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Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006

Results from a 50-State Survey

Prepared by
Vernon Smith, Ph.D., Kathleen Gifford, Eileen Ellis and Amy Wiles
Health Management Associates
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October 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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

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Executive Summary

As states deliberated FY 2006 budget decisions, most states were emerging from an extended period of extreme fiscal stress in their budgets. State revenues were starting to rebound and overall state spending growth was returning to historic averages. However, despite positive indicators, the economic recovery has been uneven across the country and 26 states are expected to face budget shortfalls in FY 2006. Additionally, Hurricanes Katrina and Rita have placed new stress on the economies of the Gulf States and the national economic impact of the hurricanes is still unknown.

During the most recent economic downturn, Medicaid costs and enrollment grew when more people fell into poverty and became eligible for the program. Medicaid serves as a critical safety-net program for providing health coverage and long-term care assistance to over 39 million people in low-income families and 13 million elderly and disabled people. It is also a pivotal piece of the overall health care delivery system filling in gaps in Medicare coverage and supporting safety-net providers. As the economy begins to recover, Medicaid spending and enrollment growth are starting to slow. However, health care costs and enrollment growth tied to demographics, poverty rates and changes in employer-sponsored health coverage, factors beyond the control of Medicaid, continue to drive program spending growth. Again, in FY 2005 and FY 2006, in response to competing demands and fiscal pressures, states implemented and plan to implement another round of Medicaid cost containment policies to try to stem cost growth.

As states grapple with Medicaid spending growth for another year, the nature of the state and federal partnership for Medicaid continues to evolve. This fall, the federal government will consider a variety of Medicaid savings proposals to meet the FY 2006 federal budget requirements to cut up to $10 billion from the program over the next five years. There is some discussion about imposing further reductions on Medicaid and other entitlement spending to offset expenditures related to rebuilding efforts in the states devastated by the recent hurricanes. Some of these proposed Medicaid reductions could shift costs to the states at a time when many states already face additional fiscal responsibility for the program as a result of formula-driven reductions in the federal match rates and the implementation of the new Medicare Part D program.

For the fifth consecutive year, the Kaiser Commission on Medicaid and the Uninsured has worked with Health Management Associates to survey state Medicaid officials about changes in Medicaid spending, enrollment trends and policy directions as states finished one fiscal year (FY) and were entering the next. This report focuses on FY 2005 and FY 2006. Drawing from data provided in previous surveys, this report also looks at these changes in the context of Medicaid actions taken since 2002. The key findings from this latest survey include the following:

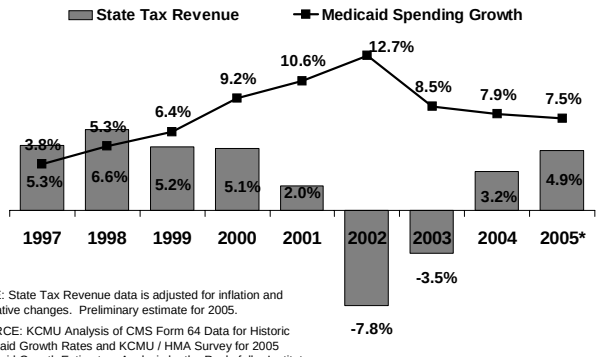
As the economy began to recover, state revenue growth started to climb and Medicaid spending growth slowed. From 2000 to 2002, state revenues plummeted, more individuals lost jobs, fell into poverty and became eligible for Medicaid as a result of the economic downturn. Rapid growth in enrollment, followed by rising health care costs,

were the dominant factors contributing to Medicaid spending growth during this period. State revenues are now beginning to rebound and Medicaid spending growth rates slowed for the third straight year to an estimated 7.5 percent in FY 2005 after peaking in 2002 at 12.7 percent (Figure 1). For FY 2005 and FY 2006, states reported that health care costs were the most significant factor driving Medicaid spending although enrollment growth, especially for the more costly elderly and disabled populations, remains a significant factor driving Medicaid spending growth. While Medicaid growth still outpaces state revenue growth, Medicaid spending continues to grow at a slower pace than private health insurance premiums.

In FY 2005, the state share of Medicaid costs grew faster than total costs, and states are projecting the same for FY 2006 as a result of the expiration of temporary federal fiscal relief that enhanced federal Medicaid matching rates (FMAP) by 2.95 percentage points through the end of FY 2004 and formula driven reductions in the federal match rates. For FY 2006, 29 states will experience match rate reductions. In addition, the diminishing availability of special financing arrangements is forcing several states to use additional state general fund dollars to replace reductions in federal matching dollars that had helped to fund their programs.

Figure 1

Underlying Growth in State Tax Revenue Compared with Average Medicaid Spending Growth, 1997-2005



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimate for 2005.

SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2005 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

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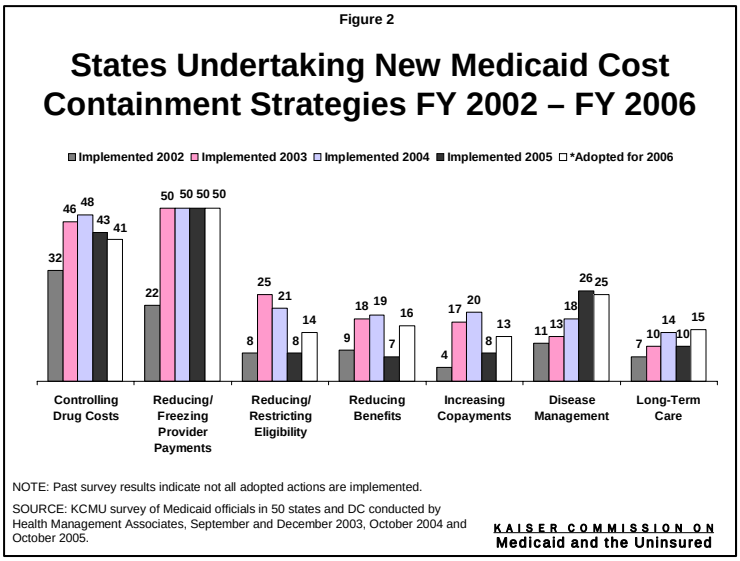
The rate of Medicaid enrollment growth dropped from a high of 9.9 percent in 2002 to 4 percent in FY 2005 and a projected 3.1 percent in FY 2006, which would be the fourth straight year of slowing growth rates. Decline in enrollment growth rates can be attributed to the economic recovery as well as some state policy initiatives to restrict Medicaid eligibility. However, enrollment levels continue to grow as the number of people in poverty rises, employer sponsored coverage declines and some states restore eligibility cuts, expand programs and introduce eligibility simplifications to help offer coverage to many individuals who otherwise would be uninsured. Medicaid officials reported that they worry that demographic trends will result in the enrollment of more elderly and people with disabilities who are more costly to the Medicaid program.

All states continued to implement and adopt a wide array of Medicaid cost containment strategies in FY 2005 and FY 2006. As in years past, state cost containment efforts were focused on controlling pharmacy costs and restricting provider payment rates (Figure 2). The number of states implementing eligibility cuts, benefit cuts and increases to copayments all declined in FY 2005, while efforts to implement disease management programs were expanded. Looking forward to FY 2006, more states adopted measures to restrict eligibility, cut benefits or increase co-payments. Particularly notable are deep eligibility cuts in Florida, Missouri and Tennessee that will eliminate coverage for a significant number of people. For FY 2006, two states (Mississippi and Florida) are reducing eligibility for aged and disabled beneficiaries which will lower the amount that those states will be required to pay the federal government under the "clawback" provisions of the Medicare prescription drug benefit. Fewer cost containment measures were implemented by states in FY 2005 than were originally planned which suggests the possibility that some of the FY 2006 measures similarly may not be implemented due to delays, external challenges or positive changes in state revenue projections.

Figure 2



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004 and October 2005.

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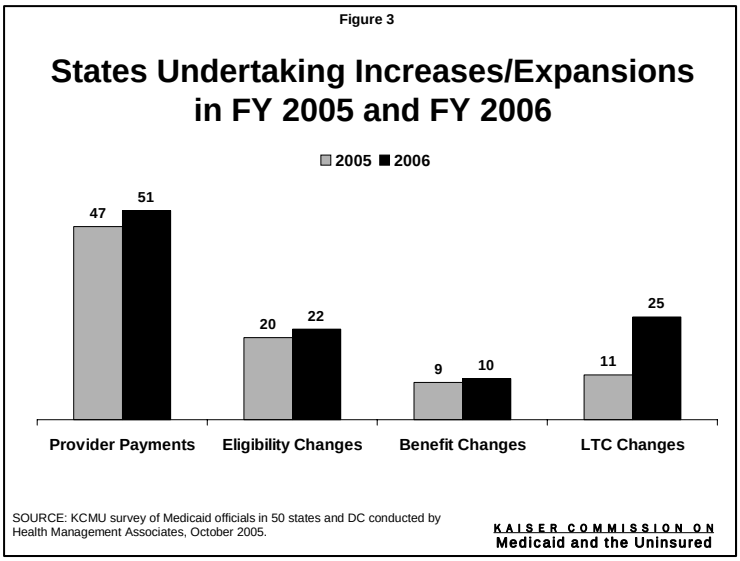
In FY 2005 and FY 2006 states also implemented more positive policy initiatives such as expansions and provider rate increases than in previous years. Forty-seven states in FY 2005 and every state including the District of Columbia in FY 2006 implemented or has plans to implement at least one provider rate increase (Figure 3). Seventeen states in FY 2005 and 20 states in FY 2006 increased physician rates, a significant increase from FY 2004 when only nine states had reported physician rate increases. Some Medicaid officials indicated that rate increases were needed to address growing concern over access to physician care, and that in some cases they were facilitated by higher than expected state revenues. More states implemented eligibility expansions or application simplifications (20 in FY 2005 and 22 in FY 2006) as states continue to use Medicaid as a vehicle to expand health insurance coverage to low-income populations. In FY 2006, 25 states plan to implement some type of long-term care expansion, mostly related to expansions in home and community-based care in an attempt to meet the growing demand for these services as Medicaid remains the dominant provider of these services.

Figure 3



About half of the states are developing new Medicaid proposals that would use existing Section 1115 waiver authority. A total of 25 states indicated that they planned to implement a new Section 1115 Medicaid reform waiver or amendment to an existing waiver in FY 2006. Eleven of these waivers had been submitted to CMS for approval at the time of the survey, and fourteen states were at various stages of development. Most often, Medicaid officials indicated that the primary goals of the waiver proposals were to reduce the number of persons without health coverage (14 states) or to reduce growth in Medicaid costs (13 states). However, in many recent waivers, authority to expand coverage has not been implemented or not fully implemented so overall gains in coverage have been small.

State Medicaid officials expressed concern that the implementation of the new Medicare Prescription Drug Benefit will generate challenges for beneficiaries, new fiscal responsibilities and administrative issues. In twenty-six states Medicaid officials expected their FY 2006 clawback obligations to result in increased costs for their state. Among these 26 states, a total of 19 did not expect cost savings in future years through at least 2010, despite the scheduled partial phase-down of the clawback. For FY 2006, only nine states reported that they expected savings, and 15 states expected their states to break even. The Medicare Modernization Act spells out new administrative responsibilities for states, including administering Part D Low-Income Subsidy eligibility determinations, but only nine states indicated that their budgets for FY 2006 included funding for this activity. Aside from the clawback, when asked to identify the most significant issues related to the implementation of the Part D benefit, half of the states (25) raised concerns over administrative issues including the need for computer systems changes, coordination of benefits issues, data and data exchange issues, state staffing impacts and general concerns as to the overall administrative burden.

State Medicaid officials expressed more optimism about the outlook for the future of Medicaid than in past years, but remain concerned about the long-term fiscal sustainability of the program. When asked to identify the key issues they envision for Medicaid over the next year or two, more Medicaid officials were able to look to the future whereas in the past, they were more focused on whether they could just get through the year. While the resilience and importance of Medicaid was manifested by its ability to weather an intensely difficult period in program history, continuing cost growth, demographic trends and the erosion of private health insurance as well as new responsibilities associated with the implementation of Medicare Part D will pose significant challenges for states in the future. Major concerns also remain over the potential impact of federal initiatives to control federal Medicaid spending which could shift the balance in financing the program in the direction of states, beneficiaries and providers. Medicaid officials saw little chance of these pressures abating in the absence of broader health reform that would address the growing uninsured problem and the lack of alternatives for long-term care assistance.

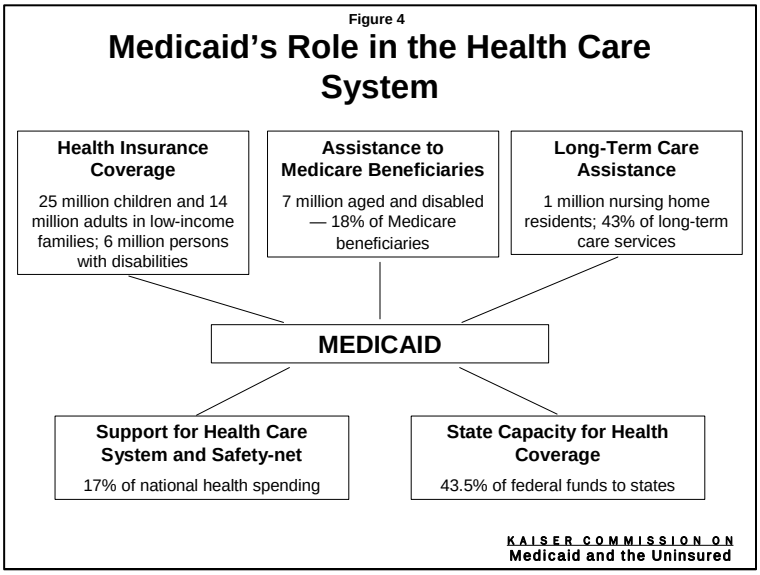
Methodology

For the fifth year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. The KCMU/HMA survey on which this report is based was conducted in July and August 2005 to document the policy actions states had implemented in the previous year, state FY 2005, and new policy initiatives that they had adopted, or expected to implement, in state FY 2006, which for most states had begun on July 1, 2005. The data in this report were based on survey responses and interviews with Medicaid directors and staff for all 50 states and the District of Columbia. Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey.

For FY 2005 and 2006, average rates of growth for Medicaid spending and enrollment are calculated as weighted averages across all states using Medicaid expenditures reported in the National Association of State Budget Officers (NASBO) State Expenditure Report for 2003 (October 2004 report).

Introduction

Medicaid serves many roles in the health care system, providing health coverage and long-term care assistance to over 39 million people in low-income families and 13 million elderly and disabled people, filling in gaps in Medicare coverage, and supporting safety-net providers. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all health care spending in the U.S. and nearly half of all nursing home care (Figure 4).



States have the responsibility to design and administer their Medicaid program within the federal rules that define the terms and conditions under which a state can earn federal matching funds. Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which services are covered, and set payment rates for providers. States also decide other key policies, such as which eligibility groups receive care within a managed care system, how the state will use Medicaid to finance a range of other medical services such as those provided through the mental health or public health systems, and special payments to hospitals that serve a disproportionate share of indigent patients. While the federal government requires states that participate in Medicaid to cover certain populations and to provide a core set of benefits, states may receive federal matching funds for the costs of covering people and services not mandated by federal statute. These are known as "optional" eligibility groups and "optional" services. Many individuals who qualify under optional categories are very poor elderly and disabled with extensive health and long-term care needs. Some critical services, including prescription drugs, are categorized as optional. About 60 percent of all Medicaid expenditures are for optional services or optional populations.[1]

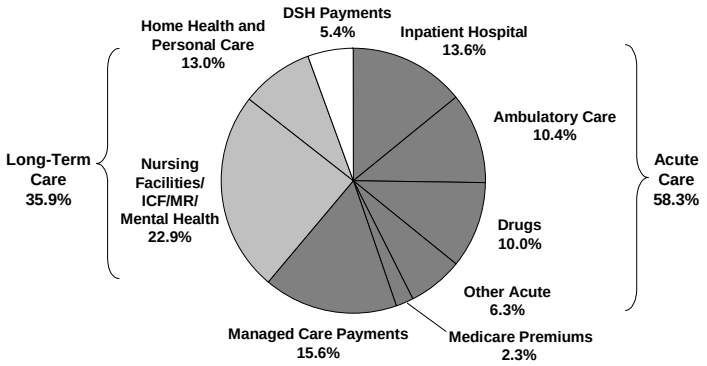
In 2003, acute care services represented 58 percent of all Medicaid and long-term care accounted for 36 percent of spending, excluding spending for administration (Figure 5).

[1] Anna Sommers, Arunabh Ghosh, and David Rousseau. "Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories." KCMU, June 2005.

Managed care payments represent the largest share of acute care spending and institutional services represent about two-thirds of all long-term care spending. Payments to hospitals serving a disproportionate share of low-income or uninsured patients (DSH) accounted for 5.4 percent of spending. Payments for administration are about 5 percent of total program expenditures, a relatively low rate compared to private insurance.

Figure 5

Medicaid Expenditures by Service, 2003



Total = $266.1 billion

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

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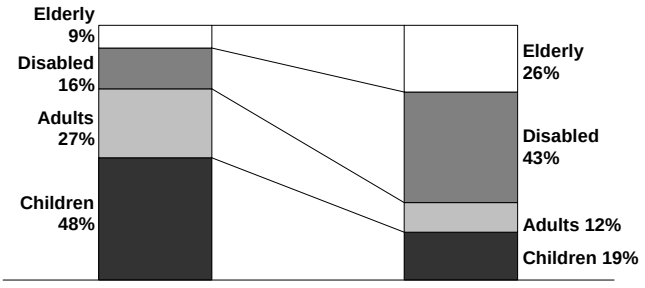
Medicaid expenditures vary by the population being served. Low-income children and their parents represent about three-fourths of all Medicaid beneficiaries, but account for only 30 percent of Medicaid spending (Figure 6). In contrast, the elderly and persons with disabilities represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, reflecting their intensive use of acute and long-term care services. Medicaid also plays a significant role in supplementing Medicare coverage for 7 million seniors and people with disabilities who are enrolled in both programs, commonly referred to as "duals". For these people, Medicaid covers services Medicare does not, most notably prescription drugs and long-term care, and assists with Medicare premiums and cost sharing. Beginning on January 1, 2006, Medicaid prescription drug coverage for duals will end and these individuals will be transitioned to Medicare Part D to receive prescription drugs.

Figure 6

Medicaid Enrollees and Expenditures by Enrollment Group, 2003



Expenditure distribution based on CBO data that includes only federal spending on services and excludes DSH, supplemental provider payments, vaccines for children, administration, and the temporary FMAP increase. Total expenditures assume a state share of 43% of total program spending.
SOURCE: Kaiser Commission estimates based on CBO and OMB data, 2004.

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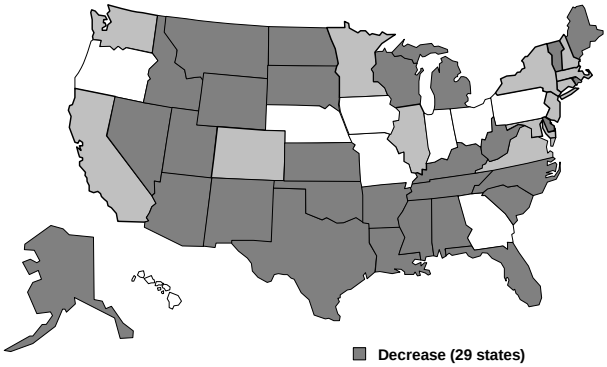
The Medicaid program is jointly funded by states and federal government. For FY 2005, total Medicaid expenditures will exceed $300 billion. The federal government provides a guaranteed match to states for Medicaid services to Medicaid enrollees. The federal matching percentage (officially known as the Federal Medical Assistance Percentage, or FMAP) varies by state from a floor of 50 percent to a ceiling of 77 percent and is based on an annual calculation 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. For FY 2006, a total of 12 states have matching rates at the statutory floor of 50 percent[2] and eleven states and the District of Columbia have FMAPs of 69 percent up to 76 percent in Mississippi.[3] For federal FY 2006, 29 states were faced with a decline in their FMAPs placing additional pressure on states to fund their programs (Figure 7).[4]

Figure 7

29 States Face a Decline in their Federal Medical Assistance Percentage (FMAP) in FY 2006



SOURCE: Federal Register, November 24, 2004 (Vol. 69, No. 226), http://aspe.os.dhhs.gov/health/fmap06.htm

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Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. For example, at a 50 percent matching rate, a state draws down an additional $1.00 for every dollar it spends. Likewise, at a 70 percent matching rate, a state draws down an additional $2.33 for every $1 it spends. Medicaid's matching formula provides an important incentive for states to increase funding for health and long-term care

[2] The twelve states with FMAP at the statutory minimum of 50.0 percent include: CA, CO, CT, IL, MD, MA, MN, NH, NJ, NY, VA, and WA. In addition, the FMAP is set in statute for the territories at 50 percent, with a cap on federal matching funds. FY2006: Federal Register, November 24, 2004 (Vol. 69, No. 226), http://aspe.os.dhhs.gov/health/fmap06.htm.

[3] The eleven states with FMAP above 69 percent include: AL, AR, ID, KY, LA, MS, MT, NM, SC, UT, and WV. In addition, the FMAP for the District of Columbia is set in statute at 70 percent.

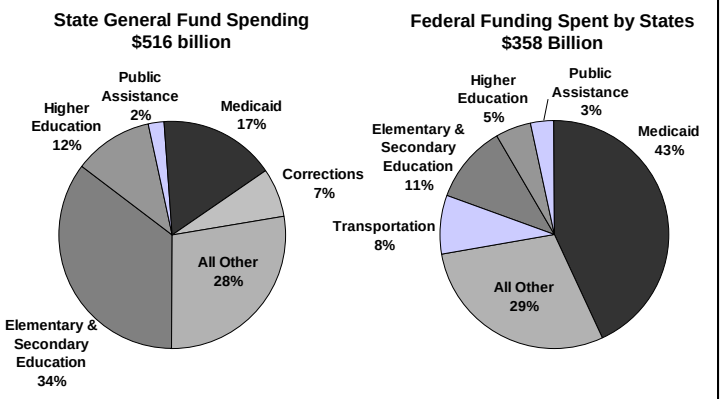
[4] Personal income data from the Bureau of Economic Analysis (BEA) for calendar years 2001 to 2003 are used to calculate the FMAPs for FY 2006. For 2003, personal income growth was 3.2 percent, faster than population growth at 2.2 percent. Unlike 2001 and 2002, all states showed positive per capita personal income growth for 2003. The BEA personal income data is part of the national income and product accounts (NIPA) that were re-benchmarked in 2003. Information from: Issue Brief 04-41: FY 2006 FMAPs. Federal Funds Information for States, September, 2004.

services because of the ability to access federal matching dollars. The converse is also true, reductions in state spending result in lower federal revenues.

Medicaid is the single largest source of federal grant support to states, representing 43 percent of all federal grants to states in 2004. 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 represents 34 percent of state spending (Figure 8).

Figure 8

Medicaid Spending In the States, 2004



SOURCE: National Association of State Budget Officers, 2003 State Expenditure Report

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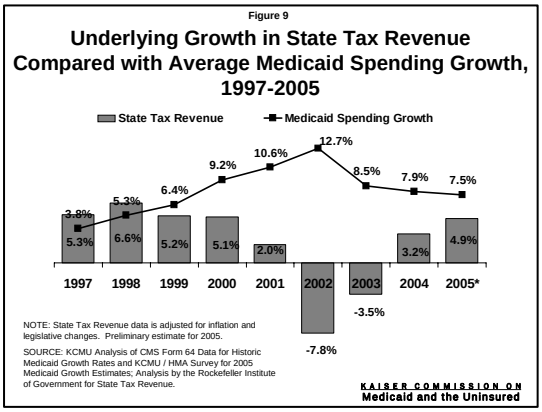
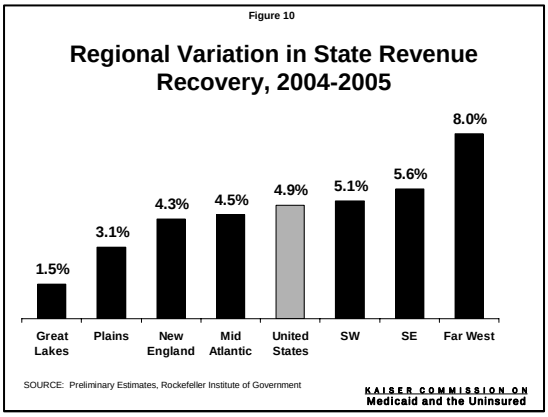
Beginning in 2001, the national economy worsened, state tax revenue plummeted, health care costs continued to rise, and more people became eligible for Medicaid as employers dropped coverage and poverty rates increased. From 2001 to 2004 cumulative state budget shortfalls exceeded $250 billion. In response to the fiscal crisis, states cut spending for services, raised taxes or fees and used reserve funds to balance their budgets. States were three times more likely to rely on spending cuts than revenue increases to close their budgets.[5] Every state and the District of Columbia implemented Medicaid cost controls during these years.

Recognizing the extraordinary state fiscal pressures, Congress passed the Jobs and Growth Tax Relief Reconciliation Act of 2003 that provided $20 billion in temporary federal fiscal relief to the states to ease budgetary pressures. Of the $20 billion total, $10 billion was provided through a temporary 2.95 percent FMAP increase. The remaining $10 billion was provided in temporary grants for states to use for Medicaid or other state programs. This fiscal relief proved instrumental in helping states to meet Medicaid and overall state budget shortfalls, avoid making potentially larger Medicaid program cuts, and to preserve eligibility. The fiscal relief expired on June 30, 2004. While the fiscal relief was in place, state spending on Medicaid was temporarily depressed and then artificially inflated in FY 2005 when the fiscal relief ended.

[5] Robert Zahradnik, Iris Lav and Elizabeth McNichol. "Framing the Choices." Center on Budget and Policy Priorities. May, 2005.

Many states are now emerging from an extended period of extreme fiscal stress in their budgets (Figure 9). While the gap is narrowing, Medicaid spending growth is still growing faster than state revenue growth. Additionally, the economic recovery is uneven across the country. Revenue growth from 2004 to 2005 averaged 4.9 percent after accounting for inflation and legislative changes but was slowest in the Great Lakes region (1.5 percent) and fastest in the far West (8 percent) (Figure 10).[6] Overall, the Southeast region experienced above average revenue growth (5.6 percent) from 2004 to 2005 with Louisiana at 7.5 percent growth. However, several state economies in the Southeast region were devastated by Hurricanes Katrina and Rita and the national impact of the hurricanes is not yet known.

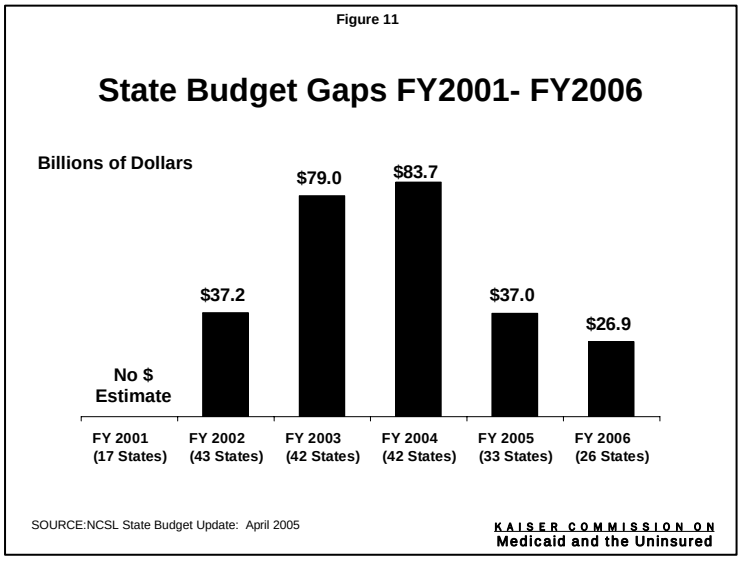




Even with recent revenue growth, about half of all states are expecting budget shortfalls totaling about $26.9 billion in 2006.[7] While these shortfalls are smaller than in previous years and affect fewer states, these data suggest that state economies are still not stable. In fact, fiscal directors in half of the states indicated that their state had a "structural deficit," a situation where ongoing revenues are insufficient to cover ongoing expenses (Figure 11).[8]

[6] Preliminary Data from Rockefeller Institute, adjusted for inflation and legislation.
[7] National Conference of State Legislatures. State Budget Update: April 2005
[8] Ibid

Figure 11



The discussion about state structural deficits comes at a time when the nature of the state and federal partnership around financing Medicaid is very much at the forefront of the policy debate. Declining FMAPs, implementation of Medicare Part D and more intense scrutiny over special financing arrangements will shift additional financial responsibility to the states in operating the Medicaid program. The Congress also passed a budget resolution in April that requires up to $10 billion over five years in Medicaid cuts. Some of the proposals under consideration would shift additional costs to the states and could further limit states' ability to provide health care coverage to low-income populations.

At the same time, states are continuing to pursue Section 1115 waiver authority as a mechanism to control costs by using federal funds in ways that do not conform to federal standards. Over the years, states have used Section 1115 waivers to test new coverage and delivery approaches with some expanding coverage to new populations. More recently, however, states have been using waivers with features designed specifically to control costs. From a beneficiary perspective, increased flexibility through some recent waivers has led to reductions in coverage, increased premiums, benefit reductions and/or limits and enrollment caps.[9]

States face continued pressure to control Medicaid costs, even though external factors such as rising health care costs and enrollment growth driven by the economy, increasing poverty rates and erosion in private insurance continue to be the dominant drivers of Medicaid costs. This survey report examines how states are responding to those pressures.

[9] Samantha Artiga and Cindy Mann. "New Directions for Medicaid 1115 Waivers: Policy Implications of Recent Waiver Activities." KCMU, March 2005.

Methodology

For the fifth year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) contracted with Health Management Associates (HMA) to conduct a survey of Medicaid officials in all 50 states and the District of Columbia.[10] These surveys have been designed to track trends in Medicaid spending and policy making during a time of significant state budget pressures. In addition to the annual surveys, mid-year update surveys were conducted for fiscal years 2001, 2003 and 2004 when many states were making budget-driven policy changes after the fiscal year had begun.

The KCMU/HMA survey on which this report is based was conducted in July and August 2005. The survey was designed to document the policy actions states had taken in the previous year, state FY 2005, and new policy initiatives that they had implemented or expected to implement in state FY 2006, which for most states had begun on July 1, 2005.[11] In all cases, state legislatures had completed their sessions or their decisions on the FY 2006 Medicaid budget at the time each survey was finalized.

The 2005 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 to address waiver issues and the Medicaid implications of the new Medicare prescription drug benefit.[12]

The data on which this report is based were provided directly by Medicaid directors and other Medicaid staff. The survey instrument was sent to each Medicaid director in mid-June 2005. Personal telephone interviews were scheduled for July and August 2005. The telephone interview provided an opportunity to review the written responses or to conduct the survey itself, if the survey had not been completed in advance. As in past years, these interviews were invaluable to clarify responses and to record the nuances of state actions. Generally, the interview included the Medicaid director along with policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid budget or policy official. Survey responses were received from and interviews conducted for all 50 states and the District of Columbia.

For FY 2006 the survey asked state officials to report only new policy changes that were implemented or would be implemented in that year. Policy changes under consideration for which there was not yet a definite decision to implement in FY 2006 were not recorded in this survey. It is important to note that some actions that were adopted for FY 2006 might not be implemented in that year. Medicaid policy initiatives often involve complex administrative changes, computer system updates or specific advance notice requirements. Sometimes, policy changes prove too difficult or complex to be implemented within the original timelines. In other cases, political decision makers reconsider previous decisions as

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

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

[12] The survey instrument is included as Appendix C to this report.

the impacts of the decisions become better understood. Thus, the actions reported here for FY 2006 are those that Medicaid programs had been directed to implement and which they expected to implement as they began the fiscal year. The actions reported here for FY 2005 are those state officials reported that they had actually implemented in that year.

This report also includes case studies of three states (Missouri, South Carolina and Virginia) that were profiled as illustrative examples of states taking major eligibility cost containment actions, developing 1115 waivers and implementing eligibility expansions. These profiles are included as Appendix B in the report.

Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey. In particular, this was done to describe selected state Medicaid cost containment activities over a five-year period from fiscal years 2002 to 2006, in addition to showing the number of states implementing these actions in FY 2005 and FY 2006.

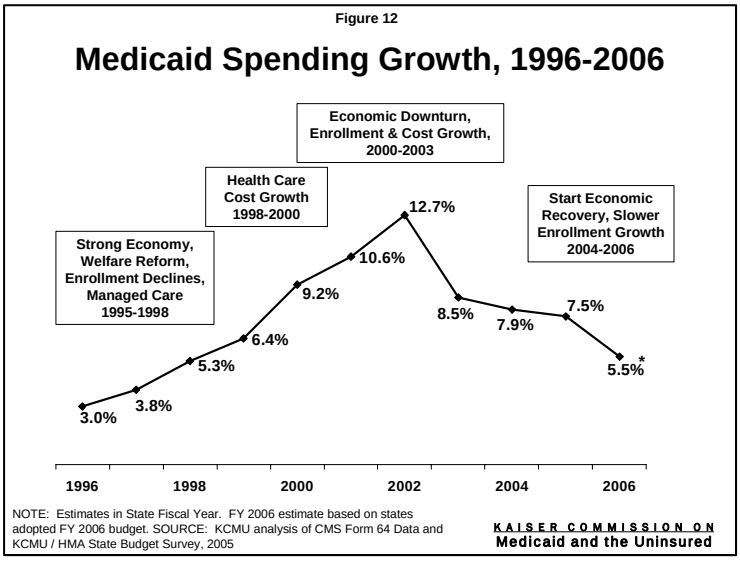
For FY 2005 and FY 2006, average rates of growth for Medicaid spending and enrollment are calculated as weighted averages across all states. Medicaid expenditures reported in the National Association of State Budget Officers (NASBO) State Expenditure Report for 2003 (October 2004 report) are used as the basis for the state weighting factors. Historic Medicaid spending and enrollment data are based on estimates prepared by the Urban Institute using data from Medicaid financial management reports (CMS Form 64). These estimates are adjusted for state fiscal years.

1. Medicaid Spending Growth Rates

Total Medicaid Expenditure Growth. The survey asked states to report their total Medicaid spending growth which includes payments to medical providers for the services they provide to Medicaid beneficiaries and special payments to providers such as Disproportionate Share Hospital (DSH) payments but does not include Medicaid administrative costs. Total Medicaid spending includes all funding sources, including the state, local and federal funds that finance Medicaid spending.[13]

Total Medicaid spending increased on average by 7.5 percent in FY 2005, the third year of slowed Medicaid growth since peaking in 2002 at 12.7 percent at the height of the economic downturn. While these rates of growth are still higher than state revenue growth, the gap has been closing as the economy rebounds, revenue growth climbs and Medicaid growth slows. Legislatures approved a 5.5 percent average increase in overall Medicaid spending for FY 2006. States have historically spent more than the original appropriation for Medicaid, so actual Medicaid growth for FY 2006 is likely to be higher (Figure 12).

Figure 12



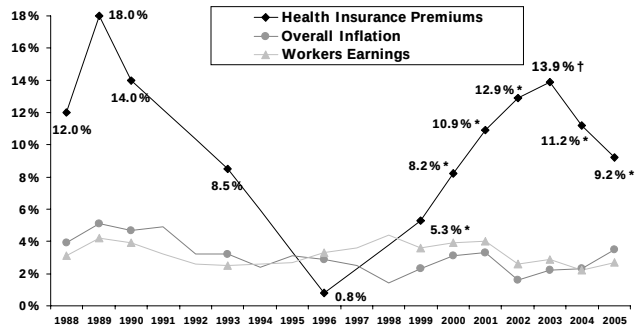
For FY 2005 (and also for FY 2006), states identified the increasing costs of medical services, prescription drug cost growth and Medicaid enrollment growth as the three most significant factors driving Medicaid cost growth. The Medicaid program has little ability to control these cost drivers. The overall costs of medical services, driven largely by new technology, and prescription drugs are also the dominant factors driving private health insurance premiums. Health insurance premiums are one indicator of growth of costs in

[13] Due to differences in the placement of the Medicaid agency across states, there is variation in what is included in the growth trends. For example, programs administered by other state agencies such as Medicaid funded mental health services are not included for every state. However, data is consistent over time for a particular state, so the trends are accurate.

the health care marketplace in which Medicaid and other insurers operate. Higher than Medicaid spending growth rates, health insurance premiums grew at double digit rates from 2001 through 2004, peaking at 13.9 percent in 2003, and dropped to 9.2 percent in 2005 (Figure 13).[14]

Figure 13

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005



•Estimate is statistically different from the previous year shown at p<0.05.
•† Estimate is statistically different from the previous year shown at p<0.1.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005.

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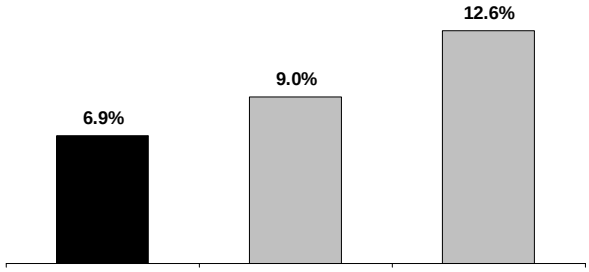
Unlike the increases in private health insurance, Medicaid costs have also been driven by increases in enrollment. In recent years, the number of individuals covered by private health insurance has declined because employers and employees have not been able to afford the increasing costs of coverage and because many workers lost jobs that included insurance. In contrast, Medicaid experienced an expansion in the number of individuals it covered during the recent economic downturn that began in 2001. Medicaid was designed to be a counter-cyclical program and therefore would be expected to expand more rapidly when increasing numbers of people lose employer sponsored health coverage and experience lower incomes.

After accounting for the effects of increased Medicaid enrollment, Medicaid has historically increased at slower rates than private health insurance on a cost per person basis. The most recent analysis of Medicaid per capita spending showed that over the three-year period from 2000 to 2003, Medicaid spending per person increased annually on average by 6.1 percent. This included annual rates of growth of 5.1 percent for long-term care and 6.9 percent for acute and primary care.[15] By comparison, per person spending for all insured persons increased by 9.0 percent, and health insurance premiums (which is similar to a per person measure) increased by 12.6 percent over the same period (Figure 14).

[14] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, "2005 Annual Employer Health Benefits Survey, September 2005.
[15] John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive*, 26 January 2005.

Figure 14

Per Capita Medicaid Spending Growth Compared to Growth in Private Health Spending, 2000-2003



[1]Strunk and Ginsberg, 2004
[2]Kaiser/HRET Survey, 2003

SOURCE: John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," Health Affairs Web Exclusive, 26 January 2005

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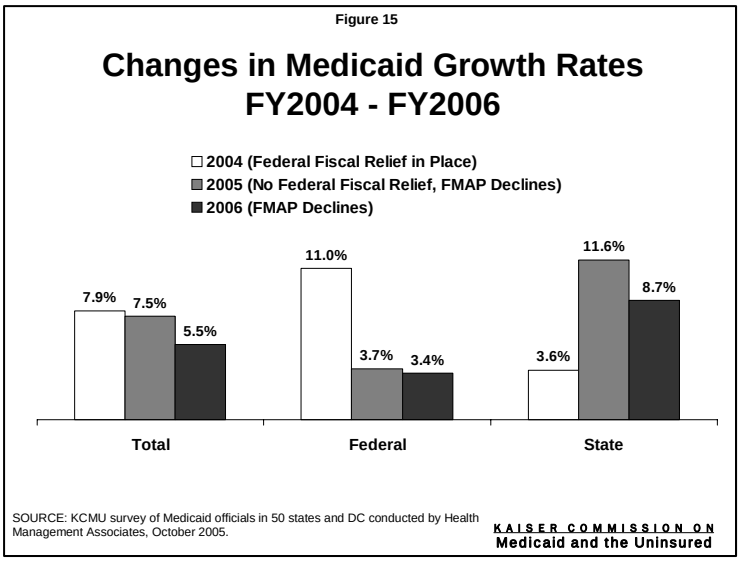
State General Fund Medicaid Cost Growth. When state officials consider policy decisions for Medicaid, a key factor is the cost increase or cost savings in state dollars. However, decisions to increase or decrease state spending are magnified because state spending determines the amount of federal revenue they receive through federal matching dollars. While total Medicaid growth slowed from FY 2004 to FY 2005, the state share of Medicaid increased. In large part, the relatively low growth in the state share of Medicaid growth in FY 2004 and the relatively high growth for FY 2005 reflects the effects of the federal fiscal relief that was in place during FY 2004 and then expired June 30, 2004. The Jobs and Growth Tax Relief Reconciliation Act of 2003, enacted in May 2003, had increased the FMAP for all states by 2.95 percentage points for the 15-month period ending in June 2004. As a result, the state share of Medicaid spending grew at a slower rate than total Medicaid expenditures in FY 2004, and a much faster rate than total expenditures in FY 2005.

For FY 2005 and then again in FY 2006, states attributed the relatively large increases in state Medicaid growth to declining FMAP rates. In FY 2006, a total of 29 states experienced a decline in their FMAP rates with a projected decline of over $500 million federal funds. States would need to make up for the loss in federal funds to maintain their Medicaid program without further cuts (Figure 15).[16]

[16] Issue Brief 04-41 FY 2006 FMAPs. Federal Funds Information for States, September, 2004.

Figure 15



States are also expecting higher scrutiny over special financing arrangements and higher costs associated with the implementation of the new Medicare Part D prescription drug benefit. These issues are discussed in more detail in later sections of the report.

As Medicaid spending continues to grow faster than spending for other state programs, it is not surprising, therefore, that when asked in July and August 2005 whether pressures on the Medicaid program were growing, subsiding or remaining constant, Medicaid officials in four-fifths of states (40 states) responded that pressures were "growing." Eleven states said that pressures were remaining constant (often at an intense level). Some states reported having created Medicaid reform committees or commissions to examine options to finance the program.

Comments of State Medicaid Officials on Fiscal Pressures:

"The pressures are still at a high level. Nothing has changed. We've done all the cost containment. The pressure to do more with less money continues."

"The things that are hurting us we don't have any control over."

"In some ways it is a mixed bag. Eligibility growth is subsiding. But, pharmacy, mental health and the MMA [Medicare Modernization Act] are huge pressure points. With medical inflation on top of enrollment growth, it is a big number."

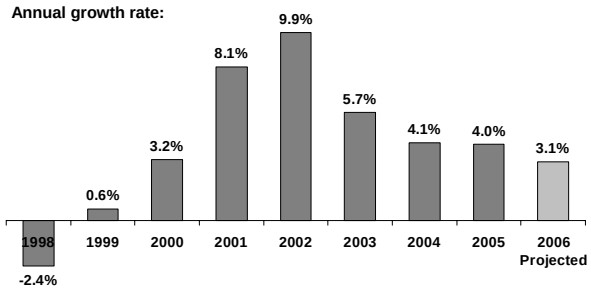
2. Medicaid Enrollment Growth

State Medicaid officials reported average Medicaid enrollment growth of 4.0 percent for FY 2005, down slightly from 4.1 percent in FY 2004 (Figure 16) and down significantly from 9.8 percent in 2002. For FY 2006, state officials projected that Medicaid enrollment

would grow on average by 3.1 percent.[17] This would make FY 2006 the fourth consecutive year in which Medicaid enrollment increased at a less rapid pace than in the previous year. For FY 2006, Medicaid officials in 25 states projected the rate of growth in enrollment to be less than it was in FY 2005. Despite the slowing growth rates, if the 3 percent projection for FY 2006 is realized, Medicaid enrollment will have increased by over 40 percent from FY 2001 to FY 2006.

Figure 16

Percent Change in U.S. Medicaid Enrollment, FY 1998- FY 2006



Note: Percentage changes from June to June of each year.

SOURCE: Health Management Associates estimates based on information provided by state officials. See: Eileen R. Ellis, Vernon K. Smith and David M. Rousseau, *Medicaid Enrollment in 50 States, June 2004 Update,* Kaiser Commission on Medicaid and the Uninsured, September 2005.

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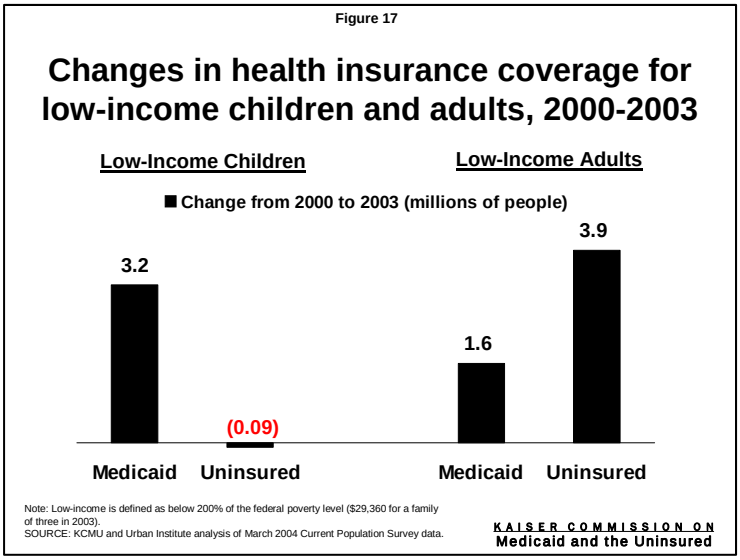
Medicaid officials attributed the economy as the most significant factor for changes in enrollment. The economic downturn was mentioned by officials in 25 states as the primary reason for increases in Medicaid caseload for FY 2005 and 20 states for FY 2006. Five states in FY 2005 and seven in FY 2006 mentioned an improving economy as a factor in a slowing rate of enrollment growth. These responses highlight the critical role that Medicaid plays in responding to changes in the economy by expanding during economic downturns, especially for children. From 2000 to 2003 as poverty rates increased and private insurance rates dropped, the numbers of low-income children enrolled in Medicaid increased by 3.2 million leading to a decline in the number of uninsured children (Figure 17). Nearly 70 percent of the increase in Medicaid enrollment from 2000 to 2003 was due to increases in the number of children on the program.[18] However, because Medicaid eligibility thresholds for adults are much lower, fewer adults were able to enroll in Medicaid and many more became uninsured during the same period.

[17] Percentage changes for enrollment growth in this report reflect weighted averages across states. Those averages are calculated on a weighted basis by total enrollment in December 2004, as reported in: Eileen R. Ellis, Vernon K. Smith and David M. Rousseau, *Medicaid Enrollment in 50 States, December 2004 Data Update,* Kaiser Commission on Medicaid and the Uninsured, forthcoming Winter 2005.

[18] John Holahan and Arunabh Ghosh. "TheEconomic Downturn and Changes in Health Insurance Coverage, 2000-2003.

Figure 17



Five states for FY 2005 and six states for FY 2006 specifically mentioned eligibility expansions as a positive factor driving Medicaid enrollment. Four states in FY 2005 and three states for FY 2006 mentioned outreach and simplifications in the application process as factors driving Medicaid enrollment. For FY 2006, seven states indicated that outreach for Medicare Part D was expected to increase Medicaid enrollment, particularly among the elderly and disabled.

Four states with slowing growth and three states with enrollment decreases (Mississippi, New Mexico and Washington) in FY 2005 cited more restrictive eligibility levels or administrative policies (e.g., documentation requirements, more effective re-determinations, or a change from 12-month to 6-month eligibility for children). For FY 2006, three states (Missouri, Mississippi and Tennessee) projected enrollment reductions.[19] In each case, the state planned to significantly restrict eligibility. These proposals are expected to affect nearly 361,000 people.

Comments of State Medicaid Officials on Enrollment:

"It is the economy. The economy is coming back, but it is not coming back in a way that is relieving the pressure…The jobs that are being created are small businesses, and they don't provide health insurance."

"The employer-based health insurance system is about to implode, and Medicaid is going to be asked to pick up these people. Employers are dropping coverage left and right."

[19] As a result of converting its Pharmacy Plus Medicaid waiver into a state-only State Pharmaceutical Assistance Program, South Carolina expects total Medicaid enrollments in FY 2006 to drop by 6.5%. If the impact of this conversion is excluded, South Carolina officials estimate that FY 2006 enrollment will essentially be flat.

"We have seen a distinct flattening out of growth [in enrollment] but we are adding more costly people."

3. Factors Contributing to Increasing Medicaid Expenditures

State Medicaid officials were asked to identify the factors they believed had been most significant contributors to Medicaid spending growth in their state over the past year, FY 2005, and for the upcoming year, FY 2006. As with past surveys, this was an open-ended, non-structured question. Responses were grouped into five categories: enrollment growth, growth in prescription drug costs, increasing health care costs, long-term care and other.[20]

The three key factors identified as the most significant driver of Medicaid spending growth in FY 2005 were the increasing costs of medical services (15 states), prescription drug cost growth (14 states), and Medicaid enrollment growth (13 states). Also identified as the most significant factor were long-term care (6 states) and a drop in the state's FMAP (3 states).

For FY 2006, more states mentioned increasing health costs as the first factor (20 states), followed by enrollment growth (11 states). Other factors mentioned as the most significant factor included prescription drug costs (7 states), and long-term care (5 states). The impact of Medicare Part D was listed first by 4 states and deceasing FMAP by 2 states.

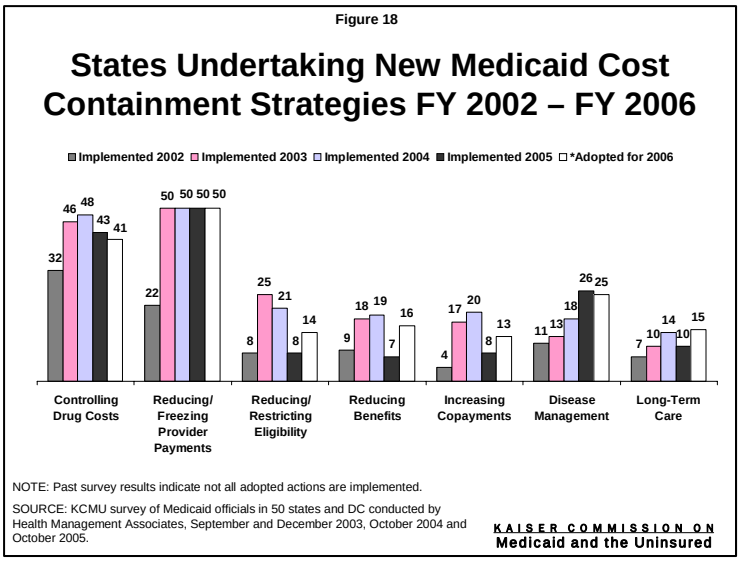
Since FY 2002, the top three factors driving Medicaid spending have remained fairly constant; however, the factor most frequently listed as the most significant contributor to Medicaid spending has changed. In FY 2004, enrollment growth was most frequently listed first as the most significant contributor to Medicaid spending growth followed by increasing costs of prescription drugs, the rising costs of medical care, and then long-term care. Previously, in FY 2002 and FY 2003, the increasing cost of prescription drugs was most frequently listed first followed by increasing growth in Medicaid caseloads.

4. Medicaid Policy Initiatives for FY 2005 and FY 2006

The survey found that every state in the nation, including the District of Columbia, implemented in FY 2005 and adopted for FY 2006 at least one new Medicaid cost containment strategy. FY 2006 will be the fifth consecutive year that most states have implemented significant new Medicaid cost containment initiatives (Figure 18).

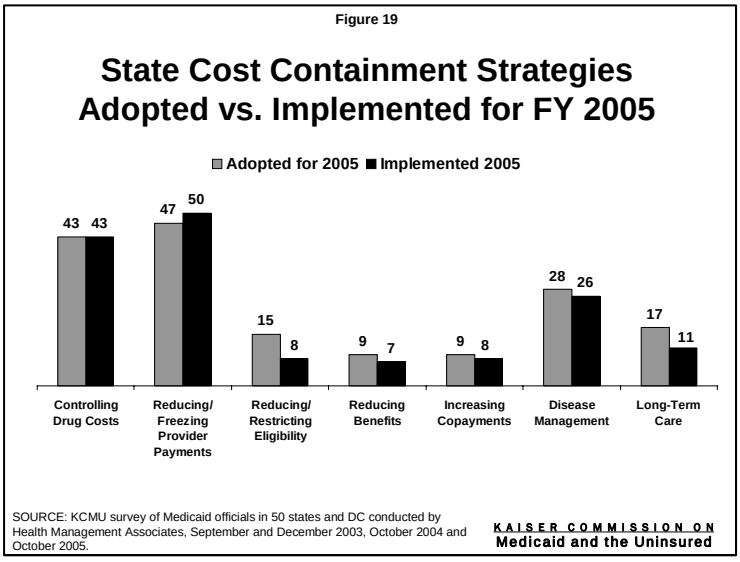
[20] For example, increasing enrollment included responses such as "higher caseloads," "more eligibles," or "higher numbers of recipients." Pharmacy cost growth included factors such as "increasing costs of drugs," "higher utilization of drugs," higher product costs for drugs." A group labeled "increasing medical costs" included "higher hospital costs and utilization," "overall medical inflation," "increases in mental health costs and utilization," "increases in managed care costs," and "higher costs for medical services." Similarly, other responses were grouped under increasing long-term care costs and other factors.

Figure 18



Many states implement not just one action, but simultaneously undertake a comprehensive set of cost containment strategies. As in past years, the most prevalent actions involve freezing provider payment rates or taking actions to control prescription drug costs. Relative to FY 2004, fewer states were implementing cost containment strategies in each area except for disease management; however, looking ahead to FY 2006, more states had adopted plans to restrict benefits or eligibility, to increase copayments or to implement a long-term care strategy. However, some of these actions may not be implemented due to delays or reversals of state Medicaid policy decisions. For example, states adopted plans for more cost containment strategies for FY 2005 than were actually implemented except for controlling prescription drugs, where 43 states adopted and implemented actions, and provider payments, where 47 states adopted and then 50 states implemented actions (Figure 19).

Figure 19



Comments of State Medicaid Officials on Cost Containment and Expansions:

"We don't have anything left to cut."

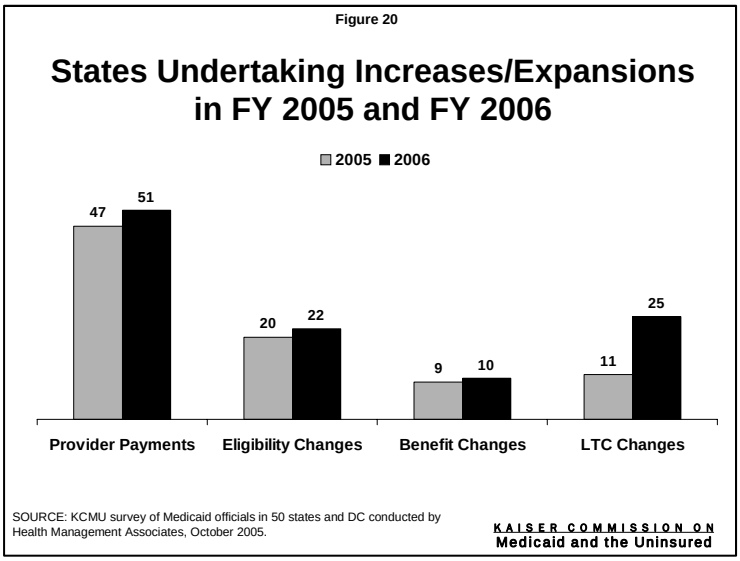
"We are going to be in a struggle. We are trying to put in some reasonable, logical controls, but there is still a push to cover more."

"Long term care is still the 800 pound gorilla."

"The legislature has looked at Medicaid seriously. For the most part, they have come to appreciate the value of Medicaid."

While most states continue to focus on policy actions to control Medicaid costs, more states than in previous years implemented or adopted plans to increase provider payment rates, expand eligibility and restore benefit cuts (Figure 20).

Figure 20



The policy actions described in this report are those implemented in FY 2005 and adopted for implementation in FY 2006. State actions adopted in previous years are not listed even though they may continue to be in effect. Specific cost-containment actions newly taken by states in FY 2005 are summarized in Appendix A-3. Actions adopted for implementation in FY 2006 are listed in Appendix A-4. Specific state-by-state actions on pharmacy, eligibility, benefits and disease management initiatives are listed in Appendices A-5 through A-14.

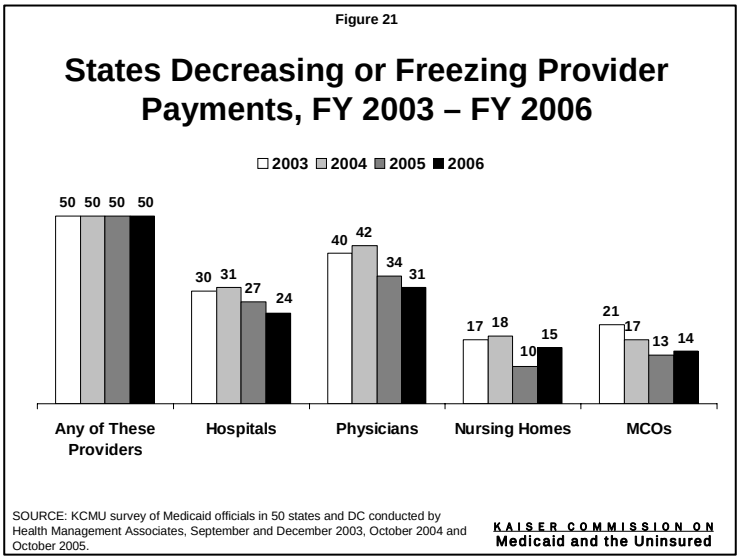
Provider Payment Rate Changes

When establishing provider payment policies, state Medicaid programs must balance cost with adequate access to services. In general, Medicaid payment rates are lower than any other payer and every state has implemented a provider rate decrease or freeze since 2002

for at least one category of providers. Many states have taken action to suspend automatic rate increases that are part of state law. For providers that experience increases in their cost of providing services, a Medicaid rate freeze is a de facto payment cut. Reductions to provider payment rates can have a negative impact on the number of providers willing to serve Medicaid populations and on beneficiary access to care.

In FY 2005 and again in FY 2006, all but one state froze Medicaid payment rates and ten states decreased rates for at least one group of providers (i.e., for hospitals, physicians, managed care organizations or nursing homes). The ten states reducing rates for at least one provider group is a substantial decrease from the 21 states that reported rate reductions for at least one provider group in FY 2004. States were much more likely to freeze rather than reduce provider payment rates; however in FY 2006 four states plan to implement rate reductions for hospitals, two states plan reductions for physicians, three states plan to reduce nursing home rates and three states plan rate reductions for MCOs (Figure 21).

Figure 21



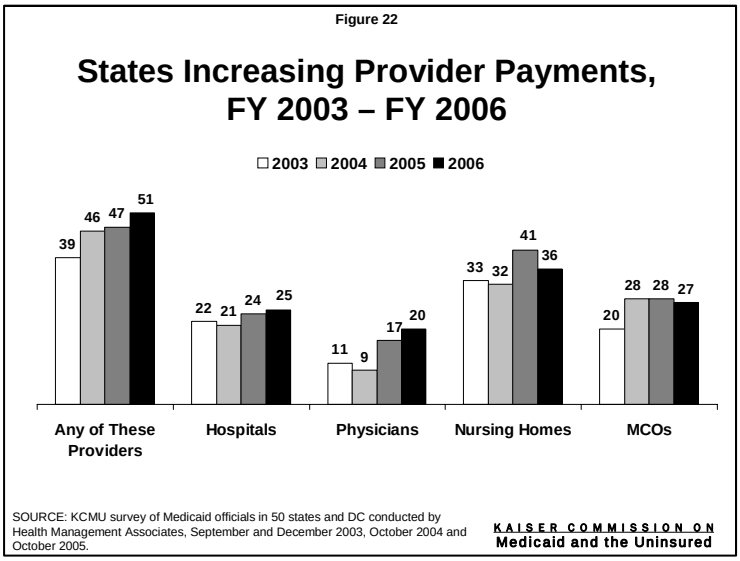
While virtually every state is still freezing or cutting some provider rates, this survey found more provider groups are receiving rate increases than occurred in FY 2004. All states indicated they would increase rates for one or more provider groups for FY 2006, compared to the 47 states increasing provider rates in FY 2005 and 46 states in FY 2004. Payment rates for physicians were most likely to be cut or frozen in FY 2005 and for FY 2006, [21] but the number of states in which these rates are cut or frozen has declined steadily since FY 2004, and the number of states in which physicians are receiving rate increases in FY 2005 is nearly double the number in FY 2004.

Nursing homes were the provider group most likely to be granted a rate increase in both years, with increases in 41 states in FY 2005, and in 36 states in FY 2006. For hospitals and nursing homes, reimbursement methodologies often include automatic adjustments based on an index relating to the cost of services so these provider groups are more likely

[21] Dispensing fees paid to pharmacists were even more likely to be cut or frozen.

than others to show increases. Additionally, some hospital and nursing home rate increases were tied to new or increased provider taxes; after netting out the cost of the provider tax, the rate increase may not be very large. Medicaid payments for managed care organizations (MCOs) became subject to requirements for actuarial soundness[22] in FY 2004, and this accounted for the greater number of rate increases for MCOs in FY 2005 and FY 2006 (Figure 22).

Figure 22



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004 and October 2005.

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Prescription Drug Utilization and Cost Control Initiatives

Cost-containment initiatives in the area of prescription drugs were implemented by 42 states and the District of Columbia in FY 2005. For FY 2006, a total of 40 states and the District of Columbia indicated that they would implement new or additional pharmacy–related initiatives. The drug cost containment efforts most widely cited in both FY 2005 and FY 2006 were subjecting more drugs to prior authorization, implementing or expanding preferred drug lists, and seeking new or enhanced supplemental rebates (Figure 23). By contrast, very few states (two in FY 2005 and three in FY 2006) reported decreasing pharmacy dispensing fees. In fact, six states in FY 2005 and seven in FY 2006 reported that they had *increased* dispensing fees possibly reflecting a concern over pharmacy access.

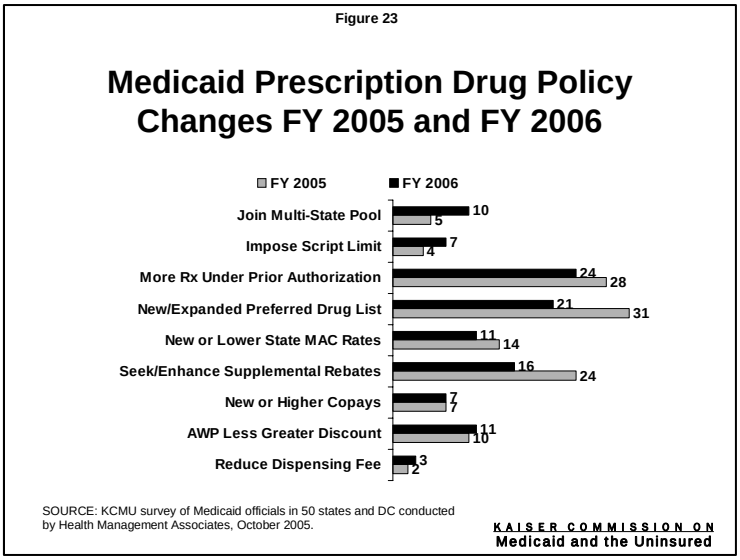
Compared to FY 2004 when a total of 15 states adopted new or higher pharmacy copayments, fewer states did so in FY 2005 (seven states) or FY 2006 (seven states). It is likely that many states were already at the statutory $3 per prescription copayment limit prior to FY 2005 and unable to increase pharmacy co-pays any higher without a waiver. The number of states implementing new actions related to preferred drug lists, prior

[22] According to Medicaid managed care regulations actuarially sound capitation rates must be developed with actuarial principles, be appropriate for the populations covered and the services furnished and be certified by actuaries.

authorization, lower MAC (Medicaid Allowable Cost) rates for generics and supplemental rebates also declined over this period.

One emerging pharmacy cost containment tool is to become a member of a multi-state purchasing pool to leverage larger supplemental rebates than a state might otherwise negotiate on its own. Five states in FY 2005 and ten states in FY 2006 reported taking this action. Also, a small but growing number of states reported imposing limits on the number of monthly prescriptions per enrollee. It is possible that states pursuing this option feel that they have already exhausted other possible drug cost containment efforts. See Appendix A-9 for more detail on pharmacy cost containment actions for FY 2005, and Appendix A-10 for FY 2006.

Figure 23



Benefits Changes

For FY 2005, state policymakers were less likely to cut benefits compared to the previous two years. A total of seven states implemented benefit cuts or restrictions in FY 2005 compared to the total of 19 states in FY 2004, and 18 states in FY 2003. However, at the beginning of FY 2006, a total of 16 states reported plans to cut or restrict benefits in the upcoming year. At the same time that states were scaling back Medicaid benefits offered, nine states in FY 2005 and ten states in FY 2006 adopted benefit restorations and expansions. See Appendix A-7 for more detail on benefit related actions for FY 2005, and Appendix A-8 for FY 2006.

In general, the benefit reductions in 2005 and 2006 focused on restricting, reducing or eliminating "optional" services, which states offer at their discretion. These restrictions, reductions and eliminations focused primarily on Medicaid benefits for adults (including, in most cases, elderly and disabled beneficiaries). A few states implemented benefit limits that affected children, such as tightening controls on dental and orthodontia coverage or adding prior authorization for durable medical equipment.

In FY 2005, a total of seven states cut or restricted benefits. Cuts in five of these states were narrowly targeted including two states placing additional restrictions on dental services for both children and adults, one state placing restrictions on durable medical equipment, one state eliminating coverage for circumcisions and one state reducing mental health clinic services. Maine and Oregon each imposed new limits on a wider number of benefits:

- **Maine** imposed new limits on several optional services including occupational, physical and speech therapies, chiropractic services, durable medical equipment and TBI (traumatic brain injury) rehabilitation services.

- **Oregon** reconfigured the benefit package for its adult waiver population ("OHP Standard") to both add and cut certain benefits. Additions included emergency dental, limited durable medical equipment and supplies, outpatient chemical dependency, and outpatient mental health. Benefit cuts included elimination of hospital services that are not for urgent or emergent care, acupuncture (except for treatment of chemical dependency), chiropractic and osteopathic manipulation, home health care, nutritional supplements taken by mouth, occupational therapy, physical therapy, private duty nursing, and speech therapy. Oregon also eliminated coverage for three lines on its Oregon Health Plan prioritized list for all Medicaid enrollees.[23]

For FY 2006, 16 states adopted plans to cut or restrict benefits. As in FY 2005, benefit cuts in most states were narrowly targeted and focused on optional benefits. The most frequently cited cuts were reductions or elimination of adult dental services (seven states), reductions in pharmacy benefits (i.e., by narrowing or eliminating coverage for over-the-counter drugs or placing limits on the number of monthly prescriptions) (five states) and reductions or eliminations of vision services (three states). FY 2006 benefit cuts in the following four states were wider and deeper:

- **Maine** plans to reduce the benefit package for its waiver expansion adults including cuts in podiatry, durable medical equipment and outpatient mental health services.

- **Missouri** eliminated a number of optional services for all adults (except pregnant women and blind beneficiaries) including dental services, dentures, comprehensive day rehabilitation, eyeglasses, certain podiatric services, certain durable medical equipment (DME), rehabilitation services (i.e. occupational, speech and physical therapy), diabetes self management training, and audiology, hearing aids and associated testing services. Examples of DME that will no longer be covered

[23] When the Oregon Health Plan (OHP) Section 1115 waiver was originally developed in the early 1990's, Oregon utilized a public prioritization process to rank a comprehensive set of primary and acute medical and mental illness conditions and services. The process included health care providers and consumers who helped decide what kind of health services were most important and most likely to result in a healthier population. The Oregon legislature sets the funding level to cover a certain number of services on the list, but cannot rearrange the list. The final list included more than 700 conditions and treatments and the legislature originally authorized funding for items 1 through 606 to comprise Oregon's Medicaid medical benefits. Effective April 1, 2005, Oregon provided coverage for lines 1 through 546.

include wheel chair accessories and batteries, three wheeled scooters, patient lifts, all body braces (orthotics), hospital beds and side rails, commodes, catheters, canes, crutches, walkers, parenteral and enteral nutrition, and augmentative communication devices.

- **Oregon** eliminated vision coverage, limited dental coverage, eliminated most over-the-counter drug coverage, imposed a monthly limit on prescription drugs, and imposed a limit on inpatient hospital days in non-public hospitals for all adults.

- **Tennessee** eliminated coverage of over-the-counter drugs, dental services, convalescent nursing home care, and methadone clinic services for all adults. Also, adult populations will be subject to prescription limits (2 brand, 5 total) and other benefit limits including a 20-day limit for inpatient hospital services.

Eligibility Changes

Eligibility reductions are among the most difficult cost containment measures undertaken by states to constrain Medicaid costs because they negatively impact low-income and vulnerable populations who rely on Medicaid for access to needed health and long-term care services. Without Medicaid, many more individuals would be uninsured or unable to access necessary long-term care and support services not available in the private market. However, due to the length and severity of the economic downturn that began in 2001, a total of 37 states have made restrictions or reductions to Medicaid eligibility in at least one of the five years from FY 2002 to FY 2006.

Cost containment actions or expansions in eligibility may be the result of changes to actual eligibility standards or changes to the application and renewal process that are designed to either expand or restrict eligibility. Examples of changes to eligibility standards include changes to the income eligibility thresholds, use of asset tests or enrollment freezes. In addition, changes to the application and renewal process include changes in continuous eligibility, face-to-face interview requirements, or presumptive eligibility.

In FY 2005, eight states reported that they reduced or restricted eligibility. Earlier in the year, at the beginning of FY 2005, a total of 15 states indicated that they had adopted plans to reduce or restrict eligibility. Some states may have opted to cancel planned reductions because of improved economic conditions, while others may have been forced to delay planned reductions because of legal challenges. Compared to the previous two fiscal years, this was a substantial reduction in number of states taking these actions; 25 states had reduced or restricted eligibility in FY 2003 and 21 states in FY 2004.[24] Reductions in FY 2005 tended to be either narrowly targeted (i.e., expected to affect relatively small numbers of people) or they capped or froze new enrollment in waiver programs.

[24]The total of eight states does not include Colorado which reported eliminating eligibility for legal immigrants for one month only and also reported eliminating presumptive eligibility for pregnant women for seven months. Both cuts were restored prior to the end of the fiscal year in which they were initially made (FY 2005).

For FY 2006, 14 states adopted plans to restrict or cut eligibility for Medicaid enrollees. Unlike the actions taken in FY 2005, however, several of the actions taken in FY 2006 were intended to eliminate eligibility for a significant number of people.[25]

In both FY 2005 and FY 2006, a number of states expanded eligibility as economic conditions improved and they had additional resources to focus on the uninsured and health coverage. The majority of states reporting changes to application and renewal processes reported changes that streamlined or simplified those processes. A few states that had previously not done so took up recently available options to offer coverage to the working disabled, to cover people under family planning waivers, and to provide coverage for uninsured women with breast and cervical cancer. Many of these expansions provide coverage for a limited set of benefits or to a targeted group of people.

The following sections describe these changes and more state-by-state detail for FY 2005 and FY 2006 is described in Appendices A-11 and A-12.

Fiscal Year 2005

Three of the eight states making eligibility reductions in FY 2005 froze or closed enrollment for waiver expansion populations. Other states made reductions in income eligibility standards, made restrictive changes in the treatment of medical expenses for purposes of meeting a spend-down threshold, and froze income standards. Three states also reversed previous simplifications or imposed changes that could make it more difficult for individuals to enroll and stay enrolled in Medicaid. More specifically, one state required face-to-face interviews and two others implemented automatic case closures.

A total of 20 states made positive changes to eligibility standards and/or the application and renewal process in FY 2005. Nine states expanded eligibility in FY 2005 [26] and 15 states made changes that streamlined or simplified their application and renewal procedures. Examples of these changes included income eligibility expansions for the aged and disabled, pregnant women and low-income parents; the implementation of a Medicaid buy-in program for disabled workers, elimination of the asset test for pregnant women and children; and restoration of twelve-month continuous coverage.

Selected examples of states making changes to eligibility criteria in FY 2005 are described below:

[25] Four of the 14 states reducing eligibility in FY 2006 also made changes to application and renewal procedures that negatively affected the number of people on Medicaid. One of the 14 states made changes to application and renewal procedures but did not otherwise reduce eligibility.

[26] For FY 2005, two states reported eligibility expansions that are funded through SCHIP rather than Medicaid and therefore are not included in the total number of states expanding Medicaid eligibility. By obtaining federal waivers, these states have used SCHIP funding to expand coverage to adults: Colorado removed the cap for prenatal care in its Children's Basic Health Plan and Illinois increased eligibility for parents and adults from 91 percent to 133 percent FPL in the FamilyCare program, covering an additional 56,000 adults.

Table 1 Selected Eligibility Changes for FY 2005		
States with Reductions or Restrictions	**States with Expansions or Restorations**	**State with Mixed Changes**
• **Oregon** closed enrollment for the Oregon Health Plan (OHP) Standard waiver program during potential open enrollment periods reducing the caseload from 55,000 in July 2004 to 27,000 in June 2005. • **Tennessee** froze enrollment of non-pregnant adults in its medically needy program and also froze enrollment in its TennCare Standard waiver program except for children who qualify as "Medicaid Rollovers" (effective April 2005).	• **Nevada** eliminated its asset test for pregnant women and children and implemented a Medicaid buy-in /Ticket to Work Program (impacting 580 individuals). • **Washington** restored twelve-month continuous coverage for children. • **Texas** restored coverage for pregnant women between 158% FPL and 185% FPL.	• **Maine** froze enrollment of non-categorical adults in its waiver program effective March 2005 and increased coverage for parents from 150% to 200% FPL in May 2005 with the expectation of covering 10,000 parents.

Fiscal Year 2006

Compared to FY 2005, more states are undertaking eligibility cuts in FY 2006 and these cuts will affect a significantly greater number of people. For FY 2006, 14 states adopted plans to restrict or cut eligibility for Medicaid enrollees.[27] Particularly notable are changes in five states that would eliminate coverage for roughly 473,000 people. In anticipation of the implementation of the Medicare prescription drug benefit, two of these five states will eliminate coverage in January 2006 for a large number of optional aged and disabled beneficiaries (Table 4). A motivation for this action is to reduce the state cost for the clawback required under Medicare Part D. The "clawback" payment requires states to pay the federal government for the costs of providing the new Medicare prescription drug benefit to duals, beginning on January 1, 2006. This payment is based on a per capita cost estimate multiplied by the number of duals. By reducing the number of duals, the state's clawback payment goes down. In addition, five states reported plans to reverse previous simplification changes including elimination of self-declaration of income that increases

[27] Florida, Illinois and South Carolina reported that their states would end their Section 1115 Medicaid Pharmacy Plus waivers when the new Medicare prescription drug benefit takes effect in January 2006. Illinois and South Carolina (but not Florida) plan to convert their waivers into non-Medicaid State Pharmaceutical Assistance Programs (SPAPs). Because Illinois and South Carolina made no other eligibility reductions in FY 2006, they are not included in the total number of states reducing eligibility in FY 2006. Florida reported other eligibility reductions for FY 2006 and is therefore included.

documentation requirements for Medicaid applications, and implementing more frequent re-verification periods than in previous years.

Other actions restricting eligibility reported by states include:

- Increasing the asset transfer look-back period from three to five years or making other changes intended to restrict financial eligibility criteria for long-term care services (New Hampshire, Ohio, Vermont);
- Limiting "countable" prior medical bills to those incurred within three months of application for purposes of meeting the spend-down threshold (Pennsylvania);
- Imposing premium requirements on parents and Medicaid expansion adults (Connecticut);
- Increasing the waiting period from six to nine months and applying a resource test for waiver expansion populations (New York); and
- Adding an asset test and freezing enrollment for 19 – 20 year old individuals (Michigan).

At the same time, 22 states are also pursuing eligibility expansions and/or positive changes to application and renewal processes. In FY 2006, 13 states planned eligibility expansions and 14 states made one or more positive changes to the application and renewal process.[28] Two of these states, Iowa and Texas, plan to implement family planning waivers, three states (North Carolina, Maryland, Texas) are planning Medicaid buy-in programs for the working disabled, and one state, South Carolina, plans to expand the age limits for an existing breast and cervical cancer program. Other states plan to eliminate the asset test or provide continuous twelve-month coverage for certain eligibility groups.

In comparison to FY 2005, a somewhat larger number of states undertook Medicaid expansions, thereby providing coverage to more people. A few states shifted people from other programs to Medicaid. For example, Iowa is using a Section 1115 waivers to obtain federal Medicaid matching funds for populations that had been covered using state-only

[28] For FY 2006, five states reported eligibility expansions that are funded through SCHIP rather than Medicaid and therefore are not included in the total number of states expanding Medicaid eligibility. By obtaining federal waivers, these states have used SCHIP funding to expand coverage to adults:

- Colorado increased the income eligibility level to 200% FPL for SCHIP children and pregnant women.
- Illinois will increase eligibility for parents and adults from 133% to 185% of the FPL in the FamilyCare program, covering an additional 56,000 adults.
- New Jersey is reopening enrollment for expansion parents in its FamilyCare program with plans to cover parents with incomes up to 100% FPL and later move to 115% and then 133%.
- New Mexico will implement its "State Insurance Coverage" waiver program that provides health care coverage (funded through employee and employer contributions and SCHIP funds) to low-income adults ages 19 to 64 (with or without children), employers who have not provided insurance to their employees in the last 12 months and uninsured employees with family incomes up to 200% FPL. First year enrollment is projected to be 10,000.
- Wisconsin is expanding eligibility for non-qualified pregnant women under BadgerCare (SCHIP), for prenatal services (estimated to impact 2,200 individuals).

funds, and North Carolina, reported shifting children ages birth to age five from SCHIP to Medicaid. Selected examples of states making changes to eligibility criteria in FY 2006 are described below:

Table 2
Selected Eligibility Changes for FY 2006

States with Reductions or Restrictions	States with Expansions or Restorations
• **Florida** is eliminating coverage for approximately 77,000 non-institutionalized Medicare eligible beneficiaries in the optional Medicaid aged and disabled program with incomes up to 88% FPL referred to as the "MEDS AD" eligibility category).[29] • **Tennessee** will eliminate coverage for adult expansion groups affecting 226,000 individuals. • **Mississippi** will eliminate coverage for aged and disabled between 100% and 133% FPL affecting 65,000 individuals.[30] • **Missouri** will eliminate coverage for nearly 70,000 beneficiaries by: eliminating extended transitional Medicaid coverage (for persons leaving TANF), reducing the income eligibility level for low-income parents from 75% FPL to the 1996 AFDC income level (about 23% FPL), reducing the income eligibility level for aged and disabled beneficiaries from 100% to 85% FPL, eliminating coverage for employed disabled persons (the "Ticket to Work" program), and by increasing the frequency of eligibility reinvestigation efforts for adults. • **Ohio** is reducing the income eligibility standard for TANF adults from 100% to 90% FPL effective January 2006 (affecting an estimated 25,000 individuals).	• **Colorado** removed its asset test for children (which will result in an expected 15,000 children moving from SCHIP to Medicaid coverage) and adults (impacting 4,000 persons) • **Connecticut** restored eligibility for parents up to 150% of the FPL effective July 2005. ▪ **Oklahoma** will implement a premium assistance program for low-income individuals and small businesses with the goal of eventually covering 70,000 individuals. Also, the state will expand eligibility to children with disabilities through age 18 living at home regardless of parental income (the "TEFRA" option) estimated to impact 500 children.

[29] Florida plans to seek a Section 1115 Medicaid waiver to preserve coverage for persons in the MEDS AD eligibility category who are not Medicare eligible.
[30] Those losing coverage in MS who are not eligible for Medicare (about 5,000) will be eligible for continued coverage (under a waiver) but with a reduced benefit package.

Copayment Requirements

Over the past several years, states have increasingly relied upon new or higher copayments as an important part of their cost containment strategies. In imposing copayments, states must comply with Federal Medicaid law, which specifies that copayments must be "nominal," generally defined as $3.00 or less per service. The law also provides exemptions so copayments cannot apply to certain services such as emergency room visits or certain eligibility groups such as children or pregnant women – protections that reflect the limited incomes and significant health care needs of Medicaid beneficiaries. In addition, federal law requires that a provider must render a service regardless of whether the copayment is collected, although beneficiaries remain liable for the amounts. A substantial body of research indicates that even nominal copayments can deter low-income individuals from receiving necessary care.[31]

In FY 2005, a total of eight states imposed new or higher copayments, down from 20 states in FY 2004 and 17 states in FY 2003. Pharmacy copayments were the most commonly added or increased with seven states imposing new or increased copayments for prescription drugs. One state increased copayments for its Working Disabled program and Georgia increased copayments for "all services" to the maximum allowed.

For FY 2006, the number of states imposing new or higher copayments increased to 13. Again, prescription drug copayments were most commonly increased or added (seven states), followed by copayments on non-emergency use of the hospital emergency room (five states). Three states imposed copayments on physician-related services; three states imposed copayments on outpatient hospital services; and two states imposed a copayment for vision and inpatient hospital services. States also imposed new or higher co-payments for dental, chiropractic, and podiatry services.

A handful of states reduced or eliminated copayments in FY 2005 and FY 2006. In 2005, Connecticut repealed all copayments and Illinois eliminated the $1.00 copayment on generic prescriptions. In 2006, Minnesota reduced the monthly copayment maximum from $20 to $12.

Fraud and Abuse Controls

States continue to enhance fraud and abuse detection using various activities. In FY 2005, 28 states reported new or enhanced activities up from a total of 17 states in FY 2004. Some of these activities relate to additional edits or enhancements to Surveillance and Utilization Review Subsystems (SURS).[32] Others include audits, studies and analyses of current

[31] Julie Hudman and Molly O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, March 2003.
[32] Federal regulations require that each state Medicaid agency maintain a Medicaid Management Information System (MMIS) for claims payment and information retrieval. The Surveillance and Utilization Review Subsystem (SURS) is a mandatory component of the MMIS and each state also has a program unit of the same name. The SURS unit, utilizing the subsystem, analyzes and evaluates provider service utilization in order to identify patterns of fraudulent, abusive, unnecessary and/or inappropriate utilization.

systems, increasing staffing, and partnering with other agencies to share information and leads. Several states focused on controlling pharmacy related fraud and abuse by implementing additional processes for reviewing dispensing behavior, new forge-proof systems and expanded "lock-in" programs.[33] In FY 2006, 21 states reported they had adopted new or enhanced activities, mostly in the area of SURS systems, staffing and lock-in. Many states reported activities related to the recovery of overpayments and third-party liability recoveries.

Disease and Case Management

The creation of new disease and case management programs and further development of existing programs continue to be a focus of Medicaid policy development. In FY 2005, the number of states that developed new or expanded disease and case management programs totaled 26. Twenty-five states reported plans to either pilot a new program or expand existing programs in FY 2006.

States continue to develop and enhance programs based on disease states, most commonly asthma, diabetes, hypertension and coronary heart disease. However, new disease and case management programs also target populations (instead of specific diseases). In FY 2005, two states and the District of Columbia designed programs around populations such as dual eligibles or high cost individuals. Three additional states reported similar programs being implemented in FY 2006. Other disease and case management programs are focused around pharmaceutical management, inappropriate emergency room usage, and comprehensive care management. Only one state reported that it will discontinue its care management program in FY 2006.

Efforts to implement disease management programs in Medicaid mirror efforts in the private insurance market. Over half of covered workers (56%) are in a plan with at least one disease management program and of the firms that offered disease management; just over half found that these programs proved very effective or somewhat effective in containing costs.[34] While many states are turning to disease management for Medicaid, savings and quality results from these programs are promising, but not conclusive due to several barriers including voluntary participation, enrollee turnover, and low payment rates.[35]

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[33] State Medicaid programs may "lock-in" a beneficiary who has utilized Medicaid services or items at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, to a single provider or limited group of providers for a reasonable period of time. State Medicaid Manual Section 2103(D).

[34] Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2005. http://www.kff.org/insurance/7315/index.cfm

[35] Claudia Williams, *Medicaid Disease Management: Issues and Promises.* Kaiser Commission on Medicaid and the Uninsured, September 2004.

Managed Care Initiatives

In FY 2005, fourteen states and 21 states in FY 2006 reported changes to managed care programs.[36] The most common change reported in both years was to expand the managed care service area (seven states in FY 2005 and eight states in FY 2006). States also moved new eligibility groups into managed care programs (three in FY 2005 and five in FY 2006). Five states in both FY 2005 and FY 2006 changed enrollment from voluntary to mandatory in either an area of the state or with a certain eligibility group.[37] In FY 2006, one state will complete a planned phase-in of mandatory managed care achieving statewide mandatory enrollment.

In FY 2005, two states expanded or implemented managed care to include behavioral health in either a separate managed care contract or within the original contracts. In FY 2006, three states have made changes regarding behavioral health with two of them carving out behavioral health from physical health and covering it separately and one state including additional eligibility groups into Behavioral Health Managed Care.

In addition to the changes described above, states are also preparing for changes associated with the implementation of the Medicare Part D prescription drug benefit on January 1, 2006.[38] (Further discussion of Medicaid issues relating to Medicare Part D is in Section 8 of this report.) In anticipation of the impending transition of dual eligibles from Medicaid drug coverage to Medicare Part D coverage, three states reported taking action related to the enrollment of dual eligibles into Medicaid or Medicare managed care plans.

In FY 2005, Alabama ramped up its outreach effort to inform its dual eligibles about the availability of Medicare Advantage (MA) managed care plans within the state because of the resulting savings to the state (e.g., lower cost-sharing) if dual eligibles enroll in MA plans. This is also expected to provide a smoother transition for dual eligibles during the implementation of Medicare Part D. In FY 2006, Arizona is working with CMS to establish passive enrollment processes so that dual eligibles currently enrolled in a Medicaid MCO (50,000 of 90,000 dual eligibles) may remain with the same MCO for purposes of Part D. In contrast, Pennsylvania is moving dual eligibles from MCOs into fee-for-service because of the prescription drug benefit. The state believes that "the remaining services covered by [Medicaid] do not require the degree of managed care performed by the MCOs."

[36] Managed care is defined as primary care case management (PCCM) and risk based managed care programs.

[37] Mandatory enrollment is defined as follows: new Medicaid recipients have a certain time period after joining the Medicaid program in which to choose a plan. If a recipient does not choose a plan in that time period, the state can assign the recipient to a managed care plan. The recipient has a period of time in which to opt-out of the plan and into another, or into fee-for-service. Specific details related to time period, opt-out, etc. are determined and therefore vary by state.

[38] Changes made in regards to Medicare Part D in Alabama in FY 2005 and Arizona in FY 2006 were not included in the number of states making changes to the managed care programs, as these are not changes directly to the Medicaid managed care programs.

Long-Term Care and Home and Community–Based Services

Long-term care (LTC) services represent over a third of total Medicaid spending in most states. LTC cannot be ignored by states seeking to slow rising Medicaid expenditures, although states find it difficult to make cuts in this area due to the medical vulnerability of LTC recipients and the growing demand for community alternatives to institutional services. Thus, while a total of ten states took action in FY 2005 to constrain long-term care service costs, eleven took actions that expanded home and community-based services (HCBS). In FY 2006, more states expanded HCBS programs (25 states) than cut or restricted LTC services (15 states).

The following section details state actions to both control costs and expand home and community-based care options:

Nursing Homes. In FY 2005, only one state (Florida) implemented cost controls related to nursing homes and seven states planned for nursing home cost controls in FY 2006. Examples of these initiatives include policies designed to reduce the number of nursing home beds, to tighten eligibility criteria, to reduce payments for bed holds, to validate patient assessments (for purposes of case mix reimbursement) and to reduce reimbursement for Medicare nursing home coinsurance costs.

HCBS Programs. States continue to expand home and community based options for long-term care driven by consumer demand and also by 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. In FY 2005, ten states expanded in this area including eight states that created new HCBS waivers or expanded existing waivers, two states that added additional services to existing HCBS waivers, one state that expanded its PACE program[39] and one state that expanded LTC eligibility by restoring coverage for certain state-defined impairment levels.

In FY 2006, 25 states expanded community service options including 18 states that created new HCBS waivers or expanded existing waivers, four states that added additional services to existing HCBS waivers, four states that implemented or expanded a PACE program and one state that increased the income eligibility for a HCBS waiver for frail elderly to 300 percent of the federal SSI standard.

Despite these expansions, four states in FY 2005 and four states in FY 2006 had cost controls directed at HCBS programs. Some of these states reduced the number of waiver slots, placed lower limits on certain waiver services, implemented a more rigorous utilization review process for waiver care plans or lowered monthly expenditure caps.

Personal Care Services. Three states in FY 2005 and two states in FY 2006 reported cost containment actions relating to personal care services (PCS) offered as a Medicaid State

[39] 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.

Plan optional (non-waiver) service including actions to reduce PCS eligibility and benefits and efforts to increase utilization review. For FY 2005, one state (Louisiana) reported adding a PCS benefit for eligibles who meet the nursing facility level of care criteria.

Other Actions. Three states in FY 2005 and four states in FY 2006 implemented or expanded LTC managed care programs. Two states in FY 2005, and one state in FY 2006, implemented estate recovery programs and one state enhanced its estate recovery program in FY 2006. States also reported a variety of other LTC policy initiatives underway in their states to improve the delivery of LTC services and increase community based alternatives. These included implementing LTC "single points of entry" systems (three states), new or uniform assessment instruments (three states), and budgetary strategies to allow "money to follow the person" from institutional placements to community based placements (three states).

5. Provider Taxes

States use provider taxes to generate state and federal funds to support their Medicaid programs in a number of ways. Some states devote all the new resources to support their overall Medicaid budgets. Others use the funds to finance specific provider rate increases. In other cases, the funds help address overall state budget shortfalls. Several states implemented and plan to implement increases or new provider taxes to generate revenue in FY 2005 and FY 2006 (Table 3).

At the beginning of FY 2005, a total of 35 states had one or more provider taxes in place. Among those taxes already in place, the most common were assessments on nursing homes, ICFs/MR, hospitals, and MCOs. In 16 states, taxes or assessments applied to more than one category of provider tax. In FY 2005, a total of 21 states increased or imposed new provider assessments or taxes. One state, West Virginia, reduced all of its three different existing provider taxes (for physicians, other practitioners and emergency ambulance services) in a plan to phase them out over a five-year period.

For FY 2006, 24 states are increasing or imposing one or more new provider assessments or taxes. States most frequently planned new taxes on MCOs and nursing homes for FY 2006. Three states reduced a total of five different existing provider taxes: Two of these were nursing homes and the three additional are the aforementioned taxes being phased out in West Virginia.

These increases in provider taxes are occurring in the context of proposals contained in the President's budget for Medicaid that would re-define and limit acceptable Medicaid provider taxes for FY 2006 and beyond. The executive budget proposals would reduce the maximum allowable provider tax rate from six percent to three percent. In addition, an acceptable managed care organization (MCO) tax would be applied to all MCOs in a state,

not just those providing services to Medicaid beneficiaries (as is allowed under current law).[40]

Table 3
Actions on Provider Taxes and Assessments in FY 2005 and FY 2006

Provider Type	In Place Prior to 2005	New in 2005	Increased in FY 2005	Decreased in FY 2005	New in FY 2006	Increased in FY 2006	Decreased in FY 2006	Total in FY 2006
Nursing Home	23	5	6	0	4	9	2	32
ICF/MR	12	5	2	0	2	1	0	19
Hospital	12	2	3	0	2	5	0	17
Managed Care Organization	6	3	1	0	6	0	0	15
Pharmacy	3	0	0	0	1	0	0	4
Home Health	2	0	0	0	0	0	2	2
Practitioner	2	0	0	2	0	0	2	2
Other	1	2	0	1	1	0	1	4

6. Special Financing Issues

As states have struggled in recent years to deal with state budget deficits and Medicaid budget shortfalls without undermining essential services to vulnerable populations, many have turned to special financing arrangements to maximize the amount of federal Medicaid revenues flowing to the states. These special financing arrangements include the use of Intergovernmental Transfers (IGTs) and/or provider taxes to provide the non-federal share of Disproportionate Share Hospital (DSH) payments and/or Upper Payment Limit (UPL) reimbursements. CMS, in turn, has increased its scrutiny of these financing arrangements, often through the Medicaid State Plan Amendment (SPA) approval process, and has also increased the number of federal auditors assigned to monitor state Medicaid fiscal practices.

State Medicaid officials were asked whether the enhanced federal scrutiny of special financing in Medicaid programs had impacted their program in FY 2005 or was expected to impact the program in FY 2006. Thirty-nine states responded that there had been an impact.

- Twenty-seven of these states indicated that they experienced delays with state plan amendments (SPAs) or waivers not related to special financing. Only two states indicated that an unrelated plan amendment had been rejected by CMS.

[40] Current federal law at Section 1903(w)(7)(A)(viii) of the Social Security Act specifies that health care services that can be taxed include "Services of a Medicaid managed care organization with a contract under section 1903(m)." Thus, under current federal law, states are allowed to limit a tax to just those MCOs that serve Medicaid clients and to use the tax revenue to enhance Medicaid MCO payments. As a result, in most states MCOs subject to Medicaid provider taxes receive enhanced reimbursement that more than offset the tax. Under the executive budget proposal, an MCO provider tax would apply equally to MCOs that do not serve Medicaid beneficiaries; these MCOs would experience the entire tax as a net cost.

- Twenty-two states indicated that they were not able to continue a previously approved special financing arrangement.
- Five states indicated that they had received a disallowance of federal matching funds relating to a previously approved special financing arrangement.
- Fifteen states indicated that there had been other impacts.

In discussing "other" impacts, four states indicated that they were working with CMS to retain some of the funding that had occurred through their IGT programs. One state was changing to a Certified Public Expenditure (CPE) model. Another developed an 1115 waiver to resolve this issue, a third is currently working on a State Plan Amendment for a new funding program, and a fourth state negotiated a transitional funding agreement with CMS.

States also indicated that they were experiencing increased CMS scrutiny related to: school-based services (two states), Upper Payment Limit programs (one state), tribal administrative claiming (one state), and general increased audit activity related to IGTs (one state). In addition, two states indicated that they had experienced deferred federal revenues related to IGTs, both of which were subsequently resolved.

Comments of State Medicaid Officials on Special Financing:

"*Any state plan amendment, anything routine, is just bogged down. And, now they are wanting us to re-do the entire state plan.*"

"Our 1115 waiver was designed to make up for the loss of IGT. We agreed to do it, and to forego any new provider taxes over the five years."

"New federal interpretations of old policies have cost us a lot of federal funds."

7. Section 1115 Medicaid Waivers

States design and operate their Medicaid programs within federal law and rules that set forth the terms and conditions that must be met for state expenditures to qualify for federal matching funds. Using authority provided under Section 1115 of the Social Security Act, the Secretary of Health and Human Services can waive statutory and regulatory provisions of Medicaid for "research and demonstration" projects that "further the objectives" of the program and still maintain federal matching funds for states.

Section 1115 waivers have been used throughout the history of the Medicaid program as useful tools to test new ways to provide coverage and deliver services to low-income populations. States also use Section 1115 waiver authority to establish single benefit Medicaid coverage, such as for family planning or prescription drug coverage for specific population groups.

In this survey, states were asked to describe whether they were in the process of designing or developing a Section 1115 waiver, and if so, the stage of development and federal approval, and the objectives they were seeking to accomplish through development of their waiver proposal.

Twenty-five states indicated that they plan to implement a new Section 1115 comprehensive Medicaid waiver or waiver amendment in FY 2006.[41, 42] At the time of this survey, eleven of these waiver applications had been submitted to CMS. One of these waivers had been approved and a second state had received verbal indication that its waiver will be approved. Fourteen states indicated that they were at various stages of developing their waiver proposals from initial planning through development of the concept paper to development of the actual waiver application. The scope and structure of actions being considered in these 1115 waivers vary substantially across the states. States indicated a wide range of goals for their waivers, and most waivers had multiple goals. The most commonly stated goals were:

- Reducing the number of uninsured individuals in the state (14 states). This was the sole goal of five waivers. At least six of the proposed waivers would expand eligibility to additional low-income parents, blind individuals, and childless adults; other waivers retain eligibility expansions from current waivers thereby preserving current coverage.
- Limiting or reducing program costs (13 states). This was the sole goal of two waivers.

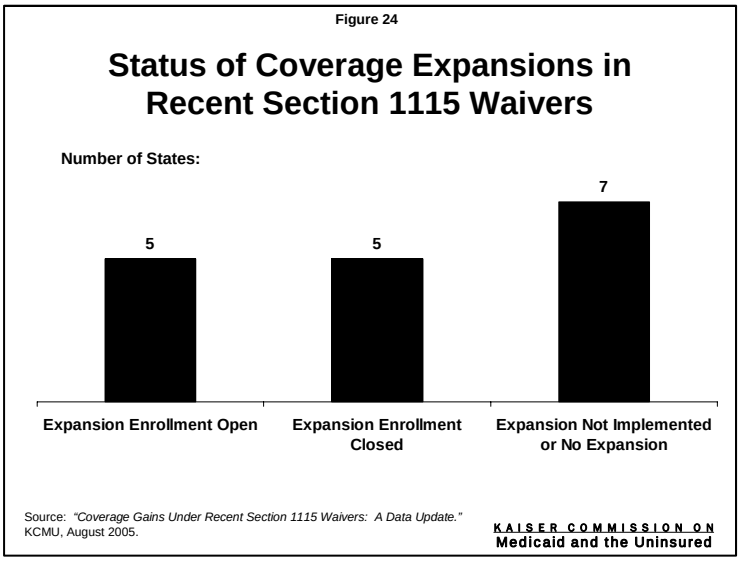
Other goals included: increasing reliance on private coverage (10 states); improving quality of care (9 states); encouraging consumer directed care (8 states); rebalancing the long-term care system (7 states); increasing administrative efficiencies (7 states); replacing special financing revenues (4 states); and modifying the structure of benefits or delivery systems through various mechanisms (3 states).

Research on the waivers approved since 2001 showed limited coverage gains and that some states that set out to expand coverage were unable to do so. While over two-thirds of the waivers had plans to expand coverage, some states did not implement the expansions, other expansions were only partially implemented or were closed under enrollment cap provisions (Figure 24). The combination of state fiscal pressures and the absence of additional federal financing resulted in a limited ability to implement coverage expansions.[43] In some cases, even though the expansions were not fully implemented,

[41] SCHIP 1115 waivers are also planned by some of the states but are not included in this survey. Some of the waivers that are included impact both Medicaid and SCHIP programs.
[42] The Administration has released a new waiver initiative on September 16, 2005, designed to assist states in providing temporary Medicaid coverage to Hurricane victims. As of October 10, 2005, waivers had been approved in Alabama, Arkansas, the District of Columbia, Florida, Georgia, Idaho, Mississippi, Puerto Rico, Tennessee and Texas. (http://www.cms.hhs.gov/katrina/1115wvr.asp) These waivers are not included in the total number of states planning to implement 1115 waivers in FY 2006.
[43] Samantha Artiga and Cindy Mann. "Coverage Gains Under Recent Section 1115 Waivers: A Data Update." KCMU, August 2005.

states did implement other changes such as limiting benefits, imposing higher cost-sharing or imposing enrollment caps on programs.[44]

Figure 24



Ten states indicated that one of their goals was to increase reliance on private coverage, but only one of the waivers is solely related to premium assistance or employer-sponsored insurance programs.[45]

Several of the proposed waivers, such as those proposed by Florida and South Carolina[46] represent major program restructuring in terms of the manner in which beneficiaries are covered. Both of these plans would provide a pre-determined set of dollars rather than a defined set of benefits to individuals. California is an example of a state pursuing a waiver to replace special financing. This waiver would allow California to capture significant federal funding to stabilize safety net hospitals over the five year waiver period and also to expand managed care.[47]

8. Impact of the Medicare Part D Prescription Drug Benefit

In January 2006, the new Medicare prescription drug benefit ("Part D") will take effect for more than 40 million Medicare beneficiaries including almost 6.4 million beneficiaries dually eligible for Medicare and Medicaid (known as duals). As of January 1, 2006

[44] Samantha Artiga and Cindy Mann. "New Directions for Medicaid 1115 Waivers: Policy Implications of Recent Waiver Activities." KCMU, March 2005.
[45] Two states are requesting family planning waivers; in one state this is the only waiver being proposed. North Carolina is the one state requesting a stand-alone family planning waiver. This waiver is not included in the total of 25 states with comprehensive 1115 waivers.
[46] Details of South Carolina's reform efforts are included in the section titled *Profiles of Selected State Medicaid Policy Changes*
[47] This aspect of the Medi-Cal Redesign Proposal replaces the former Selective Hospital Contracting waiver under which California safety net hospitals had also received significant federal funding.

Medicaid drug coverage for the duals will end and these individuals will be transitioned to Medicare for prescription drug coverage. This transition poses serious challenges for beneficiaries and for states. States also have other responsibilities related to the implementation including a fiscal obligation to fund a substantial share of the cost of this benefit for dual eligibles and a requirement to assist with eligibility determinations for the Part D Low-Income Subsidy Program.

Given these new responsibilities, questions were added to the survey exploring the fiscal impact of Part D on state Medicaid programs, state intentions regarding "wrap-around" coverage, and state funding for Part D Low-Income Subsidy eligibility determinations. State officials were also asked to identify the most significant issues that they expect to deal with relating to Part D.

Comments of State Medicaid Officials on the Beneficiary Impacts of Part D:

"The scary part is that so many things have to happen at the same time."

"The biggest thing is going to be educating the population. These are elderly people. The different formularies will be confusing. There are a lot of unanswered questions."

"My concern is that our patient population is not going to know what they have when they get it."

"We are doing all we can to send people to SSA. But we are not sure they can handle it, and we are already max-ed out on our help lines."

"The big concern for us is mental health. It is a limited amount of time for these people to make an appropriate choice. If this blows up, it will have implications all over the system, in corrections, in mental health and in Medicaid."

Fiscal Impact of Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003[48] (the "MMA") requires CMS to recoup from states much of the savings that states would otherwise have realized from shifting prescription drug coverage for dual eligibles from Medicaid to Medicare. This payment, commonly referred to as the "clawback," is calculated based on an estimate of states per capita expenditures for prescription drugs for duals in 2003, trended forward and multiplied by the number of duals enrolled in a Medicare Part D plan. This state payment phases down from 90 percent of the total calculation to 75 percent over nine years. In practice, many states believe the clawback formula may result in a negative state fiscal impact rather than a savings – even as the phase-down percentage is applied.[49]

[48] Pub. L. 108-173

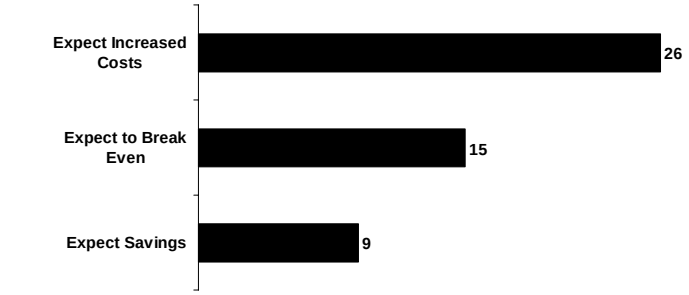
[49] It is important to note that responses presented here about the impact of Medicare Part D represent the views of Medicaid directors in July and August 2005, a period of time before states received their CMS-calculated Clawback amount in September.

- Officials in twenty-six states expected their FY 2006 clawback obligations to result in increased costs to the state, nine states expected savings, and 15 states expected their states to break even. One state indicated that they were not certain of the impact (Figure 25).

- Nineteen states did not expect cost savings in future years, at least through the year 2010, despite the scheduled partial phase-down of the clawback.

Figure 25

State Estimates of Fiscal Impact Associated with FY 2006 Medicare Part D Clawback Obligations



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

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A number of states commented that the base year (2003) used for the clawback formula did not account for pharmacy cost containment measures taken in their states after 2003 resulting in an inflated clawback obligation. Others states expected increased Medicaid costs associated with the "woodwork effect" whereby implementation of the Part D benefit would have the effect of increasing the number of dual eligibles, and thereby increase the clawback obligation. Beyond the clawback payment, increased enrollment associated with the implementation of Part D would increase Medicaid costs for Medicare premiums, co-insurance, deductibles and medical services that Medicaid pays for persons who become dual eligibles.

Some states also predicted a negative impact on their supplemental rebate programs due to the loss of pharmacy claims volume and expenditures.

Comments of State Medicaid Officials on the Fiscal Impact of Part D:

"The clawback disadvantages any state that has done aggressive cost containment, has an aging population and a low FMAP. That's our state. We don't think we will ever see savings, even when it phases down to 75 percent."

"We are the poster child of a state that did all the pharmacy control after 2003, and now we are not getting any credit for it. We are getting hammered on the clawback."

"It is going to cost us so much in the early years we don't think we will ever break even."

"At some point we do expect savings, but it is pretty far down the road, and certainly not in this budget cycle."

Wrap-around Coverage

Part D excludes coverage for a number of drug classes that are optional but commonly covered under Medicaid, including over-the-counter drugs, barbiturates used for seizures and benzodiazepines for anxiety. The MMA gives states the option to continue Medicaid coverage for these drugs for dual eligibles and continue to receive federal Medicaid matching funds. In a letter to State Medicaid Directors dated June 3, 2005, CMS advised states that federal Medicaid law requires that if a state chooses to cover excluded drugs for Medicaid recipients who are *not* dual eligibles, they must also cover them for dual eligibles. Survey respondents for 46 states indicated that they intended to continue to provide "wrap-around" Medicaid coverage for the excluded Part D drugs currently covered by the state. Only one state said they would not continue to provide coverage and four states did not know.

Low-Income Subsidy Administration

Only nine states indicated that their budgets for FY 2006 included funding for administering Part D Low-Income Subsidy eligibility determinations (i.e., funding for additional staff or to make systems changes). In general, states expect the Social Security Administration to bear the primary administrative responsibility for this function.

Significant Issues

State officials were also asked to identify the most significant issues that they expect to deal with relating to Part D. This was an open-ended, non-structured question. Responses were grouped into six categories: administrative impacts, beneficiary impacts, complexity and confusion, impact on supplemental rebates, the clawback and the woodwork effect.

> ***Administrative Impacts.*** Almost half of the states (25) raised concerns over administrative issues including the need for computer systems changes, coordination of benefits issues, data and data exchange issues, state staffing impacts and general concerns as to the overall administrative burden.
>
> ***Beneficiary Impacts***. Eighteen states raised concerns over beneficiary impacts including continuity of care issues, the impact of new copay requirements, mental health-related transition issues, access to non-formulary drugs, gaps in coverage and beneficiaries that "fall through the cracks," Native American issues, and general concerns about the transition of dual eligibles to Part D coverage.
>
> ***Complexity and Confusion***. Seventeen states cited the complexity of the Part D benefit (including the number of plans with differing benefit packages), the confusion that they expected many beneficiaries and providers to have and the

difficulty of providing adequate outreach and education to beneficiaries, providers and caseworkers.

Supplemental Rebates. Twelve states expressed concern over the impact of the Part D benefit on their existing supplemental rebate programs.

Clawback. Eleven states cited the clawback obligation as a significant concern.

Woodwork Effect. Nine states cited the fiscal impact of the woodwork effect as a significant concern.

9. The Outlook for FY 2006 and Beyond

As in previous years, Medicaid spending growth projected for FY 2006 appears to be optimistically understated, but consistent with previous patterns for budget appropriations for the program. For FY 2006 adopted budgets, states authorized total spending growth that would average 5.5 percent.

Based on appropriated levels of spending, Medicaid officials were asked to assess the likelihood that they would experience a Medicaid budget shortfall for FY 2006. For this question, a Medicaid budget shortfall would be said to occur when the original legislative appropriation was insufficient to cover expected actual expenditures. At the beginning of FY 2006, Medicaid officials in 20 states indicated that the likelihood of a budget shortfall was "not likely." However, in 31 states officials said the likelihood was at least 50 – 50, including 13 states where officials indicated that a shortfall was "almost certain."

The possibility of a Medicaid budget shortfall in many states for FY 2006 is apparent from the growth in Medicaid spending authorization provided by original legislative appropriations. This is similar to the original legislative appropriated growth of 5.5 percent for the prior year, FY 2005, when actual total spending growth turned out to be 7.5 percent. This means that many states will be re-visiting Medicaid policies during FY 2006 to determine whether to resolve the funding shortfall through supplemental funding or additional mid-year program cuts. In previous years, about two-thirds of states have experienced a Medicaid budget shortfall. The number was 35 states in FY 2003, 34 states in FY 2004, and 35 states on FY 2005.

The future of Medicaid, as seen from the vantage point of Medicaid officials in FY 2006, is distinctly influenced by the experiences of the recent past. States are starting to emerge from a period of intense fiscal stress, but while state revenue growth is rebounding, overall revenue levels remain low relative to revenues prior to the economic downturn. States are still under pressure to control Medicaid costs, although the primary drivers of the cost increases are generally beyond state control. Pressures such as enrollment growth that are a function of the economy, poverty rates and changing demographics are likely to continue to impact Medicaid spending in the future. Similarly, overall health care cost increases, while slowing somewhat, continue to outpace inflation and revenue growth.

Despite these pressures, Medicaid remains a critical program to provide health and long-term care coverage for over 52 million Americans, many who have no alternatives to receiving the coverage and services they need. Medicaid also remains the largest source of federal revenue to states, an important component of local economies, and a dominant revenue source for safety-net providers.

In this context, state Medicaid officials were asked to look into the future and describe the most important issues they see on the horizon for Medicaid for FY 2006 and beyond. First, Medicaid officials expressed more optimism than in past years. Comforted by the continued growth in state revenues after such severe declines, most state Medicaid officials expressed a measure of hope for the future.

At the same time, Medicaid faces significant issues. The issue of long-term fiscal sustainability of Medicaid is still very much on the minds of state officials. While the gap between Medicaid spending growth and state revenue growth is starting to narrow, officials expressed concern about long-term enrollment trends and cost pressures that are out of the states' control. Many noted that state fiscal capacity is not sufficient or stable as a funding source for a program like Medicaid, as was highlighted in the recent recession.

Medicaid officials were most interested, and in some cases concerned, about the direction of federal Medicaid reform. The survey was conducted as the federal Medicaid Commission was beginning its work. Officials expressed reservations about the prospect of further restrictions on federal funds that might result from the recommendations of the Medicaid Commission and the budget reconciliation process. At a time that federal matching rates are dropping in a majority of states, the possibility of an additional $10 billion of federal cuts posed the prospect of states having to dig deeper to find more of their own funds to pay for Medicaid financed services.

Medicaid officials also listed demographic changes as a significant issue facing Medicaid. Even though officials projected that enrollment growth overall would continue to slow in the future, there was concern about the aging of the population and how that would change the demographic composition of Medicaid enrollees. More elderly and disabled enrollees would translate into higher costs, even without an increase in the total number of persons on Medicaid, exacerbating the issue of long-term financial sustainability of the program. At the same time, officials were concerned about the erosion of employer-sponsored health insurance, and how this trend has significant implications for the future role of Medicaid in assuring coverage for lower-income, working Americans.

An issue on the immediate horizon was the implementation of the Medicare Part D prescription drug benefit. Medicaid officials were concerned about how it might impact Medicaid and the dual eligibles, and were also concerned about the fiscal impact of the clawback payments.

Medicaid officials listed a number of additional issues that would be on the front burner in their states. The issues mentioned most frequently were: state-level Medicaid reform, including development and implementation of Section 1115 waiver initiatives; long-term care reform and the re-balancing of the long-term care system; coordination with mental

health programs; and administrative issues such as implementing a new Medicaid information system.

Comments of State Medicaid Officials on the Outlook for Medicaid:

"What I am worried about the most is what may come out of Washington. I am afraid we may be dumped on."

"The issue for us is, will we have enough funds to do the job we are asked to do?"

"State revenue growth is expected to be in the 3 percent to 4 percent range. Medicaid spending is expected to be in the ten percent range. So the issue is one of sustainability."
"There will be increasing pressure to contain Medicaid, because it is big. But, I've done everything I can to control costs. If I have to take one percent or two percent off the top of the program, I don't know that it can be done."

"The Governor has set out a goal of covering all children by 2010. Medicaid and SCHIP are to play a major role in this effort." [For people under 200 percent of the poverty level]

Conclusion

In many ways, from a budget perspective, the period from FY 2002 through FY 2005 have been the most difficult four-year period in the history of the Medicaid program. During this period, states experienced their greatest fiscal stress since the 1930s, with two consecutive years when state revenues on average actually dropped. The economic recovery has been slow and uneven. Looking forward to FY 2006 half of the states are still expecting budget shortfalls.

Throughout this period, Medicaid has been the target of actions to control expenditure growth in every state. This report focuses on the array of policy actions implemented and planned for FY 2005 and FY 2006. States have achieved some success in slowing the rate of growth, and the evidence shows that growth in per capita cost for Medicaid enrollees has been slower than any other major health care purchaser. Still, the large number of individuals who became eligible and enrolled in the program due to the economic downturn has driven state expenditure growth, notwithstanding aggressive efforts of state Medicaid programs to moderate the spending trend. Many of these individuals, especially children, would have been uninsured if they were not picked up by Medicaid. Since 2000, the number of uninsured has increased by 6 million. Most of these people are adults who do not meet the Medicaid income threshold or categorical eligibility criteria. The projected Medicaid enrollment growth for FY 2006 is just three percent, less than one-third of the 9.9 percent growth that occurred in FY 2002. As a result, the Medicaid spending growth rates have also moderated.

More states are also turning to 1115 waivers to help reduce costs and, in some cases, expand coverage. Unfortunately, without additional federal resources to supplement scarce state dollars, many states who have recently implemented waivers have not been able to achieve significant coverage gains through the waiver mechanism. While states continue to focus on strategies to control spending growth, positive state revenue growth allowed some states to focus a more on expansions or increases to provider rates than in previous years.

States will face additional costs and responsibilities in 2006 associated with formula driven reductions in federal match rates and the implementation of Medicare Part D. As Congress moves forward with Medicaid savings proposals in the context of the budget reconciliation process, states expressed concern that some proposals could shift the balance of financing the program in the direction of states at a time when states are questioning whether state fiscal capacity can support their current financial obligations. The cumulative effect of changes at the state and federal levels could also shift costs to beneficiaries and providers.

The next few years may prove to be critical for the future of Medicaid. In significant ways, Medicaid has become the public policy response to an array of much larger problems in the health care system including demographic trends, the erosion of employer sponsored health insurance, the lack of basic universal health coverage, gaps in Medicare coverage, overall health care costs, inadequate funding for the safety-net, and a lack of viable alternatives for long-term care services. With increasing demands on the program Medicaid needs to be maintained as a critical safety net to provide health and long-term care coverage to low-income people.

Appendix A: State Survey Responses

Appendix A-1: Factors Contributing to Medicaid Expenditure Growth in 2005 – State Survey Responses

State	Primary Factor	Secondary Factor	Other
Alabama	FMAP decline	Inflation of nursing home and pharmacy costs	Enrollment growth
Alaska	Utilization - increase of personal care services	Cost - General increase in per member per month	Enrollment growth
Arizona	Enrollment / Caseload growth	Medical inflation	Health Plan encounter issues resulted in a longer reinsurance lag which drove up FY05 costs
Arkansas	Enrollment growth	Utilization increases	
California	FMAP - loss of enhanced rate ($655M GF to DHS, more to other departments (not included in our budget).	Costs for aged and disabled, including significantly increased Medicare buy-in costs ($90M GF)	Mental health services for children ($100M GF) ,
Colorado	Enrollment growth	Implementation of new eligibility determination system, Colorado Benefits Management System (CBMS)	
Connecticut	Inflation: the cost of health care	Enrollment	Economy and loss of employer sponsored health insurance
Delaware	Renegotiated managed care contract	FMAP - decline impacted spending of state funds	Economy - Slow economic recovery and steady client growth
District of Columbia	Utilization including the cost of Pharmacy	Enrollment growth	Medical inflation
Florida	Increased utilization of drugs, nursing home and hospital inpatient services.	More people qualifying for Medicaid	Large aging population in Florida
Georgia	Enrollment growth	Prices	Utilization
Hawaii	Pharmacy costs	Enrollment	Capitation pm/pm rate increase
Idaho	Pharmacy Costs	Mental Health Services	Developmentally Disabled Services
Illinois	Pharmacy costs	Enrollment in Family Care and Kid Care	$850 STB in FY2004 was actually "borrowed". FY2005 appropriations saw approximately 14 day growth in payment cycles (deficit spending).
Indiana	Waiver services / disabled	Pharmacy costs	
Iowa	Prescribed drugs	Waivers	Physicians
Kansas	Utilization - Unexpected increase in utilization of inpatient services	Enrollment growth	Pharmacy expenditure growth
Kentucky	Reimbursement increases relating to new Provider taxes	Price increases for drugs	Provider business growth
Louisiana	Pharmacy expenditures	Long-term Personal Care Services	Utilization increase in inpatient and outpatient hospitals due to enrollment and waivers
Maine	Hospitals	Pharmacy	Behavioral Health Costs

State	Primary Factor	Secondary Factor	Other
Maryland	Service cost increases, especially for Elderly and Disabled	Utilization increase of services	
Massachusetts	Enrollment	Cost	Utilization
Michigan	Enrollment growth	Special funding phase-out	
Minnesota	HCBS waivers and Home care	Disabled basic care	
Mississippi	Pharmacy - Increased cost of pharmaceuticals	Uncertainty over program funding	FMAP
Missouri	Pharmacy	Utilization increase and enrollment growth	Nursing Home Rebasing
Montana	Enrollment growth of disabled population	FMAP decline	Reinstated rate cuts and service cuts
Nebraska	Pharmacy cost	High cost of services to person with disabilities	Mental Health/Substance Abuse Services
Nevada	Hospital	Nursing Homes	Pharmacy
New Hampshire	Pharmacy utilization	Price/Inflation	Outpatient spending
New Jersey	Pharmacy	Population / Enrollment	MCO rates / actuarial spending reg.
New Mexico	Increase in waiver expenditures due to increase in the number of recipients and utilization	Increase in expenditures for NFs and ICF-MRs due to rebasing	Special financing programs (SCPH and DSH)
New York	LTC spending	Pharmacy	Hospital costs
North Carolina	Pharmacy costs	Hospital costs	Long-term Care, Mental Health Program, Physicians
North Dakota	Utilization increase	Implementation of Pharmacy Prior Authorization	
Ohio	ABD Utilization	ABD Cost/Claim	ABD Enrollment
Oklahoma	Enrollment growth	Utilization / Growth of services (hospital, dental, etc.)	
Oregon	Closed adult expansion program	Implemented provider tax	Enrollment - increased, especially TANF non-cash and SCHIP
Pennsylvania	Growth in MA populations with high cost needs such as the elderly and the disabled	Increase in cost to provide services – pharmacy is a key cost driver	Expiration of the temporary enhanced FMAP on June 30, 2004
Rhode Island	Demographics	Utilization	Rates
South Carolina	Pharmacy costs - services increased cost (product cost and utilization)	Hospital costs - services increased cost (increased utilization and upcoding)	Nursing home costs - rate increase
South Dakota	Hospital - Extreme high cost claims	Did well on pharmacy rebates	
Tennessee	Pharmacy	Utilization - Increases of Medical services	Increase of Medicaid/Medicare Crossover Services
Texas	Enrollment	Utilization increases	Pharmacy cost increases
Utah	Enrollment growth	Nursing home rate increase	Pharmacy inflation
Vermont	FMAP rates	Pharmacy trends	Medical inflation

State	Primary Factor	Secondary Factor	Other
Virginia	Population growth; Additional slots funded for home and community-based care waivers	Increased utilization of community-based mental health and mental retardation services	Growth in pharmacy expenditures slowed considerably in FY05 due to numerous savings initiatives
Washington	Managed care rates and Enrollment growth	Pharmacy expenditures	Inpatient Utilization / Expenditures
West Virginia	Utilization increased for LTC services	Utilization increased for pharmacy services	
Wisconsin	Only 10 Capitation payments in FY 05 (lowered costs $120 M)	Enrollment growth	Pharmacy costs
Wyoming	Hospital utilization	Pharmacy costs	Mental Health for juvenile population

Appendix A-2: Factors Contributing to Medicaid Expenditure Growth in 2006 – State Survey Responses

State	Primary Factor	Secondary Factor	Other
Alabama	FMAP decline	Inflation of Nursing home and Pharmacy costs	MMA, Clawback and administrative costs
Alaska	FMAP reduction	Medicare Part D	Increased demand for Long-Term Care
Arizona	Medical inflation	Enrollment growth	MMA Woodwork
Arkansas	Enrollment growth	Utilization increases, particularly mental health services	
California	Medicare Part D drug coverage	Enrollment and cost of Aged and Disabled	Quality Assurance Fee (QAF)/revised rate methodology for skilled nursing homes (level B), QAF for managed care, end of one-time saving for checkwrite delays
Colorado	Enrollment growth	Utilization increase of services	
Connecticut	Enrollment due to expansion for adults to 150% FPL with no asset test	Economy and dropping of employer coverage	Medicare Part D
Delaware	Re-negotiated managed care contract	Enrollment growth	FMAP decrease
District of Columbia	Provider payment rate increases for DDS & HH, Personal care	Utilization of Pharmacy services	
Florida	Medicaid reform	New cost effective drug formulary	
Georgia	Enrollment growth	Prices	Utilization
Hawaii	Pharmacy costs	Enrollment growth	MCO rate increases
Idaho	Mental Health	Pharmacy Costs	Medicare Part D
Illinois	Medicare D integrated with Wrap-around programs	Pharmacy rate utilization	Medicare Premiums and FamilyCare expansion
Indiana	Waivers (especially DD)	Pharmacy Costs	Caseload growth
Iowa	Economy	Effect of Medicare Part D	Approval of 1115 Waiver
Kansas	Pharmacy cost increases	Enrollment growth	
Kentucky	Pharmacy price increases	Hospital DRG increases	Enrollment growth
Louisiana	Hospital rates	Pharmacy expenditures	Long-term Personal Care Services
Maine	Hospital	Pharmacy	Behavioral Health Costs
Maryland	Cost of services, primarily elderly and disabled	Medicare Part D Pharmacy, impact uncertain at this time	
Massachusetts	Enrollment	Cost inflation	Utilization
Michigan	Enrollment growth	Special financing phase-out	
Minnesota	Inflation	Elderly/disabled cost of care	
Mississippi	Reduction in the number of Medicaid eligible persons	Changes in pharmacy benefit	FMAP decline

State	Primary Factor	Secondary Factor	Other
Missouri	Elderly and Disabled Population expenditures	Enrollment growth	Pharmacy costs
Montana	Rate increases	Utilization	FMAP decline
Nebraska	Pharmacy price	Nursing home rates	
Nevada	Hospital	Nursing Homes	Pharmacy
New Hampshire	Broad care management initiative	Pay for Prevention program for physicians	Mandated 1 1/2% rate increase for community Mental Health system
New Jersey	Pharmacy	Enrollment	MCO rates
New Mexico	Medicare premiums with price increase and woodwork effect of Part D	New program (State Coverage Insurance) and behavioral health expansion	Growth in waiver programs
New York	Part D	Family Health Plus	
North Carolina	Pharmacy costs	Hospital costs	Long-term Care, Physician
North Dakota	Utilization	Clawback payments	Woodwork effect - potential effect from Part D
Ohio	ABD Utilization	ABD Enrollment	ABD Cost/Claim
Oklahoma	Provider rate increase	Growth / utilization	HIFA waiver - premium assistance
Oregon	Enrollment growth	Federal changes in Medicaid	MMA
Pennsylvania	Enrollment growth	State revenue not keeping pace with the increased costs of the Medical Assistance Program	Loss of federal funding
Rhode Island	Utilization	Demographics	Part D
South Carolina	Physician rate changed plus utilization	Hospital cost	Pharmacy cost
South Dakota	Hospital costs	Growing costs	Minimal enrollment growth
Tennessee	Disenrollment of Optional Adult enrollment categories	The state's ability to implement benefit changes to remaining adult populations	Pharmacy inflation and Medical utilization
Texas	Utilization and Costs	Enrollment	Medicare Modernization Act
Utah	Provider inflation	Enrollment growth	Restoration of adult vision and dental
Vermont	Medical inflation	FMAP changes	
Virginia	Reimbursement rates and HCBS waiver slots	Population growth; health care inflation	Rate increase in Medicare Premiums
Washington	Pharmacy	Enrollment growth in Managed Care	Hospital costs - Inpatient
West Virginia	Long-term Care	Pharmacy	
Wisconsin	Return to paying 12 Capitation payments	Enrollment growth	Intensity increases for drugs, hospitals, personal care & Medicare premiums
Wyoming	Expansion of DD & Assisted Living Waiver	Hospital reimbursement	Mental Health

Appendix A-3: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2005

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	DM/CM	Fraud and Abuse	LTC
Alabama	X	X						X	
Alaska	X	X						X	X
Arizona	X						X		
Arkansas	X	X							
California	X	X					X		
Colorado	X	X					X		X
Connecticut	X	X							
Delaware	X	X		X	X		X	X	
District of Columbia	X	X					X	X	
Florida	X	X				X	X		X
Georgia	X	X				X	X		X
Hawaii	X	X							
Idaho	X	X	X		X				
Illinois	X	X					X	X	
Indiana	X					X		X	
Iowa	X	X					X	X	
Kansas	X	X				X			
Kentucky	X	X							
Louisiana	X	X	X				X	X	
Maine	X	X	X	X				X	X
Maryland	X	X			X			X	
Massachusetts		X				X		X	
Michigan	X	X			X		X	X	
Minnesota	X	X							X
Mississippi	X	X		X					
Missouri	X	X		X			X		
Montana	X	X					X	X	
Nebraska	X							X	
Nevada	X					X		X	
New Hampshire	X	X					X	X	
New Jersey	X								
New Mexico	X	X	X	X	X		X	X	X
New York	X	X			X	X	X	X	
North Carolina	X		X			X		X	
North Dakota	X	X					X		
Ohio	X	X				X	X	X	
Oklahoma	X	X					X	X	
Oregon	X	X	X	X		X		X	
Pennsylvania	X	X		X		X	X		

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	DM/CM	Fraud and Abuse	LTC
Rhode Island	X	X							
South Carolina	X	X	X			X	X		
South Dakota	X				X			X	
Tennessee	X	X		X				X	
Texas	X	X					X		
Utah	X	X							X
Vermont	X	X						X	X
Virginia	X	X					X	X	
Washington	X	X				X	X	X	X
West Virginia	X					X	X		
Wisconsin	X	X							
Wyoming	X	X			X		X	X	
Total	**50**	**43**	**7**	**8**	**8**	**14**	**26**	**28**	**10**

Appendix A-4: Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2006

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	DM/CM	Fraud and Abuse	LTC
Alabama	X	X							
Alaska	X	X					X	X	X
Arizona	X			X			X	X	
Arkansas	X	X						X	
California	X	X	X						
Colorado	X								
Connecticut	X	X		X	X	X		X	
Delaware	X	X							
District of Columbia	X	X				X			
Florida	X	X		X			X		
Georgia	X	X			X	X	X	X	
Hawaii	X								
Idaho	X	X	X				X		
Illinois	X	X	X						X
Indiana	X	X	X			X	X	X	X
Iowa		X					X	X	X
Kansas	X	X				X	X		
Kentucky	X	X			X		X		X
Louisiana	X	X					X	X	
Maine	X	X	X				X	X	
Maryland	X				X			X	
Massachusetts	X					X		X	
Michigan	X	X		X	X		X	X	
Minnesota	X	X	X	X		X	X	X	X
Mississippi	X	X	X	X	X				
Missouri	X	X	X	X	X				
Montana	X	X							
Nebraska	X					X			
Nevada	X	X							
New Hampshire	X	X	X	X			X		
New Jersey	X								X
New Mexico	X	X			X	X			X
New York	X	X	X	X	X	X	X	X	X
North Carolina	X	X		X	X	X		X	X
North Dakota	X	X					X		X
Ohio	X	X	X	X	X	X	X	X	X
Oklahoma	X	X							
Oregon	X	X	X			X			
Pennsylvania	X	X	X	X	X	X	X	X	

State	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Expansions	DM/CM	Fraud and Abuse	LTC
Rhode Island	X					X			
South Carolina	X	X				X			
South Dakota	X	X					X		
Tennessee	X	X	X	X		X	X		
Texas	X	X				X	X	X	X
Utah	X								
Vermont	X	X	X	X			X	X	
Virginia	X	X				X	X		
Washington	X	X					X	X	X
West Virginia	X	X	X		X	X			X
Wisconsin	X	X				X	X	X	
Wyoming	X								
Total	**50**	**41**	**16**	**14**	**13**	**21**	**25**	**21**	**15**

Appendix A-5: Positive Policy Actions Taken in the 50 States and District of Columbia in FY 2005

State	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Long Term Care Expansions
Alabama	X			
Alaska	X			
Arizona	X			
Arkansas	X			
California	X			
Colorado	X		X	X
Connecticut	X			
Delaware	X			
District of Columbia	X		X	
Florida	X		X	
Georgia				X
Hawaii	X		X	
Idaho	X			
Illinois	X			
Indiana	X			
Iowa	X		X	
Kansas	X			
Kentucky	X			X
Louisiana	X	X	X	X
Maine	X		X	
Maryland	X	X	X	
Massachusetts	X		X	
Michigan		X		X
Minnesota	X			
Mississippi				
Missouri	X	X	X	
Montana	X		X	
Nebraska	X	X		
Nevada	X		X	
New Hampshire	X			
New Jersey	X			
New Mexico	X		X	
New York	X		X	
North Carolina	X	X		X
North Dakota	X			
Ohio	X		X	
Oklahoma	X		X	
Oregon	X	X		X
Pennsylvania	X		X	X
Rhode Island	X			
South Carolina	X	X		

State	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Long Term Care Expansions
South Dakota	X			
Tennessee				X
Texas	X		X	
Utah	X	X		
Vermont	X			
Virginia	X		X	
Washington	X		X	
West Virginia	X			
Wisconsin	X			X
Wyoming	X			X
Total	**47**	**9**	**20**	**11**

Appendix A-6: Positive Policy Actions Taken in the 50 States and District of Columbia in FY 2006

State	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Long Term Care Expansions
Alabama	X			
Alaska	X	X		
Arizona	X			
Arkansas	X			
California	X	X	X	X
Colorado	X	X	X	X
Connecticut	X		X	
Delaware	X			X
District of Columbia	X		X	X
Florida	X			X
Georgia	X			X
Hawaii	X			
Idaho	X			
Illinois	X		X	
Indiana	X			
Iowa	X		X	X
Kansas	X			X
Kentucky	X			X
Louisiana	X		X	X
Maine	X			
Maryland	X		X	
Massachusetts	X	X	X	X
Michigan	X	X		X
Minnesota	X	X	X	
Mississippi	X			
Missouri	X			
Montana	X			X
Nebraska	X	X		
Nevada	X			X
New Hampshire	X		X	
New Jersey	X		X	
New Mexico	X		X	X
New York	X			X
North Carolina	X	X	X	X
North Dakota	X		X	
Ohio	X			X
Oklahoma	X		X	
Oregon	X			
Pennsylvania	X		X	X
Rhode Island	X			

State	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Long Term Care Expansions
South Carolina	X		X	
South Dakota	X			
Tennessee	X			X
Texas	X	X	X	
Utah	X	X	X	X
Vermont	X			X
Virginia	X		X	X
Washington	X			
West Virginia	X			
Wisconsin	X		X	X
Wyoming	X			X
Total	**51**	**10**	**22**	**25**

Appendix A-7: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2005

State	Benefit Change
Alabama	
Alaska	
Arizona	
Arkansas	
California	
Colorado	
Connecticut	
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	**All Adults:** Mental Health clinic services for day treatment reduced from 56 to 36 hours per week.
Illinois	
Indiana	
Iowa	
Kansas	
Kentucky	
Louisiana	**All:** Defunded routine/elective circumcision (15,000). **Aged and Disabled:** Added personal care services for eligibles who meet the nursing home level of care.
Maine	**Adults:** Limits on OT/PT/Speech, chiropractic, and DME. (2,000). **Aged and Disabled:** Placed limits on Prosthetics/orthotics and rehab for TBI.
Maryland	**Children**: Added reimbursement for health-related, therapeutic and rehabilitative services for children in out-of-home placements (4,000).
Massachusetts	
Michigan	**All Adults:** Restored coverage for chiropractic services, podiatry and hearing aids.
Minnesota	
Mississippi	
Missouri	**Children**: Expand dental services to include dental hygienists (302,023) and added coverage for scalp hair prostheses (541). **Aged and Disabled**: Provide two annual authorized nurse visits (home health/HCBS type of services) (21,590 total).
Montana	
Nebraska	**All Adults**: Added substance abuse treatment for adult populations.
Nevada	
New Hampshire	
New Jersey	
New Mexico	**Children**: Tightened orthodontia/dental oversight (500). **Parents**: Decreased coverage for dental crowns and root canals. (3,500).
New York	
North Carolina	**Children:** Expanded dental benefit to cover additional procedures and placed limits on the number of certain dental procedures per date of service (643,922 under age 21). **All:** Brush biopsy (transepithelial sample collection) added as a benefit expansion for all ages. Also, coverage ended for the following dental procedures for all ages: “re-cement

State	Benefit Change
	inlay," "re-cement crown" and pulp cap-direct." Also, "Surgical access of an unerupted tooth" and "Excision of pericoronal gingival" no longer allowed on the same date of service as an extraction for the same tooth number (480,843 over age 21).
North Dakota	
Ohio	
Oklahoma	
Oregon	**Expansion Adults:** Benefit package reconfigured adding emergency dental, limited DME and supplies, outpatient chemical dependency, and outpatient mental health, and eliminating hospital services that are not for urgent or emergent care, acupuncture (except for treatment of chemical dependency), chiropractic and osteopathic manipulation, home health care, nutritional supplements taken by mouth, occupational therapy, physical therapy, private duty nursing, and speech therapy (57,000). **All:** Eliminated three lines on prioritized list (385,000).
Pennsylvania	
Rhode Island	
South Carolina	**Children:** Added pediatric codes for DME. **Parents and Children:** Changed certain DME products to rental only, reduced number of month's rentals on certain items, changed guidelines for power chairs. **Adults**: Implemented an exception to the ambulatory care visit policy to allow visits over the benefit limit.
South Dakota	
Tennessee	
Texas	
Utah	**Aged and Disabled**: Added emergency dental (root canals).
Vermont	
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

Appendix A-8: Benefit Related Actions Taken in the 50 States and District of Columbia in FY 2006

State	Benefit Change
Alabama	
Alaska	**Children:** Added an infant learning targeted case management program for children from birth to age three.
Arizona	
Arkansas	
California	**Children**: Addition of fluoride varnish for teeth provided by a physician for young children (80,000). **All Adults:** Imposed $1,800 annual dental cap (expected to impact 16,000).
Colorado	**All:** Expanded outpatient substance abuse treatment (4,479) and implemented an obesity treatment pilot program affecting an estimated amount of 785 clients.
Connecticut	
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	**All Adults:** Added restrictions to community-based Mental Health services. (41,000)
Illinois	**All Non-institutional Adults**: Narrowed OTC pharmacy benefit for adults in community.
Indiana	**Parents:** Restrictions and prior authorization for some dental Services. **Aged and Disabled:** Activity related to spousal impoverishment and recovery against surviving spouse.
Iowa	
Kansas	
Kentucky	
Louisiana	
Maine	**Expansion Adults (non-categoricals)**: Plan to implement a reduced benefit package including cuts in podiatry, DME and outpatient mental health services.
Maryland	
Massachusetts	**Pregnant Women:** Added dental and smoking cessation benefits.
Michigan	**All Adults:** Restore adult dental and partially restore hearing and vision services.
Minnesota	**All Adults**: Eliminated payment for inappropriate emergency room visits, limited coverage for circumcisions and limited coverage for erectile dysfunction drugs. Also, eliminated $500 dental cap.
Mississippi	**All Adults:** Home health visits reduced from 60 to 25 per fiscal year. Also, reduced drug benefit from a maximum of 7 prescriptions per month to 5 with no more than 2 being a brand name drug (except LTC and EPSDT).
Missouri	**All Adults (except pregnant women and blind beneficiaries):** Eliminated dental (including dentures), comprehensive day rehabilitation, eyeglasses, certain podiatric services, certain durable medical equipment (including, but not limited to, wheel chair accessories and batteries, three wheeled scooters, decubitus care cushions and mattresses, patient lifts, trapeze, all body braces (orthotics), hospital beds and side rails, commodes, catheters, canes, crutches, walkers, parenteral and enteral nutrition, artificial larynx, and augmentative communication devices), rehabilitation services (i.e. occupational, speech and physical therapy), diabetes self management training, and audiology, hearing aids and associated testing services.
Montana	
Nebraska	**Aged and Disabled**: Added Intermediate Specialized Services – a new level of service for persons needing Nursing Home care (50).
Nevada	

State	Benefit Change
New Hampshire	**All Adults:** Prior authorization required for outpatient radiology.
New Jersey	
New Mexico	
New York	**Expansion Adults:** Limits imposed on Family Health Plus vision benefit. (507,000)
North Carolina	**All Adults:** Expanded coverage of orthotic and prosthetic devices to recipients over the age of 20 years. (5,500) **Aged and Disabled:** Increased the number of hours of Adult Care Home Personal Care Services for residents of Special Care Units from 1.1 hours per day to 4.07 hours per day. (415)
North Dakota	
Ohio	**All Adults:** Reduction in dental benefits. (800,000)
Oklahoma	
Oregon	**All Adults:** Vision coverage will be eliminated, dental coverage will be limited, most over-the-counter drug coverage will be eliminated, a prescription drug monthly limit will be implemented, and a hospital day limit imposed for non-public hospitals. (122,000)
Pennsylvania	**All Non-Pregnant Adults**: Limits imposed on visits to outpatient providers, inpatient psychiatric hospital days, hours of psychiatric partial hospitalization services and hours of psychiatric outpatient clinic services. (Limits only applicable to fee-for-service clients but could also affect clients in managed care.) (21,934)
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**All Adults:** Eliminating coverage of OTC drugs, dental services, convalescent nursing home care, and methadone clinic services. (400,000). Also, adult populations will be subject to prescription limits (2 brand, 5 total) and benefit limits including a 20-day limit for inpatient hospital services.
Texas	**Adults:** Coverage restored for eyeglasses, contact lenses if medically necessary, podiatry services provided by a podiatrist, chiropractic services provided by a chiropractor, and mental health services if available funds certified by the comptroller. (180,000)
Utah	**Parents, Aged and Disabled:** Restored dental and vision services.
Vermont	**All Adults:** Adult dental maximum benefit decreased from $475 to $325.
Virginia	
Washington	
West Virginia	**Children:** Prior authorization required for DME. **Parents:** New, hard service limits.
Wisconsin	
Wyoming	

Appendix A-9: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2005

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limit Per Month	Generic Requirement	Mail Order Contract	Multi State Purchasing
Alabama				X	X					
Alaska					X	X				X
Arizona										
Arkansas					X					
California	X									
Colorado				X						
Connecticut	X	X		X	X	X		X		
Delaware				X	X		X			
District of Columbia				X						
Florida	X	X		X	X	X				
Georgia	X					X				
Hawaii					X	X				X
Idaho		X		X	X	X				
Illinois		X		X	X	X				
Indiana										
Iowa		X			X	X				
Kansas		X		X	X	X				
Kentucky	X	X			X	X	X			
Louisiana		X			X	X				
Maine				X	X		X		X	
Maryland			X					X		X
Massachusetts	X			X	X	X				
Michigan			X		X				X	X
Minnesota					X	X				X
Mississippi				X	X					
Missouri					X	X				
Montana				X	X	X				
Nebraska										
Nevada										
New Hampshire				X	X	X				
New Jersey										
New Mexico	X			X	X			X		
New York	X									
North Carolina										
North Dakota				X						

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limit Per Month	Generic Requirement	Mail Order Contract	Multi State Purchasing
Ohio				X	X	X				
Oklahoma		X		X	X	X	X			
Oregon				X		X				
Pennsylvania	X			X						
Rhode Island				X						
South Carolina				X	X					
South Dakota										
Tennessee				X	X	X				
Texas				X						
Utah						X				
Vermont		X		X	X			X		
Virginia		X		X	X	X		X		
Washington		X			X	X				
West Virginia										
Wisconsin	X	X		X	X	X		X		
Wyoming		X		X	X					
Total	**10**	**14**	**2**	**28**	**31**	**24**	**4**	**6**	**2**	**5**

Appendix A-10: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia in FY 2006

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limit Per Month	Generic Requirement	Mail Order Contract	Multi State Purchasing
Alabama				X	X					
Alaska	X			X						
Arizona										
Arkansas					X					
California	X									
Colorado										
Connecticut	X	X		X	X	X				
Delaware					X	X				X
District of Columbia		X			X					X
Florida				X	X	X				X
Georgia			X	X						
Hawaii										
Idaho		X		X		X				
Illinois		X			X	X	X			
Indiana	X	X		X						
Iowa					X	X				
Kansas		X		X	X	X				
Kentucky					X	X				X
Louisiana					X					X
Maine								X		X
Maryland										
Massachusetts										
Michigan										
Minnesota	X			X						
Mississippi	X						X			
Missouri					X	X				
Montana				X			X			
Nebraska										
Nevada				X						
New Hampshire				X	X	X				
New Jersey										
New Mexico					X					
New York		X		X	X	X				
North Carolina				X			X			
North Dakota				X						
Ohio	X			X	X	X				X

State	AWP	New or Lower State MAC	Reduction in Dispensing Fees	More Drugs Subject to Prior Authorization	Preferred Drug List	Supplemental Rebates	Limit Per Month	Generic Requirement	Mail Order Contract	Multi State Purchasing
Oklahoma	X			X						
Oregon				X	X	X	X			
Pennsylvania	X	X		X	X					
Rhode Island										
South Carolina				X						
South Dakota				X						
Tennessee				X	X	X	X	X		X
Texas							X			
Utah										
Vermont		X		X					X	
Virginia				X	X	X				
Washington		X			X	X				
West Virginia	X	X	X							X
Wisconsin	X		X							X
Wyoming										
Total	**11**	**11**	**3**	**24**	**21**	**16**	**7**	**2**	**1**	**10**

Appendix A-11: Eligibility Related Actions Taken in the 50 States and District of Columbia in FY 2005

State	Eligibility Change
Alabama	
Alaska	
Arizona	.
Arkansas	
California	
Colorado	**Other:** Implemented the Colorado Benefits Management System in September 2004 (a rules-driven eligibility system). No general changes in eligibility standards in processing applications, however, as of June 2004, a rule ('Estimated Income for Family and Children Medicaid') now allows Medicaid eligibility to be processed under the family and children categories using a partial month of earned income verification. In this instance, the earned income calculation will result in an estimate of monthly income based on the partial month verification.
Connecticut	
Delaware	**Other:** Automated case closing and more thorough review
District of Columbia	**Other:** Shortened application from 18 to 6 pages; Use same application for multiple programs.
Florida	**Aged and Disabled:** Changed treatment of mortgages, loans and promissory notes (from income producing property to assets) and allowed uncovered medical expenses as deductions in patient responsibility calculation. **Other:** No interview required at application/renewal (unless error prone or requested). Move to self-declaration as verification for most factors of eligibility; Developed and implemented web-based application with e-signature; Utilization of interim contact at annual review.
Georgia	
Hawaii	**Other:** Passive renewal of approximately 150,000 recipients
Idaho	
Illinois	
Indiana	
Iowa	**Adults:** Extended coverage up to age 25 for young adults receiving "ill and handicapped" home and community-based waiver services who would otherwise age out of coverage at age 21 because they are not SSI eligible (impacting 40 individuals).
Kansas	
Kentucky	
Louisiana	**Other:** Accept verification of pregnancy and due date either by written or verbal statement from medical professional. Discontinued use of conversion factors and use actual income received or expected to be received in the calendar month.
Maine	**Parents:** increased coverage for parents from 150% to 200% FPL in May 2005 with the expectation of covering 10,000 parents. **Adults:** Froze enrollments of non-categorical adults in its waiver program effective March 2005.
Maryland	**Other:** For annual redeterminations of Medicaid eligibility for most community-based populations, a "passive" redetermination process was implemented as of September 2004. The customer is mailed a Case Information Form with the information currently on file for the assistance unit. The customer makes any necessary changes to the information (e.g., income amounts), signs the form, and returns it to the eligibility worker who redetermines eligibility. A mail-in form and process for QMB and SLMB initial applications were implemented effective November 1, 2004
Massachusetts	**Other:** Implementation of the Virtual Gateway and a unified application for MassHealth and free care. Approximately 37,000 members added to MassHealth caseload since October 2004.
Michigan	
Minnesota	

State	Eligibility Change
Mississippi	**Other:** Face-to-face interview is required for the application and renewal process.
Missouri	**Parents**: Reduced the income eligibility level for low-income parents from 77% to 75% FPL (impacting an estimated 324 persons). **Aged and Disabled**: Expanded Medicaid eligibility from 90% to 100% FPL for the aged and disabled, covering approximately 25,406 people.
Montana	**Other:** Simplifying application that is currently 17 pages
Nebraska	
Nevada	**Pregnant Women and Children**: Eliminated asset test **Aged and Disabled**: Implemented a Medicaid buy-in /Ticket to Work Program (impacting 580 individuals.
New Hampshire	
New Jersey	
New Mexico	**Other:** All Medicaid recipients on the assistance programs (Food Stamp, TANF, etc.) may recertify for all programs at the same time using one application; **Other:** 6 month recertification / automatic closure (only for income based population; not disabled individuals)
New York	**Other:** Allow self-attestation as of 09/04
North Carolina	
North Dakota	
Ohio	**Other:** Redesigned application form
Oklahoma	**Adults**: Added Breast and Cervical Cancer coverage (impacting over 1200 individuals) and implemented a reproductive health care waiver to provide family planning services to uninsured women and men, ages 19 and older, with incomes at-or-below 185% FPL (impacting over 2800 individuals). **Other:** Implemented phone re-certification for Medicaid cases only
Oregon	**Waiver Population:** closed enrollment for the Oregon Health Plan (OHP) Standard waiver program during potential open enrollment periods reducing the caseload from 55,000 in July 2004 to 27,000 in June 2005
Pennsylvania	**Aged and Disabled**: implemented a change in the treatment of medical expenses for purposes of spend-down eligibility and disregarded retirement, survivors or disability insurance for purposes of determining disability eligibility for a person under age 21. **Other:** Streamlining eligibility process initiative
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**Adults and Children:** Froze enrollments in TennCare Standard waiver program except for children who qualify as “Medicaid Rollovers” (effective April 29, 2005). **Adults**: Froze enrollments of non-pregnant adults in the medically needy program (effective April 29, 2005).
Texas	**Pregnant Women:** Restored coverage for pregnant women between 158% and 185% FPL.
Utah	
Vermont	
Virginia	**Other:** Implemented “ex parte” renewal process for Medicaid. Also implemented a one-page renewal form for recipients whose ongoing eligibility cannot be determined through the “ex parte” process (those individuals whose information is not readily available to the agency, those who must verify resources and those who receive long-term care services). These changes affect all Medicaid recipients.
Washington	**Children**: Restored 12-month continuous coverage. **Other:** Eliminated the requirement of a report every six months.
West Virginia	
Wisconsin	
Wyoming	

Appendix A-12: Eligibility Related Actions Taken in the 50 States and District of Columbia in FY 2006

State	Eligibility Change
Alabama	
Alaska	
Arizona	**Other**: Stopped approving QI-1 applications (as of June 30, 2005) because its federal funding allocation was not sufficient for the number of eligible people.
Arkansas	
California	**Other:** Implementation of performance standards for county welfare departments to ensure that children determined no longer eligible for Medi-Cal without a share of cost are referred to the Healthy Families (SCHIP) Program.
Colorado	**Children and Adults:** Removed asset test for children (which will result in an expected 15,000 children moving from SCHIP to Medicaid coverage) and adults (impacting 4,000 persons).
Connecticut	**Parents**: Restored eligibility for parents up to 150% FPL effective July 2005. **Parents and Adults**: Will begin charging a premium for parents and expansion adults mid-year, 2006. **Other:** Will re-institute presumptive eligibility **Other:** Will eliminate self-declaration of income October 1, 2005
Delaware	
District of Columbia	**Children and Pregnant Women**: Will expand coverage for children from 19 to 21 years of age, and for pregnant, undocumented women. **Aged and Disabled:** Will increase the income eligibility standards for the disabled from 100% to 200% FPL **Other**: Will use income disregards for the Medicare buy-in population to reduce countable income below 135% of the FPL.
Florida	**Aged and Disabled:** Revising eligibility requirements for aged and disabled individuals to limit coverage to those not eligible for Medicare unless in an institution.
Georgia	
Hawaii	
Idaho	
Illinois	**Other:** Will implement KC/FC online application (not for renewals).
Indiana	
Iowa	**Children**: Will extend coverage (including both full State Plan services and home and community-based waiver-type services) for children from birth to age 18 who have serious emotional disabilities and who would be eligible for State Plan services if they were in a medical institution (estimated to impact 800 children). **Pregnant Women**: Will extend limited Medicaid benefit coverage to pregnant women with incomes at or below 300% FPL that have incurred family medical expenses that reduce income to 200% FPL. **Adults**: Will extend limited Medicaid benefit coverage to approximately 30,000 adults ages 19 through 64 with incomes at or below 200% FPL. Iowa is also seeking approval for a family planning waiver that would extend coverage for family planning services to approximately 60,000 individuals. **Aged and Disabled**: Iowa is seeking approval to increase income disregards for persons who purchase and use long-term care insurance (expected to impact fewer than 50 persons). **Other:** Family planning waiver applications can be filed at designated Family Planning clinics.
Kansas	
Kentucky	
Louisiana	**Adults:** Will provide twelve-month continuous coverage to low-income adults using income disregards. **Aged and Disabled:** Will disregard income support and maintenance as an income type for aged and disabled enrollees.
Maine	

State	Eligibility Change
Maryland	**Aged and Disabled:** Implementing a Medicaid buy-in program for the working disabled in April 2006. (300)
Massachusetts	**Other:** Expansion of Virtual Gateway into Community Health Centers
Michigan	**Adults:** Add asset test and freeze enrollment for 19-20 year olds.
Minnesota	**Adults:** Eliminated the waiting period for active military personnel in its Medicaid expansion population **Aged and Disabled:** Made changes to eligibility criteria to treat certain trusts as available resources and repealed the retroactive effect of a 2003 law pertaining to liens on life estates. **Other:** Verification of income and assets at end of 60-day post-partum period
Mississippi	**Aged and Disabled:** Eliminate coverage for aged and disabled between 100% and 133% FPL affecting 65,000 individuals. Those losing coverage who are not eligible for Medicare (about 5,000) will be eligible for continued coverage (under a waiver) but with a reduced benefit package.
Missouri	**Children**: Added new premium requirements for SCHIP eligibles with family incomes above 150% FPL (impacting approximately 40,944 persons). **Parents:** Eliminated extended transitional Medicaid coverage (for persons leaving TANF) impacting an estimated 1,560 persons, reduced the income eligibility level for low-income parents from 75% FPL to the 1996 AFDC income level (about 23% FPL) impacting an estimated 48,079 persons, and increased the frequency of eligibility reinvestigation efforts for adults. **Aged and Disabled**: Reduced the income eligibility level for aged and disabled beneficiaries from 100% to 85% FPL (impacting an estimated 8,884 persons), eliminated coverage for employed disabled persons (the "Ticket to Work" program) impacting 8,336 persons, placed new limits on annuity investments (for purposes of Medicaid eligibility), required institutionalized spouses to divert income to the community spouse before diverting assets, and added new requirements for the enforcement of liens on all institutionalized individuals. **Other:** Reinvestigations for medical assistance eligibility
Montana	
Nebraska	
Nevada	
New Hampshire	**Aged and Disabled**: Increased the look-back period for asset transfers from 3 to 5 years. **Other:** Updating application to make it more user friendly.
New Jersey	**Other:** One page application; streamlined Presumptive Eligibility process, combined application and form to choose an HMO
New Mexico	**Other:** Simplification of recertification; Treatment of Income Disregard
New York	**Children:** Will shift children aged 6-19 in families with incomes between 100% - 150% FPL from the more comprehensive Medicaid program to Child Health Plus (SCHIP). **Adults**: Restricting eligibility for its Family Health Plus program by increasing the waiting period from 6 to 9 months, prohibiting government employees and their family members from enrolling and enacting a resource test.
North Carolina	**Children:** Transfer children age birth to five in families with incomes up to 200% FPL from the NC Health Choice Program (SCHIP) to the Medicaid Program. (30,000) **Aged and Disabled:** Ticket to Work Medicaid Expansion: implementing a Medicaid buy-in program for workers with disabilities. **Other:** Plan to implement a mail-in application for Aged/Disabled and this should impact approximately 10,000 applicants in the coming year. **Other:** Verification of state residency for Medical Assistance
North Dakota	**Other:** Redesigned application form for simplification. Development and implementation of a short application form for Aged and disabled. Will affect all new applicants (approximately 3600 per month). It is estimated that these application changes will be effective January 1, 2006.
Ohio	**Parents**: Reducing the income eligibility standard for TANF adults from 100% to 90% FPL effective January 2006 (impacting as estimated 25,000 individuals). **Aged and Disabled:** Increasing look-back period from 3 to 5 years for assets sold at less than fair market value and changing estate recovery definitions.

State	Eligibility Change
Oklahoma	**Children**: Expanding eligibility to children with disabilities through age 18 living at home regardless of parental income (the "TEFRA" option). Estimated to impact 500 children. **Adults**: Implementing a premium assistance program for low-income individuals and small businesses with the goal of eventually covering 70,000 individuals. **Other:** 12-month certification; mandatory selection of PDP w/enrollment to get rid of auto-enrollment
Oregon	
Pennsylvania	**Aged and Disabled**: Changed its long-term care eligibility to include spousal protection provision to avoid impoverishment of the community spouse; implemented partial months ineligibility due to asset transfer for less than fair consideration, and limited unpaid medical expenses to $10,000 when calculating a resident's cost of care contribution. Also, changed the eligibility criteria for its spend-down programs by limiting prior medical bills used to establish eligibility to only those bills incurred within three months prior to application.
Rhode Island	
South Carolina	**Adults:** Expanding coverage under its Breast and Cervical Cancer program to all persons aged 19 to 65. (Previously, coverage was for ages 57 to 65).
South Dakota	
Tennessee	**Adults**: Will eliminate coverage for adult expansion groups in FY 2006 (impacting 226,000 individuals). **Other:** The proposed MNSD program, if granted legal relief, will require enrollees to be reverified more frequently than current program.
Texas	**Adults**: Implementing a family planning waiver (covering an estimated 114,800 individuals) **Aged and Disabled:** Will implement a Medicaid buy-in program for the working disabled (covering an estimated 2,273 individuals) and is also planning to partially restore Medically Needy coverage (contingent upon receiving IGT approvals). **Other:** The system will allow Texans to apply for services in person, through the Internet, over the phone, and by fax or mail. Call centers will provide assistance from 8 a.m. to 8 p.m.
Utah	**Other:** Testing online eligibility determination for a variety of programs. Expected to go live later in 2006.
Vermont	**Aged and Disabled:** Changes to procedures related to income, resources and transfers of assets used to determine eligibility for long-term care coverage.
Virginia	**Pregnant Women:** increased the income eligibility level for pregnant women from 133% FPL to 150% FPL (impacting an estimated 400 persons).
Washington	
West Virginia	
Wisconsin	**Other:** We are implementing an Internet Application for Services in March 2006. We expect 5% of applications to come in through the Internet. We are implementing a Pre-Printed Review process in November 2005, which will affect about 250,000 recipients
Wyoming	

Appendix A-13: Disease Management and Case Management Related Actions Taken in the 50 States and District of Columbia in FY 2005

State	Disease Management/Case Management Initiative
Arizona	Required MCOs to identify current disease management programs and develop a disease management plan as part of their Utilization Management Plan.
California	Completion of first error rate and PAM studies
Colorado	An asthma disease management program was implemented in November 2004. A diabetes disease management program was implemented in February 2005.
Delaware	Within MCO
District of Columbia	Implementing programs for dual eligibles 8/1/05
Florida	Continuation of current disease states including: HIV/AIDS, hemophilia, diabetes, asthma, hypertension, and congestive heart failure
Georgia	Special case management for at-risk pregnancies involving the drug Matria.
Illinois	Illinois Health Women Initiative
Iowa	Diabetes Management Pilot
Louisiana	Asthma Pharmaceutical Care Management Program via the University of Louisiana at Monroe-College of Pharmacy
Michigan	A two year project entitled the Michigan Pharmacy Quality Improvement Project (PQIP) began in May 2005. It is a collaborative effort between the Mich. Dept of Community Health and Comprehensive NeuroScience, Inc., supported by funding from Eli Lilly. The project analyzes the prescribing of psychotropic medications for Medicaid members and provides information and educational materials to physicians about their prescribing practices and patients.
Missouri	Expand disease management to 3 more disease states; chronic care management; expand drug pager pilot project; telemonitoring pilot project; telemedicine pilot project.
Montana	Health Buddy for congestive heart failure (home device to alert case manager); KeenCare for abuse patterns
New Hampshire	Coronary Heart Disease, Diabetes, asthma and End Stage Renal disease
New Mexico	Implemented Envision Program, Pediatric Diabetes, Asthma, ADHD
New York	Case management for high cost individuals. Work with other agencies to manage their care.
North Dakota	Initial discussions and data collection
Ohio	Enhanced Care Management program was initiated to provide case management services to the ABD population with specified disease process.
Oklahoma	Disease Management programs expanded: pediatric diabetes program, Behavioral Health RX, adult Native American diabetes; ER utilization project; Therapy management
Pennsylvania	Includes a disease management component to provide more comprehensive and systematic care to chronically ill MA recipients with asthma, diabetes, CAD, CHF and COPD.
South Carolina	Pilots have been implemented to address: Screening, diagnosis and treatment of chronic kidney disease; Patient self-management education for hypertension and diabetes; Assessing and improving the quality of behavioral health pharmacy prescribing practices.
Texas	Implemented new fee-for-service Disease Management program for asthma, COPD, CHF, CADE, Diabetes
Virginia	DMAS implemented a pilot project in June 2004 targeting Medicaid fee-for-service recipients diagnosed with congestive heart failure and/or coronary artery disease. The Department released a Request for Proposal (RFP) for an expanded program in May 2005
Washington	Added Chronic Obtrusive Pulmonary Disease and expanded Chronic Kidney Disease programs.
West Virginia	MDDM program started Diabetes 1st program - web based education modules started 6/1/05; Evidence based benchmarking
Wyoming	Total Health Management Plan implemented

Appendix A-14: Disease Management and Case Management Related Actions Taken in the 50 States and District of Columbia in FY 2006

State	Disease Management/Case Management Initiative
Alaska	Infant learning TCM
Arizona	Research and specify AHCCCS Program evidence-based disease management practice guidelines to be implemented by MCOs. Review literature, consult with experts and develop a plan to Pay For Performance based on quality, outcomes, etc. Review literature, consult with experts and develop a plan to consider identifying and utilizing Centers of Excellence. Begin reporting Performance Measure results by race/ethnicity to allow more effective interventions to be developed and implemented. Implement developmental assessment tools for at-risk infants/toddlers to improve outcomes/school readiness through appropriate use of EPSDT services. Evaluate most challenging Performance measures and develop/implement system-wide evidence-based intervention to improve rates in preventive health measures. Continue collaboration efforts for dual eligible populations that encourage coordination of care between AHCCCS Contractors and Medicare Advantage plans. Goal to keep AHCCS members in their homes longer with a consistent or improved quality of life.
Florida	Continuation of current disease states including: HIV/AIDS, hemophilia, diabetes, asthma, hypertension, and congestive heart failure
Georgia	Implemented for ABD population, high cost cases.
Idaho	Pay for Performance incentives for Disease Management based on quality measures
Indiana	Added Chronic Renal Disease
Iowa	Pilot for Asthma management
Kansas	Care Management project in one county involving persons previously in PCCM - target high utilizers/complex conditions
Kentucky	Awarded contract to develop DM program to implement 01/06
Louisiana	Diabetes Pharmaceutical Care Management through the University of Louisiana at Monroe-College of Pharmacy. Implementation of the Clinical Decision Support Tool, a computer based reminder system available to CommunityCARE (PCCM) providers who check patient Medicaid eligibility via the internet. Messages are generated at the time of eligibility verification which alert the provider as to tests/procedures that may need to be performed. Alerts are based on claims data and accepted practice guidelines
Maine	Disease Management of A Typical Anti-Psychotic drugs
Michigan	Case management for psychotropic drugs
Minnesota	Administrative funds newly available to begin disease management on a voluntary basis.
New Hampshire	RFP for comprehensive care management
New York	RFP responses received (not just for disease states)
North Dakota	Will be implementing a DM/CM program for high cost cases and specific disease states
Ohio	Will terminate the Enhanced Care Management program
Pennsylvania	Expanded use of specialized software to flag suspicious claims that warrant a review of medical records and additional audits of selected service providers

State	Disease Management/Case Management Initiative
South Dakota	Case management for high cost cases to be implemented in '06
Tennessee	TennCare is developing a disease management program. Disease classes has not been determined.
Texas	Expand Disease Management to other diseases (chronic kidney disease)
Vermont	Practice-based Care Management for chronic conditions
Virginia	DMAS plans to award a contract and implement an expanded Disease State Management program in December 2005 for four disease states: asthma, diabetes, coronary artery disease, and congestive heart failure
Washington	New contract for DM will emphasize high risk clients and ER reduction.
Wisconsin	Establishment of a care management program for frequent ER utilizers. Extending case management services for young adults with special needs transitioning to adulthood.

Appendix B: Profiles of Selected State Medicaid Policy Changes:

- **Missouri**
- **South Carolina**
- **Virginia**

Profile of Medicaid Policy Changes: Missouri

After a period of unprecedented revenue growth during the 1990's, a combination of state tax cuts, the national recession and other factors have led to recurring annual budget shortfalls in Missouri since FY 2001. When Governor Matt Blunt took office in January 2005 facing a $1.1 billion general fund budget deficit, previous state budgets had already made a series of "core reductions" to state programs of nearly $1.4 billion in addition to employing one-time withholdings and revenue accelerations and tapping one-time revenue sources. Governor Blunt's proposed FY 2006 budget called for additional steep spending cuts to balance the budget without raising taxes while at the same time providing some increases in education funding.

Almost half of the core reductions in earlier budgets had come from the Departments of Health & Senior Services, Mental Health and Social Services. Among other things, these cuts dramatically scaled back the Medicaid eligibility expansions for low-income adults that had been implemented in the late 1990's. The new Medicaid cuts proposed by Governor Blunt and adopted by the Missouri General Assembly further reduced eligibility, restricted benefits and imposed new co-pays.

Eligibility for low-income adults was cut from 75 percent of the poverty level to the 1996 AFDC standard, about 23 percent of the federal poverty level (the federal minimum level). The new cuts also reversed much of the income eligibility expansion for the aged and disabled population that had been adopted (on a phased-in basis) in 2001 before the severity of the state's fiscal crisis was apparent. In all, nearly 70,000 enrollees (out of a total of just over one million) are expected to lose coverage during FY 2006. In addition to eligibility cuts, a total of 340,000 adults will be subject to new copayment requirements and cuts in optional services. Benefit cuts include the elimination of coverage of most dental services (including dentures), eyeglasses, certain durable medical equipment, and certain other specialty and rehabilitation services. Reflecting Governor Blunt's commitment to maintain Medicaid services for pregnant women and children, no eligibility or benefit cuts were adopted in the FY 2006 budget for these populations. However, new graduated premium requirements were adopted for SCHIP eligible children with family incomes above 150 percent FPL.

The 2005 legislation that reduced Medicaid eligibility and benefits also included a sunset of the Medicaid program on June 30, 2008. The legislation further created a new legislative Medicaid Reform Commission charged with developing a plan for a new, fundamentally transformed Medicaid program to replace the current program. Members must make their recommendations by January 2006.

Medicaid cost containment actions for FY 2005 and FY 2006 are furthered described below:

Provider Rates:

- In FY 2005, provider rates increased for inpatient hospital (+$1 million allocated for uncompensated care), emergency room physicians (+$1 million), managed care organizations (+7% to meet actuarial soundness requirement), nursing homes (+6.2%), and in-home services (+$.06 per 15 minute unit). Pharmacy, outpatient hospital and dental rates were frozen.
- In FY 2006, rate increases for in-home services were funded ($0.16 per 15 minute unit). A previously planned increase for nursing homes was repealed resulting in no change in rates for FY 2006. All other provider rates were frozen.

Eligibility Changes:

- Effective July 2004:
  - The income eligibility level for low-income parents was reduced from 77% to 75% FPL (impacting an estimated 324 persons).
  - The income eligibility level for aged and disabled beneficiaries was increased from 90% to 100% FPL (impacting an estimated 25,406 persons.)
- Effective July 2005:
  - Extended transitional Medicaid coverage (for persons leaving TANF) was eliminated (impacting 1,560 persons).
  - The income eligibility level for low-income parents was reduced from 75% FPL to the 1996 AFDC income level (about 23% FPL) impacting 48,079 persons.
  - The General Relief program (a state-only program) was eliminated impacting 2,728 persons.
- Effective September 2005:
  - The income eligibility level for aged and disabled beneficiaries was reduced from 100% to 85% FPL (impacting 8,884 persons).
  - Coverage for employed disabled persons (the "Ticket to Work" program) was eliminated (impacting 8,336 persons).
  - New limits on annuity investment (for purposes of Medicaid eligibility) were added.
  - Institutionalized spouses were required to divert income to the community spouse before diverting assets.
  - New requirements for the enforcement of liens on all institutionalized individuals took affect.
  - New premium requirements were added for SCHIP eligibles with family incomes above 150% FPL (impacting approximately 40,944 persons).

Benefit/Service Changes:

- Effective July 2004, coverage for scalp hair prostheses added for children and dental services for children expanded to include services provided by dental hygienists.
- Effective October 2004, the limit on annual authorized nurse visits for aged and disabled beneficiaries liberalized from "up to 2 visits" to "a minimum of 2 visits."
- Effective in September 2005 for all adults (except pregnant women and blind beneficiaries), the following benefits were eliminated:
  - Dental (including dentures),

- Comprehensive day rehabilitation,
- Eyeglasses,
- Certain podiatric services,
- Certain durable medical equipment (including, but not limited to, wheel chair accessories and batteries, three wheeled scooters, decubitus care cushions and mattresses, patient lifts, trapeze, all body braces (orthotics), hospital beds and side rails, commodes, catheters, canes, crutches, walkers, parenteral and enteral nutrition, artificial larynx, and augmentative communication devices),
- Rehabilitation services (i.e. occupational, speech and physical therapy),
- Diabetes self management training, and
- Audiology, hearing aids and associated resting services.

- Effective September 2005, copayment requirements ranging from $.50 to $3.00 added for adults (except pregnant women and some other exceptions) for physician-related and outpatient hospital services.

Prescription Drug Controls and Limits:

Continued expansion of the PDL and supplemental rebate programs during both FY 2005 and FY 2006. Also, continued additions of fiscal and clinical edits to pharmacy claims payment system.

Other actions:

- Existing hospital provider assessment increased in FY 2005 and Medicaid managed care organization provider assessment adopted for FY 2006.
- Expanded disease management program to 3 more disease states in FY 2005.
- Expanded drug pager pilot project and implemented telemonitoring and telemedicine pilot projects in FY 2005.
- Added new staff to manage pharmacy tax, increase third party liability collection efforts and assist with bundling/unbundling project in FY 2005.
- Increased frequency of eligibility reinvestigation efforts for adults in FY 2006.

Profile of Medicaid Policy Changes: South Carolina

When Governor Mark Sanford first took office in 2003, two themes of Sanford's campaign were restructuring state government and lowering taxes. Between 2001 and 2003 the state diverted approximately $500 million from state dedicated trust and reserve funds to cover budget deficits. Faced with an unbalanced budget and limited prospects for tax cuts in the midst of the state's continuing fiscal crises, the Governor's legislative initiatives were difficult to implement.

Like many states, South Carolina's budget outlook is improving. Year-end General Fund balances increased from $46 million in 2003 (0.9 percent of expenditures) to $239 million in FY 2005 (4.6 percent of expenditures). However, Medicaid, as a share of state general fund expenditures has increased from 14 percent in 2000 to 19 percent in 2005 despite lower than average enrollment growth trends. Curtailed outreach and increasing scrutiny of eligibility renewals served to slow growth rates. South Carolina ranked 43rd in the nation for growth in monthly Medicaid enrollment in FY 2003 (1.6 percent versus a national average of 5.9 percent). In 2005 and 2006, the state anticipates flat enrollment.

South Carolina's recent proposal to dramatically reform its Medicaid program is generating much public debate. In October 2004 the Administration submitted a concept paper to CMS for a Medicaid demonstration waiver. Revised and resubmitted in June 2005, the state is drafting a formal request with hopes for approval before January 2006. The proposed waiver, called South Carolina Healthy Connections, would significantly alter the structure of the state's Medicaid program, with the intent to "bring market place principles to the Medicaid program" and enable the Medicaid beneficiary to "participate as a prudent buyer of health care services." Major provisions in the concept document include:

- Beneficiaries (other than dual eligibles) would be provided with a personal health account (PHA) to purchase a health plan selected by the beneficiary. Individual PHAs would be capped at an amount based on the average FFS expenditures for a person's eligibility category adjusted for age, gender, and to some extent health status. If the premium for the plan selected by the beneficiary is less than the PHA amount, the balance is placed in a stored value card (SVC) account, similar to a debit card, which the beneficiary can use to purchase other optional health care services not covered under the plan. The waiver proposes four health plan options with expectations of additional structures emerging with program implementation. Plan options provide varying benefit levels:
    - **Private Insurance**: beneficiaries may use their PHA to purchase plans from PPOs, MCOs or conventional insurance companies. Providers would determine benefit options, co-pays, and deductibles for plan options within parameters set by the state. Any balances remaining in the PHA could be used for direct purchase of services not covered by the plan and for payment of copayments.
    - **Medical Home Networks (MHN)**: beneficiaries would obtain services from a network of providers with a primary care physician serving as

gatekeeper. Premiums would be equivalent to the full amount in the PHA so no residual would be available to the beneficiary. The MHNs would operate in a shared-risk arrangement, with the state sharing in any losses or savings associated with actual health care costs.

  - **"Opt-Out" Options**: beneficiaries may use their PHA to pay the insurance premium for employer-sponsored group insurance.
  - **Self Directed Care:** a self directed care demonstration will be conducted in one geographic area of the state. The beneficiary would use their PHA to purchase a limited major medical benefit that includes inpatient hospital and related coverage. Remaining health services could be purchased directly by the beneficiary with any amounts remaining in the account after the limited plan premium is paid.

- Full coverage plans for children would require a service package consistent with the current program.
- Minimum coverage for adults would require mandatory Medicaid services to be covered, plus pharmacy and Durable Medical Equipment to the extent that coverage "meets the need of most of the users of each service."
- Copayments would apply to adults ($40 for inpatient hospital and $10 for outpatient surgery are proposed for major medical coverage).
- Retroactive enrollment under the program will be limited to the beginning of the month in which a complete application is received or the date of service of an emergency or pregnancy related service if application is made within 30 days.
- Children would be redefined as beneficiaries under the age of 19 (currently defined as under the age of 21).

In addition to the waiver, South Carolina has implemented or plans to implement policy changes noted below.

Provider Rates:
• In FY 2005 provider rates increased for Managed Care Organizations (6.4%); home and community-based waiver providers (3% for RN, 15% for LPN, and 5% for adult day health providers); Nursing Homes (3.74% effective 10/1/04); Non-emergency transportation (7.4% to 10.4%); DME (3%); and orthodontic services (9% up to 92% for some procedures). Also PCCM physicians were paid an enhanced rate for participation based on either 85% or 100% Medicare reimbursement (compared to Medicaid average of 75%). • In FY 2006 average physician reimbursement will increase to 80% of the Medicare fee schedule. MCO reimbursement will be actuarially updated and adjusted effective 1/1/06. Home delivered meals and case management for HCBW providers will increase 19% and 4% respectively. Rotary wing air transportation will increase 400%. Future adjustments to nursing home rates are to be determined by 10/1/05.
Eligibility Changes:
• In FY 2006 within the state's concept paper for a demonstration waiver one component would end eligibility for children's benefits at age19 instead of the

current age of 21. 19 to 21 year olds would instead be eligible for adult benefits, which do not include early periodic screening and diagnostic testing (EPSDT) services available to children. Approximately 25,000 beneficiaries would be affected.

- The state plans to submit a SPA to expand the Breast and Cervical Cancer program to all adult women ages 19 to 65 (currently eligibility is limited to ages 47 to 65), effective Oct. 1, 2005.

Benefit/Service Changes:

- In FY 2005 the state added pediatric codes for DME, changed certain products to rental only and reduced the number of rental months allowed. They also changed guidelines for power chairs.
- Effective Feb. 2005 the state implemented an exception to the ambulatory care visit limitation policy to allow more than 12 visits in cases of acute medical need.
- The waiver concept paper proposed transitioning from a defined benefits program to a defined contribution program, with various benefit level options.

Prescription Drug Controls and Limits:

In FY 2005 the state completed review of final drug classes included on the PDL. Prior authorization requirements for growth hormone products were implemented. The state continued to expand its supplemental rebate collections. FY 2006 will be the first year for full implementation of both the PDL and supplemental rebate collections.

Other Cost Containment and Policy Changes:

- In order to comply with Federal requirements under the MMA, the SilverCard pharmacy waiver will end in January, 2006, affecting 57,000 Silver Card enrollees. The state expects to convert this to a state pharmacy assistance program to serve the affected population.
- Implemented Disease Management pilots for chronic kidney disease, hypertension, and diabetes. The state is also assessing quality of behavioral health pharmacy prescribing practices.
- Expanded MCO and PCCM service areas and implemented an enrollment lock-in requirement.

Profile of Medicaid Policy Changes: Virginia

Virginia's 2004 legislative session was controversial and unusually long (by Virginia standards). As the session began, Democrat Governor Mark Warner and a majority of the State Senate (controlled by Republicans) were in favor of raising revenue and making new investments in core state services (i.e., education, public safety and health care) while the House Republican majority opposed any tax increase. After 115 days of heated debate, the General Assembly passed a two-year general fund budget totaling over $27 billion that included a record tax increase of $1.4 billion – $400 million more in net new revenues than Governor Warner had originally proposed.

FY 2004 ended with an unexpected $323.8 million general fund surplus, primarily due to a surge in state revenue growth in the final fiscal quarter. When the 2005 General Assembly met to consider amendments to the biennial budget, they received more good news – the state was projected to take in $1.2 billion more for the FY 2005-2006 biennium than was anticipated when the budget was originally crafted during the 2004 session. As a result, the 2005 legislative session was much less contentious. Amendments to the biennial budget increased resources for higher education and transportation and also dedicated new resources for cleaning up the Chesapeake Bay. Continued strong economic growth coupled with the new revenue generated by the 2004 tax increase resulted in revenue growth of nearly 15 percent for FY 2005 and a general fund surplus of $544 million on June 30, 2005. Under state law, much of that surplus was transferred to the state's "rainy day" reserve fund increasing that fund to over $1.1 billion near its constitutional limit.

While the majority of the new funds generated by the 2004 tax increase were used for public education, some of the new revenue made it possible for the Medicaid program to improve payment rates in FYs 2005 and 2006 for a number of provider groups including hospitals, nursing homes, selected physician specialties and dentists. At the same time, the Medicaid program continued to phase-in its PDL and supplemental rebate programs, implemented additional pharmacy cost control measures and enhanced fraud and abuse controls. In FY 2006, the state will also expand coverage for pregnant women from 133 percent to 150 percent FPL (using SCHIP funds and a HIFA waiver) and will add two new home and community-based services waivers that, together, will provide services to 500 individuals. Other Medicaid actions taken in FYs 2005 and 2006 are described below.

Provider Rates:

- In FY 2005, provider rates increased for inpatient hospital (+7.7%), OB/GYN services (+34%), emergency room physicians (+2.0%), managed care organizations (+9.12%), nursing homes (+9.0%), home health (+3.0%) and community-based MR/DD services (+.35%). Pharmacy dispensing fees for generic drugs were increased from $3.75 to $4.00. Outpatient hospital, dental rates and non-MR/DD in-home service rates were frozen.
- In FY 2006, rates were increased for inpatient hospital (+8.67%), managed care organizations (+3.68%), nursing homes (+6.0%), home health (+1.6%) and community-based MR/DD services (+4.63%).
- Effective July 2005, rates for in-home personal care services increased by 5.0% and will increase by an additional 7.0% effective May 2006.
- Effective July 2005, rates for dental services increased by 28% overall (a 23% across the

board increase with additional increases for selected procedures) and will increase by an additional 2.0% effective May 2006.

- Effective May 2006, overall, rates for physician services will decrease by 1.6% although increases will be provided for selected groups: OB/GYN services (+2.5%), emergency room physicians (+3.0%), pediatric physician services (+5.0%), primary care physician services (+5.0%).
- Outpatient hospital rates remain unchanged for FY 2006.

Eligibility Changes:

Effective August 2005, the income eligibility level for pregnant women will increase from 133% FPL to 150% FPL (impacting an estimated 400 persons).

Prescription Drug Controls and Limits:

- For FY 2005:
  - New maximum allowable cost program implemented in December 2004.
  - Phase III of PDL and supplemental rebate programs implemented in July 2004. Changes resulting from annual review process made to Phase I drug classes January 2005
  - Two polypharmacy programs ("Threshold" and "Coordination of Care") implemented providing for a utilization review of recipients with greater than 9 prescriptions in a 30-day period.
  - Behavioral health pharmacy management program implemented in April 2005.
- In FY 2006, changes to PDL and supplemental rebate programs resulting from annual review process will be made to Phase I, II and III drug classes in January 2005. Will also continue to consider new drug classes for addition to the PDL.

Other Actions:

- In FY 2005, implemented an "ex parte" enrollment renewal process and also implemented a one-page renewal form for enrollees whose ongoing eligibility cannot be determined through the "ex parte" process (i.e., those individuals whose information is not readily available to the agency, who must verify resources or for those who receive long-term care services).
- In FY 2005, increased fraud and abuse controls by:
  - Enhancing Client Server Surveillance and Utilization Review (CS SURS) system to improve data-mining capability;
  - Cross-training Medicaid staff and the Medicaid Fraud Control Unit staff for improved fraud identification;
  - Adding a lead investigator to support recipient fraud/abuse efforts;
  - Enhancing Medicaid Recipient Handbook, enrollment letters, and brochures to provide more detailed information about Medicaid fraud and related penalties; Implementing long-acting narcotics step therapy protocols.
- In FY 2006, will implement two new home and community-based services waivers: a day support waiver for persons with mental retardation (300 slots) and an assisted living waiver for persons with Alzheimer's Disease (200 slots).
- In FY 2006, will expand the number of counties subject to mandatory risk-based managed care (with a corresponding phase-out of the PCCM managed care option).
- In December 2005, will implement a statewide, expanded Disease State Management program for four disease states: asthma, diabetes, coronary artery disease, and congestive heart failure.

Appendix C: Survey Instrument

Medicaid Budget Survey
For Fiscal Years 2004, 2005 and 2006

State of: _____ Name: _____ Date:_____
Phone: _____ Email: _____

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 will be sent to you as soon as it is available. If you have any questions, please call Vern Smith at 517-318-4819. When you have completed the survey, please send it via email if possible (Vsmith@healthmanagement.com) or to:

Vernon K. Smith, Ph.D.
Health Management Associates
120 N. Washington Sq., Suite 705
Lansing, MI 48933
FAX: 517-482-0920

Section I. Medicaid Expenditure Growth: State Fiscal Years 2004, 2005 and 2006

A. For each year shown below, please indicate the annual percentage change in total Medicaid expenditures (excluding administration), and the annual percentage change for each source of funds. **In calculating growth rates, please reflect the enhanced FMAP through June 2004.**

	Percent Change for Each Source of Funds			
	State Funds	Local or Other Funds	Federal Funds	Total: All Fund Sources
FY 2004 1. Percentage change: FY 2004 Medicaid Expenditures over FY 2003 Expenditures	%	%	%	%
FY 2005 2. Percentage Change: FY 2005 Medicaid Expenditures over FY 2004 Expenditures	%	%	%	%
FY 2006 3. Percentage Change: FY 2006 Medicaid Appropriations over FY 2005 Expenditures	%	%	%	%

Comments: _____

B. Was FY 2005 spending greater than the *original* appropriation? Yes ____ No _____
If "Yes," how was the shortfall covered? _____

C. What are your broad impressions of the spending and enrollment trends that your state is now experiencing? Are pressures on your Medicaid program (*check one*):
____ Growing, _____ Remaining constant, or _____ Subsiding?

Comments:_____

Section II. Medicaid in State Fiscal Year 2005

1. **Factors Driving Expenditure Changes:** What would you consider to have been *the most significant factors* contributing to the increase/decrease in your Medicaid spending in FY 2005?

a. Most significant factor? _____

b. Second most significant factor? _____

c. Other significant factors? _____

2. **Medicaid Enrollment Changes in FY 2005**:

a. Overall % enrollment growth/decline (+/–), FY 2005 over FY 2004: ____%

b. What *key factors* contributed to increases/decreases in enrollment (e.g., eligibility increases or decreases, changes in the application or redetermination process, economy, etc.)?

i. Most significant factor? _____

ii. Second most significant factor? _____

iii. Other significant factors? _____

3. **Provider Payment Rates in FY 2005**: For each provider type, please indicate any rate increases (including COLA or inflationary increases) or decreases *implemented* in FY 2005. (Please indicate % increase, % decrease, or "X" for no change in appropriate column.)

Provider Type	+ % Increase	-% Decrease	X=No Change
a. Pharmacy			
b. Inpatient hospital			
c. Outpatient hospital			
d. Doctors			
e. Dentists			
f. Managed care organizations			
g. Nursing homes			
h. Home health			
i. Home and community-based waiver providers			
j. Others:			

4. **Provider Taxes/Assessments**: Please list any provider taxes and indicate for each if it was new in FY 2005, or if changes were made to existing provider taxes in FY 2005.

Provider Group Subject to Tax	Description	New in FY '05? (Yes or No)	Discont'd in FY '05? (Yes or No)	Unchanged, Increased or Decreased in FY'05? (briefly describe)
a.				
b.				
c.				
d.				

5. Changes in Medicaid Eligibility Standards in FY 2005: Please describe any expansion, reduction, restriction, restoration or other change in ***eligibility standards*** (e.g., income standards, asset tests, retroactivity, treatment of asset transfer rules or income) *implemented* during FY 2005.

Eligibility Category	Nature of Eligibility Change: Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents			
c. Adults or expansion groups			
d. Aged/Disabled (including duals)			
e. Other (e.g., medically needy)			

6. Changes in Application/ Renewal Process in FY 2005:

a. Did your state make any changes to the ***application or renewal process*** in FY 2005 (e.g., changes in verification or face to face interview requirements, application, renewal process, etc.)? Yes ____ No ____

b. If "Yes," please describe those changes, and the estimated number of people affected:

_____

_____

7. Changes in Benefits or Services in FY 2005 Please describe below any expansion, reduction, restriction, restoration or other change in benefits or services *implemented* during FY 2005.

Populations Affected	Nature of Benefit or Service Change, Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents			
c. Adults or expansion groups			
d. Aged/Disabled (including duals)			
e. Other (e.g., medically needy)			

8. Changes in Copayments in FY 2005: Please describe any beneficiary copayment that was *newly implemented, increased* or *decreased* in FY 2005:

Populations Affected	New, Higher or Lower Beneficiary Copays (or other cost sharing requirements) by Service, e.g., for prescription drugs, dental, etc.
a. Parents	
b. Adults or expansion groups	

c. Aged/Disabled (including duals)	
d. Other (e.g., medically needy)	

9. Prescription Drug Program Changes in FY 2005: What *new a*ctions were *implemented* during FY 2005 to slow the growth in Medicaid expenditures for prescription drugs *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2005
a. Change in dispensing fees	
b. Change in ingredient cost (i.e., AWP – X%, ASP, *or* WAC + X%)	
c. Changes to state MAC process (frequency of updates, lower rates, contract admin.)	
d. More/fewer drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	
g. Limits on the number of Rx per month imposed or lifted	
h. Requirements to use generics	
i. Mail order pharmacy contract	
j. Multi-state purchasing coalition	
k. Other pharmacy policy change	

10. Long-term Care Changes: What program or policy actions were *implemented* during FY 2005, including those taken to slow the growth in long-term care expenditures *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Description of Actions Implemented in FY 2005
a. Nursing home changes: (excluding rate/tax changes listed in Questions 3 and 4.)	
b. Home and Community Based Services changes (e.g., a change in waiver services, add or drop a waiver, etc.)	
c. Long-term care managed care initiative	
d. Other LTC (including diversion and nursing home transition programs)?	

11. Other Cost Containment Measures or Policy Changes: What other program or policy actions were *implemented* during FY 2005 to slow the growth in Medicaid expenditures *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Description of Actions Implemented in FY 2005
a. Managed Care: i. Expansion/contraction of PCCM or MCO service areas ii. Enrollment of new eligibility groups (please specify) iii. Change from voluntary to mandatory enrollment (please specify by eligibility category)	
b. Disease Management or Case Management (specify disease states or approaches)	
c. Enhanced Fraud and Abuse Controls	
d. Program Administration (e.g. staffing reductions, changes or freezes)	
e. Other actions:	

Comments: _____

_____

_____

Section III: Medicaid in State Fiscal Year 2006

12. Legislative Action: Has your legislature enacted the Medicaid budget for FY 2006? Yes__ No __

13. Factors Driving Expenditure Changes: What factors do you expect to be the principal drivers of Medicaid expenditure changes in FY 2006?

a. Most significant factor? _____
b. Second most significant factor? _____
c. Other significant factors? _____

14. Enrollment Changes in FY 2006:

a. Overall % enrollment growth/decline (+/–), projected for FY 2006 over FY 2005: _____%

b. What *key factors* contributed to increases/decreases in enrollment (e.g., eligibility increases or decreases, changes in the application or redetermination process, economy, etc.)?

i. Most significant factor? _____
ii. Second most significant factor? _____
iii. Other significant factors? _____

15. Provider Payment Rates in FY 2006: For each provider type, please indicate any rate increases (including COLA or inflationary increases) or decreases to be implemented in FY 2006. (Please indicate % increase, % decrease or "X" for no change in appropriate column.)

Provider Type	+% Increase	-% Decrease	X=No Change
a. Pharmacy			
b. Inpatient hospital			
c. Outpatient hospital			
d. Doctors			
e. Dentists			
f. Managed care organizations			
g. Nursing homes			
h. Home health providers			
i. Home and community-based waiver providers			
j. Others:			

16. Provider Taxes/Assessments in FY 2006:
Please list any provider taxes in place in FY 2006, and indicate for each if it is new for FY 2006, or if changes were made for FY 2006.

Provider Group Subject to Tax	Description	New in FY '06? (Yes or No)	Discont'd in FY '06? (Yes or No)	Unchanged, Increased or Decreased in FY'06? (briefly describe)
a.				
b.				
c.				
d.				

17. Changes in Eligibility Standards FY 2006: Please describe below any expansion, reduction, restriction, restoration or other change in ***eligibility standards*** (e.g., income standards, asset tests, retroactivity, treatment of asset transfer rules or income) to be implemented during FY 2006.

Eligibility Category	Nature of Eligibility Change: Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents			
c. Adults or expansion groups			
d. Aged/Disabled (including duals)			
e. Other (e.g., medically needy)			

18. Changes in Application/ Renewal Process in FY 2006:

a. Is your state making any changes to the ***application or renewal process*** in FY 2006 (e.g., changes in verification or face to face interview requirements, applications, renewal process, etc.)? Yes ____ No ____

b. If "Yes," please briefly describe those changes, and the estimated number of people affected:

_____

_____

19. Changes in Covered Benefits in FY 2006: Please describe any expansion, elimination, restriction, restoration or other change in *benefits or services* to be implemented in FY 2006.

Populations Affected	Nature of Benefit or Service Change, Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People Affected
a. Children			
b. Parents			
c. Adults or expansion groups			
d. Aged/Disabled (including duals)			
e. Other (e.g., medically needy)			

20. Changes in Copayments in FY 2006: Please describe any beneficiary copayment to be *newly implemented*, *increased* or *decreased* in FY 2006:

Populations Affected	New, Higher or Lower Beneficiary Copays (or other cost sharing requirements) by Service, e.g., for prescription drugs, dental, etc.
a. Parents	
b. Adults or expansion groups	
c. Aged/Disabled (including duals)	
d. Other (e.g., medically needy)	

21. Prescription Drug Program Changes in FY 2006: What program or policy actions are to be adopted for FY 2006, including those to slow the growth in Medicaid expenditures for prescription drugs *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2006
a. Change in dispensing fees	
b. Change in ingredient cost (i.e., AWP – X% *or* WAC + X%)	
c. New/lower state MAC rates	
d. More/fewer drugs subject to prior authorization	
e. Preferred drug list	
f. Supplemental rebates	

g. Limits on the number of Rx per month imposed or lifted	
h. Requirements to use generics	
i. Mail order pharmacy contract	
j. Multi-state purchasing coalition	
k. Other pharmacy changes	

22. Long-term Care Changes in FY 2006: What program or policy actions will be *implemented* during FY 2006, including those to slow the growth in long-term care expenditures *or* to restore previous cuts, or other policy changes? Please briefly describe those that apply.

Program or Policy Actions	Description of Actions Implemented in FY 2006
a. Nursing home changes: (excluding rate/tax changes listed in Questions 15 and 16.)	
b. Home and Community Based Services changes (e.g., change in waiver services, add or drop a waiver, etc.)	
c. Long-term care managed care changes	
d. Other LTC initiatives (such as diversion and nursing home transition programs):	

23. Other Cost Containment Measures or Policy Changes: What other actions are to be used for FY 2006 to control the growth in Medicaid expenditures or to restore previous cuts? Please describe those that apply.

Program or Policy Actions	Description of Actions Implemented in FY 2006
a. Managed Care: i. Expansion/contraction of PCCM or MCO service areas ii. Enrollment of new eligibility groups (please specify) iii. Change from voluntary to mandatory enrollment (please specify by eligibility category)	
b. Disease Management or Case Management (specify disease states or approaches)	
c. Enhanced Fraud and Abuse Controls	
d. Program Administration (e.g. staffing reductions, changes or freezes)	
e. Other actions:	

24. Waivers:

a. Is your state currently planning to implement a new Section 1115 comprehensive Medicaid reform waiver or waiver amendment in FY 2006? Yes _____ No _____

b. If so,

i. What process stage is it in?

A. _____ Governor's proposal
B. _____ Developing concept paper
C. _____ Completed concept paper
D. _____ Developing waiver application
E. _____ Application submitted to CMS
F. _____ Other _____

ii. Is the waiver or waiver amendment designed to have any of the following effects? (*Check all that apply*.)

A. _____ Replace special financing revenue
B. _____ Limit or reduce program costs
C. _____ Reduce the number of uninsured in the state
D. _____ Increase reliance on private coverage
E. _____ Rebalance the long-term care delivery system
F. _____ Encourage consumer directed care
G. _____ Improve quality of care
H. _____ Increase administrative efficiencies
I. _____ Other _____

iii. Please briefly describe or list any key features of the waiver or waiver amendment. If the changes were already described elsewhere in this survey (for example, if the waiver or waiver amendment includes an eligibility expansion that has already been noted under questions 5 or 17 above), simply indicate here that it was already indicated.

_____
_____
_____

Comments: _____
_____
_____

25. Special Financing:

a. Has the enhanced federal scrutiny of special financing programs in Medicaid (e.g., the use of provider taxes, IGTs and Certified Public Expenditures to fund DSH and upper payment limit reimbursement systems) impacted the Medicaid program in your state in FY 2005 or is an impact expected in FY 2006? Yes _____ No _____

b. If so, how? (*Check all that apply*.)

i. Unrelated State Plan Amendments, waivers, waiver amendments, or waiver renewals have been

A. ____ rejected by CMS
B. ____ delayed by CMS
C. ____ more difficult to obtain approval for from CMS

ii. ____ The State was forced to abandon a previously approved special financing arrangement

iii. _____ The State received a disallowance of FMAP relating to a previously approved special financing arrangement

iv. _____ Other _____

_____

_____

26. Medicare Prescription Drug Benefit:

a. **Clawback.**

i. Has your state estimated its clawback payment for FY 2006? Yes ___ No ___

ii. If "yes," does your state expect its clawback obligation in FY 2006 to:

A. _____ Result in increased costs to the state

B. _____ Result in cost savings to the state

C. _____ Allow the state to break even

iii. If your state expects its clawback obligations in FY 2006 to result in increased costs to the state, does your state expect cost savings in future years (as the clawback percentage phases down)? Yes____ No ____

Comments:_____

_____

_____

b. **Wrap-around Coverage.**

i. Does your state plan to provide Medicaid "wrap-around" coverage for non-covered Part D drugs (e.g., over-the-counter drugs, benzodiazepines, etc.)? Yes____ No _____Not Known _____

ii. If "yes," what is the estimated budget impact of this decision?_____

_____

c. **Low-income Subsidy Administration.**

i. Does your FY 2006 budget include funds for administering the low-income prescription drug subsidy? Yes_____ No_____

ii. If "yes", how much has been budgeted and for what activities?

_____

_____

d. **Significant Issues.** What are the most significant issues that you expect to deal with relating to the Medicare Part D benefit that goes into effect on January 1, 2006? (This could include impacts on the remaining prescription drug spending for Medicaid enrollees – e.g., impacts on supplemental rebates, etc.)

_____

_____

_____

27. Potential FY 2006 Medicaid Budget Shortfall: When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2006 for Medicaid, how likely would you say it is that your state will experience a Medicaid budget shortfall in FY 2006? (Indicate with an **X or circle**.)

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

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

_____

_____

This completes the survey. Thank you very much.

Please send the completed survey by email or mail to the address on page one, or fax to 517-482-0920.

Please feel free to call 517-318-4819 if you have any questions.

Appendix D: 2005 Legislative Regular Session Calendar

State	Convene	Adjourn
Alabama	Feb 1	May 16
Alaska	Jan 10	May 10
Arizona	Jan 10	May 13
Arkansas	Jan 10	May 14
California	Dec 6, 2004	Sept 9
Colorado	Jan 12	May 9
Connecticut	Jan 5	June 8
Delaware	Jan 11	July 1
Florida	Mar 8	May 6
Georgia	Jan 10	March 31
Hawaii	Jan 19	May 5
Idaho	Jan 10	April 6
Illinois	Jan 12	*
Indiana	Jan 10**	April 29
Iowa	Jan 10	May 20
Kansas	Jan 10	May 20
Kentucky	Jan 4	Mar 21
Louisiana	April 25	June 23
Maine	Dec 1, 2004	March 30
Maryland	Jan 12	April 11
Massachusetts	Jan 5	*
Michigan	Jan 12	*
Minnesota	Jan 4	May 23
Mississippi	Jan 4	April 6
Missouri	Jan 5	May 26
Montana	Jan 3	April 21
Nebraska	Jan 5	June 3
Nevada	Feb 7	June 7

State	Convene	Adjourn
New Hampshire	Jan 5	July 1
New Jersey	Jan 11	*
New Mexico	Jan 18	Mar 19
New York	Jan 5	*
North Carolina	Jan 26	August
North Dakota	Jan 4	April 23
Ohio	Jan 3	*
Oklahoma	Feb 7	May 27
Oregon	Jan 10	August
Pennsylvania	Jan 4	*
Rhode Island	Jan 4	July 1
South Carolina	Jan 11	June 2
South Dakota	Jan 11	March 22
Tennessee	Jan 11	May 28
Texas	Jan 11	May 30
Utah	Jan 17	Mar 2
Vermont	Jan 5	June 4
Virginia	Jan 12	Feb 27
Washington	Jan 10	April 24
West Virginia	Feb 9	April 9
Wisconsin	Jan 12	*
Wyoming	Jan 11	Mar 3
American Samoa	Jan 10	
District of Columbia	Jan 2	*
Guam	Jan 10	*
Puerto Rico	Jan 10	June 30
Virgin Islands	Jan 10	*

* = Legislature meets throughout the year
SOURCE: National Conference of State Legislatures
http://www.ncsl.org/programs/legman/about/sess2005.htm

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