium increases (2 states). In addition five states abandoned restrictive changes that had been contemplated.

CHIPRA. CHIPRA included a number of new eligibility options for Medicaid and CHIP such as the option to extend Medicaid and/or CHIP coverage to otherwise eligible legal immigrants who have been in the country for less than five years and the Express Lane Option that would allow a state to use findings from specified public agencies (e.g. TANF, Food Stamps, National School Lunch) to evaluate a child's eligibility or renewal status for Medicaid or CHIP. CHIPRA also terminates existing CHIP coverage for parents and childless adults by December 31, 2009 giving states the option to transition them to a Medicaid demonstration program.

Other Changes. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided for an increase to the asset limits for Medicare Savings Programs (MSP), Medicaid QMB, SLMB and QI recipients beginning January 1, 2010, to equal levels used for the full Medicare Part D Low Income Subsidy (LIS) or $8,100 for individuals and $12,910 for couples in 2009. Other legislation granted special refugee status to immigrants from Afghanistan thereby allowing them to be eligible for Medicaid.

Changes to Eligibility Standards. Due to the ARRA requirements, only one state implemented an eligibility cut in FY 2009. Rhode Island reduced the income level for extended family planning and parents from 185 percent to 175 percent of FPL for FY 2009, affecting an estimated of 1,000 individuals.

Even in the face of significant economic stress, many states have been able to expand Medicaid eligibility. These expansions vary widely in their scope. In FY 2009, 15 states expanded Medicaid by raising eligibility levels or by extending coverage to new populations and 18 states plan to do so in FY 2010. For FY 2009 and FY 2010, the most common eligibility expansions included changes

[20] Centers for Medicare and Medicaid Services; SMD #09-005; August 19, 2009.

to financial eligibility criteria -- 10 states increased income standards or income disregards and six states increased asset limits. Six states reported that they were providing 12 months continuous eligibility to children and six states are implementing or expanding family planning waivers. Five states expanded Medicaid to cover 19 to 20 year old youths who had been covered by Medicaid while in foster care. Two states adopted the option for parents of disabled children to "buy-in" to Medicaid under the Family Opportunities Act (both in FY 2009). Nine states reported a variety of other expansions, including a major expansion for adults without children in Wisconsin (Table 1).

Though the survey did not ask about this explicitly, several states took advantage of new options under new federal legislation. Six states reported that they were using the new CHIPRA option to extend Medicaid coverage children and/or pregnant women who are legal permanent residents but have been in the US for less than five years. Additional states that currently cover legal immigrants with state funds may be taking advantage of this option, but these states may not have reported this because it is not an eligibility expansion. Five states expanded their Transitional Medical Assistance (TMA) under new options created by ARRA. Two states (Florida and Oklahoma) reported that they were extending the eligibility period for Afghan refugees from six months to eight months.[21] Several states also mentioned an expectation that the number of individuals enrolled in the Medicare Savings Program (MSP)[22] component of Medicaid will increase in FY 2010. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) more than doubles the minimum asset limits for MSP recipients as of January 1, 2010. One state noted that they expect that an additional 20,000 individuals will qualify for MSP under the new asset limits.

[21] The Omnibus Appropriation Act of 2009 gave states the option to extend Medicaid benefits for Afghan refugees from 6 months to 8 months.

[22] The Medicare Savings Program includes Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QIs). These groups include low-income Medicare beneficiaries that receive, based on income category, varying levels of Medicaid assistance with their Medicare premiums, coinsurance and deductible payments.

Table 1

State Reported Eligibility Expansion	States in FY 2009	States in FY 2010	States in Either FY 2009 or FY 2010
Income: Increase an Income Limit or Earned Income Disregard	FL, MD, MT, NY, OR	CO, IA, MN, ND, OK	10
Cover Legal Permanent Residents with Less than 5 Year Residency	CT, MD	DC, IA, MN, OR	6
Assets: Increasing Limits, Eliminating Test, or Change How an Asset is Counted	FL, MD, NY	FL, IN, MT, NY, OR	6
Implement or Expand a Family Planning Waiver	MO, VA	IN, MT, NH, WY	6
12 month Continuous Eligibility	AK, IA	MT, NM, NY, OR	6
Cover Youth Aging out of Foster Care	FL, GA, LA, NY	MN	5
TMA modifications under ARRA	OR	AK, IA, NY, OR, SC	5
Presumptive Eligibility	MO	IN, IA	3
Family Opportunity Act (DRA)	IA, LA		2
Optional Coverage Extension for Afghan Immigrants	FL	OK	2
Other Expansion	NH, MD, OK, WI	AK, AR, MT, NY, OR, WI	9
Any Expansion	15	18	24

While most eligibility changes affected a small number of beneficiaries, several of the expansions were large.

- ***Colorado.*** On April 1, 2010, Colorado will be increasing the income limit for Medicaid for low-income parents from 60 percent of FPL to 100 percent of FPL. The state estimates that this expansion will cover 13,000 individuals.
- ***Maryland.*** In FY 2009, Maryland increased the earned income disregard to change the effective income standard for parents and caretaker relatives from 30 percent to 116 percent of FPL. In FY 2009, Maryland also elected the new option to extend Medicaid coverage to low-income children and pregnant women who are legal permanent residents with less than five years of U.S. residency.
- ***Missouri.*** Missouri estimates that its family planning waiver implemented on January 1, 2009, will eventually cover 83,000 women.
- ***New York.*** On April 1, 2008 (the beginning of New York's 2009 fiscal year), New York made significant increases in the asset levels for low-income parents, medically needy individuals and childless adults. The allowable asset level increased from $3,000 to $13,000 for a family of one for these populations (with the asset limit further rising with household size). In addition, a single statewide childless adult eligibility level was established that raised prior eligibility levels for many counties. There were also modest increases in the income levels for the medically needy population. For most groups, the state is unable to isolate the impact of these changes, but for the medically needy, the state estimates that 13,800 individuals were affected. On January 1, 2010, New York plans to eliminate asset tests for all Medicaid groups other than the aged, blind and disabled. New

York has also expanded eligibility for young adults ages 19 and 20 who are "aging out" of the foster care system, extended the initial period of TMA from 6 months to 12 months, and as of October 1, 2009, will eliminate a prohibition against public employees enrolling in Family Health Plus.

- ***Oklahoma***: Over several years, Oklahoma has been expanding coverage for low-income residents through expansions of SoonerCare and the Insure Oklahoma program. The Insure Oklahoma initiative provides subsidies for employer sponsored insurance (ESI) for low-income employees in businesses that have qualified health plans and an individual option to "buy-in" to the Insure Oklahoma program. While there is state and federal approval to cover businesses with up to 250 employees, due to limited funding, the program is currently only available for employees of businesses with up to 99 employees. The initiative also covers certain college students ages 19 to 22 with incomes below 200 percent of FPL.

  As of July 2009 there were nearly 24,000 enrollees in Insure Oklahoma, with more than 15,500 receiving subsidies for employer-sponsored insurance and more than 8,000 enrolled in the Insure Oklahoma individual plan. Reports on the Insure Oklahoma website indicate that current tobacco tax funding is sufficient to support coverage for about 11,500 more individuals.[23] It is expected that enrollment will be closed and a waiting list created sometime in the last quarter of calendar year 2009.

- ***Oregon.*** On October 1, 2009, Oregon plans to re-open enrollment for the Oregon Health Plan (OHP) Standard program for adults without children. The state estimates that over the next few months enrollment will increase to 25,000 individuals.

- ***Wisconsin.*** Last year we reported on the expansion of coverage for low-income children, parents and pregnant women through expansions of the BadgerCare program. In FY 2009 and FY 2010, Wisconsin has extended Medicaid coverage through a waiver to childless adults with incomes up to 200 percent of FPL in two phases. Estimated enrollment is 50,000 individuals.

To the extent that states expanded eligibility after July 1, 2008, the cost of services for the expansion population does not qualify for the ARRA enhanced matching funds.

Details on these changes to eligibility standards, along with information about application and renewal process changes for FY 2009 and FY 2010 are described in Appendices A-3a and A-3b.

Changes to Application and Renewal Process. In FY 2009, 23 states implemented changes that would streamline or simplify the application and renewal process. Twenty-seven states indicate plans for simplification in FY 2010. Many of these changes would help to qualify states for the Medicaid performance bonus FMAP authorized by CHIPRA. The most common changes reported were:

- Expansion or implementation of the ability to submit applications on-line (15 states).

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[23] Oklahoma Strategic Plan, July 14, 2009 available at: http://www.oepic.us/WorkArea/showcontent.aspx?id=3720.

- Increased use of available data for application or renewal. This includes six states that have implemented Express Lane Eligibility (ELE) in FY 2009 or are exploring ELE strategies for FY 2010, four states that have implemented or expanded some form of more passive renewals using administrative data, and four states that are expanding their data matches with other agencies to reduce the documentation burden for applicants and recipients.
- Simplification of application and/or renewal forms and instructions (11 states).
- Extension of the redetermination period to 12 months for one or more groups of enrollees (6 states).

Other application related changes for FY 2009 and 2010 include elimination of a face-to-face interview requirement (4 states), pre-populated renewal forms (2 states), e-signature option (2 states) and nine states with other simplification or streamlining initiatives.

No states reported plans to implement restrictive application changes for either FY 2009 or FY 2010 due to the ARRA MOE requirements.[24] However, as previously discussed, some states reported changes that were made in early 2009 and later reversed to insure ARRA compliance.

Impact of DRA Citizenship and Identity Requirements. States were asked whether in FY 2009 the DRA citizenship and identity documentation requirements had increased the time needed to determine eligibility. All but one state responded to this question and 35 states indicated that the DRA requirements had increased eligibility processing timeframes while 15 states indicated that the time to process applications had not increased. States were also asked whether they expected to adopt the new option (available January 1, 2010) of verifying citizenship through a data matching process with the Social Security Administration. Thirty states indicated that they expect to adopt this option. Only three states said they would not use this option. Of the other 18 states, 16 did not know and two did not respond.

C. 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 affordable employer based insurance. The DRA gave states additional flexibility to impose premiums upon children and families with incomes above 150 percent of the federal poverty level, and two states report having in place three premium requirements established under DRA authority.

The use of premiums in Medicaid did not change much in FY 2009, and few changes are planned for FY 2010. In all, 35 states reported on 58 different Medicaid premium programs, of which 54 had been in place since FY 2008 or before. Only one premium program was eliminated[25] in either FY

[24] There were at least three states that made restrictive policy, procedural, or documentation changes to come into compliance with federal Medicaid statute and regulations. Some of these compliance issues were identified through audit findings, such as the Payment Error Rate Measurement (PERM) eligibility audit.

[25] Tennessee reported that reported that in FY 2009 they eliminated the premium for children enrolled in TennCare Standard.

2009 or FY 2010, and five new premium programs were added. Seven programs had premium decreases and due to ARRA only one state (Maine) increased premiums effective July 1, 2008.[26]

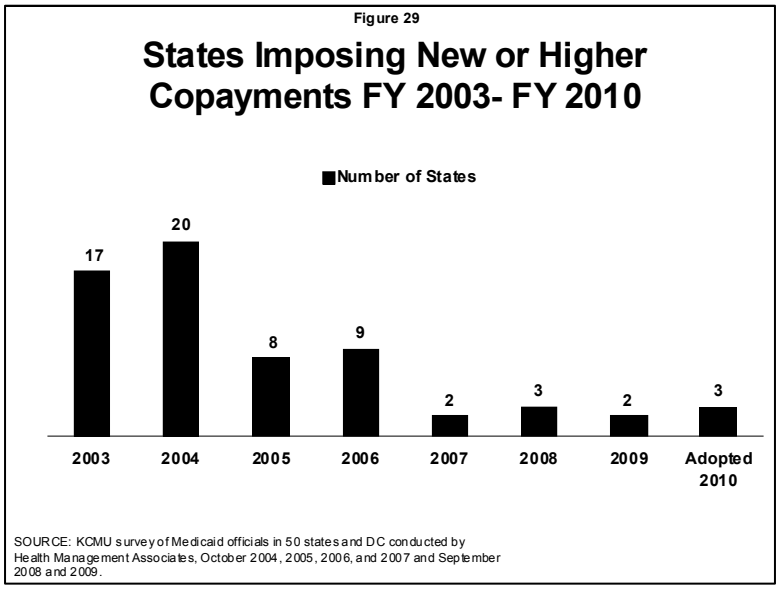
Additional information on premium programs by state is reported in Appendix A-3a and A-3b.

D. Copayment Requirements

In the past, imposing new or higher copayment requirements has been a common Medicaid cost containment tool. Thus, the vast majority of states (45) reported imposing copay requirements on one or more services, including four states that impose copayments only on drugs. Only six states (Connecticut, Hawaii, New Jersey, Nevada, Texas and Washington) reported having no copayment requirements at all. Despite worsening fiscal conditions, however, only two states in FY 2009 and three states in FY 2010 reported plans to impose new or higher copayments suggesting, perhaps, that many states may believe that they have already "maxed out" this cost containment option.

In FY 2009, Massachusetts increased copayments for over-the-counter drugs and most generics and also increased copayments for primary care services and emergency room (ER) visits for certain waiver expansion groups. Additionally, Mississippi imposed new copayment requirements on outpatient hospital services and ambulatory surgical center visits. In 2010, Minnesota reported plans to increase hospital copayments in MinnesotaCare by eliminating a copayment cap and Vermont reported plans to increase pharmacy copayments. Also, North Carolina reported a general legislative directive to increase copayment amounts by $2, but had not yet determined which copayments would be raised (Figure 29).

Figure 29



[26] The ARRA MOE requirement requires that state eligibility standards, methodologies or procedures not be more restrictive than those in effect on July 1, 2008. Since July 1, 2008 is the start of FY 2009 for Maine, this premium increase met the ARRA MOE requirement.

Two states reduced or eliminated copayments in FY 2009: Minnesota decreased the monthly cap for pharmacy copayments and Missouri reduced copayments on non-emergency medical transportation. No state reported plans to reduce or eliminate copayments in FY 2010.

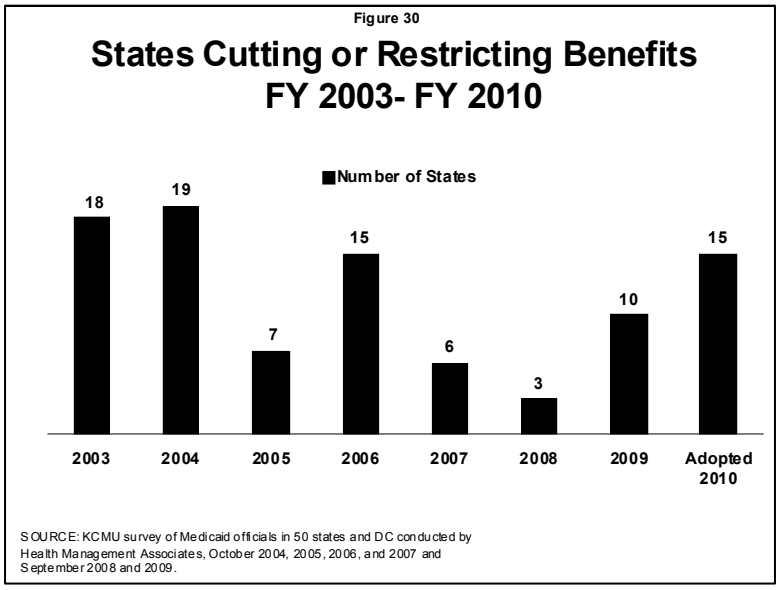
DRA Copayment Flexibility. Prior to the DRA, federal law limited Medicaid copayments to nominal amounts, generally defined as $3.00 or less per service, and prohibited states from applying copayments to certain services (e.g., emergency room visits) or certain eligibility groups (children and pregnant women). Providers were also required 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, and to vary the cost-sharing requirements by eligibility group. States may also now elect to make cost-sharing enforceable – that is, allow a provider to deny rendering services if the co-payment requirement is not met.

In this year's survey, no state reported using, or having plans to use, DRA authority to impose greater than nominal copayment requirements or to vary copayment obligations by eligibility group. Four states (Delaware, Kentucky, Utah and Wisconsin) reported that co-payment requirements were enforceable in FY 2009 for at least one eligibility group as allowed by the DRA (the same number as in FY 2008). One state (Arizona) reported plans to take advantage of the DRA authority to make co-payments enforceable in FY 2010.

E. Benefits Changes

As discussed previously, the ARRA enhanced FMAP funds allowed many states to avoid or mitigate the severity of Medicaid benefit reductions that would otherwise have been enacted in 2009. Nevertheless, the number of states reporting benefit reductions for FY 2009 or FY 2010 increased significantly from FY 2008: 10 states in FY 2009 and 15 states in FY 2010 reported reductions compared to only three states in FY 2008 (Figure 30). However, 15 states in FY 2009 and 13 states in FY 2010 also reported plans to expand benefits – somewhat fewer states than in FY 2008 (19 states) or FY 2007 (16 states), but significant given the current level of state fiscal distress.

Figure 30



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004, 2005, 2006, and 2007 and September 2008 and 2009.

Benefit restrictions reflect the elimination of a covered benefit or the application of utilization controls for existing benefits. The following states reported one or more benefit eliminations in FY 2009:

- ***Massachusetts*** eliminated coverage for non-emergency transportation for certain waiver expansion populations including enrollees in Family Assistance, Basic and Essential;

- ***Michigan*** eliminated dental, hearing aids, chiropractic care, podiatry, and eyeglasses and associated vision services;
- ***Nevada*** eliminated coverage for non-medical vision services; and
- ***Utah*** eliminated audiology and hearing services, physical, occupational and speech therapies, eyeglasses and chiropractic services for all non-pregnant adults and also eliminated coverage of physician services rendered during an inpatient stay in its Primary Care Network (PCN) waiver program.

The following states reported one or more benefit eliminations in FY 2010:

- ***California*** eliminated multiple optional services for non-pregnant, non-institutionalized adults including acupuncture, dental, audiology and speech services, optometry and optician services, podiatry; psychology services, and chiropractic services; and
- ***Utah*** eliminated dental coverage for adults.

Of the 10 states reporting cuts or restrictions for FY 2009, five applied narrowly targeted limits or utilization controls to existing benefits (monthly prescriptions in Louisiana, dental crowns in Oklahoma, Community Intensive Treatment services in Rhode Island, home health and private duty nursing in Tennessee, and prior authorization for mental health services in Virginia). One state (Nebraska) imposed limits on a wider range of services (limiting dental benefits to $1,000 per year, occupational, physical and speech therapy services to 60 visits per year; hearing aids to one every four years; eyeglasses to one every 24 months; and chiropractic services to 12 visits per year).

Of the 15 states reporting cuts or restrictions for FY 2010, 13 applied narrowly targeted limits or utilization controls to existing benefits (including imaging services in Colorado, targeted case management and private non-medical institution services in Maine, non-emergency transportation and methadone clinics in New Hampshire, other-the-counter drugs in Connecticut and New Jersey, personal care services in North Carolina, emergency room visits in Rhode Island, mental health services in Virginia, durable medical equipment in Washington, private residential treatment facilities, imaging services and eyeglasses in Wyoming, dental benefit limits in Minnesota and Oregon, and a reduction to emergency services only for adult dental benefits in Hawaii.)

In addition to states reducing benefits, a similar number of states – 15 in FY 2009 and 13 in FY 2010 – reported benefit restorations or expansions. These totals include four states in FY 2009 and seven states in FY 2010 restoring, expanding or adding mental health or substance abuse services, four states in FY 2009 and three states in FY 2010 that are restoring or expanding dental benefits and two states in FY 2009 and one state in FY 2010 that added telemedicine services.[27] (See Appendices A-4a and A-4b for more detail on benefit related actions.)

[27] The total expanding benefits for FY 2009 does not include Vermont which reinstated chiropractic services at the beginning of FY 2009, but reinstituted cuts later in the year. Vermont is included as one of the 13 states expanding benefits in FY 2010 due to the restoration of a limited chiropractic benefit in July 2009.

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 prescription drugs, dental care and personal care services. Generally, states had to offer the same set of services to all individuals covered by Medicaid in the state. The DRA allows states to replace the traditional Medicaid benefits with "benchmark" plans and provides new flexibility that 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.

Previous reports have described the DRA benchmark plans implemented by eight states[28] in FY 2007 and FY 2008. No states, however, reported adopting a DRA benchmark plan in FY 2009 or plans to do so in FY 2010.

F. Long-Term Care and Home and Community–Based Services

Medicaid is the nation's primary payer for long-term care (LTC) covering a continuum of services ranging from home and community-based services (HCBS), that allow persons to live independently in their own homes or in the community, to institutional care provided in nursing facilities and ICFs/MR-DD. Over the last two decades, states have steadily increased the amount of resources directed at HCBS options, and this year's survey results suggest that trend is continuing even in the face of formidable fiscal challenges. In FY 2009, 32 states took actions that expanded LTC services (primarily expanding HCBS programs), and 35 states planned expansions for FY 2010. This compares to 42 states taking actions to expand LTC services in FY 2008 and 35 states in FY 2007. Conversely, a total of eight states in FY 2009 and 12 states in FY 2010 took action to constrain LTC services (compared to eight in FY 2008 and seven in FY 2007). These reductions, however, tended to be more focused on HCBS services (rather than institutional services) than in the past.

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

HCBS Programs. This year's survey found that states are continuing to work 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.

As in past years, the most commonly reported LTC expansion change in both years was adopting new HCBS waivers or expanding existing waivers, and the ongoing implementation of the DRA "Money Follows the Person"[29] federal grant fund initiative. Other examples of LTC expansions

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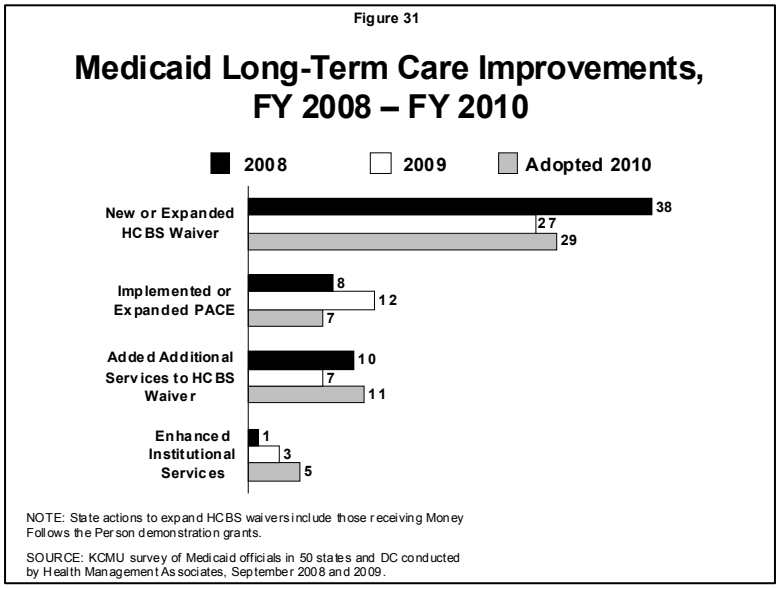
[28] West Virginia, Idaho, Kentucky, Virginia, Washington, Kansas, South Carolina and Wisconsin.

[29] A total of 31 states were awarded MFP grants in 2007 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. State grant proposals included plans to transition nearly 38,000 individuals into the community over the five-year demonstration period.

include adding additional services to an existing HCBS waiver and expanding PACE programs[30] (Figure 31).

Figure 31



While 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 in FY 2009 and seven states in FY 2010 imposed additional restrictions directed at HCBS programs. In FY 2009, Michigan eliminated its single point of entry pilot which, while in place, had led to increased utilization of State Plan community services and increased nursing facility transitions, and Nevada applied limits to personal care services. In FY 2009, Virginia added Environmental Modification and Assistive Technology services in two of its HCBS waivers but subsequently dropped these services later in the fiscal year. The reductions in a number of the seven states reporting plans to impose additional restrictions in FY 2010 are somewhat more extensive:

- ***California*** is reducing in-home supportive services to participants with the highest levels of need, limiting adult day health care (ADHC) attendance to three days per week, and revising ADHC medical necessity criteria to conform with nursing facility levels of care[31] (except for developmentally disabled, chronically mentally ill, and severely cognitively impaired enrollees), thereby reducing access to ADHC services[32];
- ***Colorado*** is placing limits on personal care services and on HCBS homemaker and transportation services;

[30] 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.

[31] ADHC is a State Plan service rather than an HCBS waiver service.

[32] On September 10th, 2009, the U.S. District Court for Northern District of CA issued a preliminary injunction against the CA Department of Health Care Services preventing them from implementing or enforcing the Adult Day Health services cuts.

- ***Minnesota*** is taking numerous steps to better control utilization of Personal Care Attendant services (including delivering provider training, limiting hours that can be worked monthly, and improving assessment processes) and is reducing budget allocations for low needs enrollees in the elderly waiver;
- ***North Carolina*** is applying utilization controls to community support services;
- ***Rhode Island*** is applying utilization controls to children's HCBS services;
- ***South Carolina*** is reducing services in its MR/DD and Head and Spinal Cord waiver; and
- ***Washington*** is reducing personal care hours for clients living at home and eliminating adult day health for clients receiving residential care.

ARRA MOE Impact on HCBS Waiver Participants

States' ability to impose certain HCBS restrictions is currently limited by the ARRA maintenance of eligibility (MOE) requirements which condition receipt of the ARRA enhanced FMAP on maintenance of the eligibility standards, methodologies and procedures in effect on July 1, 2008. Because of the link between eligibility for Medicaid long-term care services and Medicaid eligibility generally, CMS has determined that the following actions will be considered violations of the AARA MOE requirement:

- Increasing stringency in institutional level of care determination processes that results in individuals losing actual or potential eligibility for Medicaid pursuant to institutional eligibility rules or in the special eligibility group for HCBS waiver participants under 42 CFR 435.217.
- Adjusting cost neutrality calculations for section 1915(c) waivers from the aggregate to the individual, resulting in individuals being dropped from waiver coverage or hindered from moving out of an institutional setting.
- Reducing occupied waiver capacity for section 1915(c) HCBS waivers.
- Reducing or eliminating section 1915(c) waiver slots that were funded by the legislature but unoccupied as of July 1, 2008.

Source: CMS August 19, 2009 Dear State Medicaid Director Letter, SMD#09-005, ARRA#5.

Institutions. Three states in FY 2009 and five states in FY 2010 took positive action to remove restrictions on, or enhance institutional services. In FY 2009, two states (Massachusetts and North Carolina) enhanced the types of services reimbursed in a nursing facility setting and Maryland liberalized its nursing home level of care criteria.[33] In FY 2010, Georgia and Indiana are implementing nursing facility quality enhancement initiatives; Arkansas is implementing new reimbursement for "Greenhouse" nursing facilities; Florida is approving reimbursement for Medicare coinsurance costs for private institutions for mental disease (IMDs); and Mississippi is liberalizing its nursing facility bed-hold policy.[34]

In FY 2009, six states implemented cost controls related to institutional placements and seven states are planning reductions in FY 2010. Examples include:

[33] This action was counted as an expansion for both institutional and community-based services.
[34] 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.

- efforts to reduce the size of or close state-owned Mental Health/Mental Retardation facilities (Alabama, Nebraska and Wisconsin);
- policies designed to reduce the number of nursing home beds (e.g., bed trade-in processes, closure funds or increases in minimum occupancy standards) (Indiana, New York and Pennsylvania);
- reductions in payments for bed holds (Louisiana);
- increases in level of care standards for nursing facilities compared to HCBS waiver placements (Rhode Island);
- tighter nursing facility accountability measures linked to pay for performance (Iowa);
- elimination of coverage for certain high risk intervention group homes for children (North Carolina); and
- new limits on private non-medical institutional care (Maine).

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 the implementation of assessment and resource allocation tools, the revision of a nursing facility reimbursement methodology to include reimbursement for therapies, DME and over-the-counter drugs, and the consolidation of multiple HCBS programs. In particular, Rhode Island reported that in FY 2010 it would implement its recently approved Section 1115 demonstration waiver – the "Rhode Island Global Consumer Choice Compact Waiver" – which, among other things, calls for all HCBS waivers to be subsumed into the global waiver. Finally, six states in FY 2009 and eight states in FY 2010 implemented or expanded LTC managed care programs.

Rhode Island Global Consumer Choice Compact Demonstration Waiver

Effective January 16, 2009, CMS approved Rhode Island's Section 1115 Medicaid demonstration waiver request to radically restructure its Medicaid program so that the entire Medicaid program is operated under the waiver. To that end, Rhode Island's Section 1115 RIte Care and RIte Share programs for children and families, its 1915(b) Dental Waiver, and its Section 1915(c) Home and Community Based Services waivers will be subsumed under the Global Consumer Choice Compact Demonstration.

One of the central goals of the waiver is to rebalance the long-term care delivery system. To do this, the waiver establishes three levels of care based on need in order to increase access to community-based services and reduce use of institutional services. Other program changes include new flexibility to charge more premiums and to make certain programmatic changes without first obtaining CMS approval. Another significant feature of the waiver pertains to program financing. In exchange for greater state flexibility to make program changes, the state is subject to a global cap on federal funding for all Medicaid spending (excluding only disproportionate share hospital payments, payments to local educational agencies and administrative costs). In May 2009, the Global Waiver Taskforce was formed to assist the State's health and human service agencies in moving forward with implementation of the waiver.

DRA Long-Term Care Options. The DRA included provisions intended to give states increased flexibility to deliver long-term services and supports. The survey asked states to report on programs in place in FY 2008, actions taken in FY 2009, and plans for FY 2010, regarding three DRA LTC-related options. As in last year's survey, this year's results indicate widespread adoption of Long-Term Care Partnership Programs but much less take up, thus far, of the self direction or the HCBS State Plan options.

- ***Long-Term Care Partnership Programs.*** 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. Seventeen[35] states reported having in place a Long-Term Care Partnership Program in FY 2008; 12 states reported implementing a program in FY 2009 and seven states indicated that they were planning to implement a program in FY 2010, which would bring the total to about 70 percent of all states.
- ***Self-Direction of Personal Services.*** In 2008, five states (Alabama, Arkansas, New Jersey, Oregon and Texas) reported having in place the DRA State Plan option to allow for self-direction of personal assistance services, sometimes referred to as the "cash and counseling option." In last year's survey, only one state – Alabama – reported having a plan in place in FY 2007. Two states (Florida and Wisconsin) reported implementing this option in FY 2009 and another five states (California, Kentucky, Louisiana, Massachusetts and Nevada) reported plans to implement this option in FY 2010. A number of states noted that they already had cash and counseling options in place under existing state waivers and were not considering the DRA State Plan option.
- ***HCBS State Plan Option.*** Only one state (Iowa) reported having in place the HCBS State Plan option in FY 2008 (the same as reported for 2007 in last year's survey.) This 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 with mental illness. Two states (Colorado and Nevada) reported implementing this DRA option in FY 2009. Nevada is providing adult day health, habilitation, and partial hospitalization services (designed for persons with chronic mental illness) to persons with a range of disabilities including functional deficits and cognitive and/or behavioral impairments. Colorado is using the DRA option to provide consumer-directed personal care, homemaker and home health aide services to persons whose health is at risk without appropriate supports due to a chronic condition or progressive disease, and who meet a less stringent level of care standard than is otherwise applicable for the state HCBS waivers. Four additional states reported plans to implement the HCBS State Plan option in FY 2010 (California, Oregon, Washington, and Wisconsin).

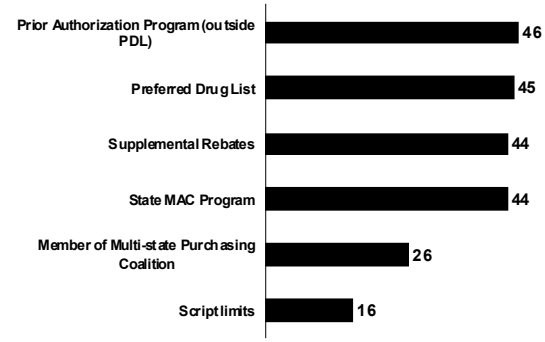
[35] Four of the 17 states that reported having plans in place in FY 2008 (California, Connecticut, Indiana and New York) have had demonstration model programs underway since 1992 and did not utilize DRA authority.

G. Prescription Drug Utilization and Cost Control Initiatives

While the implementation of the Medicare drug benefit in 2006 reduced direct Medicaid drug spending by nearly half (as dual eligibles shifted from Medicaid to Medicare coverage), states have continued to refine and enhance their pharmacy programs. To control spiraling drug costs, the vast majority of states dramatically reformed their pharmacy benefit programs between 2001 and 2005 adopting or enhancing preferred drug lists (PDLs), prior authorization programs, supplemental rebate programs, state maximum allowable cost ("state MAC") programs and other cost containment measures. For the fourth consecutive year, the survey identified the number of states that had certain pharmacy cost containment measures in place at the beginning of the survey period. At the beginning of FY 2009, there were incremental increases in each category except imposing limits on the number of monthly prescriptions which declined from 19 states to 16 states (Figure 32).

Figure 32

Medicaid Pharmacy Cost Containment Measures in Place by FY 2009

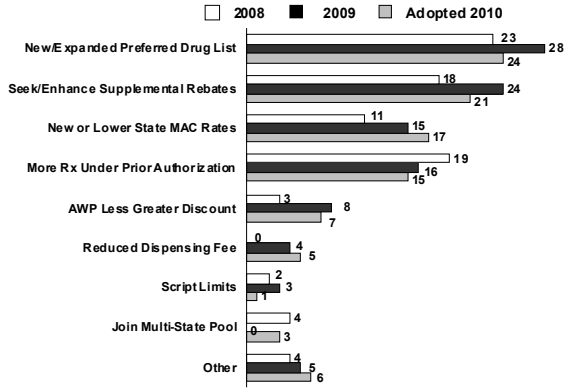


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009.

Thirty-five states in both FY 2009 and FY 2010 implemented cost-containment initiatives in the area of prescription drugs, comparable to the numbers in FYs 2008 and 2007 (33 and 30 respectively). As has been true in the past few surveys, the majority of actions reported were additions, expansions or refinements of existing PDLs, prior authorization programs, supplemental rebate programs, and state MAC programs. In 2010, however, Nebraska reported plans to implement a new PDL program, Nebraska and North Carolina reported plans to implement new supplemental rebate programs and Nebraska, North Carolina and Oregon reported plans to join a multi-state purchasing pool. Also, compared to 2008, there was a noticeable uptick in the number of states reporting dispensing fee cuts and cuts to ingredient cost reimbursement in both FY 2009 and FY 2010 (Figure 33).

Figure 33

Medicaid Prescription Drug Policy Changes FY 2008 -- FY 2010



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008 and 2009.

Several states reported other types of pharmacy cost containment measures for FY 2009 and FY 2010 including: three states (Massachusetts, North Carolina and Vermont) increasing drug copayment requirements; two states (Indiana and Ohio) that carved pharmacy benefits out of their managed care contracts; two states (Rhode Island and Washington) that implemented generic first dispensing policies; one state (Connecticut) that discontinued covering most over-the-counter drugs; one state (Georgia) that reduced reimbursement to physicians for physician administered drugs; one state (Pennsylvania) implementing efforts that focus on specialty pharmacy products; one state (New Jersey) that eliminated coverage for cough, cold and cosmetic drugs; one state (Virginia) that began collecting rebates on J-code and hospital dispensed drugs; and one state (Washington) requiring the dispensing of a 90-day supply of certain maintenance medications for certain clients to reduce overall dispensing fee expenditures.

Finally, a number of states reported pharmacy-related expansions or reversals of previous pharmacy cost containment actions including: increasing dispensing fees (Iowa and Montana), increasing reimbursement of ingredient costs (Delaware, North Carolina and Utah), increasing reimbursement under a state MAC program (North Carolina), discontinuation of a PDL (Hawaii), discontinuation of participation in a multi-state purchasing pool (Georgia), implementation of incentive payments for e-prescribing (New York), and implementation of reimbursement for pharmacy counseling (Wisconsin).

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

H. Managed Care, Medical Homes, Disease and Chronic Care Management

Except for Alaska and Wyoming, every state Medicaid program now has some form of managed care. Nationally, about two-thirds of Medicaid enrollees receive some or all of their care through a managed care delivery system. In most states, managed care refers to prepaid, capitated at-risk HMOs operating as licensed health care delivery systems. These systems must meet a number of stringent federal regulatory requirements, including standards for adequacy of a provider network that is geographically accessible to Medicaid enrollees, standards for the quality of providers and requirements for credentialing, providing the ability to show data that documents the timeliness of appointments and services for primary and specialty care, and the ability to provide data that can measure care provided, rates of utilization and the quality of care. Managed care organizations must focus on quality and quality improvement, and the state must contract with an external quality review organization to audit both claims and medical records to ensure that the data and the care meet standards of high quality. Reimbursement is capitated, and federal rules require that the capitation payments be paid at a level that is "actuarially sound."[36]

Medicaid managed care also includes Primary Care Case Management (PCCM) programs, which are systems of care organized and managed by the Medicaid agency itself or its contractor. PCCM programs vary from state to state, but all seek to assure a medical home with a primary care provider (PCP) and to provide structure to the delivery system that allows for the measurement, monitoring and improvement of quality of care. The PCP is usually paid a small per member, per month case management fee but other services are usually paid on a fee-for-service basis.

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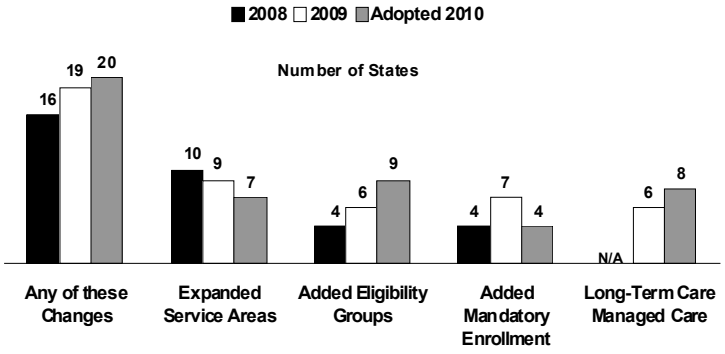
[36] Federal requirements for Medicaid managed care, including payment rates, quality assessment and performance improvement, external quality review, protections for persons enrolled in managed care, state contracts with managed care organizations, and other requirements, are found at 42 CFR 438.

Medicaid Managed Care. Medicaid managed care programs continue to develop and expand. In 2009, a total of nineteen states expanded service areas, added eligibility groups to managed care, required enrollment into managed care or implemented new long-term care managed care programs. In FY 2010, a total of 20 states (including seven states in the 2009 group, plus eight other states) adopted such policies (Figure 34). The most common managed care policy change involved enrolling individuals in the "Aged, Blind and Disabled" (ABD) eligibility group that previously had not been enrolled in managed care in that state. Other eligibility groups included children in foster care, persons in nursing homes, persons enrolled in specific waivers such as HIV/AIDS or persons receiving SSI.

Figure 34

Medicaid Managed Care Changes FY 2008 -- FY 2010



Note: Changes to long-term care managed care not asked in 2008 survey.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2008 and 2009.

Long-Term Care Managed Care. Several states have recently been applying the principles of managed care in the long term care area. In FY 2009, six states undertook new initiatives in long term care managed care including initiatives to integrate acute and long term care within the MCO delivery system (Florida, Hawaii, Minnesota, New Mexico, New York and Wisconsin). In FY 2010, a total of eight states adopted managed long-term care strategies, including additional steps in three of the states counted in 2009 (Florida, New York and Wisconsin) and five additional states (Illinois, New Jersey, Pennsylvania, Tennessee and Texas).

Medical Homes. One of the primary reasons that Medicaid programs have pursued and developed managed care has been that it has assured a "medical home" with a primary care provider. For almost three decades, Medicaid programs have used the term "medical home" in the context of HMOs and PCCM programs. Medicaid policy as long ago as the 1980s in some states set specific requirements and extra PCCM reimbursement rates for primary care providers who agreed to provide coordination of care, to assure primary and preventive care, and to meet certain standards of access, availability and quality. However, in recent years, the term "medical home" has taken on a more specific meaning, with more rigorous standards and expectations. The National Committee on Quality Assurance (NCQA) has established a "Physician Practice Connections® - Patient Centered Medical Home™" program to assess providers against specific benchmarks and to recognize those who meet the standards as medical home providers.[37]

The value of medical homes has caught the attention of Medicaid programs and state health policymakers. Several states have developed new medical home initiatives, including reimbursement strategies to encourage them. In FY 2009, three states indicated that they had specific medical home initiatives, and for FY 2010 an additional seven states described specific initiatives. In Florida, for

[37] NCQA. See: http://www.ncqa.org/tabid/631/Default.aspx

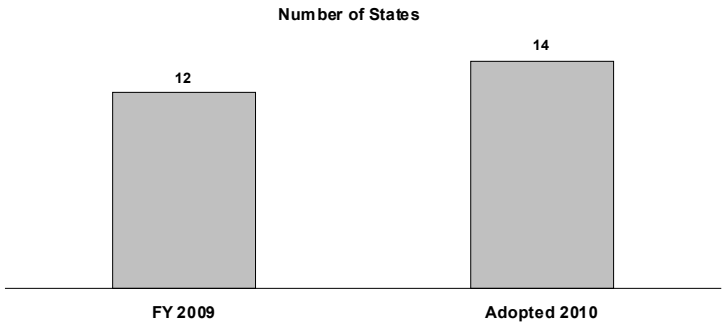
example, the Medicaid agency was directed by the legislature to establish a medical home task force, with an implementation plan to be developed by February 2010. The Maryland Health Quality and Cost Council is working on recommendations for a medical home initiative. Minnesota is planning to implement a Medicaid initiative in the fall of 2009. New York is planning to establish reimbursement that would provide incentives for providers meeting specific standards for medical homes. In Illinois, the medical home is within the PCCM program. Texas is planning to implement multiple medical home pilot projects including some in and some not in managed care.

Disease and Care Management. Medicaid programs also continue to pay special attention to specific chronic conditions and diseases. The goal is to assure appropriate care, improve quality and to assure that Medicaid funds are being used wisely in the care of individuals with specific conditions. The programs have existed for over a decade, beginning as special programs that provided case management for individuals with specific diagnoses. Over time, programs have adapted and evolved to provide more comprehensive chronic care management that spans specific diseases and considers the whole person and all conditions. In some states, these programs are separate contracts with care management providers, and in other states the care management is incorporated into the Medicaid contracts for capitated health plans.

In FY 2009 and FY 2010, a total of 22 states indicated that they had implemented or planned to implement or expand existing care management or disease management programs. These included 12 states in FY 2009 and again 14 states in FY 2010; the total in FY 2010 included four states that were implementing or expanding programs in both years (Figure 35). The initiatives included new contracts with Medicaid health plans for enhanced care management for members with special health needs, HIV/AIDS, diabetes or high risk pregnancies; new RFPs for disease management for asthma, diabetes and congestive heart failure; a special program within the PCCM program for persons requiring high cost, complex care; a special reimbursement for intensive care coordination that would vary based on patient acuity; programs for persons requiring behavioral health services; and other programs through contractors and existing delivery systems.

Figure 35

New or Expanded Medicaid Disease Management or Care Management Initiatives FY 2009 – FY 2010



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2008 and 2009.

I. Quality and Health Information Technology

Rather than slow Medicaid efforts to improve quality, the current fiscal stress has underscored the importance of Medicaid obtaining the greatest possible value for its limited funds. State programs continue to adopt policies designed to measure, monitor and improve the quality of care provided to Medicaid beneficiaries, and the performance of health plans and medical providers that provide the care.

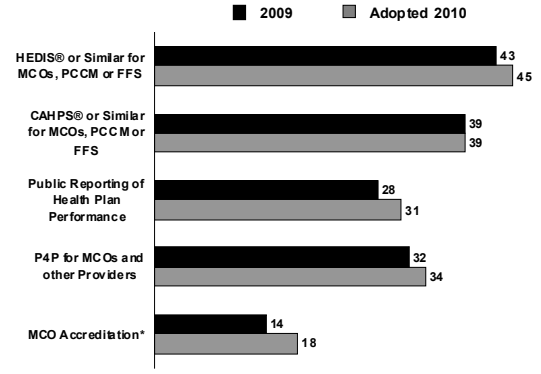
Health Plan Performance: States that contract with managed care organizations use the Healthcare Effectiveness Data and Information Set (HEDIS®), a standard set of benchmark measures developed by the National Committee on Quality Assurance. Originally, these measures were developed for the employer-based, commercially-insured population but over the past decade measures have been adapted or added to focus more specifically on populations served by Medicaid. States generally choose a specific subset of the HEDIS® measures that apply to Medicaid populations, such as well-child EPSDT visits, immunization status, prenatal and postpartum care, breast or cervical cancer screening, management of antidepressant medications or comprehensive diabetes care. Data for these measures is derived from the database for paid claims and from a review of medical charts. Some Medicaid programs have adapted or developed their own HEDIS-like measures to address state-specific policy priorities. Medicaid health plans that are accredited by NCQA in 2009 are required to report performance for 26 HEDIS® measures.[38]

In FY 2009, a total of 43 states used HEDIS® or HEDIS-like measures to monitor quality of care for individuals served in managed care, including HMOs or state-administered Primary Care Case Management programs, or in fee-for-service. These included 36 states that used these measures with capitated MCOs and 22 states that used these measures with PCCMs or in FFS. Fifteen states used these measures in both MCOs and FFS / PCCM programs, and seven states only for PCCM or FFS.

For FY 2010, the number of states using HEDIS® or HEDIS-like measures increased by two to 45 (Figure 36). The same 36 states used these measures for MCOs, while the number using such measures in its PCCM or FFS programs increased by three from 22 to 25; the additional three included one state that already used HEDIS® for their health plans and two states that had not used such measures previously for Medicaid. Sixteen states used these measures both in MCOs and in PCCM / FFS programs, and nine states only in FFS / PCCM programs.

Figure 36

States with Selected Medicaid Quality Initiatives FY 2009 – FY 2010



*Note: MCO Accreditation includes states that require or reward accreditation.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.

[38] National Committee for Quality Assurance. Accessed September 6, 2009: http://www.ncqa.org/tabid/855/Default.aspx

Surveys of Patient Experience: In addition to measures of utilization and health plan performance, which are based on paid claims data and reviews of medical charts, Medicaid programs also conduct surveys to determine the consumer perspective on health care quality, access and other indicators of patient satisfaction. The most commonly used tool is the Consumer Assessment of Healthcare Providers and Systems (CAHPS), developed by the federal Agency for Healthcare Research and Quality (AHRQ) in association with other agencies within the Department of Health and Human Services. CAHPS is designed to be used for Medicare and commercial populations as well as Medicaid to measure consumer experiences with health plans and health care providers. Medicaid agencies sometimes adapt the survey to focus on specific issues of interest in that state, however, when surveys are conducted in accordance with CAHPS guidelines, the data can be submitted to a national data base and compared with national benchmarks. According to AHRQ, a total of 17 states submitted data in 2008, up from 13 states in 2007.[39]

In 2009, a total of 39 states conducted surveys of patient experiences with the health care they received, the timeliness and accessibility of appointments for primary care providers and for specialists, and their satisfaction with the care they received. The 39 states included 34 states that used CAHPS or similar surveys for health plan enrollees, including 14 states that used CAHPS or similar surveys for populations in a health plan and PCCM or FFS. A total of 19 states used CAHPS® or similar surveys for populations in a PCCM or in FFS, including five states that used these surveys only for these populations.

Public Reporting of Health Plan Performance: As Medicaid programs increasingly focus on quality and benchmarks for performance, it has become more common that the HEDIS®, CAHPS® and other data on performance of health plans and Medicaid providers is made available publicly. In some states, the information is made available in the form of a report card that is distributed to Medicaid enrollees to assist them in their choice of a health plan. In other states the information is published on a web site or in annual reports. In FY 2009, a total of 29 states indicated that they published data on health plan performance, and in FY 2010, a total of 32 states indicated this information would be available publicly. In addition, health plans also report data to NCQA, available on the NCQA web site, and for the last five years US News and World Report has annually ranked Medicaid health plans.[40]

Pay for Performance for Health Plans and Other Providers: The performance data for health plans provides an opportunity for Medicaid programs to recognize better care and encourage quality improvement through enhanced reimbursement. Higher performing health plans can be rewarded financially through performance-based reimbursement systems. Such systems may provide incentive payments for higher performance, or may involve a holdback from the monthly capitation payment that is awarded only if specific benchmarks of performance are achieved. Performance also can be rewarded through auto-enrollment into higher performing plans when an individual does not choose a specific health plan.

In addition to health plans, states may have pay-for-performance systems in place for other providers, including physicians, hospitals or nursing homes. In FY 2009, a total of 32 states reported

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[39] The CAHPS Benchmarking Database for Health Plans. Accessed September 6, 2009 at: https://www.cahps.ahrq.gov/CAHPSIDB/Public/about.aspx

[40] See: http://health.usnews.com/sections/health/health-plans/index.html

that they had reimbursement incentives in place for MCOs or other providers. For FY 2010, the number increased to 34 states.

Health Plan Accreditation: States are able to require as a condition of participation with Medicaid that health plans are accredited by a recognized standard-setting organization such as NCQA. Accreditation provides assurance that providers serving Medicaid enrollees meet high levels of care, that the structure, processes and performance of the plans are monitored and that mechanisms are in place for ongoing quality improvement. For FY 2009, a total of 14 states indicated that they required or rewarded plans for accreditation. For FY 2010, the number requiring or rewarding accreditation increased to 18 states.

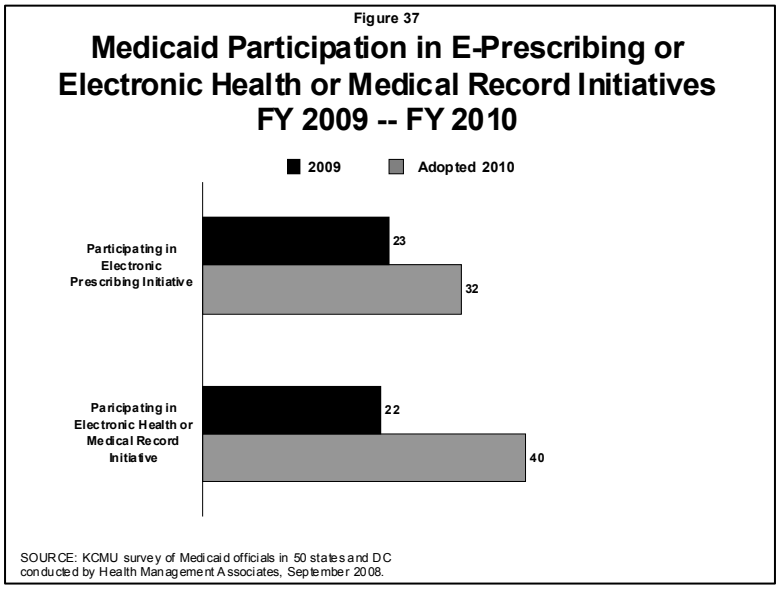
Use of Technology: Electronic Prescribing and Electronic Health or Medical Records: Health information technology (HIT) continues to provide opportunities to improve the efficiency, safety and quality of health care. Across the health care system, providers and insurers alike are examining applications of new technologies. Two specific approaches are being examined by a number of states, including the Medicaid programs in those states. This survey asked whether the Medicaid agency was participating in initiatives related to electronic prescribing or relating to electronic health or medical records (EHRs or EMRs). These initiatives might be led by a state office that coordinates HIT activities, or might be coordinated through a statewide public-private organization that could include provider, business, technology and consumer stakeholders. Because the issues involve the entire health system, it would often be difficult for Medicaid to require or implement HIT initiatives on its own. Accordingly, the focus of this inquiry was on participation, even if Medicaid did not have the lead on an initiative for e-prescribing, EHR or EMR.

In FY 2010, there was a dramatic uptick in Medicaid involvement in these HIT initiatives. In part, this has been the result of federal funding that was intended to facilitate the development and use of technology in the states. Pursuant to the Deficit Reduction Act of 2006, the federal government awarded a total of $150 million in Medicaid Transformation Grants to a total of 35 states in 2007 and 2008, for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid.[41] Then, in early 2009, ARRA authorized $19 billion over five years for HIT initiatives for Medicare and Medicaid, including financial incentives through Medicare to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a meaningful way. These federal initiatives sparked considerable interest across the states.

[41] For detailed descriptions of state initiatives, see: http://www.cms.hhs.gov/MedicaidTransGrants/

In FY 2009, a total of 23 states indicated they were participating in an initiative for electronic prescribing (Figure 37). For FY 2010, an additional nine states planned to participate in an electronic prescribing initiative, bringing the total to 32 states. In FY 2009, a total of 22 states indicated they were participating in an initiative for EMRs or EHRs. For FY 2010, the number almost doubled to 40 states.

Figure 37



J. Behavioral Health

Medicaid now pays for over half of all publicly financed mental health services and more than one quarter of all mental health services nationally. For the 2008 Medicaid budget survey, Medicaid directors indicated the extent to which various potential Medicaid behavioral health issues in their states were concerns. The large majority of Medicaid directors indicated that the following behavioral health care issues represented major or moderate concerns: proposed federal regulations (45 states), budget concerns (44 states), behavioral health drug utilization (44 states), emergency room use (41 states), and inpatient psychiatric hospitalization (39 states). In addition, over half of the states indicated that interagency coordination between Medicaid and mental health was a moderate or significant concern. Subsequently the restrictive federal regulations that generated the greatest concern were rescinded.

The current survey did not repeat these questions but asked Medicaid directors to describe any Medicaid behavioral health initiatives implemented in FY 2009 or planned for FY 2010.

The most common theme from the current survey involved changes in the management or coordination of behavioral health care services through implementation of managed care, care coordination, case management, or integration/coordination of behavioral health care with physical health care. In particular, six states reported a variety of initiatives to coordinate physical health care with behavioral health care. These include integration of benefits in a single MCO (TN), regional networks to manage chronic care for individuals with mental illness and chronic physical illness (WA), required memoranda of understanding (MOU) between primary care physicians and mental health clinics to co-managed prescribed drugs and services (CT), integration grants to providers and an FQHC integration pilot (IN), development of three mental/physical health integration initiatives (OR), and a coordinated care management pilot (CA) for individuals with multiple critical healthcare

needs. Nine other states mentioned care coordination, case management or managed care initiatives within behavioral health care services.

States continue to focus on moving Medicaid behavioral health services to community settings. One-fourth of states mentioned initiatives of this nature. Six states mentioned substance abuse treatment initiatives, four states plan to implement or expand behavioral health programs that use the rehabilitation option, three states mentioned initiatives related to behavioral health medications, three are implementing or developing telehealth initiatives for behavioral health services, two states are implementing autism waivers, and two states mentioned a focus to insure that the right person received the right service at the right time and place (and for the right price). Only nine states indicated that they had no special Medicaid initiatives related to behavioral health services in either FY 2009 or FY 2010.

4. Key Medicaid Issues

Key Section Findings:

- Over the last decade, federal oversight and audits of Medicaid spending have intensified. While there was still a lot of concern about federal oversight activities, in comparison to previous surveys there were few negative comments and less frustration about the nature of the federal – state relationship.
- Broad support for health reform exists, although state Medicaid officials were concerned about any new fiscal responsibilities including the potential costs of eligibility expansions, mandated minimum provider rates and administrative costs.
- Looking ahead, Medicaid Directors were most concerned about the immediate and mounting fiscal challenges, including the challenge of adopting a budget for FY 2011 when the ARRA enhanced FMAP will expire. Other operational priorities in FY 2010 include new Medicaid Management Information Systems (MMIS), developing patient-centered medical home initiatives, improving delivery systems, adopting new information technologies and positioning the state for anticipated national health reform.

A. Impact of Federal Oversight Activities

Over the last decade, federal Medicaid program integrity efforts have intensified. After the GAO added Medicaid to its list of high risk federal programs in 2003,[42] CMS responded in a number of ways to increase federal oversight by: hiring funding specialists to examine and eliminate high-risk state funding practices, creating the Division of Reimbursement and State Financing (DRSF) to review state plan amendments related to payment methodologies, using focused financial reviews and OIG audits to identify inappropriate state claims for federal reimbursement, implementing the Medicare-Medicaid ("Medi-Medi")[43] data match project, and implementing the Payment Error Rate Measurement (PERM) project.[44] In 2006, the DRA included a new Medicaid Integrity Program to increase the government's capacity to prevent, detect, and address fraud and abuse in Medicaid, and during the past year, two other types of oversight were implemented:

- ***Disproportionate Share Hospital (DSH) Audits:*** On December 19, 2008, CMS promulgated a new rule (effective January 19, 2009) implementing Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. In order to receive federal financial participation (FFP) for DSH expenditures, states must submit an annual report and an independent certified audit to CMS for each completed Medicaid state plan rate year (starting with audits of the 2005 and 2006 state plan years which must be completed by September 30, 2009).
- ***GAO State ARRA Oversight Audits:*** Among other things, ARRA tasks the GAO with the responsibility for conducting bi-monthly reviews of selected states and localities regarding

[42] GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).
[43] The Medi-Medi data match project matches Medicare and Medicaid claims information on providers and beneficiaries to identify potential improper billing and utilization patterns which could indicate fraudulent schemes.
[44] 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).

their use of ARRA funds, including the ARRA enhanced FMAP. The reviews focus on 16 states and D.C.

For the third year, the survey included a question exploring the administrative impact on state Medicaid programs of enhanced CMS oversight activities. Specifically, the survey included an open-ended question inviting state officials to comment on federal Medicaid oversight activities or audits in FY 2010, including any changes they were seeing or expected to see.

While there was still a lot of concern about the administrative burdens and other duplication of review efforts, in comparison to previous surveys which also addressed the issue of federal oversight, the lack of negative comments on the federal – state relationship was noteworthy. The focus had changed. Beyond the issue of audits and a clear view that federal reviews could be better coordinated and administered, some states expressed a hopeful sense in this survey that the federal – state relationship would improve. In contrast to previous surveys, states did not say the federal government was working to stifle state initiatives or to shift federal costs to states.

Regarding the oversight activities, the most common area of concern (raised by 21 states) was the administrative burden on state staff and resources to support multiple, simultaneous federal audits and oversight efforts, especially in light of hiring freezes, staff reductions or mandatory state employee furlough days in many states. As one state noted, "It is a huge burden on the agency; the time requirements are so large, it is a real drain on staff resources." Another state commented, "We are so overwhelmed." A number of states also noted that the need to respond to federal audits and reviews detracted from other state priorities and two state officials suggested that the federal government should provide enhanced FMAP for program integrity efforts (as is the case for CHIP[45]).

The second most common area of concern (raised by 14 states) was the high level of duplication among various federal audit and review efforts and therefore the need for greater coordination. Other areas of concern included the following: the lack of timely CMS guidance and/or and the need for greater standardization or consistency in CMS decision making (8 states); the negative provider impact related to audits (6 states) including two states that were particularly concerned with the potential impact of the DSH audits and one small state that commented that the requirements for a statistically valid audit sample size meant that many of the state's providers were hit in every audit); the State Plan approval process (including timeliness issues) (5 states); the need for improved training of CMS' contracted auditors (3 states), and the requirement that overpayments identified in an audit must be repaid to CMS before the state has been able to recoup the funds from the provider (3 states).[46] A number of states (11 states) generally described ongoing audits, but did not identify specific areas of significant concern. One state expressed appreciation for the support from the CMS Medicaid Integrity Group and the course offerings at the Medicaid Integrity Institute.

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[45] CHIPRA provides for a 90 percent Federal match for CHIP spending related to PERM administration and excludes such spending from the 10 percent administrative cap.

[46] The State must repay the Federal share of the overpayment to CMS within 60 calendar days of receipt of the final audit report, whether or not the State recovers, or seeks to recover, the overpayment from the provider. Among other things, state officials commented that the 60-day period does not allow time for resolution of provider appeals.

B. Section 1115 Waivers and State Health Reform

Under Section 1115 of the Social Security Act, states are able to carry out experimental, pilot, or demonstration projects that promote the objectives of the Medicaid statute. When they are approved by the Secretary of Health and Human Services, state Medicaid programs can demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Under this authority, states can expand eligibility to individuals who would not otherwise be eligible for the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. Under an approved Section 1115 waiver, a state can obtain federal Medicaid matching funds for services and expenditures that otherwise would not qualify for federal funding.

A key provision of Section 1115 waivers is that they must be "budget neutral." This has come to mean that the federal Medicaid cost over a five-year period cannot be more than it would have been without the waiver. Savings that accrue to other federal programs, such as Medicare, cannot be considered when calculating budget neutrality. These waivers are approved for a period of five years, after which states have been allowed to request approval for an additional five-year period.

In this survey, state Medicaid officials were asked if they were planning to develop, seek approval for, or implement a Section 1115 comprehensive Medicaid reform waiver, waiver amendment or renewal that was intended to reduce the number of uninsured persons in their state. A total of 22 states indicated that they currently were at one of these stages with a Medicaid waiver.

- Two states reported approved waivers. Massachusetts received approval for its health reform waiver, and Maryland received approval to add benefits to its primary adult care program, which serves childless adults up to 116 percent of the FPL.

- A new waiver, waiver amendment or waiver renewal was under review at CMS in nine states. Of these, six states would provide or expand coverage to adults or children (Louisiana, Montana, New York, Oklahoma, Pennsylvania, and Texas). Utah would provide premium assistance to parents or childless adults who purchase COBRA or insurance from the high risk pool, and Vermont would expand its premium assistance program from 200 percent to 300 percent of the FPL. Indiana, which has enrolled 40,000 individuals in its Healthy Indiana Plan, has received over 150,000 applications and would expand that program.

- A total of 11 states indicated that a comprehensive waiver was still under development. The primary focus of these proposed waivers would be on health coverage for adults that do not qualify for Medicaid.

With the current budgetary stress across almost all states, the survey asked those states proposing new waivers or renewal of existing waivers if state budgetary concerns had caused them to scale back or abandon their original plans. At least six states indicated that due to current budget concerns their plans had been reduced in scope, delayed, portions abandoned or proposals to expand a current waiver were not considered. On the other hand, one state indicated that budget pressures certainly had now slowed development of their waiver, which was designed to save costs, and in fact, may have accelerated their plans.

C. Federal Health Reform

This year's survey was conducted while federal policy makers were developing proposals for health care reform including legislation pending before the U.S. House of Representatives and other options being widely discussed that included expanding Medicaid. The survey asked state officials to provide any comments, concerns or issues that they had related to these federal health reform discussions.

Broadly speaking, Medicaid officials expressed support for the principles underpinning federal reform, including strategies to expand coverage to the uninsured. As many states have already used Medicaid as a vehicle to expand health coverage, Medicaid officials expressed general support for an expanded role for the program; however, they also identified a variety of concerns and issues.

Reflecting current budget situations across the states, three-quarters of states (38 states)[47] reported concerns about the potential fiscal impact on states. The major concern was that eligibility expansions, mandated minimum provider rates and new administrative costs could all add to state fiscal woes, depending on how they were financed. In particular, many officials felt that their states would be unable to finance the cost of a Medicaid eligibility expansion unless the federal government assumed 100 percent of the costs, especially during the early years given the dire fiscal conditions states are facing due to the recession.

Twelve states expressed concerns regarding the potential administrative impacts reform will have on states with a number commenting on the difficulty states would have providing "wrap-around"[48] benefits if required to do so. Eight states also indicated that they were particularly monitoring how Medicaid would be required to interface with one or more new insurance exchanges. Eight states that have already implemented optional Medicaid eligibility expansions were concerned about an eligibility maintenance of effort that might place them at an unfair financial advantage. Also, seven states mentioned concerns regarding potential changes or reductions to the Disproportionate Share Hospital (DSH) program.

Other comments included: the need for state flexibility (five states) so that, among other things, states would be able to mange their program budgets; concerns regarding the adequacy of provider access (five states); the need to better integrate care for persons dually eligible for Medicare and Medicaid (three states); the importance of allowing adequate time for implementation (three states); the desirability of simplifying Medicaid eligibility categories (one state); the need for aggressive payment reform (one state); the need to allow states to set higher insurance regulatory standards if federal minimums are met (one state); and a concern that federal reform efforts *not* impose new barriers to the use of evidence-based medicine approaches (one state).

State officials were also asked whether health reform discussions at the federal level had affected state level health reform plans. Sixteen states responded "yes" with the majority of these commenting that various state reform discussions had been put on hold pending the outcome of federal policy decisions.

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[47] Four states chose not to provide any comments.

[48] This refers to a reform option that would require state Medicaid programs to provided additional "wrap-around" benefits to certain low-income persons receiving health insurance coverage through a new health insurance exchange.

D. Looking Ahead: Perspectives of the Medicaid Directors

Medicaid directors were asked to list the most significant issues or challenges that Medicaid would face over the next year. With the level of fiscal stress mounting throughout FY 2009 and with little prospect for relief in FY 2010, it was not surprising that Medicaid directors would list fiscal challenges as the most significant issue. Limits on funding have made this an especially difficult time for Medicaid programs and for those who have had to make difficult, budget-driven decisions. Even with the ARRA and enhanced federal funding, the budget pressure on Medicaid programs has been intense. Dealing with these issues has been all the more difficult as administrative budgets have been cut, caseloads and workloads have increased, Medicaid staff have faced layoffs and furlough days along with other state workers, and everyone has been asked to do more with less.

Other concerns were financially related as well. There was concern about the budget for FY 2011, which was at the early stages of development as the survey was conducted. In particular, Medicaid officials were acutely focused on the impact of ending the enhanced federal matching rate in mid-FY 2011. State officials were worried that state revenues will not have begun to recover by the end of calendar 2010, especially since the historic pattern has been that state revenues recover long after the general economy. Officials were concerned that state funding needed just to maintain Medicaid would not be available, which might precipitate major cuts to Medicaid, including cuts to eligibility. Medicaid officials were also focused on the impact of federal health reform, particularly if federal reform placed new fiscal burdens on states.

Looking into FY 2010, the immediate priorities for Medicaid programs relate primarily to dealing with budget shortfalls. As one Medicaid director said: "Survival is right at the top of the list." Notwithstanding the budget pressure, state officials had other priorities on their list of things they want to attain over the next year. States listed re-procurement of a Medicaid Management Information System (MMIS), developing policies or initiatives such as a patient-centered medical home, improving delivery systems, adopting new information technologies or positioning the state for anticipated national health reform as other key priorities for FY 2010.

At the same time, when asked what Medicaid is achieving and has achieved that was most significant, almost without exception Medicaid officials pointed to Medicaid's positive impact on the health and health care of the populations it serves. Directors expressed pride that even during this most difficult of fiscal times, Medicaid coverage had been protected and in some cases expanded and that they were able to further initiatives to improve quality, accountability and program integrity.

Conclusion

At the beginning of FY 2010, state Medicaid programs are working hard to continue to provide vital health care services to their most vulnerable citizens in the midst of an economic downturn that has sent Medicaid caseloads soaring and state revenue collections plummeting. While Medicaid budget cuts are occurring in almost all states, the ARRA enhanced FMAP funding successfully averted virtually all eligibility reductions and substantially mitigated the severity of other types of cuts as well. At the same time, a significant number of states have continued to move forward with some positive changes that expand eligibility, improve benefits, reorient long term care delivery systems and incentivize quality.

As states look ahead to FY 2011, however, considerable uncertainty remains regarding the prospects for improved economic conditions. While the recession may have officially ended by then, state revenues are unlikely to rebound quickly and caseloads are likely to remain high and growing. With few, if any, options left for achieving significant additional Medicaid cost reductions, and faced with the expiration of the ARRA enhanced FMAP in December 2010, many states may be forced to consider previously unthinkable eligibility and benefit reductions.

Another enormous "unknown" for states as they plan for the future is the outcome of health care reform discussions currently underway at the federal level which could bring dramatic changes to state Medicaid programs. It is highly likely that federal health care reform, if successful, will build on existing state Medicaid programs resulting in new fiscal and administrative challenges for states. Along with these challenges, however, is the potential opportunity to address the long desired goals of better managing care for high need populations (including the dual eligibles), simplifying Medicaid eligibility rules and the enrollment process, and closing the gaps in the current health care social safety net.

Despite these and many other uncertainties, states are continuing to pursue their ongoing efforts to improve quality and outcomes for Medicaid beneficiaries, establish new value-based purchasing strategies and embrace health information technology – all driven by the relentless need to achieve the greatest value possible for each dollar spent. Clearly, state Medicaid programs face many significant challenges in FY 2010 as they seek to maintain and improve their programs, live within severely constrained budgets and assure the best possible care for the populations served.

Appendix A: State Survey Responses

Appendix A-1a: Positive Policy Actions Taken in the 50 States and District of Columbia FY 2009 and FY 2010

States	Provider Payment Increases		Benefit Expansions		Eligibility Expansions		Simplification to Application/ Renewal		Decreased Co-Payments		Long Term Care Expansions	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama	X	X					X	X				
Alaska	X	X			X	X		X				
Arizona	X	X										
Arkansas	X	X		X		X		X				X
California	X	X					X	X			X	X
Colorado	X		X	X		X		X			X	X
Connecticut	X				X						X	X
Delaware	X	X										X
District of Columbia	X	X				X						X
Florida	X	X	X		X	X	X	X			X	X
Georgia	X	X			X						X	X
Hawaii	X	X	X								X	X
Idaho	X	X	X				X					
Illinois	X	X									X	X
Indiana	X	X				X					X	X
Iowa	X	X			X	X		X			X	X
Kansas	X	X						X			X	
Kentucky	X	X					X				X	X
Louisiana	X	X	X		X		X	X			X	X
Maine	X	X										
Maryland	X	X		X	X		X		X		X	X
Massachusetts	X	X					X	X				X
Michigan	X	X					X	X			X	
Minnesota	X					X		X	X			
Mississippi	X	X	X									X
Missouri	X	X			X		X	X			X	X
Montana	X	X	X	X	X	X		X			X	X
Nebraska	X	X	X				X	X			X	X
Nevada	X	X		X				X				X
New Hampshire				X	X	X	X	X				
New Jersey	X	X					X	X			X	
New Mexico		X		X		X	X	X			X	X
New York	X	X	X	X	X	X	X	X			X	X
North Carolina	X	X									X	X
North Dakota	X	X		X		X					X	X
Ohio	X	X	X				X	X			X	X
Oklahoma		X	X		X	X	X	X			X	X
Oregon	X	X			X	X	X	X				
Pennsylvania	X	X	X				X				X	X
Rhode Island	X	X										X
South Carolina	X	X				X					X	X
South Dakota	X											
Tennessee	X	X									X	
Texas	X	X	X	X			X				X	X
Utah	X	X		X								
Vermont	X		X	X			X	X			X	
Virginia	X	X			X						X	X
Washington	X		X				X	X				X
West Virginia	X	X									X	X
Wisconsin	X	X		X	X	X	X	X			X	X
Wyoming	X	X				X		X				
Total	**48**	**44**	**15**	**13**	**15**	**18**	**23**	**27**	**2**	**0**	**32**	**35**

Appendix A-2a: Cost Containment Actions Taken in the 50 States and District of Columbia FY 2009 and FY 2010

States	Provider Payments		Pharmacy Controls		Benefit Reductions		Eligibility Cuts		Changes to Application and Renewal		Copays		LTC	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama	X		X	X									X	
Alaska			X	X										
Arizona	X	X												
Arkansas	X													
California	X	X	X	X		X								X
Colorado		X	X	X		X								X
Connecticut	X	X				X								
Delaware	X	X	X	X										
District of Columbia	X	X		X										
Florida	X	X	X											
Georgia	X	X		X										
Hawaii		X		X		X								
Idaho	X	X	X	X										
Illinois		X	X	X										
Indiana	X	X	X	X										X
Iowa													X	
Kansas	X	X	X	X										
Kentucky			X	X										
Louisiana	X	X	X	X	X								X	
Maine	X	X	X	X		X								X
Maryland		X												
Massachusetts	X		X	X	X						X			
Michigan	X	X	X	X	X								X	
Minnesota	X	X	X	X		X						X		X
Mississippi											X			
Missouri	X	X	X											
Montana			X	X										
Nebraska				X	X								X	
Nevada	X	X			X								X	
New Hampshire	X	X	X			X								
New Jersey	X	X	X	X		X								
New Mexico	X	X												
New York	X	X	X	X									X	X
North Carolina	X	X	X	X		X						X		X
North Dakota														
Ohio	X	X	X	X										
Oklahoma	X	X	X	X	X									
Oregon			X	X		X								
Pennsylvania	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									
Texas	X	X	X											
Utah	X	X	X	X	X	X								
Vermont		X		X								X		
Virginia		X	X	X	X	X								
Washington	X	X	X	X		X								X
West Virginia			X	X										
Wisconsin		X	X	X									X	X
Wyoming		X	X	X		X								
Total	**33**	**39**	**35**	**34**	**10**	**15**	**1**	**0**	**0**	**0**	**2**	**3**	**8**	**12**

Appendix A-3a: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2009

State	Eligibility, Premium and Application Changes
Alabama	**Application & Renewal (+):** Phone interview is not required if all documentation is received with application.
Alaska	**Children (+):** Alaska extended continuous eligibility for children under the age of 19 from 6 months to 12 months. (4/1/09)
Arizona	**ARRA Maintenance of Eligibility (nc):** Eligibility renewals for the waiver category, AHCCCS Care, were extended from 6 months to 12 months, reversing a change that went into effect in September 2008.
Arkansas	**Application & Renewal (nc):** Added a form for children for ID purposes to comply with DRA citizenship verification.
California	**ARRA Maintenance of Eligibility (nc):** The reduction of continuous eligibility for children from 12 months to 6 months and mid-year status reporting requirement for children effective January 1, 2009 was not implemented and suspended until December 31, 2010. **Application & Renewal (+):** Implemented a revised joint Medi-Cal/Healthy Families Program application.
Colorado	
Connecticut	**Pregnant Women (+):** Covering pregnant women under 250% of FPL who are qualified aliens but have less than five-years of US residency. (4/1/09)
Delaware	
District of Columbia	
Florida	**Children (+):** Extend Medicaid to youth up to age 21 who exit adoption subsidy at age 18 and meet certain criteria. (unknown number, 8/08) **Children (+):** Immigrant juveniles from Cuba and Haiti considered paroled and not subject to 5-year ban. (11/08) **Children (+):** Foster children eligible in unlicensed placements. (12/08) **Non-Citizens (+)**: Clarify residency criteria to cover noncitizens with temporary visas. (09/08) Declaration used as verification of income from sponsor. (03/09) Extend coverage from 6 to 8 months for Afghan immigrants. (06/09) **Other (+):** Exclude census earnings for some groups. (02/09) Exclusion of retirement accounts and pension plans for certain groups. (10/08) **ARRA Maintenance of Eligibility (nc):** In order to comply with ARRA maintenance of eligibility standards, the Florida Legislature continued funding of services to adults under the Medically Needy program and restored the Meds-AD program beyond June 30, 2009. These two programs were funded in state FY 2008-09 with non-recurring dollars. The Legislature has now funded these programs for the duration of the recovery period, through December 2010. **Application & Renewal (+)**: Implemented accelerated eligibility renewal process for disabled individuals released from public institutions such as correctional facilities.
Georgia	**Children (+):** Extended Medicaid eligibility for children that age out of foster care. (200, 07/08)
Hawaii	**ARRA Maintenance of Eligibility (nc):** The period of retroactive eligibility for the aged and disabled was reduced from 90 days to 30 day, but then restored 6/09 due to ARRA requirements. Also stopped passive renewals for adults 02/09, but then restored due to ARRA. **Application & Renewal (nc):** New requirements for all non-pregnant adults to document residency, household composition, income and assets to comply with PERM. (9/1/08) **Premiums (nc):** Decreased premiums for recipients at 250% of FPL and above. **Premiums (nc)**: Spend-down obligation for medically needy converted to a premium.
Idaho	**Application & Renewal (+):** Changes were made in the local office processes and call centers and consolidation of offices were established to improve timeliness, increase coordination and simplify the application and renewals processes.
Illinois	
Indiana	**ARRA Maintenance of Eligibility (nc):** Restrictions on Personal Services Contracts as a means of asset sheltering for long-term care were reversed due to ARRA.
Iowa	**Children (+):** Continuous eligibility for children. (2,500, 7/1/08) **Children (+):** Implemented Family Opportunity Act. (185, 1/1/09)
Kansas	
Kentucky	**ARRA Maintenance of Eligibility (nc):** Reversed an increase in the documentation requirements for income trusts. **Application & Renewal (+)**: Eliminated face-to-face interview requirement for children as of

State	Eligibility, Premium and Application Changes
	November 2008. Now accept mail-in applications.
Louisiana	**Children with Disabilities (+):** Expansion of Family Opportunity Act to ages 13 to 18. (50, 10/1/08) **Children (+):** Extended Medicaid eligibility for children that age out of foster care up to age 21. (13 in 2009, 322 in 2010, 3/1/09) **Application & Renewal (+):** Expansion of administrative renewal option for cases meeting certain characteristics (child related cases w/RSDI or other stable income).
Maine	**Adults without Children (nc):** Continuation of waiting list for MaineCare. (13,000 as of 12/08) **ARRA Maintenance of Eligibility (nc):** $25 annual participation fee for adult beneficiaries between 150% and 200% FPL was reversed. **Premiums (nc)**: Increased premiums for "Katie Beckett" program were reversed as of 4/1/09. **Premiums (nc)**: Increased premiums for HIV waiver effective 7/1/08.
Maryland	**Children & Parents (+):** Added an additional disregard to the section 1931 group to increase the effective income standard to 116% of the FPL. Eliminated the asset test for the 1931 group. (10,609 children and 16,605 parents, 7/1/08) **Working Disabled (nc):** Moving Employed Individuals with Disabilities (EID) program into the state plan using the TWWIIA groups. **Non-Citizens (+)**: Expanded Medicaid coverage to pregnant women and children immigrants that have been in country less than 5 years. (4/1/09) **Application & Renewal (+):** Face-to-face interview requirement dropped for medically needy and disabled, and families and children.
Massachusetts	**ARRA Maintenance of Eligibility (nc):** In December 2008 MassHealth decreased the time standard to return an annual review form from 45 to 30 days. In March 2009, due to CMS interpretation of the ARRA requirements, the 45 day time standard was reinstated. **Application & Renewal (+):** Electronic data match with vital records implemented August 2008. (MassHealth applications modified to collect needed data elements and applicant/member permission for the data match.) (Data period for vital record match expanded in August 2009.) **Application & Renewal (+)**: Effective December 20, 2008, with a member's permission, information on homeless status, residential address; mailing address; telephone number; ethnicity/race and pregnancy can be submitted through an electronic application portal. **Application & Renewal (+):** Starting in March 2009, MassHealth began to generate the new Pre-populated eligibility review forms and send them to Commonwealth Care-only households.
Michigan	**Application & Renewal (+)**: The Healthy Kids and MIChild renewal application is now available online.
Minnesota	**ARRA Maintenance of Eligibility (nc):** Minnesota released waiver slots to ensure compliance with ARRA requirements. **Premiums (nc)**: Decreased for MinnesotaCare families.
Mississippi	
Missouri	**Children (+):** Presumptive Eligibility expansion. (324, 07/01/08) **Other (+):** Family Planning Waiver was expanded to include women ages 18-25 with a net family income at or below 185% of the poverty level with assets totaling no more than $250,000 who still require family planning services. (83,000, 1/1/09) **Application & Renewal (+):** A new web application for parents, pregnant women and children was implemented on 5/19/08.
Montana	**Medically Needy (+):** Increased general income deduction to $100. (6,054, 07/01/08)
Nebraska	**Application & Renewal (+):** Eliminated face-to-face interview; changed renewal for children's medical from 6 to 12 months. **Premiums (nc)**: New autism waiver includes premiums.
Nevada	
New Hampshire	**Children (+):** Newborns eligible for 12 months even if mother does not complete a 60 day redetermination if hospital verifies baby is with mother and they reside in New Hampshire. **Application & Renewal (+)**: The redetermination time frame for Healthy Kids Gold increased from 6 months to 12 months for families also receiving Food stamps.
New Jersey	**Application & Renewal (+):** Implemented Express Lane Eligibility using adjusted gross income from the most recent State Income tax filing.
New Mexico	**Application & Renewal (+)**: Medicaid Renewal project continued. In 2009, implemented a central point for mail/fax renewals. Also, web-based PE form brought up in 2009.
New York	**Children (+):** Extending coverage to children aging out of foster care to age 21. Income and resources of children released from foster care at age 18 are exempt until age 21. (350, 01/09) **Parents & Childless Adults (+):** The asset level increased from $3,000 to $13,000 for a family of one, rising with household size. The income standard for childless adults was set statewide at the level of the highest county. (unknown, 04/08) **Medically Needy (+):** Asset level changes the same as for parents and income standards were also increased by a moderate amount. (13,800, 04/08) **Application & Renewal (+):** Maintain Medicaid eligibility for incarcerated individuals and reinstate coverage upon release until renewal. (4/1/08)

State	Eligibility, Premium and Application Changes
North Carolina	
North Dakota	
Ohio	**Application & Renewal (+):** E-gateway for transmitting applications from volunteer enrollment sites; also allowed an electronic signature. **Premiums (nc)**: Proposed expansion for children above 200% of FPL includes premiums.
Oklahoma	**Other (+):** Insure Oklahoma - expand current employer sponsored insurance and individual plan coverage from an employee size of 50 to 250 employees. (153,101, 3/1/09) **Other (+)**: Include coverage for Oklahoma full-time college students age 19 through 22. (3,000, 3/1/09) **Application & Renewal (+)**: Electronic application for newborns implemented statewide. (Pilot began in April 2008.)
Oregon	**Parents (+):** Income exclusion of 1 to 2 months for families otherwise eligible to transition to TMA. (1,683, 10/01/08) **Parents (+)**: Child Support Disregard implemented; excludes $50 per child, per month, up to $200 per financial group for TANF Medical and Substitute or Adoptive Care. (10/1/08) **Application & Renewal (+):** An online application has been implemented that can be submitted electronically. **Application & Renewal (+):** Redetermination period was extended from 6 months to 12 months.
Pennsylvania	**ARRA Maintenance of Eligibility (nc):** Two policy changes were posted that were subsequently rescinded due to ARRA. The first change, effective 11/13/08, established a time frame in which individuals must provide proof of citizenship and identity or Medical Assistance coverage would be terminated. The second change, effective 12/8/08, required mandatory verification of residency. Both changes were rescinded and reversed in April 2009. **Application & Renewal (+):** Statewide implementation of "Health Care Hand Shake" (automated referral and eligibility data transfer process between Medicaid & CHIP). 10/15/08
Rhode Island	**Parents and Family Planning Waiver (-):** Reduced income eligibility from 185% to 175% of FPL. (1,000, 10/01/08) (exempted from ARRA MOE for legislation passed before July 08 but implemented after July 08).
South Carolina	**ARRA Maintenance of Eligibility (nc):** TMA income disregard was restored (retroactive 1/1/09), Aged, Blind and Disabled and childcare disregards were restored and verification of pregnancy back to within 30 days of presumptive eligibility was restored. Restored the time for applicants to submit needed verification information from 10 days back to 21 days. If application is denied for failure to provide information, new application no longer has to be filed if information is provided within 30 days of the denial. Review date for Breast and Cervical cancer program was changed from 4 months back to 6 months.
South Dakota	
Tennessee	**Premiums (nc)**: Premiums for waiver children were eliminated in FY 2009.
Texas	**ARRA Maintenance of Eligibility (nc):** The requirement to verify pregnancy was removed as of 6/3/09 due to ARRA. **Application & Renewal (+)**: Pre-population of demographic and household information for Children's Medicaid renewal applications. **Application & Renewal (+):** Correspondence provided to Children's Medicaid clients has been modified to be more reader-friendly and places emphasis on the household's need to return the renewal application in order to continue receiving benefits. **Application & Renewal (+):** Online application for children's Medicaid available statewide. **Premiums (nc)**: New $500 upper limit on premiums for the working disabled buy-in group.
Utah	
Vermont	**ARRA Maintenance of Eligibility (nc):** Reversed premium increases that were effective 7/1/08. **Application & Renewal (+):** Streamlined and simplified application forms.
Virginia	**Other (+):** Expanding family planning waiver from 133% to 200% of FPL. (7/1/08)
Washington	**Application & Renewal (+):** Implemented a simplified redesigned online application.
West Virginia	
Wisconsin	**Adults without Children (+)**: The Badger Care Plus Core Plan waiver expansion added coverage for long-term unemployed childless adults aged 19-64 up to 200% of the FPL that were previously enrolled in a county medical program. (12,500, 1/1/09) **Application & Renewal (+):** Began accepting applications for new childless adults benefit via internet or phone application only- no paper applications. Applications processed centrally by state. **Premiums (nc):** Premiums were reduced for caretaker relatives in families with incomes over 150% FPL.
Wyoming	

Appendix A-3b: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2010

State	Eligibility, Premium and Application Changes
Alabama	**Application & Renewal (+):** Will implement Express Lane Eligibility for renewals with CMS approval.
Alaska	**Children (+):** Alaska will no longer prohibit eligibility for children under the age of 19 when the household voluntarily drops insurance coverage within the previous 12 months, and the household's income is greater than 150% but less than 175% of the federal poverty guidelines for Alaska. (50, 10/1/09) **Parents (+)**: Alaska will allow 12 months of Transitional Medicaid without requiring periodic reports. (1,200, 9/1/09) **Application & Renewal (+):** Beginning 9/1/09, Alaska will allow 12-month review periods for all Medicaid recipients.
Arizona	
Arkansas	**Children (+):** ArKids expansion to public employees. **Application & Renewal (+)**: On-line application process.
California	**ARRA Maintenance of Eligibility (nc):** New programs were started to retain Medi-Cal eligibility for those seniors and persons with disabilities losing SSI due to the SSP reductions. (20,000, 7/1/09) **Application & Renewal (+)**: A process is being implemented to share SSA information with the counties on individuals denied SSI/SSP due to excess income so that individuals linked to the SSI/SSP reductions can retain or attain Medi-Cal eligibility. (7/1/09)
Colorado	**Parents (+):** Increased eligibility for parents from 60% to 100% FPL. (13,000, 4/1/2010) **Application & Renewal (+):** Plan to implement an on-line application for Family Medicaid in FY 2010.
Connecticut	**Application & Renewal (nc):** Implementing an eligibility modernization project during the biennium.
Delaware	**Premiums (nc):** New Ticket to Work program has premiums.
District of Columbia	**Children (+):** Extending coverage to optional immigrant children who are in the five-year waiting period. (800 to 1000, 10/1/09) **Pregnant Women (+):** Extending coverage to optional undocumented pregnant women. (10/1/09)
Florida	**All Eligibility Groups (+):** All vehicles excluded in asset test. (Approx. 4,800, 09/09) **Application & Renewal (+)**: Foster care application process via the Florida Safe Family Network information system. **Application & Renewal (+)**: Passive review for annual redetermination. **Application & Renewal (+):** Revision of the Florida KidCare application form and plan to improve the transition of KidCare applicants and recipients between KidCare partner programs.
Georgia	
Hawaii	
Idaho	**Premiums (nc):** New sliding scale premium for Katie Beckett enrollees. (Due to ARRA, payment of premium will be optional.)
Illinois	
Indiana	**Parents & Pregnant Women (+):** Asset Disregard of 529 Educational Savings Accounts and income disregard for census temporary workers. (SPAs to be submitted) **Pregnant Women (+)**: Presumptive Eligibility. (awaiting CMS approval) **Other (+)**: New Family Planning Waiver to 150% FPL. (awaiting CMS approval).
Iowa	**Children (+):** Implemented coverage of legal permanent resident children. (246, 7/1/09) **Children (+)**: Implementing presumptive eligibility. (TBD, 10/1/09) **Pregnant Women (+):** Expanded coverage to 300% FPL. (1,000, 7/1/09) **Parents (+):** Implement ARRA option to eliminate TMA quarterly reporting. (1,573, 10/1/09) **Application & Renewal (+)**: Implement a 14-day grace period for applications and renewals. (1/1/10) **Application & Renewal (+):** Performance Bonus Initiatives: Implement Express Lane Eligibility; Implement single application/enrollment processes. **Premiums (nc):** Premium decrease for Medicaid Employed Persons with Disabilities. (8/1/09)
Kansas	**Application & Renewal (+)**: Implementation of new simplified Family Medical application form planned 01-01-10.
Kentucky	
Louisiana	**Application & Renewal (+):** Redesign and revision of application forms, renewal forms and processes to implement Express Lane Eligibility. **Application & Renewal (+):** Additional administrative renewal of cases meeting certain criteria

State	Eligibility, Premium and Application Changes
	(child related cases within 75% of income limit, LTC MNP with income below facility rate, LTC couple members who are certified individually.)
Maine	**Adults without Children (nc):** Continuation of waiting list for MaineCare. (10,000 as of 07/09)
Maryland	
Massachusetts	**Application & Renewal (+):** MassHealth members can view their information online and submit changes electronically for the following items: homeless status, residential address; mailing address; telephone number; ethnicity/race and pregnancy. (7/1/09) **Application & Renewal (+):** MassHealth Application revisions related to parental affidavit for identify verification for a child under age 16 and Iraqi/Afghan special immigrant codes. Eligibility determination logic will be enhanced to afford applicants/members a time limited benefit pending submission of citizenship/identity or immigration verifications. (09/09) **Application & Renewal (+)**: Reformat the application flow of both paper and electronic applications in an effort to minimize conflicting or blank member responses. (12/09)
Michigan	**Application & Renewal (+):** Applying for a CHIPRA grant to develop Express Lane Eligibility for the school lunch program.
Minnesota	**Non-Citizens (+):** Added coverage for immigrant children & pregnant women within first five years. **Children (+)**: Add coverage for children above 275% at full premium, upon federal approval. **Children (+)**: Children in foster care on 18th birthday deemed Medicaid eligible without premium or insurance barrier. **Application & Renewal (+):** Agency to provide assistance to applicants applying on-line. Efforts to speed up state disability reviews. **Premiums (nc)**: Decreased for MinnesotaCare families.
Mississippi	
Missouri	**Application & Renewal (+):** Evaluating options for efficiency enhancement.
Montana	**Children (+):** Asset test removed, 12 month continuous eligibility implemented. (10,649, 10/1/09) **Other (+):** New Family Planning Waiver. (1,950, 10/1/09) **Other (+)**: Basic Medicaid waiver extension amendment to add 400-800 uninsured Mental Health Services Plan (MHSP) individuals with incomes at or below 150% FPL. (Waiting for CMS approval) **Application & Renewal (+):** Common application for kids for Medicaid/CHIP.
Nebraska	**Application & Renewal (+)**: Implementing ACCESS Nebraska - phasing in online application process for all public assistance programs. **Premiums (nc)**: New Autism waiver has premiums.
Nevada	**Application and Renewal (+):** Internal procedural changes related to timeframes for TMA reporting.
New Hampshire	**Other (+):** Implementing a new Family Planning Waiver. (awaiting CMS approval) **Application & Renewal (+):** Conducting a cross-match with vital statistics for citizenship and ID verification.
New Jersey	**Application & Renewal (+):** Implemented administrative renewals.
New Mexico	**Children (+):** Implementing 12 month continuous eligibility. **Application & Renewal (+):** Implementation of Express Lane Eligibility.
New York	**Children (+):** Eliminate resource test for Family Health Plus (FHP) children age 19-20. (1/1/10) **Parents, Pregnant Women, Medically Needy and Childless Adults (+):** Eliminate resource test for all non-SSI related traditional Medicaid groups. (1/1/10) **Parents & Adults without Children (+)**: Eliminate resource test for FHP. (1/1/10) **Parents (+):** Transitional Medical Assistance extended from 6 months to 12 months. (1/1/10) **Adults (+):** Twelve months continuous coverage for non-institutionalized adults subject to federal approval. **Other (+)**: Eliminate prohibition on state employees enrolling in Family Health Plus. (1/1/10) **Application & Renewal (+):** Eliminate the Automated Finger Imaging System (AFIS) requirement.
North Carolina	
North Dakota	**Medically Needy (+):** Increased medically needy standard to 83% of FPL (from 58% for 1 person and from 44% for 2 persons). (7/1/09)
Ohio	**Application & Renewal (+)**: Elimination of face-to-face redetermination for ABD Medicaid. Change from 6 to 12 month redetermination for parents. Elimination of an optional form at redetermination for all populations.
Oklahoma	**Non-Citizens (+):** Allow an additional 2 month period of coverage for Afghans with special immigrant status (upon Governor's approval). **Other (+):** 1115 waiver amendment currently pending at CMS to increase Insure Oklahoma eligibility to 250% FPL and increase children to 300% FPL. **Application & Renewal (+):** No Wrong Door Electronic Eligibility Determination (scheduled for

State	Eligibility, Premium and Application Changes
	testing in Nov/Dec; first use in March 2010).
Oregon	**Children (+):** Eliminate asset test. (10/1/09) **Children (+)**: Eliminate the 5-year ban for Legal Permanent Resident Children. (10/1/10) **Children (+)**: Implementation of 12 month continuous eligibility for children. (10/1/09) **Parents (+):** Adopting the changes allowed per ARRA to eliminate the requirement for families to have TANF medical for 3 of the previous 6 months for TMA and providing 12 months rather than 6 months TMA before must meet reporting requirements. (10/1/09) **Other (+)**: Reopening OHP Standard, Oregon's Medicaid expansion demonstration for adults. Also includes adults with children. (25,000, 10/1/09) **Application & Renewal (+)**: An interactive online application is being developed, hopefully to be implemented by January 1, 2010.
Pennsylvania	
Rhode Island	
South Carolina	**Parents (+)**: TMA - changed 3 of 6 month rule to 1 month. (less than 100, 7/1/09)
South Dakota	
Tennessee	
Texas	
Utah	**Premiums (nc)**: Premiums for the Primary Care Network program were eliminated for American Indians.
Vermont	**Application & Renewal (+)**: Modernization project underway to change front-end of eligibility process; implement web-based application; 1-800 number; pilot program currently implemented and full implementation expected by June 2010.
Virginia	**ARRA Maintenance of Eligibility (nc):** Reversed recently enacted policy counting the value of a life estate – due to ARRA. (7/1/09)
Washington	**Application & Renewal (+):** Approval by legislature for electronic signatures at application, to be implemented 7/09. Simplified application for specific medical programs implemented. Exploring Express Lane Eligibility.
West Virginia	
Wisconsin	**Adults without Children (+):** Expanded BadgerCare Plus Core Plan statewide. (37,500, 7/15/09) **Application & Renewal (+):** Introducing on-line renewal process around December 2009.
Wyoming	**Other (+):** New family planning waiver for women between the ages of 16 and 45. (Under review at CMS) **Application & Renewal (+)**: Implementing an on-line screening tool.

Appendix A-4a: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2009

State	Benefit Change
Alabama	
Alaska	
Arizona	
Arkansas	
California	
Colorado	**Aged & Disabled (+)**: Adopted consumer directed attendant support services through DRA State Plan option.
Connecticut	
Delaware	
District of Columbia	
Florida	**Children (+):** Allow liver transplant from living donors.
Georgia	
Hawaii	**Aged & Disabled (+):** Care Coordination and personal assistance level 1 services expanded through new Quest Expanded Access (QExA) integrated long term care managed care program. **All Adults (+):** Preventive and restorative dental benefits added.
Idaho	**All (+)**: Partial hospitalization and outpatient mental health services added to Basic Plan with utilization controls. **All Adults (nc):** Sole source contract for substance abuse program coverage.
Illinois	
Indiana	
Iowa	
Kansas	
Kentucky	
Louisiana	**Children (+):** Removed lifetime maximum limit for root canals; added multi-systemic therapy (a behavioral health service). **Non-institutionalized Adults (-):** Imposed a 5 prescription limit (with physician override).
Maine	
Maryland	
Massachusetts	**Expansion Adults (-)**: Discontinued coverage for non-emergency transportation in the Family Assistance, Basic and Essential waiver programs.
Michigan	**All Adults (-):** Eliminated dental, hearing aids, chiropractic care, podiatry, and eyeglasses and associated vision services.
Minnesota	
Mississippi	**Pregnant Women (+):** Added Implanon and Essure to the Family Planning Waiver contraceptive coverage.
Missouri	
Montana	**Children (+):** Added Psychiatric Residential Treatment Facilities (PRTF) assessment services (14 day stay in PRTF for the purpose of assessment). **All Adults (+)**: Increased types of organ transplants covered.
Nebraska	**All Adults(-)**: Dental benefits limited to $1,000 per year; Occupational therapy/Physical therapy/Speech therapy limited to 60 visits per year; hearing aids limited to 1 every 4 years; eyeglasses limited to 1 every 24 months; chiropractic limited to 12 visits per year. **All Adults (+):** Added coverage for tobacco cessation services.
Nevada	**All Adults (-):** Eliminated coverage for non-medical vision services.
New Hampshire	
New Jersey	
New Mexico	
New York	**All (+)**: Expanded mental health counseling in medical settings and asthma and diabetes education.
North Carolina	
North Dakota	

State	Benefit Change
Ohio	**All Adults (+)**: Restored dental benefits.
Oklahoma	**Children (-)**: Applied prior authorization for dental coverage for (1) a second set of panoramic films taken within 3 years of the first set and (2) a second provider to correct poorly rendered restorative procedures by original provider of services. Restricted coverage for the application of ceramic based and cast metal crowns to natural teeth only. **All (+)**: Added coverage for telemedicine. **Expansion Adults (+):** Expanded Insure Oklahoma Individual Plan to cover physical, occupational and speech therapy services in an outpatient hospital setting.
Oregon	
Pennsylvania	**Children (+)**: Added developmental delay and autism screens and implemented a pediatric dental periodicity schedule.
Rhode Island	**Children (-)**: Reconfigured Community Intensive Treatment services to add utilization controls and to include under managed care contracts.
South Carolina	
South Dakota	
Tennessee	**Adults (-)**: Limited scope of benefits for home health and private duty nursing.
Texas	**Children (+):** Specialty reimbursement for telephone consults with primary care providers who are conducting clinician directed care coordination was added to the clinician directed care coordination policy. **All (+):** Increased the types of medical services that may be reimbursed through telemedicine, expanded allowable patient site presenters, removed limitations on distant site providers, added reimbursement of a facility fee payable to the patient site, and added local health departments as an additional location where patients may receive telemedicine services. Also, added coverage for bariatric surgery for adults and children.
Utah	**Non-Pregnant Adults (-):** Effective 11/1/08, eliminated audiology and hearing services, physical, occupational and speech therapies, eyeglasses and chiropractic services. **Expansion Adults (-)**: Eliminated coverage of physician services rendered during an inpatient stay in the Primary Care Network (PCN) waiver program.
Vermont	**All Adults (+)**: Added coverage for services provided by a naturopathic physician. **All Adults (nc):** chiropractic services initially reinstated but then cut in February 2009.
Virginia	**All (-)**: Implemented prior authorization for mental health services.
Washington	**Adults (+):** Expanded number of mental health visits from 10 to 20 and allowed service by any mental health professional (previously just allowed psychiatrists).
West Virginia	
Wisconsin	**Expansion Adults (nc)**: Coverage expansion to childless adults provides a limited benefit package of basic health care services ("BadgerCare Plus Core Plan") including primary and preventative care plus generic drugs. With certain exceptions, an annual application fee will apply in lieu of premiums. In addition, co-pays for some services and drugs will apply.
Wyoming	

Appendix A-4b: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2010

State	Benefit Change
Alabama	
Alaska	
Arizona	
Arkansas	**Adults (+)**: Adding coverage for dental service, and telemedicine; also seeking a Substance Abuse Demonstration Waiver.
California	**Non-Institutionalized, Non-Pregnant Adults (-):** Eliminating acupuncture, dental (with exceptions); audiology and speech services; optometry and optician services; podiatry; psychology services; chiropractic services and incontinence creams and washes. Applies to both managed care and fee for service.
Colorado	**Children (+)**: Adding coverage for fluoride varnish. **All (-)**: Requiring all outpatient clinics to obtain prior authorization for non-emergent CT, non-emergent MRI and all PET scans.
Connecticut	**All:** Discontinuing coverage for most over-the-counter drugs effective July 2009.
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	**All Adults (-)**: Dental benefits reduced to emergency only.
Idaho	
Illinois	
Indiana	
Iowa	
Kansas	
Kentucky	
Louisiana	
Maine	**Adults (-)**: Adding functional eligibility limits on targeted case management and private non-medical institutional services.
Maryland	**All (+)**: Adding a targeted case management benefit for adults with serious mental illness and children with serious emotional handicaps. **Expansion Adults (+):** Adding substance abuse and ER services to the primary adult care 1115 waiver program.
Massachusetts	
Michigan	
Minnesota	**All Adults (-)**: Applying limits on dental coverage, such as comprehensive exams once in five years, periodic exams once per year.
Mississippi	
Missouri	
Montana	**Children (+):** Will add wraparound facilitation, family support specialist and peer to peer support as services in the Psychiatric Residential Treatment Facility (PRTF) demonstration grant program. **Aged & Disabled (+):** Addition of Illness Management and Recovery (using SAMHSA Evidence Based Practice Model) as a reimbursable rehabilitation service for adults with severe disabling mental illnesses. **Expansion Adults (nc):** Benefit for proposed 1115 waiver expansion group (Mental Health Services (MHSP) individuals) would be the same limited benefit package as current 1115 Basic Medicaid waiver population or would receive premium assistance only (with no Medicaid wrap benefits) for an employer-sponsored plan or for private insurance. Also, instituting a lifetime cap of $1 million.
Nebraska	
Nevada	**All Adults (+):** Restored coverage for non-medical vision services.

State	Benefit Change
New Hampshire	**All (+):** Implementing hospice benefit. **All (-):** Adding prior authorization requirements for occupational therapy, non-emergent - ambulance services, and methadone clinics.
New Jersey	**All (-)**: Eliminating coverage of specific cough, cold and cosmetic drugs.
New Mexico	**Children (+)**: Increasing autism services. **Aged & Disabled (+):** Adding coverage for intensive outpatient services for substance abuse and removing restrictions on limited substance abuse treatment.
New York	**Children & Pregnant Women (+):** Adding coverage for smoking cessation counseling services. **All (+):** Adding coverage for cardiac rehabilitation; substance abuse screening, brief intervention, and referral for treatment (Emergency Department). **Expansion Adults (nc)**: Family Health Plus buy-in for union benefit funds and employers.
North Carolina	**Aged & Disabled (-)**: Applying utilization controls to personal care services.
North Dakota	**All Adults (+):** Expanding coverage for optometric services by increasing eyeglass replacement policy from 1 every 3 years to 1 every 2 years.
Ohio	
Oklahoma	
Oregon	**Non-Pregnant Adults (-):** Reducing vision and dental benefits.
Pennsylvania	
Rhode Island	**Adults (-)**: Limiting ER visits to 12 per year.
South Carolina	
South Dakota	
Tennessee	
Texas	**Children (+)**: Will expand Texas Health Steps preventative dental services to include dental cleanings and fluoride treatments beginning at 6 months of age instead of 1 year. **All (+)**: Adding a comprehensive substance abuse benefit for children and adults to include: medically supervised, residential or, outpatient detoxification, medication management, residential and outpatient services, specialized residential services for women, and outpatient chemical dependency counseling.
Utah	**Non-Pregnant Adults (+):** Coverage for physical and occupational therapies restored to levels in effect prior to 11/1/08. **Non-Pregnant Adults (-):** Coverage for all dental benefits eliminated.
Vermont	**All Adults (+):** Reinstating coverage for limited chiropractic services.
Virginia	**All (-)**: Applying prior authorization to additional mental health services.
Washington	**All Adults (-):** Durable Medical Equipment (DME) benefit reduced including elimination of coverage for bath support equipment, limits on oral enteral nutrition and new quantity limits on certain medical supplies including incontinence and diabetic supplies and on non-sterile gloves.
West Virginia	
Wisconsin	**Adults (+):** Adding coverage for screening, brief intervention and referral to treatment (SBIRT) services for individuals with or at-risk for substance use-related problems.
Wyoming	**Aged & Disabled (-):** Applying utilization restrictions to psychiatric residential treatment facilities. **All Adults (-):** Reducing coverage on ultrasounds and other radiology; reducing coverage for eyeglasses (less frequent replacement).

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	Bench-mark Benefit Package	Copay Flexibility/ Enforceability
Alabama	X				X		X			
Alaska		X								
Arizona	X						X			
Arkansas	X		X		X		X			
California	X		X	X	X					
Colorado				X						
Connecticut	X		X				X			
Delaware			X				X			X
Columbia			X				X			
Florida	X	X			X		X			
Georgia	X	X	X				X			
Hawaii			X				X			
Idaho	X								X	
Illinois	X		X				X			
Indiana	X	X	X				X			
Iowa	X		X	X		X				
Kansas	X	X	X				X		X	
Kentucky	X		X		X		X		X	X
Louisiana	X		X		X	X				
Maine	X									
Maryland	X	X	X				X			
Massachusetts					X		X			
Michigan			X				X			
Minnesota	X						X			
Mississippi		X					X			
Missouri			X				X			
Montana	X	X					X			
Nebraska	X		X							
Nevada	X			X	X		X			
New Hampshire	X		X							
New Jersey	X		X		X		X			
New Mexico							X			
New York	X		X							
North Carolina			X				X			
North Dakota	X		X			X	X			
Ohio	X		X				X			
Oklahoma	X		X				X			
Oregon	X		X	X	X		X			
Pennsylvania	X		X				X			
Rhode Island	X						X			
South Carolina	X	X	X					X	X	
South Dakota	X									
Tennessee	X						X			
Texas	X		X		X		X			
Utah							X			X
Vermont										
Virginia	X	X	X						X	
Washington			X	X			X		X	
West Virginia							X		X	
Wisconsin	X		X	X	X		X		X	X
Wyoming	X									
Total	**36**	**10**	**31**	**7**	**12**	**3**	**36**	**1**	**8**	**4**

(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/ (Puerto Rico also received a Round 2 grant award.)

Appendix A-6a: Pharmacy Cost Containment Actions in Place in the 50 States and District of Columbia in FY 2009

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		X	X
Colorado	X	X	X			X
Connecticut	X	X	X			X
Delaware	X	X	X	X		X
District of Columbia	X	X	X	X		
Florida	X	X	X			X
Georgia	X	X	X	X		X
Hawaii	X	X	X	X		X
Idaho	X	X	X	X		X
Illinois	X	X	X		X	X
Indiana	X	X	X			X
Iowa	X	X	X	X		X
Kansas	X	X	X		X	X
Kentucky	X	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		X
Minnesota	X	X	X	X		X
Mississippi	X		X		X	
Missouri	X	X	X			X
Montana	X	X	X	X		
Nebraska		X				X
Nevada	X	X	X	X		X
New Hampshire	X	X	X	X		X
New Jersey						
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
Pennsylvania	X	X	X	X	X	X
Rhode Island	X	X	X	X		
South Carolina	X	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		X
Vermont	X	X	X	X		X
Virginia	X	X	X			X
Washington	X	X	X			X
West Virginia	X	X	X	X	X	X
Wisconsin	X	X	X	X		X
Wyoming	X	X	X	X		X
Total	**45**	**46**	**44**	**26**	**16**	**44**

Appendix A-6b: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia FY 2009 and FY 2010

States	Impose Script Limits		Reduce Disp Fee		Reduce Ingredient Cost		Preferred Drug List		More Drugs/ Prior Auth.		Suplemental Rebates		Multi-State Purchasing Coalition		New/Lower State MAC		Other Actions	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama							X	X	X	X	X	X			X	X		
Alaska							X	X	X	X						X		
Arizona																		
Arkansas																		
California				X	X	X		X				X				X		
Colorado						X	X	X	X	X	X	X				X		
Connecticut																		X
Delaware					X		X	X	X	X								
District of Columbia																X		
Florida			X		X		X		X		X				X			
Georgia												X						X
Hawaii		X																
Idaho							X				X					X		
Illinois							X	X	X	X	X	X			X	X		
Indiana							X	X		X					X			X
Iowa																		
Kansas															X	X		
Kentucky							X	X			X	X						
Louisiana	X															X		
Maine	X						X	X			X	X						
Maryland																		
Massachusetts							X	X	X	X	X	X			X	X	X	
Michigan							X	X			X	X						
Minnesota						X	X	X			X	X						
Mississippi																		
Missouri															X			
Montana							X	X	X	X	X	X						
Nebraska								X				X		X				
Nevada																		
New Hampshire			X				X		X		X							
New Jersey			X	X	X	X												X
New Mexico																		
New York					X		X	X			X	X						
North Carolina						X			X	X		X		X				X
North Dakota																		
Ohio				X			X				X							X
Oklahoma							X	X	X	X	X	X						
Oregon							X	X			X			X	X	X		
Pennsylvania							X	X	X	X	X	X			X	X	X	
Rhode Island							X				X						X	
South Carolina	X																	
South Dakota																		
Tennessee																		
Texas							X		X		X				X			
Utah					X		X	X			X	X			X	X		
Vermont				X		X												X
Virginia				X	X		X	X			X	X			X	X	X	
Washington						X	X	X	X	X					X		X	
West Virginia							X	X	X	X	X	X			X	X		
Wisconsin			X		X		X	X		X	X	X				X		
Wyoming							X	X	X	X	X	X			X	X		
Total	**3**	**1**	**4**	**5**	**8**	**7**	**28**	**24**	**16**	**15**	**24**	**21**	**0**	**3**	**15**	**17**	**5**	**7**

Appendix A-7: Medicaid Care Management Taken in the 50 States and District of Columbia FY 2009 and 2010

States	Managed Care Policy Changes: New Service Areas, Populations, Mandatory Groups or Managed LTC Initiatives		New Medical Homes Initiatives		New Disease Management or Chronic Case Management Initiatives	
	2009	2010	2009	2010	2009	2010
Alabama					X	X
Alaska						
Arizona						
Arkansas						X
California	X	X				
Colorado	X		X	X		
Connecticut	X	X				X
Delaware						
District of Columbia						
Florida	X	X		X		
Georgia					X	
Hawaii	X					
Idaho						
Illinois	X	X	X			X
Indiana	X					X
Iowa		X				
Kansas						
Kentucky					X	X
Louisiana						X
Maine	X			X	X	
Maryland				X		
Massachusetts		X		X		X
Michigan	X	X				
Minnesota	X				X	
Mississippi						
Missouri	X				X	
Montana	X					X
Nebraska		X			X	
Nevada					X	
New Hampshire						
New Jersey	X	X				X
New Mexico	X					
New York	X	X		X	X	X
North Carolina	X	X			X	
North Dakota						
Ohio		X	X			
Oklahoma						
Oregon		X			X	
Pennsylvania		X				X
Rhode Island	X	X				
South Carolina						
South Dakota						X
Tennessee		X				
Texas		X		X		
Utah						
Vermont						
Virginia						
Washington		X			X	X
West Virginia	X	X				
Wisconsin	X	X				
Wyoming						
Total	**19**	**20**	**3**	**7**	**12**	**14**

Appendix A-8: Medicaid Quality Measures in Place in the 50 States and District of Columbia FY 2009 and 2010

States	HEDIS® or Similar Performance Measures: MCOs		HEDIS® or Similar Performance Measures: PCCM or FFS		CAHPS® or Similar Patient Surveys: MCOs		CAHPS® or Similar Patient Surveys: PCCM or FFS		Public Reporting of MCO Performance		Pay for Performance for MCOs or Other Providers		Require or Provide Incentives for MCO Accreditation	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama				X					X	X	X	X		
Alaska														
Arizona	X	X							X	X	X	X		
Arkansas			X	X			X	X	X	X	X	X		
California	X	X			X	X			X	X	X	X		
Colorado	X	X	X	X	X	X	X	X	X	X	X	X		
Connecticut	X	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			X	X
Georgia	X	X	X	X	X	X	X	X		X			X	X
Hawaii	X	X			X	X			X	X		X	X	X
Idaho											X	X		
Illinois	X	X	X	X	X	X	X	X	X	X	X	X		
Indiana	X	X	X	X	X	X			X	X	X	X		X
Iowa	X	X	X	X	X	X	X	X	X	X	X	X		
Kansas	X	X	X	X	X	X	X	X	X	X				
Kentucky	X	X		X	X	X								
Louisiana				X			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	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		X
Montana			X	X										
Nebraska	X	X			X	X	X	X					X	X
Nevada	X	X	X	X	X	X					X	X	X	X
New Hampshire			X	X										
New Jersey	X	X			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	X	X	X	X
Oklahoma			X	X			X	X			X	X		
Oregon	X	X			X	X	X	X	X	X	X	X		
Pennsylvania	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Rhode Island	X	X			X	X					X	X	X	X
South Carolina	X	X	X	X	X	X	X	X		X				X
South Dakota														
Tennessee	X	X							X	X	X	X	X	X
Texas	X	X	X	X	X	X	X	X	X	X	X	X		
Utah	X	X	X	X	X	X	X	X	X	X	X	X		
Vermont			X	X			X	X						
Virginia	X	X			X	X	X	X	X	X			X	X
Washington	X	X			X	X			X	X	X	X		
West Virginia	X	X			X	X							X	X
Wisconsin	X	X			X	X			X	X		X		
Wyoming			X	X			X	X			X	X		
Total	**36**	**36**	**22**	**25**	**34**	**34**	**19**	**19**	**29**	**32**	**32**	**34**	**14**	**18**

Appendix A-9: Participation in E-Prescribing and EMR/EHR Initiatives in the 50 States and District of Columbia FY 2009 and 2010

States	Participating in Electronic Prescribing Initiative		Participating in Electronic Health or Medical Record Initiative	
	2009	2010	2009	2010
Alabama	X	X	X	X
Alaska				X
Arizona	X	X	X	X
Arkansas	X	X		X
California	X	X		X
Colorado				
Connecticut		X		
Delaware	X	X		
District of Columbia			X	X
Florida	X	X		X
Georgia			X	X
Hawaii				X
Idaho			X	X
Illinois		X	X	X
Indiana			X	X
Iowa			X	X
Kansas	X	X	X	X
Kentucky				X
Louisiana	X	X	X	X
Maine				
Maryland		X		X
Massachusetts				
Michigan				X
Minnesota	X	X	X	X
Mississippi	X	X	X	X
Missouri	X	X	X	X
Montana	X	X	X	X
Nebraska				
Nevada	X	X		
New Hampshire	X	X		X
New Jersey		X		X
New Mexico	X	X	X	X
New York	X	X		X
North Carolina				
North Dakota				
Ohio	X	X		
Oklahoma	X	X		X
Oregon	X	X	X	X
Pennsylvania		X		X
Rhode Island		X		X
South Carolina			X	X
South Dakota	X	X	X	X
Tennessee	X	X	X	X
Texas		X	X	X
Utah		X	X	X
Vermont				X
Virginia				
Washington	X	X		X
West Virginia		X		X
Wisconsin				X
Wyoming	X	X	X	X
Total	**23**	**32**	**22**	**40**

Appendix A-10: Provider Taxes in Place in the 50 States and District of Columbia FY 2009 and FY 2010

States	Hospitals		ICF/MR-DD		Nursing Facilities		Managed Care Organizations		"Other"		Any Provider Tax	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
Alabama		X			X	X			X	X	X	X
Alaska												
Arizona							X	X			X	X
Arkansas		X		X	X	X					X	X
California			X	X	X	X	X				X	X
Colorado		X	X	X	X	X					X	X
Connecticut					X	X					X	X
Delaware												
District of Columbia				X	X	X					X	X
Florida	X	X		X	X	X					X	X
Georgia					X	X	X				X	X
Hawaii												
Idaho	X	X				X					X	X
Illinois	X	X	X	X	X	X			X		X	X
Indiana			X	X	X	X					X	X
Iowa			X	X		X					X	X
Kansas	X	X									X	X
Kentucky	X	X	X	X	X	X	X		X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X	X	X	X	X			X	X	X	X
Maryland	X	X	X	X	X	X	X	X			X	X
Massachusetts	X	X			X	X					X	X
Michigan	X	X			X	X	X				X	X
Minnesota	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X					X	X
Missouri	X	X	X	X	X	X	X		X	X	X	X
Montana	X	X	X	X	X	X					X	X
Nebraska			X	X							X	X
Nevada					X	X					X	X
New Hampshire	X	X			X	X					X	X
New Jersey			X	X	X	X	X	X			X	X
New Mexico							X	X	X	X	X	X
New York	X	X			X	X			X	X	X	X
North Carolina			X	X	X	X					X	X
North Dakota			X	X							X	X
Ohio	X	X	X	X	X	X	X	X			X	X
Oklahoma					X	X					X	X
Oregon	X	X			X	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	X	X			X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X							X	X
Tennessee			X	X	X	X	X	X			X	X
Texas			X	X			X	X			X	X
Utah			X	X	X	X					X	X
Vermont	X	X	X	X	X	X			X	X	X	X
Virginia												
Washington												
West Virginia	X	X	X	X	X	X					X	X
Wisconsin	X	X	X	X	X	X				X	X	X
Wyoming												
Total	**23**	**26**	**28**	**31**	**35**	**37**	**16**	**11**	**10**	**11**	**45**	**45**

*Kentucky, Minnesota, Missouri, New York & Vermont all reported multiple "other" provider tax in both 2009 and 2010

Appendix B: Profiles of Selected States:

- **Connecticut**
- **Nevada**
- **Washington**
- **Wisconsin**

Profile of Medicaid Policy Changes: Connecticut

Connecticut entered FY 2009 in relatively good fiscal shape. It closed FY 2008 with over $1.38 billion in reserves, or about 8.5 percent of General Fund expenditures, a higher percentage than that enjoyed by about half of all states.[49] A weakening economy, however, caused Governor M. Jodi Rell in June 2008 to order state agencies to cut 3 to 5 percent from FY 2009 budgets to help cover "an anticipated shortfall of about $150 million." This followed other executive measures including a hiring freeze, out-of-state travel ban, and cuts in gasoline usage.[50] These measures however, did not solve the state's worsening budget situation. Connecticut's unemployment rate rose steadily from 5.5 percent in June 2008 to 6.6 percent by December, and stood at 8.0 percent in June 2009.[51] Although well below national rates, the percent of mortgages in foreclosure had been climbing steadily prior to the beginning of 2008, but jumped to over 1 percent in the first quarter of 2008 compared to approximately 0.7 percent one year earlier – an increase of over 40 percent.[52] By mid-fiscal year it was clear FY 2009 revenue would fall short of projections by $1.4 billion[53] widening the FY 2009 expenditure gap from $150 million to a gaping $1.3 billion.[54]

The fiscal crises heightened tensions as Connecticut lawmakers, enjoying a Democratic majority in both chambers, and the Republican Governor struggled to agree on a FY 2009 budget reduction plan while simultaneously anticipating even larger deficits in the coming biennium. In particular, the Governor placed a high priority on conserving state reserves to help bridge what was anticipated to be a very slow recovery, and on holding the line against tax increases. Late in February the legislature passed a bill to cover the FY 2009 deficit and Governor Rell signed it on March 3. The bill reduced appropriations across the board, moved $220 million from numerous "off-budget" accounts into the General Fund, and used $281 million of Budget Reserve Funds and approximately $373 million in federal ARRA stimulus funding to avert the FY 2009 crises.

With 2009 resolved,[55] the state turned to face the $8.56 billion shortfall projected for FYs 2010-2011. Governor Rell's budget proposal released in February totaled $38.4 billion for the biennium and proposed to balance the budget without raising taxes by realigning a considerably smaller state

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[49] National Association of State Budget Officers (NASBO), and National Governors Association; *The Fiscal Survey of the States: June 2009;* Accessed August 17, 2009; http://www.nasbo.org/Publications/PDFs/FSSpring2009.pdf.
[50] Office of Governor M. Jodi Rell; *Governor Rell Orders Fiscal 2009 Budget Cuts at State Agencies, Commissions;* Press Release June 24, 2008.
[51] Bureau of Labor Statistics, Current Population Survey; Accessed August 17, 2009; http://www.bls.gov/CPS/.
[52] Federal Reserve Bank of Boston; *Foreclosures in Connecticut and New England: Analysis of Mortgage Bankers Association National Delinquency Survey Data through Q1-09;* June 11, 2009; accessed August 21, 2009 at http://www.bos.frb.org/commdev/foreclosures/index.htm.
[53] NASBO, June 2009.
[54] Office of Fiscal Analysis, Connecticut General Assembly; *FY 09-FY 12 General Fund and Transportation Fund Budget Projections;* February 2, 2009. Accessed August 21, 2009 at http://www.cga.ct.gov/OFA/Documents/Statements/2009/Feb_2_2009_Statement.pdf.
[55] Notwithstanding the actions taken to cover the FY 2009 budget deficit, on August 31 during the 2009 Special Session, the Connecticut legislature passed a bill directing the State Treasurer to issue Economic Recovery Notes to fund the FY 2009 General Fund once the final shortfall could be determined. The shortfall was estimated at approximately $950 million for a total debt service (principal and interest) of $1.19 billion. The notes are required to be retired by July 1, 2016. This allowed the state to retain state surplus balances in the Budget Reserve Fund to help cover FY 2010 -2011 budget shortfalls. Governor Rell signed the legislation on September 1, 2009.

government: it shed 20 state agencies and 70 boards and commissions through consolidation or elimination; removed 400 state positions; increased fees; canceled bonds for earmark projects totaling $400 million; and delayed university construction projects. It also flat-lined state aid to municipalities for two years, including education funding.[56] The Legislature adjourned its regular session on June 3 without passing a budget.

Returning to the task in a special session, the legislature passed a $36 billion budget on June 26, just days before the beginning of the new fiscal year. The bill included tax increases totaling $2.5 billion including a personal income tax increase for high income earners; a temporary surcharge on the estate tax and corporate income tax; and a cigarette tax increase. It also included a directive to sell unspecified state assets to generate $112.5 million; unspecified state agency cuts of $70 million; and consultant contract reductions of $195 million. Governor Rell vetoed the bill on July 1, and the state, lacking a budget, began operating under executive order which continued through August.

On August 31, the legislature passed what was deemed to be a compromise budget of around $37.6 billion for the biennium. The bill results in a net General Fund revenue gain of nearly $3 billion in FY 2010 and $2.6 billion in FY 2011. Appropriations are cut 1.1 percent in FY 2010 from FY 2009 levels, and increase only 1.9 percent in FY 2011.[57] Ending the longest budget battle in state history, Governor Rell declined to sign or veto the bill, allowing the bill to become law five days after passage according to the state's constitution. Governor Rell also pledged to use line item veto authority to eliminate $8.3 million in earmarks.[58] Major provisions of Connecticut's Final FY 2010-2011 budget bill include:

- Personal income tax rate increases for high income earners and other delays in certain scheduled increases to the personal exemption and certain income tax credits;
- A *reduction* in the state sales tax from 6 percent to 5.5 percent beginning January 2010, but with a trigger to repeal the decrease if state revenues fall more than 1 percent lower than projected;
- A 10 percent surcharge on corporate taxes of businesses with gross receipts of $100 million or more in 2009 through 2011;
- An increase in the estate and gift tax threshold; removal of a tax "cliff" by applying the tax to the marginal amount over the threshold; and a reduction in the rate for estates valued under $10.1 million from 16 to 12 percent;
- A tax increase on cigarettes (from $2 to $3 per pack) and on other tobacco products;
- Transfers of the entire Budget Reserve Fund balance ($1.38 billion) to the General Fund (including amounts earmarked for FY 2009)[59] and transfers of other off-budget funds and accounts to the General Fund totaling $102.5 million;
- A directive for the State Treasurer to develop a financing plan to raise up to $1.3 billion for FY 2011 which can include various debt instruments and securitization of state lottery revenue;

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[56] Governor M. Jodi Rell; *Transcript of Rell's Budget Address;* February 4, 2009.
[57] Connecticut General Assembly Office of Legislative Research; Fiscal Note for HB 6802 as amended by House "A" and "C"; Accessed September 1, 2009 at: http://www.cga.ct.gov/2009/FN/2009HB-06802-R01-FN.htm.
[58] Office of Governor M. Jodi Rell: *Governor Rell: Budget Will Become Law Without Her Signature – and Without Pork-Barrel Spending;* Press Release, September 1, 2009.
[59] See footnote #7 above.

- A directive for the State Treasurer and Office of Policy and Management to jointly establish a plan to sell state assets to raise $60 million over the biennium; and
- Various appropriation reductions to consultant contracts, state personal services and other unspecified expenses.

Health Care Reform on Hold

During rosier fiscal conditions, the state made progress toward increased health care coverage for Connecticut families. In FY 2008, the state increased eligibility for parents and caregivers of Husky eligible (Medicaid) children from 150 percent up to 185 percent FPL, and eligibility for pregnant women increased to 250 percent FPL. In July 2008 the state also began accepting applications for the Charter Oak Health Plan, Governor Rell's initiative to cover uninsured adults without dependent children. The Charter Oak Health Plan provides affordable insurance coverage to adults aged 19 to 64 who lack medical benefits through work, and who do not qualify for public programs such as Medicaid or Medicare. With no income limit to eligibility, participants pay a monthly premium and are subject to deductibles based on income. Charter Oak enrollment reached 10,000 in August 2009.

In FY 2009, Connecticut also took advantage of coverage options made available with passage of CHIPRA to cover qualified aliens who have not yet met the five-year residency requirements. Connecticut covers such children under the age of 19 through the Husky B (CHIP) program, and pregnant women up to 250 percent FPL through Medicaid. These two groups were previously covered through state-funded medical assistance for non-citizens. In FY 2010, the state began providing state-funded medical coverage to children in the care of the state's department of developmental services who have not yet qualified or who are ineligible for Medicaid.

In spite of the budget battles during the 2009 session, the Legislature avoided cuts to health care, likely due in large part to the estimated $760 million in additional Medicaid funding through the ARRA enhanced FMAP. The legislature, however, also passed two health bills in an ongoing effort to address healthcare access for the estimated 9 percent of the Connecticut population that is uninsured. The Connecticut Health Partnership "pooling" bill was debated in several past legislative sessions, and passed by the General Assembly in 2008 only to be vetoed by the Governor. The 2009 bill would allow small businesses, nonprofits, and municipalities to purchase healthcare benefits for their employees through the state employees' plan, with the intent to leverage the clout of the large state plans and achieve lower prices in negotiating with insurance companies. Governor Rell once again vetoed the 2009 legislation and the General Assembly once again was unable to override the veto.

A second health bill, based on a proposal to establish a "high quality public health insurance plan" called SustiNet, would initially pool state employees and retirees with the state's Medicaid low income families and CHIP program into a self-insured pool. Individuals without affordable health insurance would be added as well as a buy-in option for employers. The plan would provide subsidies for low-income individuals to purchase insurance, apply a 4 percent payroll tax for employers that do not offer health insurance, and require provider reimbursement rates sufficient to cover the "reasonable cost" of providing necessary services. The budget situation, the hefty price tag on the SustiNet plan ($950 million to $1.75 billion), and the uncertainty around federal health reform, caused SustiNet supporters to re-craft the legislation, creating a Board tasked with

developing recommendations on the details and implementation of the SustiNet plan by 2011. The bill also creates various task forces to address public health issues such as obesity and tobacco use. The legislation passed by large margins in both the House and Senate, but the Governor, who noted "the objective is health care for everyone, a laudable goal and one I share," nevertheless vetoed the bill primarily because of cost and concerns about alignment with federal reform.60 The General Assembly's vote to override the Governor's veto, in this case, passed by wide margins in both chambers.

Other actions related to Medicaid and health care taken by the state, or planned in the near future are described below.

Eligibility Changes
• In FY 2009, expanded Medicaid eligibility for pregnant women and CHIP eligibility for children under age 19 under 250 percent of FPL who are qualified aliens but have less than five-years of U.S. residency.
Provider Rates
• In FY 2009, increased provider rates for doctors and dentists including an outpatient hospital rate increase of 2.5 percent. • For FY 2010, froze rates for most providers.
Long-Term Care Changes
• Will use its Money Follows the Person demonstration grant to transition up to 700 individuals from institutional settings to community settings over five years beginning in the first quarter of calendar year 2009. • In FY 2009, implemented a new HCBS waiver to divert or transition from institutional care Medicaid individuals with serious mental illness. Services began in April 2009. • In FY 2010: – Will expand the Personal Care Assistant state-funded pilot program for seniors to a full Medicaid waiver targeted for implementation in April, 2010. – Exploring a new disabled waiver which would provide Medicaid coverage for adults earning less than 75 percent FPL. The state currently provides medical services for such adults through the state funded State Administered General Assistance program (SAGA). – Will implement an HCBS waiver for individuals with HIV/AIDS in FY 2010.
Prescription Drug Policy
• Discontinued covering most over-the-counter drugs July, 2009.
Medicaid Quality and HIT Initiatives
• In FY 2009, implemented pay-for-performance for behavioral health providers. The state plans to first monitor performance through reporting, then develop performance standards, and then establish rewards for performance achievement. • In FY 2010, will: – Publish health plan performance for acute or primary care measures. – Develop pay-for-performance measures for health plans. – Implement an E-prescribing initiative in October 2009.
Managed Care Changes
• Piloted PCCM managed care as an option to MCO enrollment in two counties in FY 2009, with plans to expand the option to two additional counties in FY 2010. • Developing a chronic care waiver for FY 2011 that would include managed long-term care using Special Needs Plans (SNPs).

[60] Connecticut General Assembly Office of Legislative Research; OLR Report; *2009 Veto Package;* July 10, 2009; 2009-R-0232; accessed August 25, 2009 at http://www.cga.ct.gov/2009/rpt/2009-R-0232.htm.

Profile of Medicaid Policy Changes: Nevada

Economic conditions in Nevada have changed dramatically in the last two years. In his January 2007 State of the State message, Governor Gibbons indicated that Nevada had exceeded the nation in economic growth. And one year later Nevada had a "rainy day fund" balance of more than $267.7 million as of January 1, 2008.

Everything changed with the current national economic recession which has affected Nevada more dramatically than most states. According to a recent analysis of economic stress levels under which states are operating, Nevada ranked number one – meaning Nevada is suffering more distress than any other state in the nation given its current economic circumstances.[61] The analysis combined three distinct measures, including (1) the foreclosure rate in July 2009; (2) the percentage point change in monthly unemployment between July 2008 and July 2009; and (3) the percentage change in monthly food stamp participation between May 2008 and May 2009. Nevada ranked first in foreclosures filed (1 in every 56 housing units) as well as in the increase in food stamp participation (42.5 percent increase) and second only to Michigan in the percentage point increase in unemployment (5.8 points). (From July 2008 to July 2009 the Nevada unemployment rate increased from 6.7 percent to 12.5 percent while the national average increased from 5.8 percent to 9.4 percent.)

It is not surprising that Nevada has also experienced one of the deepest revenue downturns of any state. Gaming and the state sales taxes account for about two-thirds of state general fund revenues. The recession has affected both of these revenue sources. For example, the number of visitors to Las Vegas and gaming revenues both declined significantly. According to a report by Don Boyd of the Rockefeller Institute, Nevada is one of only eight states in which real per capita personal income declined by more than 10 percent from July 2007 to mid-2009.[62] Nevada also experienced the largest decline in housing prices of any state, with a drop of 28.4 percent from the first quarter of 2007 to the first quarter of 2009. (The national average declined by 3.7 percent.)[63]

Medicaid programs face the greatest risk in states with significant budget deficits and low Medicaid benefits (in terms of rates, eligibility and covered services). Nevada fits both categories. In the 2007-2009 biennium Nevada had four rounds of budget cuts. In addition to non-implementation of physician rate increases (to 90% of Medicare rates) that had been authorized in 2007, Nevada cut hospital reimbursement by 5 percent effective September 1, 2008, eliminated funding for Graduate Medical Education on October 1, 2008, eliminated rate enhancements for pediatric and obstetric care on September 1, 2008, eliminated non-emergency vision services for adult Medicaid recipients as of September 1, 2008, and limited the provision of personal care services effective September 1, 2008. There were also cuts in other areas of state government, and the Governor withdrew $267 million from the state's rainy day fund, exhausting this asset that was intended to help the state weather

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[61] Kaiser State Health Facts; *Measures of State Economic Distress: Housing Foreclosures and Changes In Unemployment and Food Stamp Participation;* Accessed September 2, 2009; http://www.statehealthfacts.org/comparetable.jsp?ind=649&cat=1

[62] http://www.rockinst.org/pdf/government_finance/2009-08-01-Boyd_ABA.pdf

[63] Source: Federal Housing Finance Agency (all transactions index)

cyclical revenue declines. Without the enhanced FMAP and other stimulus funds from ARRA, the Nevada Medicaid program was facing the potential of additional provider rate cuts in FY 2009. These cuts were avoided with the enactment of ARRA.

Nevada faced a $1.2 billion gap before the budget for the 2009-2011 biennium (July 2009 through June 2011) was adopted. This gap represented 37.8 percent of total general fund dollars. Only Arizona had a higher percentage gap in state general funds.[64] Development of the Nevada budget for July 2009 through June 2011 proved extremely challenging. The process was also very politically contentious and was played out in the media. The initial budget presented by the Governor proposed significant cuts, including a 36 percent cut in support of higher education for 2010, elimination of the Medicaid waiver program which provides a premium subsidy for low wage employees and coverage for pregnant women from 134 percent up to 185 percent of FPL, cuts to Medicaid provider rates, and a 6 percent cut in salaries for state workers among other reductions. The budget included no new revenues.

The ARRA enhanced FMAP helped reduce the size of the state's budget shortfall, helped pay for Nevada's increased Medicaid caseload, enabled Nevada to avoid Medicaid benefit and eligibility cuts beyond those already in place[65], lessened the scope of provider rate cuts and helped reduce the overall general fund budget shortfall. Despite ARRA funding, the state was still facing a budget gap, even if the legislature accepted the Governor's proposed level of cuts. The budget that Nevada eventually adopted for FY 2010 and FY 2011 was a balanced budget at the time it was adopted based on revenue assumptions that included a degree of economic recovery. However Medicaid caseload growth is already ahead of the level anticipated in the budget and revenues are lower than budgeted levels.

While the ARRA enhanced FMAP and other ARRA funds enabled Nevada to avoid significant Medicaid cuts, the final budget for FY 2010 and FY 2011 did include cuts in non-Medicaid programs. The budget also included furlough days for state employees (12 for the biennium, representing 4.6 percent of pay, for a savings of $333 million.) The actual number of furlough days could be greater or less than 12 days depending on economic factors.

The Nevada Medicaid program is facing spending pressures that exceed those of most states. While Nevada began FY 2010 with one of the lowest per capita Medicaid enrollment rates in the country, Medicaid enrollment is currently growing faster in Nevada than in any other state. State officials indicate that enrollment increased by nearly 9 percent in FY 2009 and is projected to increase by about 13 percent (or more) in FY 2010. This increase, in conjunction with HMO rate increases to meet actuarial soundness requirements, are the primary factors driving Medicaid spending growth of around 7.5 percent per year for FY 2009 and FY 2010. Spending growth would be higher without provider rate reductions and benefit reductions that were made in FY 2009 and sustained in FY 2010. In light of these cost pressures, Nevada's Medicaid program was fortunate to avoid major budget cuts for FY 2010.

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[64] Elizabeth McNichol and Iris J. Law, *New Fiscal Year Brings No Relief From Unprecedented State Budget Problems,* Center in Budget and Policy Priorities, Updated September 3, 2009.

[65] Non-working parents in Nevada are covered with incomes up to 26 percent of FPL. Nevada's income disregards raise the income threshold for parents with earned income to 91 percent of FPL. These income disregards were under consideration for reduction without the ARRA maintenance of eligibility mandate. In addition, the state was considering elimination of the HIFA waiver, Nevada Check Up, which provides subsidies to low-wage employees of eligible businesses.

There had been discussions in the Nevada legislature of a state agenda for health reform and consideration of a Medicaid reform waiver. With the potential of national health care reform, both of these items were abandoned.

Other actions related to Medicaid and health care taken by the state or planned in the near future are described below.

Provider Rates:
• In FY 2009: – Increased HMO rates by 7 percent. – Reduced inpatient hospital rates by 5 percent. – Eliminated pediatric and obstetric rate enhancements. – Eliminated Graduate Medical Education payments. • In FY 2010: – Increased HMO rates by 4.7 percent. – Other provider rates frozen.
Eligibility Changes & Application/Renewal Changes:
• No changes in FY 2009 or FY 2010 due to ARRA MOE requirements. (Nevada had otherwise intended to revise income disregards for TANF-related Medicaid. Elimination of the HIFA waiver was also proposed by the Governor as noted above.)
Benefit and Cost-Sharing Changes:
• In FY 2009: – Eliminated non-emergency vision benefits for all adults. – Limited personal care services to one hour for bathing, grooming, dressing; eliminated personal care services for exercise. • In FY 2010, will restore non-emergency vision benefits for adult Medicaid beneficiaries.
Long-Term Care Changes:
• In FY 2009: – Implemented DRA HCBS State Plan option. • In FY 2010: – Will increase number of HCBS waiver slots. – Will add Self-Directed Personal Assistance Services options.
Managed Care Changes:
• In FY 2009, implemented care management and coordination for SED children and frequent ER users (mostly SSI enrollees).
Medicaid Quality and HIT Initiatives:
• In FY 2009, began participating in an E-prescribing initiative. • In FY 2010, discontinued an HMO initiative with P4P incentive payments based on improvements in targeted HEDIS measures (due to budget cuts).

Profile of Medicaid Policy Changes: Washington

Washington entered the economic slump at a later date than most states. At the end of FY 2008, the State's surplus balances were healthy at $1.09 billion, approximately 9.1 percent of total expenditures.[66] The supplemental budget passed in April, 2008 was expected to leave a total of $850.1 million in savings, with $446 million in the recently established Budget Stabilization Account and $404.1 million in unobligated revenue. In a press release, Governor Chris Gregoire noted, "This is one of the largest supplemental budget surpluses in state history and it will help us meet future needs at a time when about 30 other states face deficits. We are the envy of many states across the nation."[67] Further, the June 2008 General Fund State (GFS) revenue forecast for the following 2009-2011 biennium was $31.8 billion, a healthy 8 percent increase over 2007-09.

FY 2009: Freefall Slide

Washington's tax structure is different from most states in that it has no personal or corporate income tax. The majority of General Fund revenue comes from the retail sales and use tax, business and occupation tax, and the property tax. These three sources account for about 85 to 87 percent of General Fund State (GFS) revenues, with the sales and use tax the largest component of revenues. Just like consumers in other states, Washington consumers began to curtail their spending in response to the crumbling economy and also as a result of restricted consumer credit arising from the financial sector crisis. The resulting impact on the State's budget, with its heavy reliance on retail sales, took revenues into a freefall throughout FY 2009, and state policy makers through a series of actions to address the fiscal problem before it got out of hand. The experience in Washington is illustrative of how quickly the economic crises developed and the challenge states faced to effectively respond.

August, 2008: In response to a weakening economy, Governor Gregoire directed state agencies to reduce fuel consumption by 5 percent; implemented a hiring freeze, ban on non-emergency travel, new equipment purchases, and non-emergency personal services contracts.[68] These actions were projected to save $90 million.

September 2008: The forecast for 2007-2009 biennium was $29.1 billion in GFS revenues or $273.1 million less than the June forecast. The 2009-2011 forecast for GFS revenue also fell from $31.8 to $31.5 billion.

October 2008: The Governor directed the Office of Financial Management (OFM) to find an additional $200 million in savings to offset revenue losses. Savings were generated through across-the-board cut of 1 percent of unspent appropriations; redirecting the use of prior year reversions, various other operating expenses, and interest on fund balances; and increased access to federal funds.

November 2008: The FY 2007-2009 GFS revenue forecast dropped to $28.6 billion, nearly $800 million below the June forecast. FY 2009-2011 revenue projections plummeted $1.68 billion from the June forecast to $30.1 billion. The OFM identified $260 million in additional cuts to incorporate

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[66] National Association of State Budget Officers; *Fiscal Survey of States: June 2009;*
[67] Washington Office of the Governor; Press release April 1, 2008.
[68] Washington Office of the Governor; Press release August 4, 2008; accessed September 2009 at http://www.governor.wa.gov/news/archive.asp.

into the Governor's supplemental FY 2009 budget. Targeted agency reductions included $15 million from the Health Care Authority Health Services Account, and nearly $181 million from the Department of Social and Health Services.[69]

December 2008: Governor Gregoire proposed a FY 2009-2011 budget with cuts to plug an estimated aggregate $5.7 billion shortfall. Savings were achieved through program reductions, suspension of state employee, teacher and care worker salary increases, pension changes, increased federal contributions and the use of the state's rainy day fund.

February 2009: The Legislature passed a supplemental budget that cut $290 million from FY 2009 appropriations, transferred $91 million from other accounts and relied on federal stimulus funding to close the gap. A preliminary budget forecast late in the month estimated an additional $721 million loss in revenues for FY 2009 and an additional $1.6 billion loss in the next biennium bringing total revenue loss in FY 2009-2011 to $6.8 billion.

March 2009: The forecast for FY 2009 continued to fall with year-end GFS estimates now $1.5 billion lower than the June 2008 forecast, and FY 2009-2011 projections $3.8 billion less than originally forecast.

April 2009: The Legislature passed a FY 2009-2011 biennial budget. Praising lawmakers for their hard work, but calling the budget "a necessary evil" the Governor signed the legislation in May. Falling revenue collections were expected to leave the state $9 billion short of a "maintenance-level" budget. Lawmakers trimmed planned spending by $4.4 billion over three years, used $3 billion in ARRA stimulus funds, and $800 million transferred from the state's construction budget. Policy makers expected the enacted budget to leave the state with about $750 million in surplus – unless revenues continued to languish. Major elements of the $35 billion spending plan include:

- A 40 percent reduction to the Basic Health program providing non-Medicaid state-subsidized health insurance to low-income people lacking coverage;
- Modified state pension contributions;
- Elimination of 3,000 jobs from state agencies and colleges;
- No cost of living increase for the next two years for teachers and state workers;
- Cuts to hospitals, doctors and nursing home reimbursement totaling $200 million;
- Cuts to mental health care and drug and alcohol treatment programs;
- No major new tax increases, but relies on license and fee increases, sharp increases to tuition at state colleges, and expanded liquor sales; and
- Reliance on nearly $3 billion in ARRA stimulus funds.

"This is a responsible budget," Gregoire stated, praising lawmakers who wrote it. "It reflects courage." K-12 education and health care for kids were notably spared from significant reductions.

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[69] Washington Office of Financial Management; Memo to State Elected Officials, Agency Directors; Presidents of Higher Education Institutions and State Boards and Commissions: November 25, 2008.

In June 2009, after the budget was signed, a new revenue forecast again brought dismal news projecting a combined $482 million deficit in the General Fund in the FY 2009 budget and the next biennium. In its report, the Economic Revenue Forecast Council noted:

> *While Washington consumers and businesses are expected to start spending again by the end of the year, the forecasted recovery in state revenues is quite slow. By the end of the forecast period (FY 2011), GF-S revenue is still expected to be below the level of FY 2008. Biennial totals of GF-S revenue… were forecasted to contract by 0.2% in the2007-09 biennium and 0.1% in the 2009-11 biennium – the first time we are likely to have two biennia with back-to-back negative growth rates since the current data series began in FY 1961.*[70]

The Governor issued yet another directive to agencies to decrease their General Fund employee costs by 2 percent from what was budgeted. Governor Gregoire also directed that controls on spending be maintained for equipment purchases, out-of-state travel and personal service contracts, and also asked higher education and separately elected officials to voluntarily follow her hiring and purchasing directives.

Budget Impact on Health Programs

The 2009-2011 budget included a 43 percent cut to Washington's Basic Health program, which provides non-Medicaid state-subsidized health insurance to lower income Washingtonians. Rather than restrict eligibility for the program to achieve the required savings, the Health Care Authority increased premiums and the annual deductible. Under the new budget constraints, the average premium will increase from about $36 per month to $61.60 per month, and the annual deductible will increase from $150 to $250 beginning January 1, 2010.[71] The agency also identified members who were either eligible for Medicaid (3,000) or were already enrolled in Medicaid (5,000) that could be removed from Basic Health rolls.

The budget also rolled back recent Medicaid provider reimbursement increases to nursing facilities, hospitals, dental and managed care. The cuts to nursing homes prompted a federal lawsuit filed in July, which resulted in a temporary restraining order against the reductions. Additional lawsuits were filed to block other budget savings actions that eliminated adult day health for clients in residential settings; reduced personal care services for children with developmental disabilities; and barred home-health agencies from assigning relatives to care for family members, requiring relatives to become individual providers of care which is less expensive for the state. Such legal actions present additional barriers in the state's ongoing effort to navigate a difficult budget climate.

Other state Medicaid actions taken in 2009 and planned for 2010 are described below.

Provider Rates:
• In FY 2009: – Increased inpatient hospital rates (2 – 3 percent); dentist, and nursing home reimbursement (3.5 percent); – Reduced physician and MCO reimbursement. • In FY 2010 reduced rates for inpatient and outpatient hospital (-4 percent each), physicians, dentists, MCOs, and nursing home reimbursement (-5 percent).
Application/Renewal Process:

[70] Economic Revenue Forecast Council; *Washington State Economic and Revenue Forecast;* June 2009.
[71] Basic Health website accessed September 4, 2009 at http://www.basichealth.hca.wa.gov/.

- In FY 2009, implemented a simplified redesigned on-line application.
- In FY 2010:
  - Legislature approved an electronic signature allowing state to implement full online application process July 2009.
  - Will implement simplified applications for specific medical programs;
  - Exploring the possibility of simplifying the application process for children with Express Lane eligibility.

Benefit Changes

- In FY 2009, expanded number of mental health visits for all adults from 10 to 20 and allowed service by any mental health professional. (Previously the state just allowed services by psychiatrists).
- In FY 2010, reduced the durable medical equipment benefit for adults including the elimination of coverage for bath support equipment, limits on oral enteral nutrition and new quantity limits on certain medical supplies such as incontinence, diabetic supplies and non-sterile gloves.

Long Term Care

- In FY 2010:
  - Will reduce personal care hours for clients living at home by an average of approximately 3.8 percent.
  - Will eliminate adult day health services for clients receiving residential care.
  - Will add 90 or more new community placements for persons with Developmental Disabilities.

Prescription Drug Controls

- In FY 2009:
  - New drug classes added to Preferred Drug List (PDL).
  - Implemented Smart PA to reduce PA burden for providers and Medicaid staff.
  - Increased the number of drugs covered under the state MAC and made various adjustments to MAC pricing.
  - Implemented the Generic First Dispensing Law allowing restrictions on brand name drugs where generic alternatives are available.
  - Reduced dispensing fee expenditures by requiring 90-day dispensing for clients stable on selected maintenance medications.
- In FY 2010:
  - Changed ingredient cost reimbursement from AWP-14 percent to AWP -16 percent, beginning July 1, 2009.
  - Will add a new drug class to the PDL.
  - Will continue to expand Smart PA to promote the appropriate use of drugs with the least administrative burden to staff and providers.

Managed Care Changes

- In FY 2009:
  - Modified the chronic care management program to target aged, blind and disabled with chronic medical conditions and a mental health and/or chemical dependency diagnosis.
- In FY 2010:
  - Will begin enrollment of SSI children into Managed Care.
  - Will implement through the mental health system one or more chronic care management programs for the aged, blind and disabled with chronic conditions and a mental health and/or chemical dependency diagnosis.

Profile of Medicaid Policy Changes: Wisconsin

In February 2008, a weakening national economy led Governor Jim Doyle to call a legislative special session to address a $652 million state budget deficit for the 2007-2009 biennium. The legislature succeeded in closing the gap by, among other things, refinancing the state's bonding of the tobacco settlement payments. By the fall of 2008, however, it became obvious that even the dismal economic forecast of a few months earlier underestimated the extent of the economic crisis. Lower than projected sales and employment tax revenues, combined with a demand for more services, created still greater budget gaps. By February 2009, the Legislative Fiscal Bureau was estimating an additional FY 2009 budget shortfall of $600 million and was also projecting a $5.7 billion budget deficit for the 2009 – 2011 biennium. Before the 2009 legislative session ended, even those forecasts proved over-optimistic, and the deficit estimate was increased by another $1 billion – the largest budget deficit in state history.[72]

The legislature took action in February 2009 to address the FY 2009 budget deficit and to begin to address the projected shortfall for the 2009-2011 biennium, passing legislation in only two days. The bill included a hospital assessment which the Governor had proposed, the previous fall that would generate $78 million in new revenues for FY 2009 and $224 million for the 2009 – 2011 biennium.[73] This legislation also made adjustments to state spending, including adding back $50 million dollars previously cut from the Medicaid budget, now needed to address a projected shortfall. State revenues were further increased primarily through changes in corporate and franchise tax provisions. At the same time, cuts were made in business taxes, by way of credits for research and development, job creation, and new business venture investments, in hopes of stimulating economic growth.

Budgeting for the 2009-2011 Biennium

Despite the severity of the state's fiscal condition, legislators succeeded in passing a budget for the new biennium *before* it actually started for the first time since 1977.[74] Like other states, the availability of federal stimulus funds through the American Recovery and Reinvestment Act (ARRA) was a key tool in this process. A core principle behind ARRA – enabling states to avoid large cuts in education, health care and public safety – aligned well with Governor Doyle's priorities which also included protecting the middle class from tax increases and minimizing the potential negative impact of one-time federal relief in the future.

In addition to relying on ARRA stimulus funds, the new budget included more than $3 billion in spending cuts, approximately $2 billion from new or enhanced taxes and fees, and a number of short-term measures (i.e., restructuring state debt and delaying local aid payments).[75] Key features of the new budget include:

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[72] Office of the Governor, Press Release, June 29, 2009.
[73] Summary of Budget Adjustment Provisions, 2009 Wisconsin Act 2, Legislative Fiscal Bureau, February 23, 2009.
[74] Office of the Governor, Press Release, June 29, 2009.
[75] Comparative Analysis of Act 28: The 2009-2011 Biennial Budget (Updated June 30, 2009), Wisconsin Council on Children and Families, accessed at http://www.wccf.org/pdf/budget_summary_2009-11_analysis_AB75.pdf .

- Over $3 billion in cuts to agency budget requests and base budget funding, including across-the-board cuts of 1 percent to the base budget of nearly every general fund appropriation, plus at least 5 percent in additional targeted cuts to the base budgets of certain agencies;
- State employee cuts including elimination of a scheduled 2 percent pay raise, 16 furlough days (eight per year), and approximately 1,000 layoffs;
- A reduction in the capital gains exclusion;
- Creation of a fifth (higher) state income tax bracket for high income earners;
- Increased taxes on cigarettes of $.75 per pack, and on other tobacco products;
- A two-year delay phasing-in the individual income tax deductions for health insurance, medical insurance premiums, and certain child and dependent care expenses established by the 2007-2009 budget bill;
- An increase in the nursing home bed assessment to increase Medicaid rates to nursing homes by 2 percent each year of the biennium; and
- A re-estimate in the state's base funding for SeniorCare,[76] which reduced funding by approximately $67 million over the 2009-11 biennium.

Despite the severe cuts, the budget also included targeted increases to expand access to affordable health care coverage including increased funding to:

- Support the statewide implementation of childless adult coverage under the BadgerCare Plus Core Plan;
- Expand FamilyCare statewide; and
- Add long-term support services, including respite care grants, for children with physical, sensory and developmental disabilities, or severe emotional disturbances.

Finally, the budget bill also included insurance-related provisions to expand health care coverage and access including mandating coverage for autism and contraceptive services, requiring insurance coverage for dependents up to age 27 under group health policies, and granting group health insurance and retirement survivor benefits to domestic partners of state employees and University of Wisconsin faculty and staff.

Other state Medicaid actions taken in 2009 and planned for 2010 are described below.

Provider Rates:
• In FY 2009:

[76] SeniorCare is Wisconsin's Prescription Drug Assistance Program for Wisconsin residents who are 65 years of age or older and who meet eligibility requirements.

- Increased reimbursement rates for inpatient and outpatient hospitals through hospital assessment funds and for nursing homes through nursing home assessment funds.
- Increased reimbursement rates for doctors and dentists (1 percent) and MCOs.

- In FY 2010:
  - Planned decrease in MCO administrative rates.
  - 2 percent annual increase in provider rates for county and municipal nursing homes.

Eligibility Changes:

- In FY 2009, piloted BadgerCare Plus Core Plan which provides limited coverage for long-term unemployed adults (19-64) without dependent children at 200 percent of the FPL or less; includes basic health care services, primary and preventive care, and generic drugs. Converted the state-only program to an 1115 waiver program. The program started by transitioning individuals from county health care programs for the indigent to CORE.
- In FY 2010:
  - Will expand BadgerCare Plus Core Plan, statewide.
  - Will expand eligibility for family planning services to include eligible men.

Application/Renewal Changes:

- In FY 2009:
  - Centralized eligibility processing.
  - Implemented internet and phone applications only for childless adults including telephonic signatures.
- In FY 2010:
  - Will introduce an on-line renewal process.
  - Will adopt option to verify citizenship through SSA data matching process.

Benefit and Cost-Sharing Changes:

- In FY 2009:
  - Piloted limited benefit plan including copays under BadgerCare Plus Core Plan.
  - Decreased premiums for parents/caretakers.
  - Eliminated cost-sharing for tribal members per ARRA.
- In FY 2010:
  - Will expand limited benefit plan statewide under BadgerCare Plus Core Plan.
  - Adding coverage for screening, brief intervention, and referral to treatment (SBIRT) services for individuals with or at-risk for substance abuse.

Long-Term Care Changes:

- In FY 2009:
  - Expanded Family Care, a combination 1915b/c waiver and managed care program that integrates home and community-based services, institutional care, and Medicaid personal services, to a total of 47 counties; some including the fully integrated Partnership program (LTC/primary and acute care/ prescription drugs).
  - Expanded IRIS, Wisconsin's Self-Directed Supports Waiver, to each new county into which Family Care expanded.
  - Expanded PACE program to two additional counties.
  - Accelerated voluntary relocations from state ICFs/MR through attrition (estimated 24)
  - Relocated willing beneficiaries from nursing homes and private ICFs/MR to community and home-based settings.
- In FY 2010:
  - Will expand Family Care and IRIS programs to five more counties.
  - Will continue voluntary relocations from state ICFs/MR (estimated 46 relocations).
  - Will continue voluntary relocations from nursing homes and private ICFs/MR to community and home-based settings.
  - Will implement the HCBS State Plan option for mental health-related services.
  - Will increase long-term support waiver slots for children with disabilities; 1,000 over

four years.

Prescription Drug Controls:

- In FY 2009:
  - Decreased dispensing fee for branded drugs (from $4.88 to $3.44) and for generic drugs (from $4.88 to $3.94).
  - Changed prescription drug reimbursement for ingredient cost from AWP-13 percent to AWP-14 percent.
  - Added new drug classes to PDL;
  - Secured new supplemental rebates through enhancements to PDL.
- In FY 2010:
  - Will continue to enhance PDL and related supplemental rebates.
  - Will expand prior authorization for exceeding quantity limits.
  - Implementing contractual review of State MAC pricing and review of reimbursement policy for specialty pharmacy drugs.
  - Adding reimbursement for pharmacy counseling.

Managed Care Changes:

- In FY 2009:
  - Expanded BadgerCare Plus managed care to three additional counties, bringing the total number of counties served by MCOs to 68 out of 72.
  - Converted 21 counties from voluntary MC enrollment to mandatory MC enrollment within BadgerCare Plus.
  - Converted BadgerCare Plus Core Plan beneficiaries in pilot county to managed care.
  - Expanded Family Care managed care program to a total of 47 counties.
- In FY 2010:
  - Expansion of BadgerCare Plus managed care to additional counties where adequate provider networks are able to be established.
  - Conversion of additional counties from voluntary to mandatory MC within BadgerCare Plus, where adequate provider networks can be established.
  - Expansion of BadgerCare Plus Core Plan managed care in all areas where managed care is available.
  - Continued expansion of Family Care program through regional consortia rather than county-by-county.
  - Contracting for disease management services as a part of the fee-for-service payment reform initiatives which are underway.

Other Quality and Program Improvement Initiatives

- In FY 2009, implemented a new hospital assessment with a portion of the assessment dollars to be used to pay hospitals for meeting state performance measures.
- In FY 2010:
  - Adding Ambulatory Surgical Centers to the list of entities covered by the hospital assessment.
  - Increasing the in bed assessment for nursing homes and ICFs/MR.
  - Participation in an electronic health project organized by the Wisconsin Health Information Organization to develop a statewide data mart that will be a central repository for health care claims data used to track, analyze and evaluate quality and cost measures over time.

Appendix C: Survey Instrument

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2008, 2009 AND 2010

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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1. Medicaid Expenditure Growth: State Fiscal Years 2008, 2009 and 2010

a. For each year, please indicate the annual percentage change in total Medicaid expenditures and the annual percentage change for each source of funds. (Please exclude administration and Medicare Part D clawback payments to the federal government).

Fiscal Year (generally, July 1 to June 30)	Percent Change for Each Fund Source			
	State	Local or Other	Federal	All Fund Sources
FY ending in 2008 (FY 2008) i. Percentage change: FY 2008 Medicaid Expenditures over FY 2007 Expenditures	%	%	%	%
FY ending in 2009 (FY 2009) ii. Percentage Change: Estimated FY 2009 Medicaid Expenditures over FY 2008 Expenditures	%	%	%	%
FY ending in 2010 (FY 2010) iii. Estimated Percentage Change: FY 2010 Medicaid Appropriations over FY 2009 Expenditures	%	%	%	%

Comments: _____

b. In the absence of the enhanced FMAP provided by the ARRA[1], would your FY 2009 non-federal share spending for Medicaid have exceeded the *original* appropriation? ☐ Yes ☐ No

c. After accounting for the ARRA enhanced FMAP, did your FY 2009 non-federal share spending for Medicaid exceed the *original* appropriation? ☐ Yes ☐ No

d. Has your legislature enacted the Medicaid budget for FY 2010? ☐ Yes ☐ No

e. Looking now at the FY 2010 Medicaid appropriation (or the expected appropriation), how likely is a Medicaid budget shortfall in your opinion (check one)?

☐ Almost certain no shortfall	☐ Not likely	☐ 50-50	☐ Likely	☐ Almost certain to be a shortfall

[1] American Recovery and Reinvestment Act of 2009.

2. The State Economic/Budget Situation and Enhanced FMAP Issues

a. Very briefly, how would you describe the economy in your state and its current direction?

_____

b. Is your state projecting an overall state budget shortfall for FY 2010? ☐ Yes ☐ No

c. How has your state used or planned to use the enhanced Medicaid FMAP provided by the ARRA? *(Check all that apply.)*

i.	☐ Closed or reduced a Medicaid budget shortfall
ii.	☐ Avoided/reduced provider rate cuts
iii.	☐ Avoided benefit cuts
iv.	☐ Avoided or restored eligibility cuts
v.	☐ Helped to pay for increases in caseload
vi.	☐ Closed or reduced a state general fund shortfall
vii.	☐ Other_____

d. Did your state experience any delays in receiving the enhanced FMAP? ☐ Yes ☐ No

i. If "yes" please indicate the cause of any delay:_____

e. What do you expect will occur when the enhanced FMAP expires in January 2011?

_____

Additional comments: _____

3. Factors Driving Expenditure Changes

Excluding the impact of the enhanced FMAP provided by the ARRA, what would you consider to have been *the most significant factors* contributing to increases or decreases in your Medicaid spending in FY 2009 and what factors do you expect to be the principal drivers in FY 2010 (e.g., enrollment, healthcare inflation, rate changes, utilization, policy changes, etc.)?

	FY 2009	FY 2010
a. Most significant factor that is an **upward** pressure on spending?		
b. Other significant factors that are **upward** pressures on spending?		
c. Most significant factor that is a **downward** pressure on spending?		
d. Other significant factors that are **downward** pressures on spending?		

4. Medicaid Enrollment

a. Overall % enrollment growth/decline (+/–), FY 2009 over FY 2008: _____ %

b. Overall % enrollment growth/decline (+/–), projected for FY 2010 over FY 2009: _____ %

c. What do you believe are the *key factors or pressures* that contributed to increases or decreases in enrollment in FY 2009, and will do so in FY 2010 (e.g., changes in eligibility or other policies, application or redetermination processes, outreach, the economy, etc.)?

	FY 2009	FY 2010
i. Most significant factor that is an **upward** pressure on enrollment?		
ii. Other **upward** pressures on enrollment?		

	FY 2009	FY 2010
iii. Most significant **downward** pressure on enrollment?		
iv. Other **downward** pressures on enrollment?		

Comments (e.g., on enrollment changes for specific eligibility groups, such as children, families, disabled, etc.): _____

5. Provider Taxes/Assessments

Please list any provider taxes and indicate for each if it was or will be new in FY 2009 or 2010, or if changes were made or will be made in FY 2009 or 2010.

Provider Group Subject to Tax	In place in FY 2008?	New in:		Discontinued in:		Increased, Decreased or No Change (+, -, or 0) in:		Change Federally Mandated?
		FY 09?	FY'10?	FY '09?	FY '10?	In FY '09?	In FY '10?	
a. Hospitals	☐	☐	☐	☐	☐			
b. ICF/MR-DD	☐	☐	☐	☐	☐			
c. Nursing Facilities	☐	☐	☐	☐	☐			
d. Managed Care Organizations	☐	☐	☐	☐	☐			☐
e. Other:	☐	☐	☐	☐	☐			
f. Other:	☐	☐	☐	☐	☐			

Comments (e.g., regarding replacement of MCO tax, other federal impacts, etc.):

_____

6. Provider Payment Rates

a. Compared to the prior year, please indicate by provider type any rate increases (include COLA or inflationary increases) or decreases *implemented* in FY 2009 or *to be implemented* in FY 2010. Use "+" for an increase, " – " for a decrease and "0" for no change. Optional: if available, please indicate actual percentage change as well.

Provider Type	FY 2009	FY 2010
i. Inpatient hospital		
ii. Outpatient hospital		
iii. Doctors		
iv. Dentists		
v. Managed care organizations		
vi. Nursing homes		

b. Please briefly indicate whether any provider rate changes in FY 2009 had an impact, or were expected or intended to have an impact on provider access or participation:

_____

c. To receive the enhanced FMAP, states must comply with the federal Medicaid prompt pay requirements.[2] Briefly describe the impact on your state, if any, of this requirement:

_____

Comments (e.g., whether rate changes were court-ordered/litigation-related, any other significant changes, etc.): _____

7. Medicaid Eligibility Standards

a. Please describe changes in Medicaid eligibility standards* (e.g. expansion, reduction, restriction or restoration) implemented during FY 2009 or to be implemented in FY 2010. (Please exclude CHIP funded changes or DRA mandated changes related to long term care eligibility.)

Eligibility Category	Fiscal Year	Nature of Eligibility Change*	Effective Date	Est. Number of People Affected	By Waiver Authority?
i. Children	'09				☐
	'10				☐
ii. Parents/ Pregnant Women	'09				☐
	'10				☐
iii. Aged/ Disabled (incl. duals)	'09				☐
	'10				☐
iv. Medically Needy	'09				☐
	'10				☐
v. Adults Without Children	'09				☐
	'10				☐
vi. Other:	'09				☐
	'10				☐

* "Eligibility standards" include income standards, asset tests, retroactivity, continuous eligibility, 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).

b. Please indicate any changes in *eligibility standards* abandoned or reversed due to ARRA maintenance of effort requirements: _____

8. Application/ Renewal Process

a. Please describe any changes to the ***application or renewal process*** (e.g., changes in forms, verification or face to face interview requirements, frequency of redeterminations or renewals, etc.). Also, please identify changes made to qualify your state for the performance bonuses under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA):

In FY 2009:	
In FY 2010	

[2] Unless waived by the HHS Secretary.

b. Please indicate any changes in the *application and renewal process* that were abandoned or reversed due to ARRA maintenance of effort requirements: _____

c. In FY 2009, did the DRA citizenship and identity documentation requirements increase the time needed to determine eligibility? ☐ Yes ☐ No

d. Do you expect your state to adopt the new option (available January 1, 2010) of verifying citizenship through a data matching process with the Social Security Administration?
☐ Yes ☐ No ☐ Don't know

Comments on changes in application or renewal processes:

_____

9. Premiums

a. Please list any Medicaid eligibility group subject to a premium requirement and whether changes were made in FY 2009 or will be made in FY 2010.

Eligibility Group Subject to a Premium Requirement	In Place in FY 2008?	New, Increased, Decreased, Eliminated or No Change (New,+, -, Elim., or 0)		By DRA Authority?	By Waiver Authority?
		FY '09?	FY '10?		
i.	☐			☐	☐
ii.	☐			☐	☐
iii.	☐			☐	☐
iv.	☐			☐	☐

b. Please indicate any premium changes abandoned or reversed due to ARRA maintenance of effort requirements: _____

10. Benefits

Please describe below any expansion, reduction, restriction, restoration or other change in benefits or services *implemented* during FY 2009 or to be implemented in FY 2010.

Populations Affected	Fiscal Year	Nature of Benefit Change	Effective Date	By DRA Authority?	By Waiver Authority?
a. Children	'09			☐	☐
	'10			☐	☐
b. Parents/ Pregnant Women	'09			☐	☐
	'10			☐	☐
c. Aged/ Disabled (incl. duals)	'09			☐	☐
	'10			☐	☐
d. Medically Needy	'09			☐	☐
	'10			☐	☐
e. Adults Without Children	'09			☐	☐
	'10			☐	☐
f. Other:	'09			☐	☐
	'10			☐	☐

11. Cost Sharing

a. Does your state require copays (*check one*)? ☐ Yes ☐ Yes, but only for drugs ☐ No copays

b. Are copayments enforceable for any eligibility group as allowed by the DRA (*check one)*?
☐ Yes ☐ No ☐ Plan to implement in FY 2010 ☐ N/A

c. Please describe any changes in beneficiary cost sharing in FY 2009 and FY 2010 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.)	By DRA Authority?	By Waiver Authority?
i. Children	'09		☐	☐
	'10		☐	☐
ii. Parents/ Pregnant Women	'09		☐	☐
	'10		☐	☐
iii. Aged/ Disabled (incl. duals)	'09		☐	☐
	'10		☐	☐
iv. Medically Needy	'09		☐	☐
	'10		☐	☐
v. Adults without Children	'09		☐	☐
	'10		☐	☐
vi. Other:	'09		☐	☐
	'10		☐	☐

d. Please indicate any cost sharing changes abandoned or reversed due to ARRA maintenance of effort requirements: _____

12. Long Term Care Policy

Briefly identify long term care reductions, restrictions or expansions implemented during FY 2009 or that will be implemented in FY 2010. (*Exclude* rate and tax changes reported under questions 5 and 6). Where applicable, indicate if the change was made possible by the DRA.

Program or Policy Actions	Actions Implemented in FY 2009	Actions To Be Implemented in FY 2010
a. Community service* restrictions		
b. Community service* expansions		
c. Institutional** reductions		
d. Institutional** expansions/ increases		
e. Other:		

* Community service restrictions or expansions include changes to waiver slots or services, state plan personal care services, PACE sites, nursing home diversion/transition programs, level of care requirements, etc.

** Institutional reductions or expansions include changes to bed-hold policies, Medicare cross-over payments, bed moratoriums, level of care requirements, quality enhancement initiatives, etc.

13. Long Term Care DRA Changes

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

	In Place in FY 2008		New in FY 2009		New in FY 2010	
a. Long Term Care Partnership Program	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b. HCBS State Plan Option	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c. Self-Directed Personal Assistance Service Options (Cash & Counseling)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

14. Prescription Drug Policy

What new prescription drug policies were *implemented* during FY 2009 or will be implemented for FY 2010? Please briefly describe those that apply.

Program or Policy Actions	Was policy in place at the end of FY 2008? *(Check all that apply)*	Actions Implemented During FY 2009	Actions To Be Implemented in FY 2010
a. Change in dispensing fees (indicate "+" or "-")		☐	☐
b. Change in ingredient cost (indicate "+" or "-")		☐	☐
c. Preferred Drug List (PDL) i. Newly implemented? ii. Enhanced? iii. Eliminated or reduced?	☐	☐ ☐ ☐	☐ ☐ ☐
d. Prior authorization w/out PDL i. Newly implemented? ii. Enhanced? iii. Eliminated or reduced?	☐	☐ ☐ ☐	☐ ☐ ☐
e. Supplemental rebates i. Newly implemented? ii. Enhanced? iii. Eliminated or reduced?	☐	☐ ☐ ☐	☐ ☐ ☐
f. Joined a multi-state purchasing coalition?	☐	☐	☐
g. Limits on number of Rx per month i. Adopted or tightened? ii. Liberalized or lifted?	☐	☐ ☐	☐ ☐
h. State MAC program i. Newly implemented? ii. Enhanced? iii. Eliminated or reduced?	☐	☐ ☐ ☐	☐ ☐ ☐
i. Other:	☐	☐	☐

Comments: _____

15. Behavioral Health

Please briefly describe any Medicaid behavioral health initiatives implemented in FY 2009 or planned for FY 2010: _____

16. Medicaid Quality and Health Information Technology (HIT) Initiatives

a. For each item below, please indicate with an "X" if the initiative was already in place in FY 2008, or was newly implemented in FY 2009 or FY 2010:

Quality and HIT Initiatives	In place in FY 2008	New in FY 2009	New in FY 2010	N/A or "No"
Managed Care Quality Initiatives:				
1. Health plans must be accredited, e.g., by NCQA?	☐	☐	☐	☐
2. Plans that are accredited are rewarded by:				
i. extra points in procurement for MCOs?	☐	☐	☐	☐
ii. auto-enrollment?	☐	☐	☐	☐
iii. enhanced reimbursement?	☐	☐	☐	☐
3. HEDIS© (or similar) measures used for:				
i. capitated health plans?	☐	☐	☐	☐
ii. Primary Care Case Management?	☐	☐	☐	☐
4. CAHPS© (or similar) consumer surveys conducted for:				
i. capitated health plans?	☐	☐	☐	☐
ii. Primary Care Case Management?	☐	☐	☐	☐
5. Health plan performance is published (e.g. web-based report cards, reports) for acute or primary care quality measures?	☐	☐	☐	☐
6. Health plan performance on HEDIS© or CAHPS© is a factor in selecting health plans that can participate in Medicaid.	☐	☐	☐	☐
7. Health plans earn reimbursement incentives (bonus payments or penalties) based on performance on quality measures (e.g., P4P)? Briefly describe if applicable: _____	☐	☐	☐	☐
Quality Initiatives for Providers Not in Managed Care:				
8. HEDIS© (or similar) measures used?	☐	☐	☐	☐
9. CAHPS© (or similar) consumer surveys conducted?	☐	☐	☐	☐
10. Individual providers earn reimbursement incentives (bonus payments or penalties) based on performance on quality measures (e.g., P4P)? Briefly describe if applicable: _____	☐	☐	☐	☐
HIT Initiatives:				
11. Medicaid is participating in an E-prescribing initiative?	☐	☐	☐	☐
12. Medicaid is participating in an Electronic Health Record (EHR) or Electronic Medical Record (EMR) initiative?	☐	☐	☐	☐

b. If any Quality or HIT measure was discontinued in FY 2009 or FY 2010, please briefly describe what was discontinued: _____

Comments or additional information on quality or HIT initiatives:

_____

17. Managed Care

a. During FY 2009, were non-dually eligible aged or disabled populations enrolled in capitated managed care? ☐ Yes ☐ No

b. What managed care program or policy actions were *implemented* during FY 2009, or will be implemented in FY 2010? Please briefly describe those that apply.

	Program or Policy Actions	Actions Implemented FY 2009	Actions To Be Implemented FY 2010
i.	Expand/contract PCCM or MCO geographic service areas		
ii.	Enroll new eligibility groups (please specify)		
iii.	Change from voluntary to mandatory enrollment (specify by eligibility category)		
iv.	Implement/expand long term care managed care		
v.	Implement or expand disease management, care management for high cost/complex cases, or a chronic care management program (if applicable, specify disease state)		
vi.	Implement a medical home initiative		
vii.	Other actions:		

Comments: _____

18. Section 1115 Waivers and State Health Reform

a. Is your state currently planning to implement a Section 1115 Medicaid reform waiver or waiver amendment in FY 2010 that is intended to reduce the number of uninsured? ☐ Yes ☐ No

b. If yes,

i. Has it been approved? ☐ Yes ☐ No, still being developed ☐ No, pending at CMS

ii. Please briefly describe key waiver goals and features:

_____

iii. Was the waiver initiative for FY 2010 reduced in scope or significance from previous plans due to budget concerns? ☐ Yes ☐ No ☐ N/A

c. Did your state abandon Medicaid reform waiver plans for FY 2010 due to budget concerns? ☐ Yes ☐ No

Comments on state health reform or waivers: _____

19. Federal Health Reform

a. From a state perspective, please provide any comments, concerns or issues you have related to current federal health reform discussions:

_____

b. Have federal health reform discussions affected state level health reform plans? ☐ Yes ☐ No

i. If "yes," how have state discussions been affected?

_____

20. Impact of Federal Medicaid Oversight

Please provide any comments that you might have about federal Medicaid oversight activities or audits in FY 2010 (e.g., CMS, OIG, GAO, ARRA-related audits), including any changes you are seeing or expect to see:

_____

21. Outlook for Medicaid in the Future

What do you see as the most significant issues or challenges Medicaid will face over the next year or two?

This completes the survey. Thank you very much.

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