kaiser commission on medicaid and the uninsured

Low Medicaid Spending Growth Amid Rebounding State Revenues

Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007

Prepared by
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Health Management Associates
and
Robin Rudowitz, Molly O'Malley and Caryn Marks
Kaiser Commission on Medicaid and the Uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

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kaiser commission medicaid and the uninsured

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.

James R. Tallon
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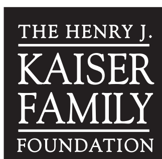

October 2006

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Executive Summary

FY 2006 represented an important turning point for Medicaid as spending growth slowed and state revenues continued to recover. Medicaid, administered and financed jointly by states and the federal government, provides health coverage and long-term care assistance to over 41 million people in low-income families and nearly 14 million elderly people and persons with disabilities.[1] Following a period of severe fiscal stress from 2001 through 2004, where state revenues plummeted and Medicaid spending and enrollment growth peaked, revenue growth started to rebound in FY 2005. In FY 2006 state revenue growth exceeded Medicaid cost growth for the first time since the late 1990's.

An improved fiscal picture eased the imperative to implement major cost containment measures and allowed for some program investments. However, states continue to approach Medicaid policy changes from very different fiscal and policy perspectives. For example, some states like Michigan are experiencing actual drops in state revenue, while states like Idaho are experiencing strong revenue growth. Some states like Tennessee and Missouri enacted major eligibility restrictions, whereas Massachusetts and Illinois are moving forward with major health care expansions building on a strong base of Medicaid coverage.

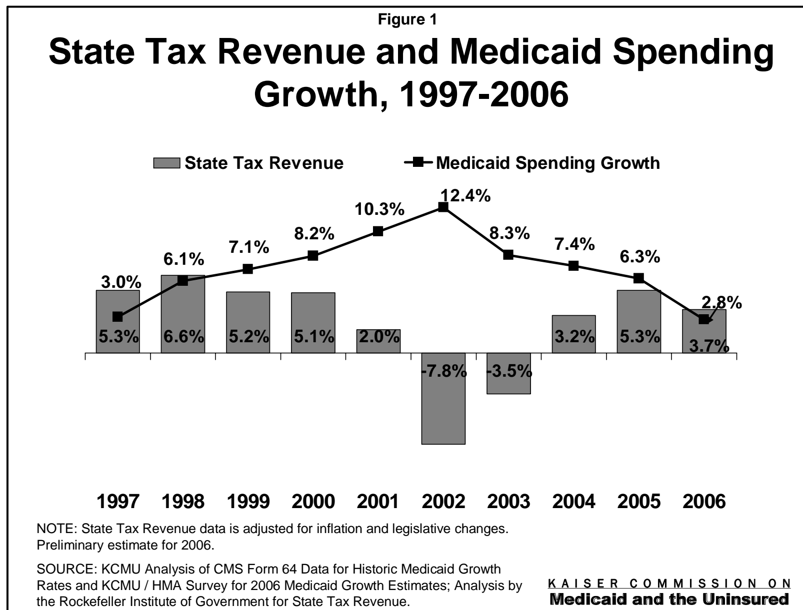
In addition to changes in state fiscal situations, two major pieces of federal legislation had significant implications for Medicaid. First, the passage of the Medicare Modernization Act resulted in the transition of over 6 million low-income seniors and individuals with disabilities (duals) from Medicaid drug coverage to newly created Medicare Part D plans on January 1, 2006. Second, the President signed the Deficit Reduction Act (DRA) of 2005 in February of 2006. This legislation included a number of new requirements for state Medicaid programs (related to new documentation requirements for citizens applying for Medicaid and new asset transfer rules) as well as new flexibility for states to offer alternative Medicaid benefit packages and to impose cost sharing.

This report presents findings from a survey (of Medicaid officials from all 50 states and the District of Columbia) about changes in Medicaid spending, enrollment and policies for state fiscal years 2006 and 2007, conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. Key survey findings include the following:

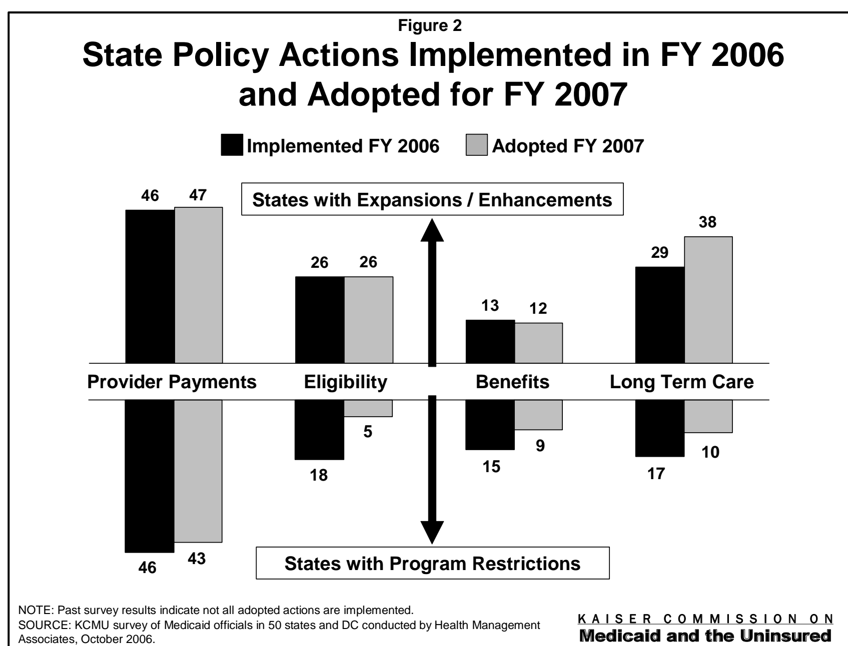
Medicaid spending slowed to near record lows as state revenues continued to rebound. Across all states, total Medicaid spending increased in state fiscal year 2006 by just 2.8 percent on average – the lowest rate of growth in Medicaid since 1996 growth of 2.7 percent. FY 2006 also marked the first year since 1998 that state revenues grew at a rate faster than total Medicaid spending. A dramatic slowing in program enrollment growth to just 1.6 percent, the lowest rate since 1999, was a major factor contributing to lower spending growth. Slower enrollment was mostly attributable to the improving economy resulting in fewer individuals becoming eligible for the program. The shift of prescription drug spending for the dual eligibles from Medicaid to Medicare was another factor contributing to declining Medicaid spending growth. States are now obligated to finance a portion of this Medicare coverage through a payment referred to as the "clawback" to the federal government. Most states continue to count the clawback payments as state Medicaid spending, but since these payments are not matched with federal funds, they are not included in calculations of

[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS data.

federal Medicaid spending. Without accounting for state clawback payments, total Medicaid spending would have been even lower (about 1.7 percent) (Figure 1).



States continue to focus on measures that control costs, but improving fiscal conditions allowed for more program investments than in previous years. Throughout the economic downturn, the most prevalent cost containment action taken by states was to freeze or reduce provider payment rates. While many states continued to freeze provider rates in efforts to control costs, more states implemented in FY 2006, or plan to implement in FY 2007, provider rate increases. As economic conditions improved, states felt pressure to increase rates that had been cut or frozen over the last several years. Some states continue to implement mostly targeted benefit cuts, while the number of states moving forward with benefit restorations has increased relative to previous years. For FY 2006, several states including Tennessee, Missouri, Florida and Mississippi implemented policies that significantly restricted Medicaid enrollment. However, looking forward to FY 2007, only five states have plans to restrict eligibility, while 26 states have plans to restore cuts from previous years, expand to new populations, or make positive changes to Medicaid application and enrollment procedures (Figure 2).



Many states expect the new citizen documentation requirements included in the DRA to increase administrative costs and to negatively affect enrollment. One of the mandatory provisions in the DRA effective July 1, 2006 requires all individuals applying for or renewing their Medicaid coverage to provide documentation of their identity and citizenship status. This is not a change in Medicaid citizenship requirements, but a major change from current state enrollment practices where 47 states allow applicants to self-declare citizenship status. Over half of the Medicaid directors expected these requirements to have a negative impact on Medicaid enrollment while others remained uncertain. All but three states (three of the four states that already had documentation requirements in place) indicated that the new requirements would increase state administrative costs.

Few states planned to use new flexibility allowed under the DRA to change benefits or impose cost sharing in FY 2007, but others are considering these options. Three states, Kentucky, West Virginia and Idaho had plans approved to change benefits. Kentucky also used new cost sharing options. Kentucky and Rhode Island plan to make copayments enforceable, using another DRA option that would allow providers and pharmacists to deny services if beneficiaries cannot pay copayment amounts. State officials indicated that they will continue to evaluate these options, which suggests there may be more activity in the future. The DRA included changes that some states had been pursuing through the use of Medicaid 1115 Waiver authority. After the passage of the DRA, state plans to implement 1115 Waivers slowed from FY 2005. A few states like Florida and Vermont are still moving ahead with new Medicaid reform plans using waiver authority, but nine states indicated that they were re-thinking their plans because of the new DRA authority.

A growing number of states are moving forward to expand community based long-term care services, with nearly three-quarters planning to implement expansions in FY 2007. Increasingly, states are focusing their efforts on significant changes to their Medicaid long-term care delivery systems, and the clear focus is on enhancing home and community-based programs. In FY 2006, over half of the states enhanced home and community based services (HCBS), usually by adopting new or expanding existing waivers or adding services. In FY 2007, a total of 38 states plan to

adopt expansions of HCBS, including 13 states that plan to implement or expand a PACE program. The DRA includes new provisions that give states flexibility in delivering long-term care services in addition to new mandatory changes to the asset transfers rules that affect qualifying for Medicaid nursing home services. Most states expected the fiscal impact of the asset transfer provisions to be insignificant, but reported that these provisions could have negative implications for beneficiaries seeking nursing home care. Almost half of all states reported plans to implement a long-term care partnership policy to encourage the purchase of private long-term care insurance (22 states), apply for a "Money Follows the Person" demonstration grant to increase the use of community versus institutional services (18 states), or take advantage of the cash and counseling option that allows for self-direction of personal assistance services (16 states).

States were more focused on expanding disease management, quality initiatives and program integrity efforts, which are more likely to have longer-term program benefits rather than immediate savings. States continue to develop and expand their disease management initiatives focusing on high cost cases, recognizing data that shows that a small fraction of enrollees (4 percent) account for about half of all Medicaid spending. Similar to efforts in Medicare and the private sector, Medicaid programs have adopted policies designed to improve quality of health care. By FY 2007, more than two-thirds of all states will have quality initiatives in place, most classified as "pay for performance." Many of these initiatives use bonuses or penalties for performance that meets or falls short of specific quality criteria or there are automatic managed care enrollment formulas that reward higher performing plans with more enrollees. Seventeen states in FY 2006 and 21 in FY 2007 adopted policies to improve program integrity through the use of new technologies, data mining, additional staff, and better procedures to improve coordination across agencies. New program integrity efforts will emerge as CMS implements plans for the Medicaid Integrity Program that was established in the DRA. States also continue to take actions to expand their use of managed care by expanding service areas, adding eligibility groups, such as the elderly and persons with disabilities, and making enrollment into managed care mandatory.

While states and beneficiaries have overcome some of the early Medicare Part D implementation issues, state officials identified several on-going concerns. On January 1, 2006, Medicaid drug coverage ended for over six million duals (those eligible for both Medicare and Medicaid) whose coverage was transferred to new Medicare "Part D" prescription drug plans. Duals faced numerous problems accessing needed drugs during this transition and many states stepped in to provide temporary coverage programs.[2] CMS established a Medicare demonstration program to repay states for the costs of their temporary programs; however, at the time of the survey, many states had not received any reimbursement from this program. States expressed immediate and on-going concerns related to Part D including the impact on duals, (such as access to non-formulary drugs and the impact of potentially new copayment requirements), the clawback (with officials in 15 states stating that the FY 2007 clawback obligation is more costly to their states compared to the amount they would have spent in the absence of Part D), other fiscal issues (including the impact on supplemental rebates), administrative issues (especially ongoing data exchange issues), and FY 2007 contracting concerns.

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[2] *See* Vernon Smith, Kathleen Gifford, Sandy Kramer and Linda Elam, *The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation, Results from a 50-State Snapshot*, Kaiser Commission on Medicaid and the Uninsured, February 2006, Publication No. 7467.

While the direction of Medicaid may be determined by the outcome of state gubernatorial elections in many states, on-going fiscal pressures, as well as the changing balance in the federal-state partnership for Medicaid, will continue to be major factors affecting the program in the future. Despite dramatic slowing of Medicaid spending and enrollment growth, pressure to control Medicaid spending growth remains strong. Requirements to balance state budgets each year, rising health care costs, increasing numbers of Americans without health insurance and the aging population (contributing to more elderly and more persons with disabilities) all continue to impose demands on Medicaid. States may be facing additional strains around Medicaid financing as formula driven changes continue to push down federal match rates and as the Center for Medicare and Medicaid Services (CMS) continues to scrutinize state financing practices regarding what expenditures qualify for federal matching dollars. Many states expressed frustration that the "rules of the road" around these fiscal issues are murky, changing, and inconsistently applied, which makes budgeting for Medicaid extremely difficult. Even with these challenges, a rebounding economy has made it possible to move beyond measures to produce immediate cost savings and focus more on improving the quality and integrity of the program. Looking forward, some states plan to continue to evaluate new options made available in the DRA and a number of states look to expand health coverage to new populations. Major reform efforts in states like Massachusetts or Illinois are building on a strong Medicaid base of coverage and financing.

Methodology

For the sixth consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. The survey also asked Medicaid officials about the impact of Medicare Part D and the DRA on their programs. The KCMU/HMA survey on which this report is based was conducted in July and August 2006 to document the policy actions states had implemented in the previous year, state FY 2006, and new policy initiatives that they had adopted, or expected to implement, in state FY 2007, which for most states had begun on July 1, 2006. 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.

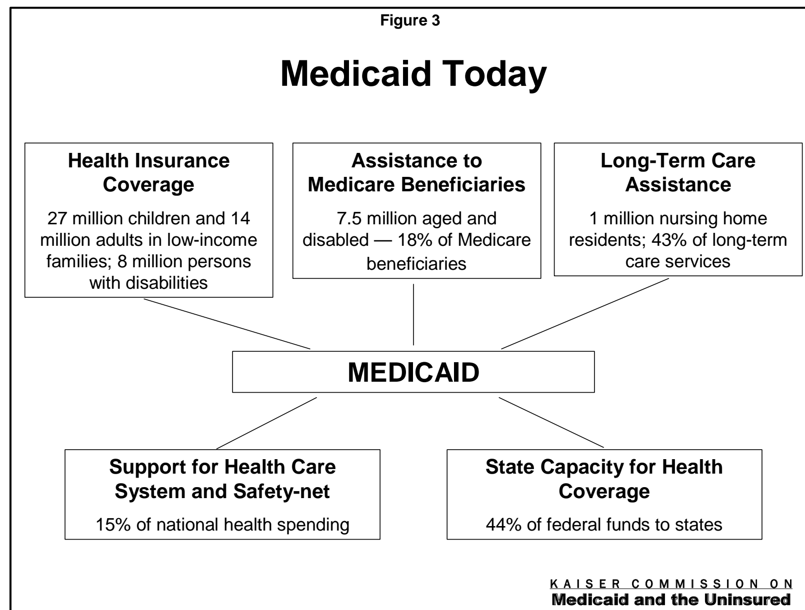
For FY 2006 and 2007, average rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states using Medicaid expenditures reported in: National Association of State Budget Officers (NASBO), *State Expenditure Report,* October 2005, and state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2005.

Background / Introduction

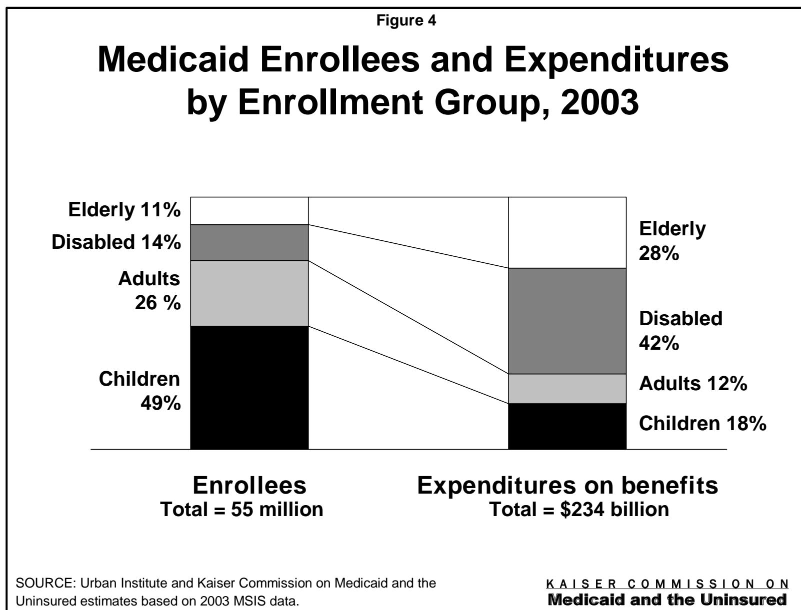
Medicaid has been at the center of both federal and state policy and budget debates over the last few years. This debate has been fueled by rising health care costs, an increase in the number of uninsured, the aging population, a severe economic downturn where state revenues plummeted and Medicaid spending and enrollment peaked, and a strong interest in cutting taxes while cutting the federal deficit at the same time. In 2005, the number of people lacking health insurance increased to a record high of 46.6 million.

One of the most fundamental changes for Medicaid programs that occurred last year was the implementation of Medicare Part D which meant transitioning over 6 million low-income seniors and individuals with disabilities (duals) from Medicaid drug coverage to newly created Medicare Part D plans. In addition, the President signed the Deficit Reduction Act (DRA) of 2005 in February of 2006. This legislation included a large number of changes in Medicaid policy which are expected to affect many elements of the Medicaid program.

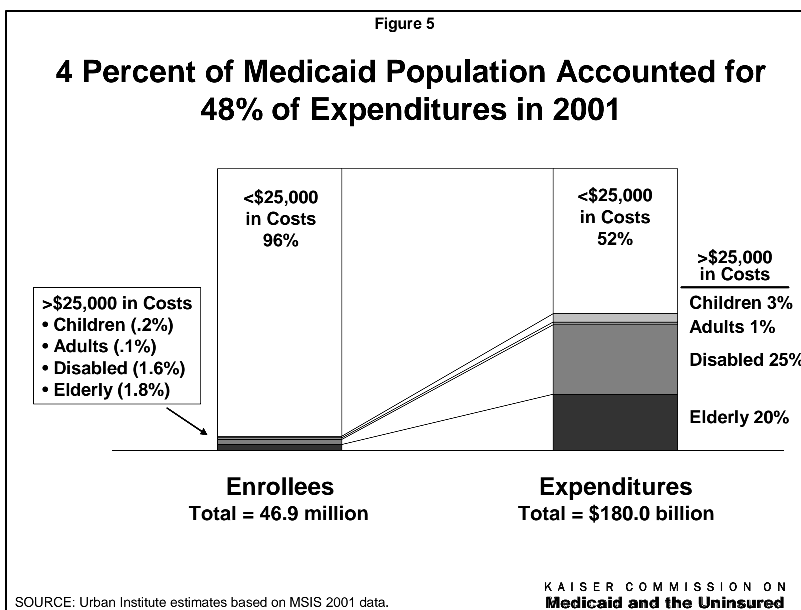
Medicaid serves multiple roles in the health care system. The program provides health coverage and long-term care assistance to over 41 million people in low-income families and nearly 14 million elderly and disabled people, fills in gaps in Medicare coverage for 7.5 million low-income Medicare beneficiaries, and supports safety-net providers. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all health care spending in the U.S. and nearly half of all nursing home care. Finally, Medicaid represents the largest source of federal revenue to states which helps support state capacity to finance health coverage (Figure 3).



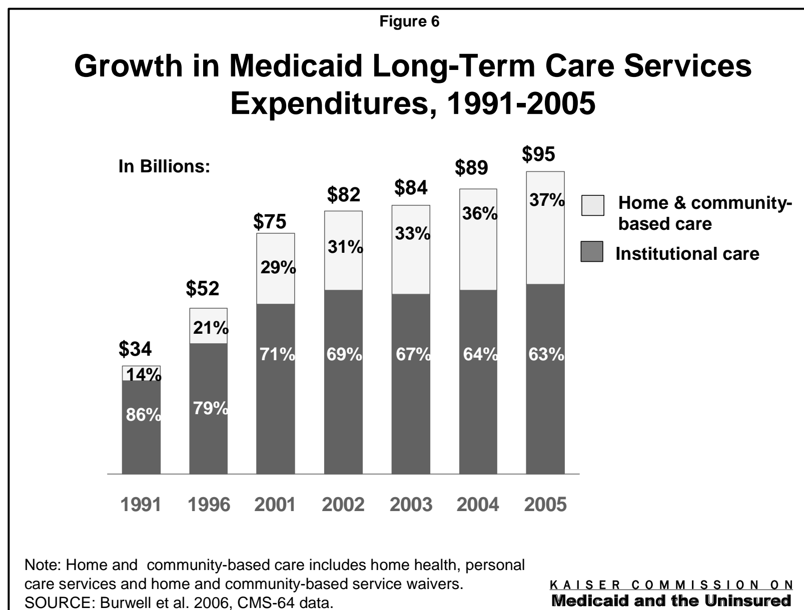
About three-quarters of the beneficiaries served by the program are children and non-disabled adults. The elderly and people with disabilities represent a smaller share of program enrollees, but account for nearly 70 percent of program spending because these groups tend to have higher utilization of acute and long-term care services (Figure 4).



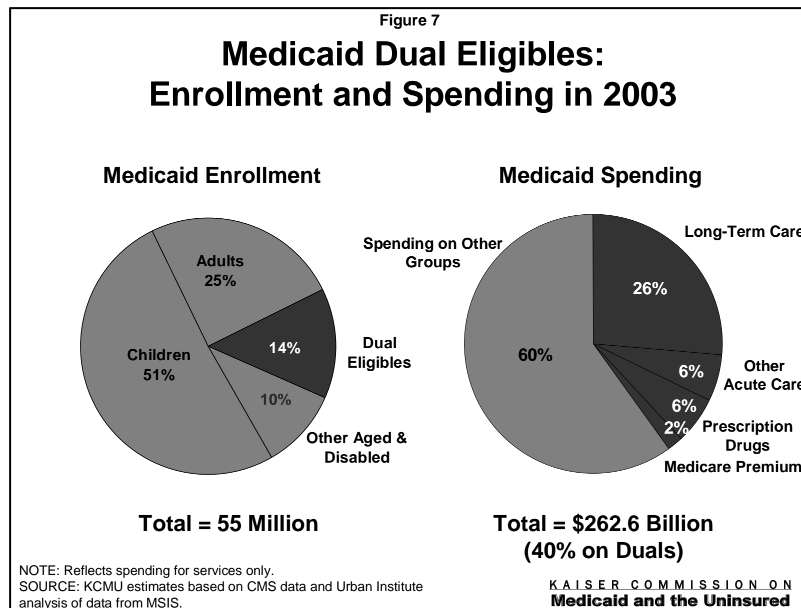
A further refinement of Medicaid data shows that about four percent of Medicaid beneficiaries account for nearly 50 percent of program spending. This distribution of spending has been the basis for more concentrated state efforts to better coordinate care for high-cost cases (Figures 5).



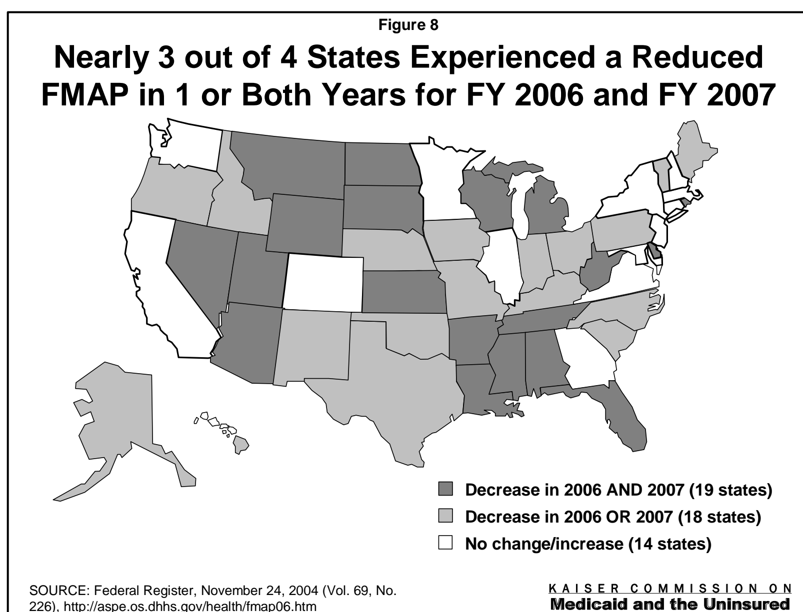
Spending on long-term care services represents over a third of total Medicaid spending. Medicaid is the nation's major source of financing for long-term services, covering services for both elderly and non-elderly persons in institutional settings and in home and community-based setting. Over the past two decades spending on Medicaid home and community-based services has been growing as more states attempt to balance their long-term care programs by increasing community-based service options. In 2005, spending on home and community-based care accounted for 37 percent of total Medicaid long-term care spending, up from 14 percent in 1991 (Figure 6).



Individuals covered by both the Medicare and Medicaid programs (duals) represent only 14 percent of program enrollees, but account for 40 percent of total Medicaid spending. The duals rely on Medicaid to pay Medicare premiums, cost sharing, and to cover critical benefits not covered by Medicare, such as long-term care. Prescription drug coverage for the duals was transitioned to the Medicare Part D program on January 1, 2006; however, states are now obligated to finance a portion of this Medicare coverage through a payment referred to as the "clawback" to the federal government. Most states continue to count the clawback payments as state Medicaid spending, but since these payments are not matched with federal funds, they are not included in calculations of federal Medicaid spending. In fact, the federal government accounts for these payments as Medicare revenue (Figure 7).



The Medicaid program is jointly funded by states and the federal government. For FY 2006, 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.[3] [4] The FMAP is inversely proportional to a state's average personal income, relative to the national average. States with lower average personal incomes have higher FMAPs. Personal income data is lagged so data for FY 2006 is from 2001 to 2003. Almost three-quarters of the states experienced declines in their FMAP for either 2006 or 2007 (with 19 states experiencing declines in both years).[5] Most of the states that did not experience a decline in FMAP were states that were at the 50 percent floor.[6] Declines in FMAPs place pressure on states to allocate additional state general revenues to maintain current level programs (Figure 8).



Because of the matching formula, growth in state spending on Medicaid brings increased federal dollars to the state and provides an important incentive for states to increase funding for health and long-term care services. At a minimum, states draw down $1.00 of federal money for every dollar of state funds spent on Medicaid. Federal Medicaid dollars represent the single largest source of federal grant support to states, representing an estimated 44 percent of all federal grants to states in 2005. On average, states spend about 18 percent of their own funds on Medicaid, making it the

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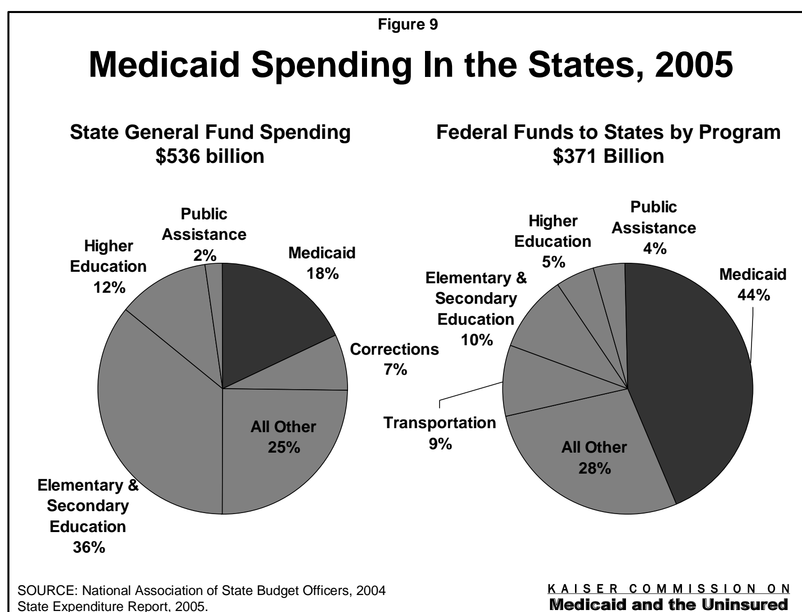
[3] The twelve states with FMAP at the statutory minimum of 50.0 percent include: CA, CO, CT, DE, IL, MD, MA, MN, NH, NJ, NY, and VA. In addition, the FMAP is set in statute for the territories at 50 percent, with a cap on federal matching funds. FY2007: Federal Register, November 30, 2005 (Vol. 70, No. 229), http://aspe.os.dhhs.gov/health/fmap07.htm

[4] The ten states with FMAP above 69 percent include: 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.

[5] 29 states had an FMAP decline in federal FY 2006 and 27 states in FFY 2007

[6] CA, CO, CT, IL, MD, MA, MN, NH, NJ, NY, and VA all held at the 50 percent FMAP for FY 2006 and FY 2007. The District of Columbia has an FMAP set in federal statute. GA experienced a slight increase in its FMAP for FY 2006 and FY 2007 and WA had a small increase in FY 2007.

second largest program in most states' general fund budgets following spending for elementary and secondary education which represents 36 percent of state spending (Figure 9).

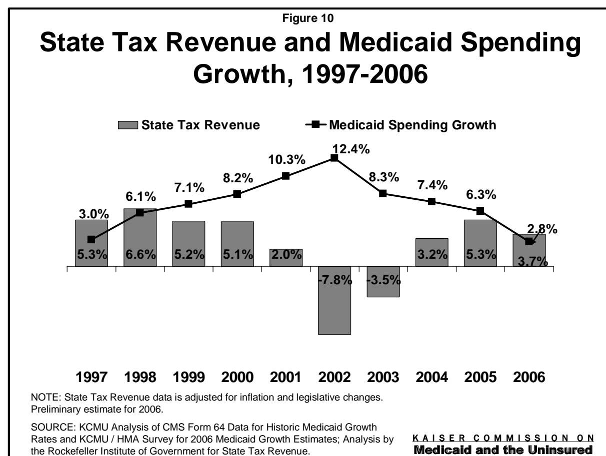


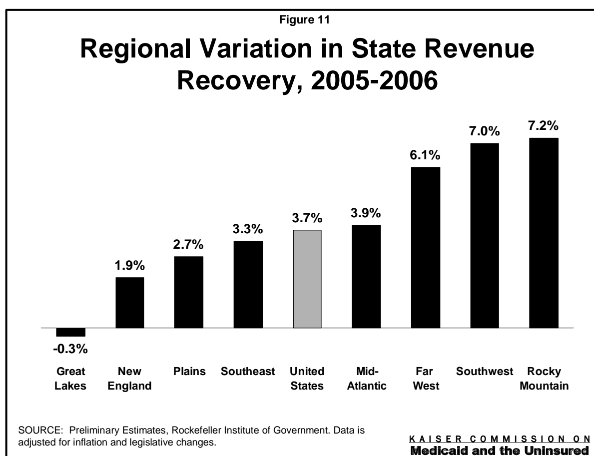
Beginning in 2001, the national economy worsened, state tax revenue plummeted, health care costs continued to rise, and more people became eligible for Medicaid as employers dropped coverage and poverty rates increased. From 2001 to 2004 cumulative state budget shortfalls exceeded $250 billion. In response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

FY 2005 marked the start of the fiscal recovery for many states and this recovery continued through FY 2006. State revenue from 2005 to 2006 averaged 3.7 percent after accounting for inflation and legislative changes, exceeding original targets in 44 states.[7] In March 2006, 42 states were expecting to end state fiscal year 2006 with unobligated balances or surpluses, a dramatic change from many states expecting shortfalls in previous years.[8] States also experienced a dramatic slowing in Medicaid spending and enrollment growth making 2006 the first year since 1998 where state revenues grew at a faster pace than Medicaid spending. Despite strong revenue growth, actual revenue levels are still below levels projected prior to the economic downturn and states in certain regions (particularly the mid-west) continue to struggle with their budgets. Even with recent revenue growth, fiscal directors remain concerned about "structural deficits," a situation where ongoing revenues are projected to be insufficient to cover ongoing expenses. While spending for

[7] Preliminary Data from The Rockefeller Institute of Government and State budget Update: March 2006. *National Conference of State Legislatures*
[8] State budget Update: March 2006. *National Conference of State Legislatures*

Medicaid, education and corrections are often cited as driving these deficits, other research points to state tax systems as the dominant contributors to these deficits.[9] Ten states were projecting structural gaps in FY 2007, 19 states for FY 2008 and 24 states in one or more years over the 2007 to 2009 period (Figures 10 and 11).

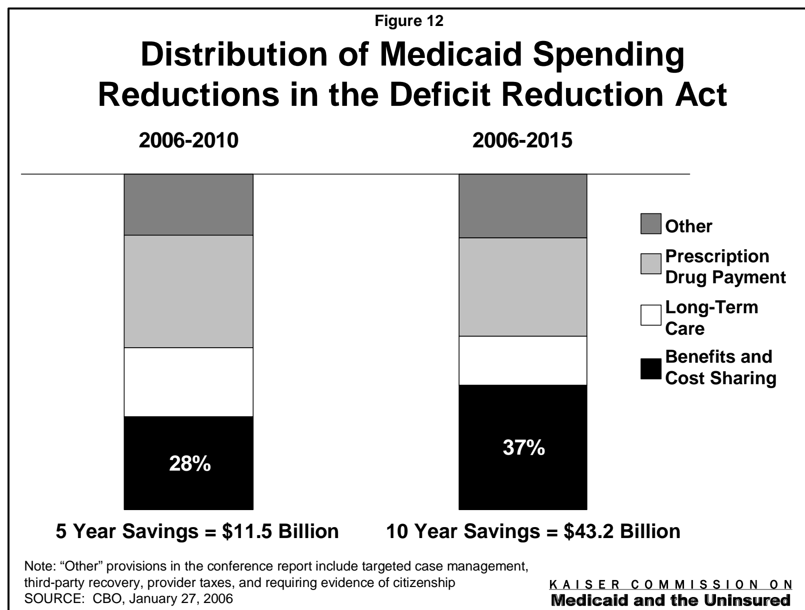




It is in this budget context that states will begin to implement and make decisions about whether to adopt new options included in the DRA. The DRA contains extensive Medicaid policy changes related to benefits, cost sharing, long-term care services, program integrity and eligibility which are expected to save the federal government $26.1 billion over the next ten years. The overall impact of the new law on beneficiaries as well as the amount of savings that will accrue depends on whether states adopt new options to re-structure benefits and cost sharing. A few states that were in the midst of developing Medicaid reform Section 1115 waiver proposals (such as Kentucky, West Virginia and Idaho) were poised to take advantage of the new options and, in some cases, were encouraged by the Centers for Medicare and Medicaid Services (CMS) to do so. Few other states reported plans to adopt policy changes using DRA flexibility around benefits and cost sharing during FY 2007, although some states were continuing to review these options as well as other options to expand the use of community based long-term care options.

The DRA also included several mandatory provisions, including changes to the asset transfer rules that could affect eligibility for nursing home services and the new requirement that citizens applying for Medicaid provide documentation to prove their citizenship status. The documentation requirements are likely to create new enrollment barriers as well as new administrative burdens for states. Over the next year, CMS will be working with states to develop further guidance and implement a range of other provisions, ranging from changes to prescription drug pricing to new program integrity efforts (Figure 12).

[9] Ibid, and Elizabeth McNicol and Iris Lav, "State Budgets: On the Edge?" *Center on Budget and Policy Priorities.* June 2006.



The federal-state tension over Medicaid financing continues. The President's FY 2007 budget included several regulatory policy changes that would reduce allowable provider taxes, limit payments to government providers and restrict Medicaid reimbursement for school-based administrative services, rehabilitation and transportation. These changes may not reduce overall program spending, but instead shift costs to states. Other Medicaid changes, perhaps focused on reforms to long-term care, could be forthcoming at the end of the calendar year when Secretary Leavitt's Medicaid Commission is expected to release final program recommendations.

Methodology

The Kaiser Commission on Medicaid and the Uninsured (KCMU) commissioned Health Management Associates (HMA) to conduct this survey of Medicaid directors in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy making. This is the ninth KCMU/HMA survey of Medicaid officials designed to address these issues, including six surveys conducted at the beginning of state fiscal years 2002 through 2007, and three mid-year surveys during the economic downturn in fiscal years 2002, 2003 and 2004 when deepening state revenue shortfalls forced many states to make mid-year Medicaid policy changes.[10]

The KCMU/HMA survey on which this report is based was conducted in July and August 2006. The survey was designed to document the policy actions states had taken in the previous year, state FY 2006, and new policy initiatives that they had implemented or expected to implement in state FY 2007, which for most states had begun on July 1, 2006.[11] Legislatures had adopted the FY 2007 Medicaid budget at the time each survey was finalized.

The 2006 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 state initiatives in quality improvement and the impact of various provisions of the Deficit Reduction Act of 2005 (DRA), which was signed into law in February 2006.[12]

The data on which this report is based were provided directly by Medicaid directors and other Medicaid staff in response to a written survey and telephone interviews. The survey was sent to each Medicaid director in late June 2006. Personal telephone interviews were scheduled for July and August 2006. The telephone interview provided an opportunity to review the written responses or to conduct the survey itself, if the survey had not been completed in advance. As in past years, these interviews were invaluable to clarify responses and to record the nuances of state actions. Generally, the interview included the Medicaid director along with policy or budget staff. In a limited number of cases the interview was delegated to a Medicaid budget or policy official. Survey responses were received from all 50 states and the District of Columbia.

As has been the case in each annual survey, the focus of the 2006 survey was on policy directions, policy changes and new initiatives. The survey did not attempt to catalog all current policies, but asked state officials to describe new policy changes that were implemented in their FY 2006 or would be implemented in FY 2007. Policy changes under consideration for which there was not yet a definite decision to implement in FY 2007 were not recorded in this survey. It is important to note that some actions that were adopted or planned for implementation in FY 2007 at the time the survey was completed might not be implemented in that year. Medicaid policy initiatives often involve complex administrative changes, computer system updates, specific advance notice requirements and various political considerations. It sometimes happens that policy changes are

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

[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.

not implemented within the original timelines, or that policy makers reconsider previous decisions as the impacts become better understood. The actions reported here for FY 2007 are those for which Medicaid officials indicated that as of the date of the survey response a definite decision had been made to implement during the fiscal year. The actions reported here for FY 2006 are those state officials reported that they had actually implemented in the past year.

This report also includes case studies of three states (Idaho, Michigan, and New York) that were profiled as illustrative examples of policy changes in states in FY 2007. Every state is unique in its Medicaid policy making, and these case studies show how these states are using the DRA state flexibility provisions, taking major eligibility cost containment actions, and developing 1115 waivers to implement 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 six-year period from fiscal years 2002 to 2007, in addition to showing the number of states implementing these actions in FY 2006 and FY 2007.

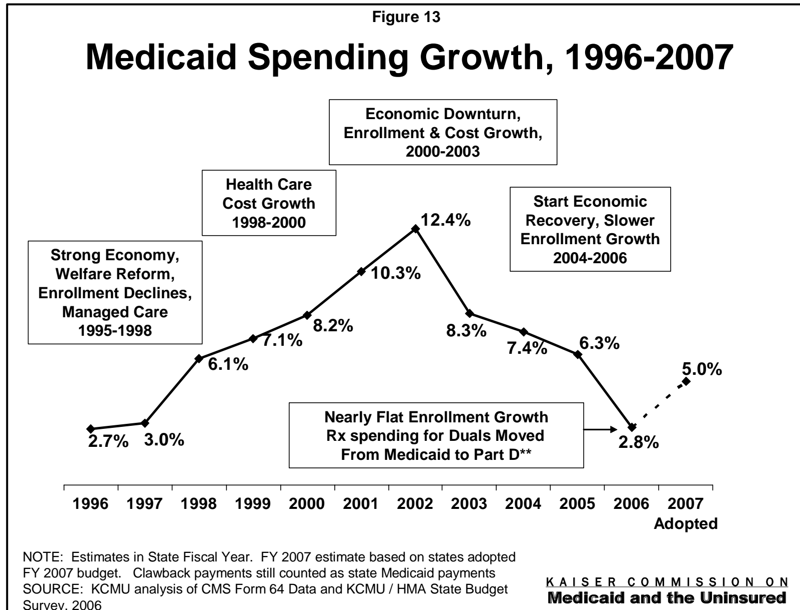
For FY 2006 and FY 2007, annual rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states. Average annual Medicaid spending growth was calculated using weights based on state Medicaid expenditure data reported in the National Association of State Budget Officers (NASBO) *State Expenditure Report*, October 2005. Average annual Medicaid enrollment growth is calculated based on weights developed from state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2005. For years prior to the periods covered by the HMA/KCMU surveys, Medicaid spending and enrollment data are based on estimates prepared by the Urban Institute using data from Medicaid financial management reports (CMS Form 64), adjusted for state fiscal years.

Survey Results for Fiscal Years 2006 and 2007

1. Medicaid Spending Growth Rates

Total Medicaid Spending Growth

States reported average growth of just 2.8 percent for FY 2006, a dramatic deceleration in overall Medicaid spending growth, less than half the average growth rate in FY 2005 and the lowest rate of spending growth since 1996. FY 2006 was the fourth consecutive year of slowing growth after spending growth peaked in 2002 at 12.4 percent at the height of the economic downturn (Figure 13).



Total Medicaid spending includes all payments from all fund sources (federal, state and local) made to medical providers for the services they provide to Medicaid beneficiaries, and also includes Disproportionate Share Hospital (DSH) payments to hospitals that qualify for special payments because of the volume of services they provide to persons who are on Medicaid or are uninsured. Total Medicaid payments do not include administrative expenses.[13]

The relatively low rate of spending growth in 2006 is explained by two significant factors. The first factor was the low rate of growth in the number of persons enrolled in Medicaid. Averaging just 1.6 percent, this was the lowest rate of growth in enrollment since 1999, when the economy was robust and strong. (There is more discussion about changes in enrollment growth in the following section).

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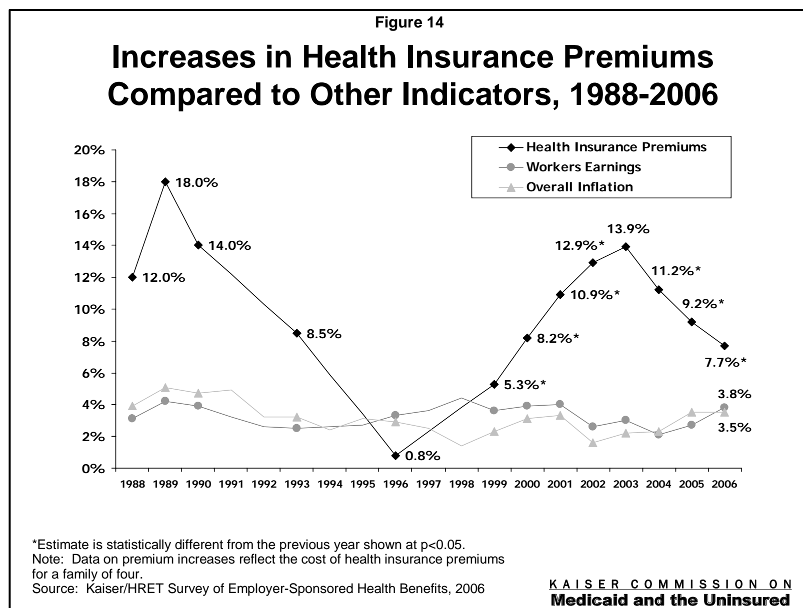
[13] Medicaid agencies were asked to use a consistent definition of expenditures from year to year when calculating annual growth rates. Across states, there was variation in the definition of what expenditures were included when calculating a rate of growth in Medicaid spending. For example, the Medicaid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

The second key factor in the relatively low rate of growth in overall Medicaid spending was the implementation of the Medicare Part D. Beginning January 1, 2006 mid-way through state fiscal year 2006, prescription drug spending for the dual eligibles was shifted from Medicaid to Medicare.[14] These expenditures represented approximately six percent of all Medicaid spending. States still have an obligation to finance a portion of this care, through a payment to the federal government based on a per capita calculation of the state share of Medicaid drug spending for the duals multiplied by the number of duals. Most states continue to count this payment, referred to as the "clawback," as part of state Medicaid spending even though it does not qualify for federal matching funds. Since the clawback reflects only state Medicaid spending, overall Medicaid spending is lower.[15] A rough estimate shows that if states did not include the clawback in their calculations of Medicaid spending, total growth would have been 1.7 percent (compared to 2.8 percent).

Overall states had initially authorized total Medicaid spending increases of 5.5 percent for FY 2006. Because of lower than expected spending, only 21 states, the lowest number since 2002, reported a shortfall in Medicaid spending last year. Despite this slow down in growth, Medicaid officials indicated that pressures including the continued growth in overall health care costs, erosion of employer sponsored health coverage and pressure to increase provider rates are expected to push Medicaid growth to higher levels in the upcoming fiscal year. Because of the size of the program and these pressures, no Medicaid official reported that overall pressure to constrain Medicaid spending growth was subsiding.

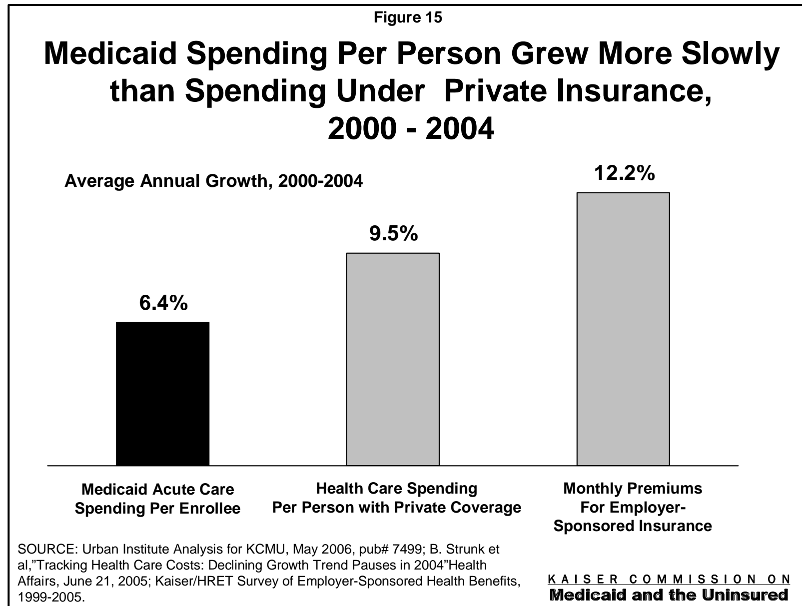
Growth in private health insurance premiums averaged 7.7 percent in 2006, slower than the 9.2 percent growth in 2005, but about twice the growth in wages and well above the rate of inflation. This is significant because Medicaid buys services in the private market place so this cost growth in the private sector is an important factor for Medicaid as well (Figure 14).



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

[15] All states except Texas (which initiated a lawsuit challenging the legality of the clawback) included the clawback amounts in total Medicaid spending calculation for their state fiscal years 2006 and 2007.

However, after accounting for the effects of enrollment, Medicaid acute care spending growth per enrollee was about half of the spending growth for private monthly premiums from 2000 to 2004 (Figures 15).



For fiscal year 2007, state legislatures appropriated funding for Medicaid that authorized an average increase of 5 percent over spending in FY 2006. Medicaid officials in 32 states believed that the initial legislative authorization would be sufficient to meet Medicaid's fiscal obligations for 2007. This was the greatest degree of confidence in the sufficiency of the initial appropriation in the six years over which Medicaid officials have been surveyed on this question.

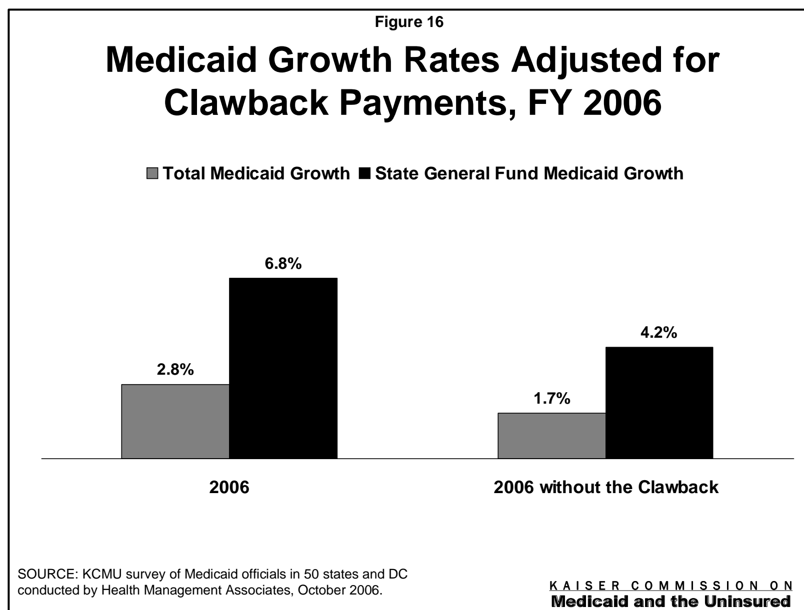
State General Fund Medicaid Cost Growth

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. When state revenues plummeted, there was significant pressure to constrain overall Medicaid spending in order to ease the pressure on state general funds. With revenues rebounding, there was some relief, but most states are required to balance their budgets annually so there is still competition for limited resources across program areas.

For FY 2006 and FY 2007, declines in the formula-driven calculations in the FMAP have meant that states needed to come up with more state general fund dollars just to maintain the same program. Almost three-quarters of all states experienced a decline in their FMAP in either FY 2006 or FY 2007 with 19 states experiencing a decline in both years. States also reported that intense scrutiny from the Centers for Medicare and Medicaid Services (CMS) over the ways in which states finance their programs (including the use of intergovernmental transfers or IGTs) has put pressure on states to come up with new general fund spending for Medicaid. The President's FY 2007 budget included several regulatory policy changes that would reduce allowable provider taxes, limit payments to government providers and restrict Medicaid reimbursement for school-based

administrative services, rehabilitation and transportation. While these regulations have not yet been released, these changes could shift costs from the federal government to the states and further increase the state share of Medicaid spending. States reported that these pending regulations as well as uncertainty about the rules around Medicaid financing makes it difficult for states to predict and manage state Medicaid spending. In addition, as discussed above, the clawback payment for Medicare Part D is an expenditure that now affects only the state share of Medicaid funding. Without the state clawback payment, the state share of Medicaid growth would have been about 4.2 percent (compared to the 6.8 percent reported growth).

All of these factors contributed to higher growth in state general fund spending than for overall program spending. In 2006, state general fund spending for Medicaid increased on average by 6.8 percent compared to total spending increases of just 2.8 percent. However, the 6.8 percent growth in general funds was less than the 8.7 percent growth in state general fund spending initially appropriated by state legislatures on average for FY 2006.[16] For 2007, state legislatures appropriated 6 percent growth in general fund spending for Medicaid, again higher than average appropriations of 5 percent growth for total spending (Figure 16).



Comments of State Medicaid Officials on Pressures on Medicaid:

"Our population has plateau-ed and inflation has moderated...."

"A program of this size creates its own demands. The pressures exist, and they are increasing."

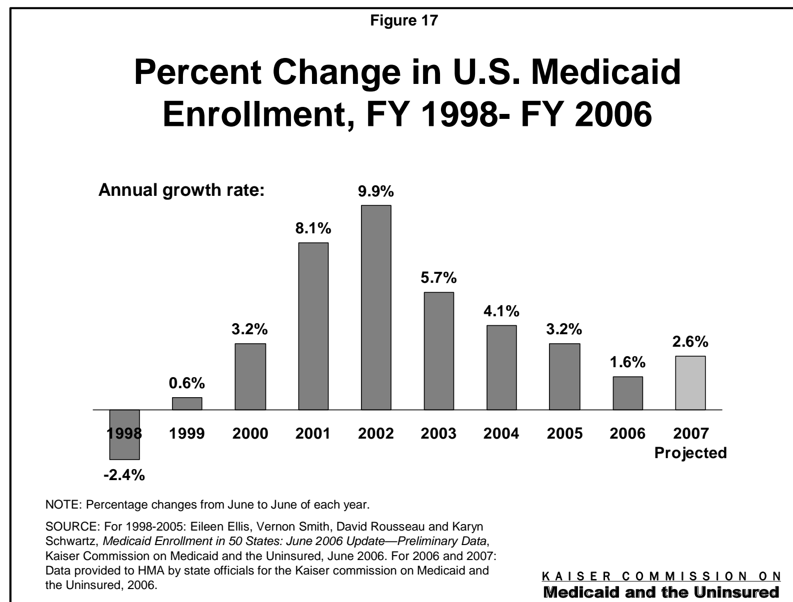
"CMS has been very successful in shaking the tree and reducing the federal share of Medicaid...I don't have any sense of security about federal funding for Medicaid."

[16] Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006, KCMU. http://www.kff.org/medicaid/7392.cfm

2. Medicaid Enrollment Growth

States reported that the number of persons with Medicaid coverage increased by just 1.6 percent in FY 2006, the lowest rate of growth since 1999. Despite years of slowing growth, the number of Medicaid enrollees increased by over 40 percent from 2000 to 2006, driven primarily by large recession-driven increases from 2001 to 2004. During that period, increasing poverty rates and declines in private insurance coverage pushed Medicaid enrollment up, especially for children, because Medicaid has higher eligibility thresholds for children compared to adults. In 2005, the number of people lacking health insurance increased to a record high of 46.6 million. While the rate of increase in private health insurance premiums has slowed in the last few years, cost continues to be a factor driving down the number of people with private health insurance. The percentage of full-time workers without health insurance increased significantly in 2005. These trends put increased demands on Medicaid coverage.

At the beginning of fiscal year 2006, Medicaid officials had projected increases in Medicaid enrollment growth that would average 3.0 percent. Actual growth was about half the projected level. Officials attributed the lower than expected enrollment growth to a number of factors, most significantly to an improving economy. Several states reported negative enrollment growth including Tennessee, Missouri and Mississippi, all states that had significant eligibility cuts that went into effect in FY 2006. Officials in ten states indicated that more restrictive eligibility policies were a factor, citing such policies as more stringent income verification and more frequent or stringent re-determination requirements. In addition, some states reported they had experienced a drop in Medically Needy enrollment related to the new Medicare prescription drug benefit, noting that some individuals had attained Medicaid eligibility based on the high cost of their medications, which were now covered by Medicare Part D. Officials in six states mentioned that they were experiencing increases primarily in elderly and disabled caseloads, and that greater enrollment of these individuals would have a disproportionate impact on program costs (Figure 17).



For 2007, Medicaid officials projected that Medicaid enrollment would increase by 2.6 percent. If this projection is accurate, FY 2007 would be the first year since 2002 where enrollment growth would increase at a faster pace than in the previous year. States attributed the anticipated higher rate of growth in 2007 to growth in the number of uninsured children and adults, continued erosion of employer sponsored health coverage, planned expansions of eligibility, demographic trends and population growth. Many states mentioned that caseload growth that they projected would be less than otherwise expected because of the identity and citizenship documentation requirements that were mandated by the Deficit Reduction Act of 2005, although states were not able to report specific estimates.

Comments of State Medicaid Officials on Enrollment:

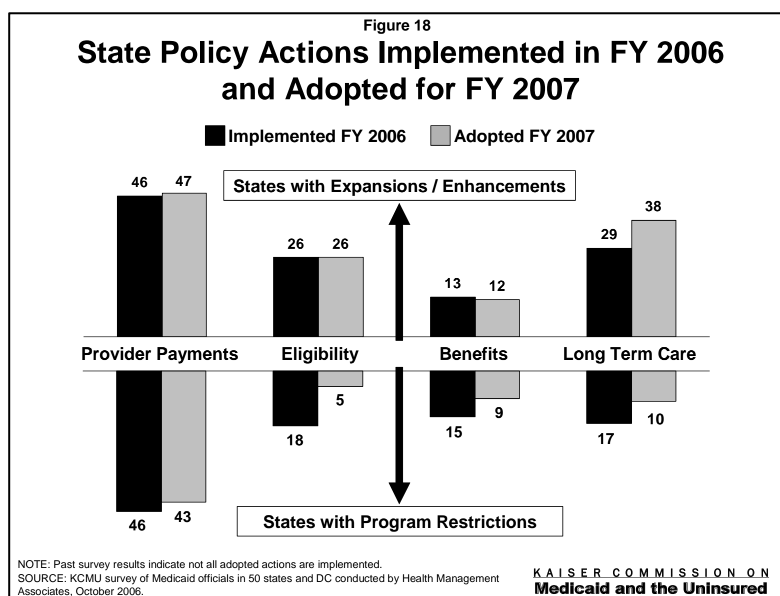
"In previous years, the pressure was enrollment growth. Enrollment is still growing, but it is leveling."

"The big driver for us is our enrollment counts. We are still picking up a lot of people, even though our unemployment rate is low. People are working part-time, they are still low-income, and they don't have health benefits."

3. Medicaid Policy Initiatives for FY 2006 and FY 2007

According to survey responses, Medicaid policy initiatives shifted from a primary focus on cost containment strategies to a broader spectrum of changes that still included policies to control costs, but now also included policies to expand benefits or eligibility, improve quality and change the delivery of long-term care services. The fiscal relief afforded by better economic times relieved some of the urgency simply to cut the program to achieve large and immediate dollar savings that had characterized much of Medicaid policymaking since 2002.

In FY 2006, all states implemented at least one new cost containment strategy and 49 states planned at least one cost containment strategy for FY 2007. As in previous years, these efforts were mostly targeted towards controlling provider rates and spending for prescription drugs. Balancing these cost containment strategies, all but one state implemented more expansive policies in FY 2006 and 49 states have adopted policies in FY 2007, to enhance provider rates or to expand or restore benefits or eligibility. In addition, states increasingly are focusing on disease management and quality initiatives that are designed to improve health care for beneficiaries and to provide better value for the dollars the program spends. A significant trend is the adoption of policies directed at balancing the long term care system, by enhancing services provided in the home and community that can be used in place of care otherwise provided in an institutional setting, such as a nursing home (Figure 18). For more information on cost containment and positive policy actions taken by states see Appendices A-1 and A-2.



The following sections focus on specific categories of Medicaid policy actions taken by states in FY 2006 and FY 2007.

Provider Payment Rate Changes

When establishing provider payment policies, state Medicaid programs must appropriately balance cost effectiveness with adequate access to services. In recent years, cutting or freezing provider payment rates was a primary lever for states to help control Medicaid spending. In many states, automatic rate increases that had been in place historically were suspended for several years. As states emerged from the fiscal crisis, starting in FY 2004, states were less likely to cut provider rates and more likely to increase provider rates.

The amount that Medicaid pays providers can influence provider participation in Medicaid and therefore affects access to services for beneficiaries. Despite some recent increases in provider rates, a recent study found decreases in the proportion of physicians accepting Medicaid patients that can be linked to low pay and administrative hassle.[17] These findings suggest that states need to be mindful that lowering payment rates and adopting policies such as cost sharing that could shift additional costs to providers could create access issues for Medicaid enrollees.

In FY 2006, almost all states (46) froze or cut rates for at least one provider, but almost all states (46) also increased rates for at least one group of providers. This trend will continue in FY 2007 with 47 states planning to increase rates for at least one group of providers and 43 states planning any rate freezes or cuts.[18] Most of the major categories of Medicaid providers were more likely to

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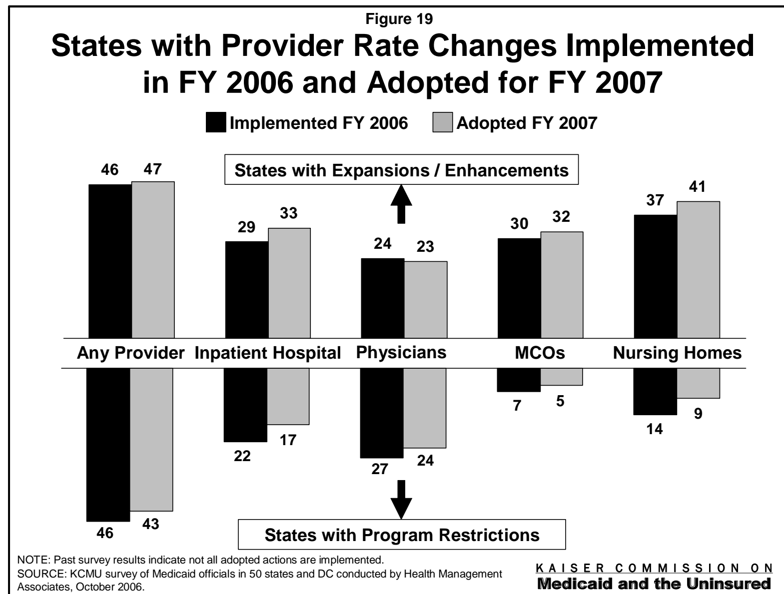
[17] Peter Cunningham and Jessica May. "Medicaid Patients Increasingly Concentrated Among Physicians." Center for Studying Health System Change. August 2006.

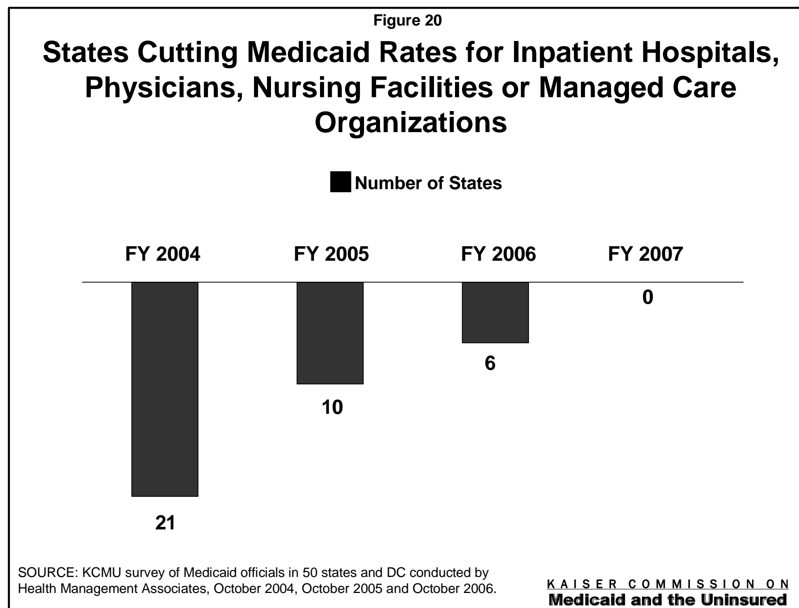
[18] As of the date of this survey, five states indicated they had not yet finalized rate decisions for FY 2007. One example is North Carolina. For FY 2007 the North Carolina legislature appropriated $12 million in state funds (plus federal matching funds) for January 1, 2007 rate increases. North Carolina has engaged independent consultants and financial

see rate increases than freezes or cuts in FY 2006 and FY 2007, a reverse of the pattern during the economic downturn. Among major provider groups, payment rates for nursing facilities were the most likely to be increased for FY 2006 and FY 2007. Reimbursement methodologies for hospitals and nursing facilities often include automatic adjustments based on an index relating to the cost of services so these provider groups are typically more likely than others to show increases. Some hospital and nursing facility rate increases were tied to new or increased provider taxes; in these cases the real rate increase net of the provider tax could be less than the nominal increase (Figure 19).



Looking at the major provider groups (physicians, inpatient hospitals, nursing facilities or managed care organization), only six states cut payment rates in FY 2006 for one or more groups compared to ten in FY 2005 and 21 from FY 2004. In FY 2007, no states plan to cut rates for any of these major providers, the first year this has occurred since these surveys began in 2002 (Figure 20).

experts to assist the state in developing a proposal for "an equitable standard to provide inflationary rate increases and other cost related increases to service providers in the Medicaid program".



Comment of State Medicaid Official on Provider Payment Rates:

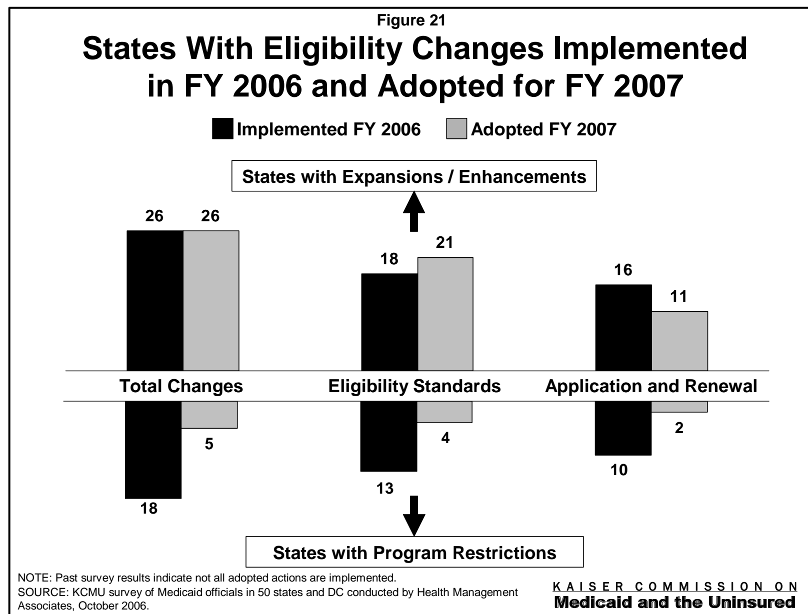
"Now that the state's fiscal pressures have improved, we have been able to increase rates. A few years ago, we couldn't have considered these increases."

Eligibility and Enrollment Changes

Eligibility changes may be the result of changes to eligibility standards, changes to the application and renewal process that are designed to either expand or restrict coverage, or changes in premiums. Examples of changes to eligibility standards include increasing or reducing the income eligibility thresholds, eliminating, and adding or changing asset tests. A state can also affect enrollment by making changes in its Medicaid application and renewal processes. Examples would include changes in state policies for continuous eligibility, face-to-face interview requirements, or presumptive eligibility.

Eligibility reductions are among the most difficult cost containment measures undertaken by states to constrain Medicaid costs because they negatively affect low-income and vulnerable populations who rely on Medicaid for access to needed health and long-term care services. However, due to the length and severity of the economic downturn that began in 2001, a total of 45 states made restrictions or reductions to Medicaid eligibility in at least one of the five years from FY 2002 to FY 2006.

In FY 2006 a total of 18 states took an action that restricted eligibility, more than double the eight states that made such changes in FY 2005. However, in FY 2007 only five states have adopted actions that in any way restrict eligibility standards or processes. At the same time, about half of the states reported that they were restoring, expanding or simplifying application procedures in FY 2006 and FY 2007. A few states, however, undertook broader coverage expansions outside of the Medicaid program including two states that had expanded Medicaid coverage to optional populations in previous years, Massachusetts and Illinois (Figure 21).



Eligibility changes for FY 2006 and FY 2007 are described in detail in Appendix A-3a and A-3b. (Note that Appendix A does not include the mandatory DRA changes related to transfer of assets and documentation of citizenship.)

Eligibility Standards

In FY 2006 a total of thirteen states undertook eligibility cuts, compared to five states that took such action in FY 2005. Changes in five states were intended to eliminate eligibility for large numbers of people. In two states, Florida and Mississippi, these actions occurred in response to the new Medicare Part D benefit. These actions included:

- **Tennessee** restricted eligibility in its waiver resulting in the elimination of coverage for 171,000 adults that do not meet traditional Medicaid categorical eligibility requirements.[19]

- **Missouri** eliminated coverage for more than 79,000 beneficiaries by eliminating extended Transitional Medical Assistance, 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 Medical Assistance for the Working Disabled (MAWD) and increasing the frequency of eligibility reinvestigation efforts for all adults.

- **Florida** eliminated full-benefit Medicaid coverage for 70,000 Medicare beneficiaries in the optional Medicaid for Aged or Disabled (MEDS-AD) program for individuals with incomes

[19] Tennessee's Medicaid program, TennCare, has operated under a Section 1115 waiver since 1994; the original waiver broadly expanded coverage for children and adults and placed all beneficiaries in managed care.

below 88 percent of FPL on January 1, 2006. A waiver program was created to cover individuals in the MEDS-AD program who were not eligible for Medicare.[20]

- **Mississippi** also eliminated its program for Poverty Level Aged and Disabled (PLAD) program on January 1, 2006 which had covered 66,000 aged and disabled individuals with incomes up to 135% of FPL. Mississippi concurrently implemented the "Healthier MS Waiver" which provides Medicaid coverage to individuals with incomes below 135 percent of FPL that are not eligible for Medicare (about 5,000 people).[21]

- **Ohio** reduced income eligibility for parents from 100% to 90% FPL. (25,000 persons.)

In FY 2007, by contrast, only four states adopted plans to restrict or cut eligibility standards for Medicaid enrollees. Two of these states (Rhode Island and South Carolina) are adding asset limits that will affect small numbers of parents and children.

In both FY 2006 and FY 2007, more than one-third of states changed eligibility standards to expand coverage (18 states in FY 2006 and 21 states with policies adopted for FY 2007). One of the most common changes reported was to alter the manner in which net income was calculated or to increase asset limits. A few states took up options to offer coverage to the working disabled or to cover people under family planning waivers. Other expansions provide premium assistance to working individuals. In FY 2007, eight states plan to expand the income limits for parents, pregnant women, children, or adults without children and Colorado, Montana and New Mexico expanded coverage for children by removing or increasing asset limits of income disregards. In addition, Massachusetts increased and Indiana has plans to increase income eligibility for the aged and disabled by increasing income eligibility for a HCBS waiver or a PACE program to 300 percent of the federal SSI standard.

Application and Renewal Process Changes

In FY 2006, ten states reversed previous simplifications or imposed changes that could make it more difficult for individuals to enroll and stay enrolled in Medicaid. By contrast, the only negative changes to the application and renewal processes adopted for FY 2007 are a Rhode Island state requirement to verify state residency and a Colorado state requirement to verify that an individual is legally in the USA. This change will be subsumed by the federal DRA citizenship requirements (discussed later in this section).

Restrictive changes made in FY 2006 include: implementing more frequent re-verification periods than in previous years; elimination of self-declaration of income and/or assets: requiring additional documentation at either application or renewal; requiring face-to-face applications and renewals; and requiring verification of citizenship (Georgia implemented this in FY 2006 prior to the new federal requirement) or state residency (one state).

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[20] Duals are still eligible for Medicare Part B premiums and copayments under the Qualified Medicare Beneficiary (QMB) category and some of these individuals will receive assistance from Florida Medicaid under the Medically Needy category once they have incurred the required level of medical expenses to qualify.

[21] Dual eligibles with incomes below 135% of poverty will still qualify for assistance with their Medicare premiums under the Specified Low-Income Medicare Beneficiary (SLMB) program and those with incomes below 100% of FPL will qualify for assistance with Medicare premiums and deductibles under the QMB program. However, Mississippi does not have a medically needy program for these individuals cannot qualify for full Medicaid coverage even with high medical expenses.

A total of 16 states made changes that streamlined or simplified their application and renewal procedures in FY 2006 and a total of 11 states adopted policies with one or more positive changes to the application and renewal process in FY 2007. These changes for FY 2006 and 2007 included: implementation or expansion of presumptive eligibility (which allows an individual to begin receiving assistance prior to complete review of the application for assistance); development of on-line application processes; the option to self-declare income; simplified eligibility and renewal forms and/or telephone renewal options; increased time periods between re-determinations; and the removal of the face-to-face interview requirement in one state.

Some Medicaid officials commented during the interviews that the new requirements for citizens to document citizenship will negatively affect efforts to simplify application process.

Premium Changes

Historically, states have been prohibited from charging Medicaid enrollees premiums or enrollment fees outside of an 1115 waiver or various Medicaid "buy-in" programs that have been introduced for working individuals with disabilities who do not have access to employer based insurance.[22] On January 1, 2006, Vermont increased premiums by between $1 and $10 per month for Vermont Health Access Program (VHAP) and Dr. Dynasaur expansion groups (adults with incomes above 50 percent FPL, pregnant women above 185 percent FPL and children above 185 percent FPL).[23] In FY 2007 Idaho reported an increase in the premium for its program for working disabled individuals with incomes between 133 percent and 250 percent FPL.

[22] The Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentive Improvement Act (TWWIIA) of 1999 both included this type of program.
[23] Premiums in Vermont are unchanged for FY 2007, but legislation has been enacted that would reduce all existing premiums by as much as 50 percent on July 1, 2007.

Documentation of Citizenship Changes In the DRA

Effective July 1, 2006, the DRA required all individuals applying for or renewing their Medicaid coverage to provide documentation of their citizenship status. Prior to the DRA, 47 states allowed applicants to self-declare citizenship status. Only four states – Georgia, Montana, New Hampshire, and New York – required documentation of citizenship for all Medicaid applicants. These changes affect the application process but do not change the Medicaid eligibility rules. Most immigrants are still subject to a 5 year ban on Medicaid eligibility after entering the country even if they meet other program requirements and illegal immigrants are still only eligible for emergency Medicaid services. Regulations issued by the Department of Health and Human Services exempted aged and disabled individuals that also receive Medicare or Supplemental Security Income since these groups would have already met documentation requirements for those programs. The rules specified that applicants must first use a Passport or birth certificate and then are able to use other evidence of citizenship only if these documents are not available. Sworn affidavits attesting to citizenship are only allowed in "rare circumstances".[24]

All but three states expect to experience administrative cost increases. The two states that did not expect a cost increase (Georgia and Montana) and the one state that was uncertain of the administrative impact (New York) are three of the four states that already required documentation of citizenship. New Hampshire, the other state that previously required documentation of citizenship, expects some administrative cost increases due to more extensive documentation of identity required by the DRA.

While some states are uncertain about the impact of the documentation requirements on enrollment, over half (29 states) indicated that they expect a negative impact on Medicaid enrollment. Montana and New Hampshire, states that already required documentation of citizenship, were two of six states that did not expect a change in enrollment (Figure 22).

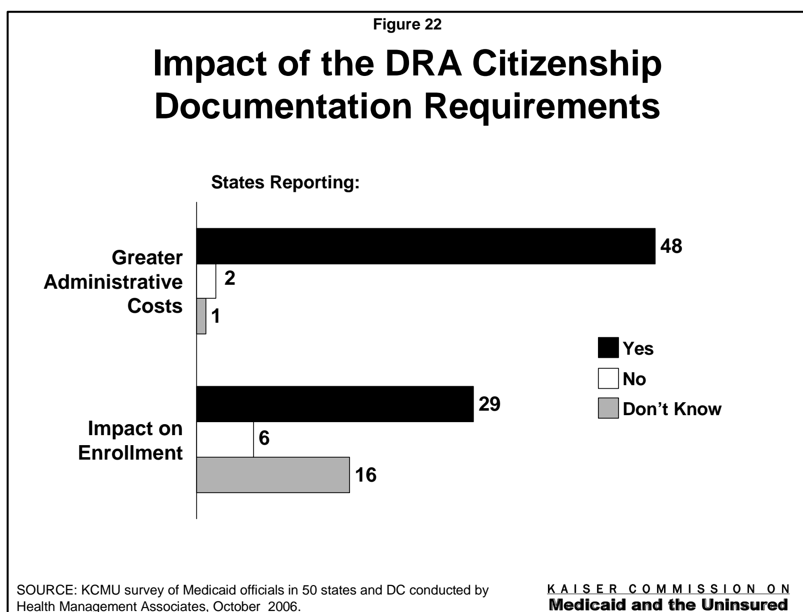
Comments by state officials on the DRA citizenship documentation requirement:

"We'd planned to go to electronic application and this makes it hard to do."

"Additional staff resources are needed to help individuals obtain records they might not have. I am concerned about delays in processing benefits, clients getting cut-off with critical medical needs, and/or having to forego getting medical attention."

"CMS has relaxed the documentation standards with their regulations released June 30, 2006. We sincerely hope that CMS will further relax these standards after the comment period ends on the rules."

[24] For more details see: http://www.kff.org/medicaid/7533.cfm



Copayment Requirements

Over the past several years, states have used new or higher copayments as part of their cost containment strategies. According to the results of this year's survey, a total of 45 states impose copayment requirements, including six states that impose copayments only on drugs. Only six states responded that they had no copayment requirements at all.

In FY 2006, a total of nine states imposed new or higher copayments, comparable to the number in FY 2005 (eight), but down from the 20 states in FY 2004 and 17 states in FY 2003. Copayments on pharmacy services were the most commonly added or increased (seven states). Six states imposed new copayment requirements on emergency room services; five states imposed new requirements on physician services and outpatient hospital services; and four states imposed new requirements on inpatient hospital services. Three states imposed new requirements on dental services and two states added new requirements for vision, chiropractic and laboratory/radiology services.

For FY 2007, three states reported adopting new copayment requirements: one on emergency room services, another on drugs, and Kentucky used new DRA options to impose an array of new cost sharing requirements.

A few states reduced or eliminated copayments in FY 2006 and FY 2007 (three states and two states respectively). In particular, Florida's Medicaid reform waiver allowed health plans to waive or reduce – but not increase – cost sharing and a number of plans chose to do so to attract enrollments.

Copayment Changes in the DRA

Prior to the passage of the DRA, Federal Medicaid law limited copayments to nominal amounts, generally defined as $3.00 or less per service, and also prohibited states from applying copayments to certain services (e.g., emergency room visits) or certain eligibility groups (children and pregnant women). Federal law also required providers to render services regardless of whether the copayment is collected, although beneficiaries remained liable for the amounts. Further, with the exception of the Medicaid buy-in program for employed workers with disabilities (the "Ticket to Work" program) and certain Section 1115 waiver program expansion populations, federal law prohibited Medicaid programs from imposing premiums.

Subject to certain limits and exemptions, however, the DRA now provides new authority for states to impose premiums and greater than nominal cost-sharing on certain eligibility groups and most services. States may vary the premium and cost-sharing requirements by eligibility group and may also elect to make cost-sharing enforceable – that is, allow a provider to deny rendering services if the copayment requirement is not met.

Kentucky was the only state that reported plans to take advantage of the new DRA authority (effective June 2006) to impose higher than nominal cost sharing on certain eligibility groups. In connection with the creation of four new benefit packages, Kentucky imposed a number of new copayment requirements that vary by benefit package and population including a $50 inpatient hospital copayment for non-pregnant, institutionalized adults. Aged and disabled beneficiaries requiring long-term care services have a $10 inpatient hospital copayment requirement. Other areas subject to new, mostly nominal, copayment requirements include physician services, laboratory, diagnostic and radiology services, dental services, therapy services, chiropractic services, drugs, non-emergent visits to the emergency room, DME, and outpatient hospital visits. Aggregate annual drug copayments are limited to $225, as are aggregate annual medical copayments. Also, there is an aggregate family cap equal to five percent of income. Finally, Kentucky has elected to make the copayment requirements enforceable by providers.

Enforceability. Survey respondents were asked for FY 2007 whether their state had plans to make copayments enforceable for any eligibility group as allowed by the DRA. Only two states answered "Yes" (Kentucky and Rhode Island) and 28 states answered "No." Another 21 states, however, answered "Don't Know" suggesting a number of states may be considering this option for implementation in the future.

Benefits Changes

For FY 2006, 15 states implemented benefit cuts or restrictions, higher than the number for FY 2005 (seven) but lower than the total number of states restricting benefits in FY 2004 (19) or FY 2003 (18). For FY 2007, nine states reported plans to cut or restrict benefits including three states (Kentucky, West Virginia and Idaho) that used the DRA benefit flexibility provisions to redesign their Medicaid benefit packages. While participation is "voluntary" for beneficiaries in Idaho and some beneficiaries in Kentucky, meaning beneficiaries may "opt-out" if they wish to retain standard Medicaid, it is not clear how the opt-out will work and the new plans do have more limited packages than prior to the re-design. (See Appendix B for a more detailed discussion of Idaho's benefit restructuring.) No other state reported benefit changes for either FY 2006 or FY 2007 under the new DRA authority, although some state officials indicated that DRA options continued to be reviewed and evaluated.

Most benefit reductions in FY 2006 and FY 2007 were narrowly targeted and focused primarily on optional benefits for adults. Of the 15 states that cut or restricted benefits in FY 2006, seven states

placed limits on the number of monthly prescriptions, four states reduced or eliminated adult dental services, and three states reduced or eliminated adult vision services. For FY 2007, the most frequently cited cuts were reductions or elimination of adult dental services in four states, reductions in pharmacy benefits (three states), reductions or eliminations of adult vision services (three states), and reduction or elimination of chiropractic or mental health services (two states).

In addition to three states implementing benefit related DRA changes, three states in FY 2006 implemented broad benefit cuts (Maine, Missouri and Pennsylvania) and Oregon has fairly extensive benefit cuts planned for FY 2007:

- **Maine** reduced the benefit package for its waiver expansion adults including cuts to therapy services, podiatry, durable medical equipment (DME) 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 (which were restored in FY 2007), certain podiatric and DME services, rehabilitation services, diabetes self management training, audiology, hearing aids and associated testing services;

- **Pennsylvania** imposed limits on coverage for inpatient hospital care, inpatient medical rehabilitation, visits to outpatient providers (not applicable to pregnant women), inpatient psychiatric hospital care, and outpatient mental health services; and

- **Oregon** adopted policy changes to cut benefit for all adults including the elimination of vision coverage (except pregnant women), new limits on dental coverage (except pregnant women), elimination of most over-the-counter drug coverage, and a limit on inpatient hospital days.

At the same time that some states were reducing Medicaid benefits, 13 states in FY 2006 and 12 states in FY 2007 adopted benefit restorations and expansions. This includes four states in FY 2006 and seven states in FY 2007 that are restoring or expanding dental benefits. (See Appendix A-4a and A-4b for more detail on benefit related actions.)

Benefit Changes in the DRA

The DRA allows states to make some significant changes to their benefit structures. Prior to the DRA, all states were required to cover a set of mandatory services and states could receive federal match for covering optional services including drugs, dental care, and personal care. The DRA allows states to replace the current Medicaid benefits package with new "benchmark" or "benchmark equivalent" plans for certain groups. These benchmarks look like those used in the State Children's Health Insurance Program (SCHIP) and include an option for coverage approved by the Secretary of HHS. The DRA maintains Early Periodic Screening Diagnostic and Testing (EPSDT) services as a wraparound benefit for children, which essentially entitles children to a comprehensive set of services even if the services are not otherwise covered in the state's Medicaid plan. How children access these important services will need to be carefully monitored as states begin to implement changes under the DRA. The DRA also allows states to vary benefit structures across beneficiary groups and geographic areas of the state. However, the new benchmark benefit packages cannot be applied to groups that were not previously covered by Medicaid in a particular state. Kentucky and West Virginia were the first two states to use new authority in the DRA to restructure their benefit packages.[25]

Kentucky created KYHealth Choices with four benefit packages: Global Choices (the "default" package for those not falling into another package), Family Choices (for children, including SCHIP), Optimum Choices (for persons with MR/DD needing long term care services) and Comprehensive Choices (for elderly and disabled in need of long term care services). Each package has different service limits and cost-sharing requirements.[26] New service limits may apply to audiometric services, chiropractic services, dental services, home health, and various therapies. The state also limits the amount of funding it will pay (imposes new dollar limits) for hearing aids, prosthetic devices and vision hardware. Kentucky intends to phase in "Get Healthy" incentives that will be awarded for successful compliance with a disease management program. Incentives can be used to pay for additional services (dental, vision, or nutritional or smoking cessation counseling). Kentucky's reform plan also will provide premium subsidies for private coverage to beneficiaries that choose employer-sponsored insurance as an alternative benefit package. Under this option, beneficiaries would not receive Medicaid wrap around coverage, but they could move back to the Medicaid benchmark plan at any time.

West Virginia received approval under the DRA for an alternative benefit package for (non-pregnant) parents and children. The state will provide an "Enhanced" plan to persons that sign and comply with a "Medicaid Member Agreement" and a more limited "Basic" plan to those who do not sign the agreement. If the state determines an individual has not met his or her member agreement responsibilities, the individual will be moved from the "Enhanced" plan to the more limited "Basic" plan. The Basic plan includes all mandatory and some optional services but is more limited than the standard West Virginia Medicaid benefit package excluding, for example, diabetes care and mental health care and imposing a limit of four prescriptions per month limit. Children are covered for the EPSDT benefit in both the "Basic" and "Enhanced" plan. West Virginia also plans, in the future, to pilot "Healthy Reward Accounts" that will allow beneficiaries to earn credits for healthy behaviors that can be used to cover medical and pharmaceutical copayments. Any balance at the end of the year can be used for non-covered health services.

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[25] For more details on West Virginia and Kentucky see http://www.kff.org/medicaid/7529.cfm and http://www.kff.org/medicaid/7530.cfm

[26] Changes to cost-sharing are discussed in more detail in the copayments section of this report.

Long-Term Care and Home and Community–Based Services

While long-term care (LTC) services are not immune from the ongoing pressure to constrain Medicaid expenditure growth, a growing number of states are taking actions to balance their long-term care delivery systems by reducing reliance on institutional care and increase home and community-based service (HCBS) options. Cost containment actions or expansions in long-term care may be the result of changes related to nursing homes and ICRs/MR, or changes related to community-based long-term care services and supports. In FY 2006, 29 states took actions that expanded LTC services (primarily HCBS), while even more states plan expansions in LTC services (38 states) in FY 2007. This compares to 11 states taking actions to expand HCBS in FY 2005. Conversely, a total of 17 states took action to constrain long-term care service costs in FY 2006 and 10 states plan to cut or restrict LTC services in FY 2007.

The following section details state actions to both control and expand long-term care services in both institutional and community-based settings.[27] This section also includes results from survey questions about the impact of DRA long-term care eligibility changes and several new DRA-related long-term care options, grants and demonstration programs.

HCBS Programs. Spending on home and community-based services accounts for over one-third of total Medicaid long-term care spending, up from 21 percent a decade ago. This year's survey found that increasingly states are focusing efforts on reorienting their Medicaid long-term care delivery systems towards more community-based services. States efforts to expand HCBS options for long-term care are driven by consumer demand, the United States Supreme Court decision in Olmstead v. L.C. in June 1999 that stated that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act, and an effort to control long-term care costs.

Only five states in FY 2006 and three states in FY 2007 had new restrictions directed at HCBS programs. Most states already have limits in place for their community-based services such as coverage limits, enrollment caps, and waiting lists for services. This year's survey found that states are: imposing utilization controls or placing lower limits on certain waiver or personal care services, eliminating household support services for certain waiver populations; and placing a moratorium on new home health agencies.

In FY 2006, 26 states expanded their HCBS programs, while even more states plan to take action in FY 2007 (38). By far, the most commonly reported LTC expansion change in both years was adopting new HCBS waivers or expanding existing waivers. Other examples of LTC expansions include adding additional services to an existing HCBS waiver; expanding PACE programs;[28] permitting beneficiaries to hire certain related persons to provide personal care attendant services, and expanding eligibility for HCBS services by revising level of care (LOC) criteria (Figure 23).

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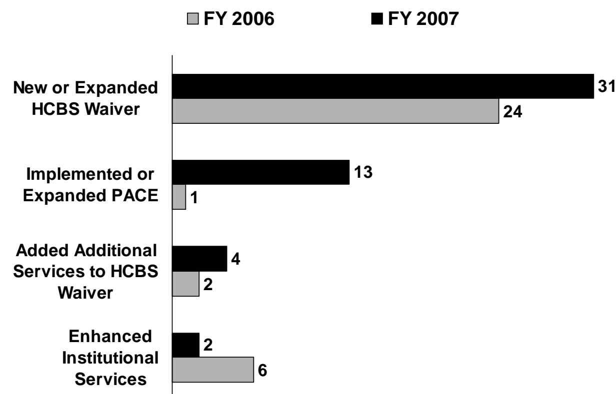
[27] Changes reported in this section exclude changes in financial LTC eligibility criteria which were reported under the "Eligibility section" of this report.
[28] The "Program of all All-Inclusive Care for the Elderly" (PACE) is a capitated managed care benefit for the frail elderly provided by a not-for-profit 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.



Institutions. In FY 2006, nine states implemented cost controls related to nursing homes and ICFs/MR, and six states are planning reductions in FY 2007.[29] Examples include policies designed to reduce the number of nursing home beds or ICFs/MR beds (through a moratorium, tightening of a certificate of need process or other bed closure effort), to tighten the LOC criteria for nursing facility services while leaving the LOC criteria for HCBS services unchanged (upon federal approval), to reduce payments for bed holds, and to restructure state-owned Mental Health/Mental Retardation facilities.[30]

Six states took positive action in FY 2006 and two states plan to take action in FY 2007 to remove restrictions on, or enhance, institutional services. Nebraska altered eligibility for nursing facility care by allowing third parties to provide an income supplement to cover the cost of a private room without having that supplement count as income to the Medicaid beneficiary. Other policies include repealing nursing facility bed moratoria and implementing quality add-on payments or a tiered reimbursement structure that provides for enhanced funding for nursing facilities based on quality indicators. In addition, the District of Columbia altered its ICF/MR bed-hold policy (increasing from 18 to 60 days per year) and New Hampshire increased the number of allowable bed-hold days.

Other LTC Actions: States also reported a variety of other LTC policy initiatives underway to improve the delivery of LTC services and increase community based alternatives. These initiatives are not counted as institutional or community-based expansions or restrictions in this survey, but were additional LTC actions reported by the states. State policies included initiatives to gather and report nursing facility quality indicators; preparation of long term care financing assessments, documenting investments in institutional and community-based care; implementation of a LTC "single point of entry" (SPOE) system or the renegotiation of exiting SPOE contracts to increase accountability; development of a universal LTC assessment instrument; and implementation of a pilot to evaluate tele-monitoring equipment in home care services. Additionally, three states in FY 2006 and eight states in FY 2007 implemented or expanded LTC managed care programs. Nine states in FY 2006, and four states in FY 2007, implemented or enhanced existing estate recovery programs.

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[29] Both Georgia and Louisiana made changes to the LOC determination process in FY 2007 (e.g. implementing a new tool and employing private contractors to electronically link LOC determinations to nursing facility or HCBS waiver acuity data). This action was counted as a restriction for both institutional and community-based services.

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

Long-Term Care Changes in the DRA

The DRA includes new provisions that give states increased flexibility in delivering long-term services in addition to new prohibitions on asset transfers that affect qualifying for Medicaid. The survey included several questions about the impact on states and beneficiaries of the mandatory DRA long-term care eligibility changes (e.g., changes to asset transfer rules, the treatment of home equity, application of penalty periods, etc.[31]), and the states' current plans to take advantage of one or more of the DRA LTC-related options, grants or demonstration programs.

The DRA requires states to lengthen the look-back period for asset transfers to establish Medicaid's eligibility for nursing home coverage from 3 to 5 years and changes the start date of the penalty period from the date of the transfer to the date of Medicaid eligibility. It also excludes coverage for individuals with home equity in excess of $500,000 (or up to $750,000 at state option). Regarding the impact of these DRA LTC eligibility provisions on Medicaid costs, over half (27) of the states estimated the impact as "insignificant." However, when asked to report on the impact on beneficiaries, most felt the impact on beneficiaries would be "moderate" (25) or "significant" (8).

The survey also asked states to report on their intentions in FY 2007 regarding the various DRA LTC-related options. Results found:

Long Term Care Partnership Program. 22 states indicated that they were planning to implement a Long-Term Care Partnership Program - policies designed to increase the role of private long-term care insurance in financing long-term services by allowing persons who purchase qualified long-term care insurance policies to shelter some or all of their assets when they apply for Medicaid after exhausting their policy benefits.

Money Follows the Person. 18 states indicated that they would apply for the "Money Follows the Person" demonstration grant to increase the use of community versus institutional services.

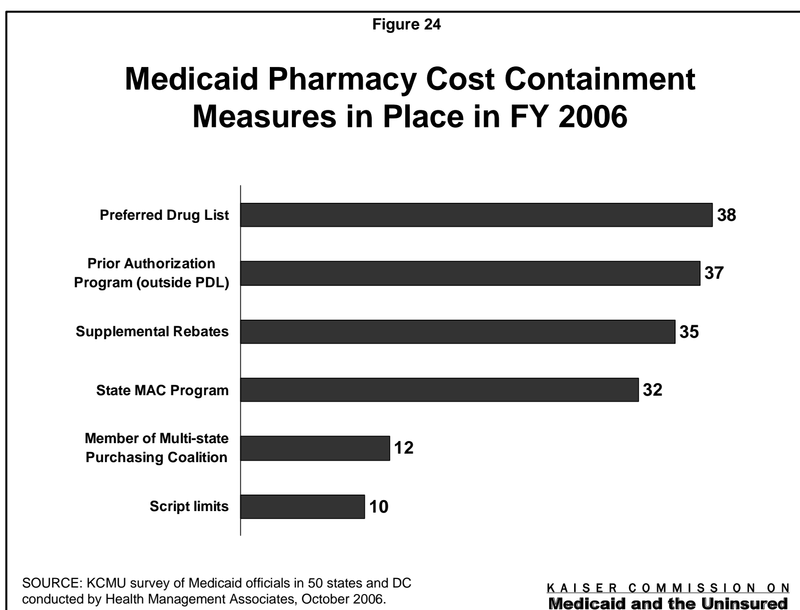
Self-Direction of Personal Services. 16 states also indicated that they would take advantage of the cash and counseling option which permits states to allow for self-direction of personal assistance services without a waiver.

HCBS as State Plan Option. No state reported plans to take advantage of the DRA option to offer HCBS services as a state plan option. The lack of CMS guidance on a number of critical programmatic issues (at the time of the survey) likely prevented states from determining how to modify existing HCBS waiver programs in ways that are compatible with the DRA provision. For example, the DRA allows an upper income limit of only 150 percent of the federal poverty level (FPL) while Section 1915(c) waiver authority allows states to match the upper income limit for institutional care which for many states is 300 percent of the SSI standard, or about 222 percent FPL. Also, states currently utilize multiple waivers with varying services that target specific populations (e.g. aged and disabled, developmentally disabled, traumatic brain injury, etc.). Further guidance from CMS is needed to clarify the parameters for needs criteria that could be included in the SPA in lieu of targeting specific populations.

[31] DRA Sections 6011, 6014 and 6016. See also: http://www.kff.org/medicaid/7486.cfm

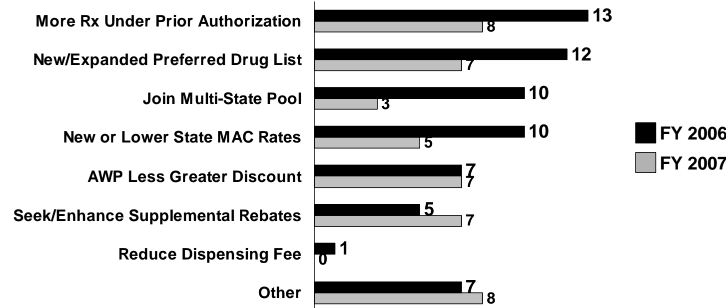
Prescription Drug Utilization and Cost Control Initiatives

Over the last six years, states have been aggressive in implementing policies designed to slow the growth in Medicaid spending for prescription drugs. Questions were added to this year's survey to quantify the number of states that had certain pharmacy cost containment measures in place by FY 2006. State responses show the widespread adoption of prior authorization programs, preferred drug lists (PDLs), supplemental rebate programs, and state MAC programs in particular (Figure 24).



Given the number of states with pharmacy cost controls in place and given the fact that the implementation of the Medicare prescription drug benefit reduces states' direct drug expenditures by almost half, state efforts to implement new or expanded pharmacy cost controls appear to have slowed down in FY 2006 and FY 2007. Twenty-nine states in FY 2006 and 27 states in FY 2007 implemented cost-containment initiatives in the area of prescription drugs, fewer than in previous years.

The most commonly implemented cost containment efforts include adoption of prior authorization programs, and establishing or enhancing a preferred drug list (Figure 25). Only one state (West Virginia in FY 2006), however, reported decreasing pharmacy dispensing fees while five states in FY 2006 and five states in FY 2007 increased dispensing fees. In FY 2006, West Virginia increased dispensing fees for generic drugs while reducing them for brands. (See Appendix A-5 for more detail on pharmacy cost containment actions.)



Federal Upper Limit (FUL) Changes in the DRA

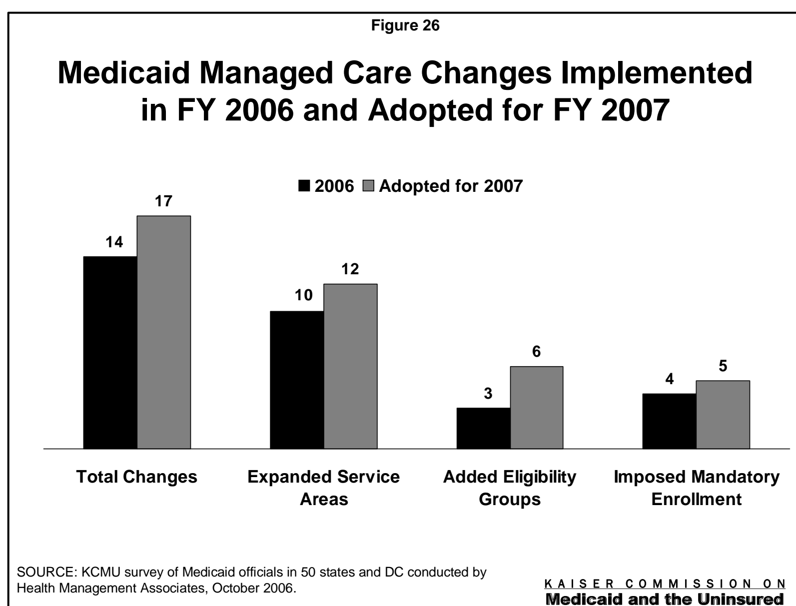
The DRA changed the way in which state Medicaid programs pay pharmacists for prescriptions. The changes included: modifying the federal upper payment limit (FUL) from 150 percent of the Average Wholesale Price to 250 percent of the Average Manufacturer Price (AMP) for the lowest cost drug; and requiring only two (instead of three or more) therapeutic equivalents before adding a drug to the FUL list. The DRA also included provisions related to rebates for physician administered drugs and for the inclusion of authorized generic drugs in the calculation of "best price" for drugs.

A question was added to this year's survey to gauge the potential impact of the new DRA changes to the FUL program. States were asked whether, in FY 2007, they expected the changes to produce "none or insignificant savings," "some or modest savings" or "significant savings." Responses were essentially split with 26 states estimating none or insignificant savings and 23 states estimating some or modest savings. No state estimated that the savings would be significant and two states answered that they did not know or could not estimate the likely impact.

Other Policy Changes

Managed Care Initiatives

States continue to expand the use of managed care delivery systems (14 states in FY 2006 and 17 with policies planned for FY 2007). CMS data indicate that as of December 2005, the proportion of all Medicaid beneficiaries enrolled in a managed care system had reached 63 percent.[32] Most of the managed care changes were related to states expanding managed care service areas followed by states that added new eligibility groups and states that made managed care enrollment mandatory (Figure 26).



A few states made changes that limited managed care. For example, Pennsylvania removed dual eligibles from managed care in FY 2006 and Colorado was required to return to voluntary enrollment in areas that had been mandatory when one of two remaining managed care organizations (MCOs) chose to end its contract with the state in FY 2007. Massachusetts reported that it phased down their primary care case management (PCCM), known as the Primary Care Clinician Program, and re-enrolled beneficiaries into managed care organizations in FY 2006, and Texas discontinued its PCCM program in urban counties in FY 2007, while at the same time expanding the PCCM program in rural areas.

Disease and Case Management

States continue to develop and enhance disease management and care management programs. Based on discussions with Medicaid officials, primary goals of these programs relate to improving quality of care and coordinating care especially for individuals with complex and chronic conditions such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF),

[32] CMS, "Medicaid Managed Care Enrollment as of December 31, 2005," Accessed 25 September 2006 at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/05_MdManCrPenRateandExpEnrll.asp

asthma or diabetes. States operate these programs as separate contracts with disease management organizations or through contract provisions with managed care organizations.

In FY 2006, a total of 12 states indicated that they initiated or added to disease management programs and 26 states adopted new disease management and care management initiatives for FY 2007. Based on discussions with Medicaid officials, the trend is to expand the programs to include additional disease states, such as programs for HIV/AIDS in addition to the more common programs that focus on diabetes, asthma, hypertension, congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD). For example, Arkansas initiated a program for high-risk pregnancy that involves tele-management, California and Florida expanded HIV/AIDS programs, and Utah was to implement a program for hemophilia disease management in FY 2007.

Two states reported that they ended their programs in FY 2006, one of which is currently in the bid process for another vendor scheduled to commence again during FY 2007.

Fraud and Abuse Controls

Maintaining the fiscal and program integrity of Medicaid is fundamental to program administration. In recent years, states have enhanced their integrity efforts by using new tools and technologies to prevent and detect fraud and abuse. This is an ongoing priority area in all Medicaid agencies which has taken on additional significance as it has received increasing attention in legislatures, in federal audits and in the press.[33]

Medicaid officials in 17 states indicated that they had taken specific actions to enhance their fraud and abuse control activities in FY 2006, and 21 states reported that they adopted new activities in this area for FY 2007. The new efforts included adding new staff for Surveillance and Utilization Review (SURS), enhanced data mining capabilities, contracting with vendors who specialize in this area with advanced fraud detection algorithms, acquiring new technologies and developing internal protocols and policies to improve coordination with the attorney general, inspector general and other state and federal agencies. In FY 2006, two states reported becoming a part of the Medi-Medi program, and two additional states indicated they will join Medi-Medi in FY 2007.

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[33] For example, see: Clifford J. Levy and Michael Luo, "New York Medicaid Fraud May Reach Into Billions," New York Times, July 18, 2005.

Program Integrity Provisions in the DRA

The DRA created a new Medicaid Integrity Program to increase the government's capacity to prevent, detect, and address fraud and abuse in the Medicaid program. The law requires CMS to develop a comprehensive Medicaid program integrity plan before October 2006. Under the new Medicaid Integrity Program, which is modeled on a similar program created for Medicare in 1996, CMS can enter into program integrity contracts to review the activities of providers, perform audits, identify overpayments, and educate providers and beneficiaries. The law also requires CMS to hire 100 new employees to support states in their efforts to address provider fraud and abuse. The program provides new resources to CMS to carry out these responsibilities, as well as to the Department of Health and Human Services' (HHS) Office of Inspector General (OIG). The DRA also included funding to expand the Medicare-Medicaid (Medi-Medi) data match program that currently operates in 10 states. The program coordinates Medicare and Medicaid program integrity efforts to protect both programs from fraud, waste and abuse by matching data and comparing billing patterns for providers that participate in both programs. The DRA also provides states incentives to establish State False Claims Acts (FCA).

Grants, Demonstrations and Other State Plan Options in the DRA

Buy-In Program for Disabled Children. The DRA includes a new option which allows low-income families of disabled children to purchase Medicaid coverage for such children. Federal participation is limited to families with incomes below 300% of the federal poverty level. Three states indicated that they plan to implement this option.

Medicaid Transformation Grants. The DRA included $75 million in FY 2007 and FY 2008 for Medicaid Transformation Grants to fund research and design of ways to transform Medicaid systems to increase the quality and efficiency of care. CMS encouraged states to look at nine particular focus areas that are quite varied – from improving collection rates from estates of amounts owed under Medicaid to promoting personal responsibility and prevention services for beneficiaries. The states were notified in late July 2006 that they could apply by September 15, 2006 (later revised to October 2, 2006) for these grants. Twenty-six states indicated that they are applying for Medicaid transformation grants. Four states indicated that their grant applications would relate to either health information technology or electronic medical records or both and one state indicated that they hoped to get a grant to work on integration of behavioral health care with primary care.

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

State Option to Establish Non-Emergency Medical Transportation Program. The DRA allows states to establish a non-emergency medical transportation brokerage program in order to provide more cost effective transportation for Medicaid enrollees that need access to medical services and have no other means of transportation. The DRA would require a competitive bidding process to select the transportation broker. Twelve states indicated that they planned to implement this option.

See Appendix A-6 for more information on DRA related changes

4. Provider Taxes

States use provider taxes to generate funds to support their Medicaid programs. The funds generated by these taxes are used by states to support their overall Medicaid budget, finance specific provider rate increases or to help address overall state budget shortfalls. The most common provider categories that are assessed include nursing facilities, intermediate care facilities for the mentally retarded (or developmentally disabled), hospitals, and managed care organizations that contract with state Medicaid programs.

At the start of fiscal year 2006 there were thirty-eight states that had a Medicaid tax for at least one category of providers. Twenty-three of these states taxed more than one category of providers. In FY 2006, eleven states implemented new provider taxes, although nearly half of all states said they planned to increase or impose new provider assessments or taxes in last year's survey. The President's FY 2006 budget included legislative proposals that would have re-defined and limited acceptable Medicaid provider taxes for FY 2006 and beyond. These proposals prompted states to adopt some of these taxes so they could potentially generate additional revenue for one year or perhaps request legislation to be "grandfathered" or exempt from future changes. Ultimately, Congress never passed legislation to enact the President's proposals. By the end of FY 2006, 41 states had at least one Medicaid provider tax including 30 nursing home provider taxes, 22 ICF-MR taxes, 18 hospital taxes, and 14 MCO taxes.

Many of these same proposals were included in the President's FY 2007 budget, although this year the Administration indicated that it may implement some or all of these limitations on Medicaid provider taxes by promulgating new rules. A group of Senators, House members and the National Governor's Association sent letters to Secretary Leavitt requesting that HHS not issue these new rules. The outcome of these proposals is still uncertain, but in the meantime, these financing measures have been met with intense scrutiny from CMS. As a result, only one new provider tax (a tax on Intermediate Care Facilities for the Developmentally Disabled) is being implemented in FY 2007 and only seven states are planning to increase any provider taxes.

5. Quality Initiatives and Pay for Performance

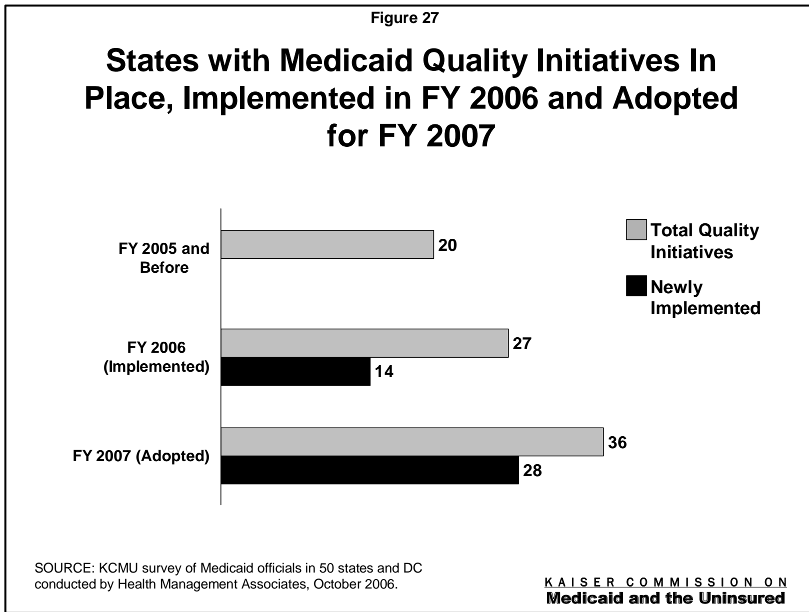
An emerging area of policy focus for Medicaid is to improve the quality of health and health care among Medicaid beneficiaries through specific reimbursement and other quality-focused incentives. Over the past decade, many Medicaid programs have followed the lead of the private sector and have begun to measure and monitor specific services and actions that are proxies for health care quality, most frequently related to primary and preventive care for children or pregnant women and care for people with chronic conditions. Medicaid programs have focused on monitoring the performance of managed care providers, specifically looking at immunization rates, access to prenatal care, and the extent to which people with chronic conditions (like asthma and diabetes) received recommended tests, medications and other treatments according to evidence-based guidelines.

With the development of HEDIS® and CAHPS® by the National Committee on Quality Assurance (NCQA), state Medicaid programs were able to use nationally accepted, state-of-the-art measures

that had credibility among providers and policy makers.[34] States increasingly began to measure the performance of health plans and their primary care case management systems, to track improvement over time, to create report cards for the public to help inform beneficiary decisions around plan selection and to allow Medicaid as a purchaser to assess the performance of the providers with which it contracts.

For this survey, states were asked to identify whether they had used quality incentives of any kind in FY 2005 or before, and to specify new quality strategies they implemented in FY 2006 and planned to implement in FY 2007. Medicaid officials in 20 states indicated in the survey that they had "quality incentives" in place in 2005 or before. Discussions with Medicaid officials indicated that these programs often included financial incentives for managed care organizations or provider groups that met or exceeded specified benchmarks on a range of measures (including immunizations, prenatal care, and diabetes care management). The financial incentives may be a with-hold from or add-on to the per-member-per-month capitation payment from Medicaid, bonus payments or an algorithm to auto-assign more mandatory managed care enrollees in plans with better performance. In many cases, public reporting on MCO performance was cited as a non-financial component of incentive programs.

During 2006, a total of 14 states indicated that they had implemented specific new quality incentive programs, including 10 states that classified their new policies as "pay for performance." For 2007, a total of 28 states indicated that they were implementing new quality incentive initiatives, including 23 states that characterized their initiatives as pay for performance (Figure 27).



[34] The National Committee for Quality Assurance (NCQA) sponsors, supports and maintains HEDIS data. HEDIS (Health Plan Employer Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

Some examples of these programs include the following:

- Pennsylvania instituted an array of pay for performance programs for physicians (designed to encourage disease management), PCCM programs (5 percent bonus for performance on measures such as well care visits, emergency department visits, prenatal visits, EPSDT screens and cancer screens), hospitals (rate increases tied to performance on specified measures such as re-admission rates for chronic disease, clinical indicators, pharmacy error reduction and quality reporting), and MCOs (earn up to 1 percent of their capitated premium based on HEDIS performance measures).

- Massachusetts was implementing pay for performance under the health reform law, including measures to reduce racial and ethnic disparities as well as improving overall quality.

- Minnesota withholds 5 percent of the capitation, which is returned when the MCO meets performance targets for administrative and clinical measures. Funds not paid go to a "bonus pool" which is paid to reward outstanding performance on specific clinical measures.

- Tennessee links payment to MCOs to five quality measures, and pays a disease management bonus based on health outcomes. Tennessee also instituted a per claim bonus for pharmacists based on the generic dispensing rate. (Note: in FY 2007 this policy was replaced with an increased dispensing fee for generics.)

- Georgia was implementing a statewide roll-out of managed care in 2007, with health plans able to earn incentives based on the improvement of health outcomes of their enrollees.

- Missouri will auto assign enrollees to plans based on HEDIS performance, and will provide incentive bonus and penalties for EPSDT screening performance.

The survey interview also asked Medicaid directors whether the state the state used various quality performance measures. A total of 34 states indicated that they required the use and reporting of HEDIS® measures, a total of 31 states reported that they required the use and reporting of CAHPS®, and 18 states indicated that they required health plans with which they contract to be accredited by NCQA. One state indicated that it gave extra credit in the bid process to plans that were NCQA accredited.

Comment of State Medicaid Officials on Quality:

"We are doing disease management and care management. The goal of the whole Medicaid enterprise is improved health outcomes for our members. We continue to move forward in that direction so we are interested in both quality and cost-effectiveness."

6. Section 1115 Medicaid Waivers

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

Section 1115 waivers have been used throughout the history of the Medicaid program to test new ways to provide coverage and deliver services to low-income populations. States also use Section 1115 waiver authority to establish single benefit Medicaid coverage, such as for family planning or prescription drug coverage for specific population groups (Figure 28).

Figure 28

Key Periods of Medicaid 1115 Waiver Activity

	Waiver Activity
1965–1990	Limited waiver activity
1990s	Mandatory managed care and coverage expansions (Including Oregon Health Plan & TennCare)
2000–2004	SCHIP waivers HIFA waiver initiative released As fiscal pressures grew, most waivers focused on reductions
2005–Current	Broad restructuring Tiered benefits Changes in special financing arrangements

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As discussed in other sections of this report, the Deficit Reduction Act of 2005 contained provisions designed to enable states to accomplish through Medicaid State Plan Amendments many changes that would have previously required a waiver. In this survey, states were asked about plans to implement Section 1115 Waivers.

- 12 states indicated that they plan to implement a new Section 1115 comprehensive Medicaid reform waiver or waiver amendment in FY 2007. By contrast there were 25 states that indicated an intention to implement a new Section 1115 waiver in FY 2006.[35,36]

- Three of these waiver applications have been approved by CMS (Arkansas, Florida and Vermont)

[35] Some of the states that planned to implement Section 1115 Medicaid waivers in FY 2006 did not complete that implementation in FY 2006 and are still working on the same waivers for FY 2007.
[36] 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.

- Nine states indicated that they had previous plans to move forward with a Section 1115 waiver that changed in light of the new DRA options.

States indicated a wide range of goals for their waivers, and most waivers had multiple goals. The three top goals for waivers were: increasing private or employer-sponsored coverage (ten states), encouraging personal responsibility through premiums or cost sharing (seven states), and expanding eligibility (five states).

Florida is an example of one state implementing an 1115 Waiver in FY 2007 with major changes to their already-eligible Medicaid population.

Florida Waiver

Florida is using an 1115 Waiver to convert the acute care side of its Medicaid program from a defined benefit approach (where it pays for a guaranteed set of benefits) to a defined contribution approach (where it pays a fixed amount for each beneficiary). Under the waiver, the state offers participating managed care plans risk-adjusted premiums for beneficiaries and allows the plans new discretion to design benefits within state standards and to control utilization. Adults are also subject to a new annual maximum benefit limit. Children remain entitled to EPSDT coverage. Beneficiaries choose among the different managed care plans available in their area or can "opt-out" and have the premium go toward the purchase employer-sponsored or individual coverage.

The plan also would allow individuals to earn "Enhanced Benefits" as a reward for healthy behavior. Up to $125 per year of credits may be earned and used to purchase services not covered by their health plan or health-related products and supplies. Enrollment in the Florida waiver started on a pilot basis in 2 counties in September 2006.

7. Impact of the Medicare Part D Prescription Drug Benefit

On January 1, 2006, Medicaid drug coverage ended for over six million beneficiaries eligible for both Medicare and Medicaid ("dual eligibles"). These individuals were transitioned to newly implemented Medicare "Part D" prescription drug coverage. Various transition problems, however, made it difficult for some dual eligibles to obtain needed prescriptions causing many states to step in to provide temporary coverage programs.[37] CMS took a number of corrective actions at the federal level and also took the unusual step of creating a Medicare demonstration program to repay states for the costs of their temporary programs.

The FY 2006 survey asked states about the fiscal impact of the "clawback," Part D-related Medicaid enrollment impacts, state actions regarding "wrap-around" coverage for Part D copayments as well as state reimbursements under the Medicare demonstration program and an open-ended question about other Part D issues that the states expected to affect Medicaid in FY 2007.

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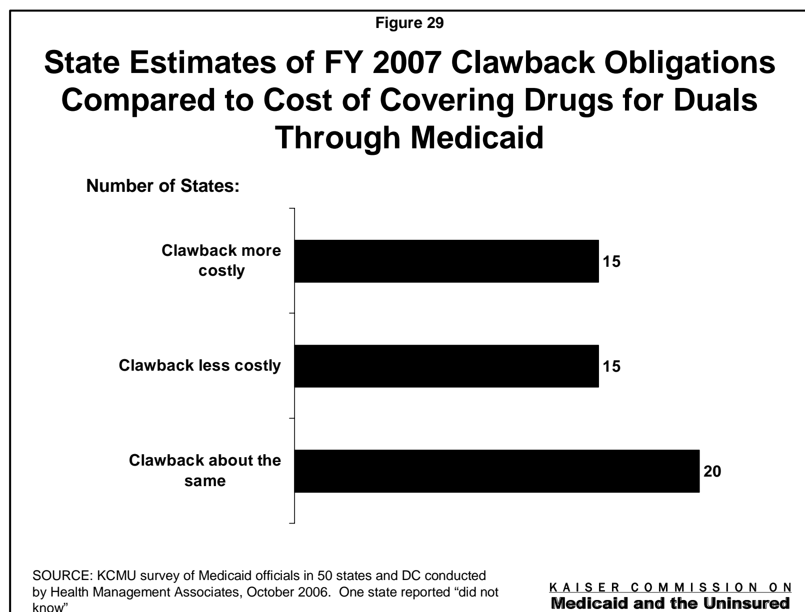
[37] *See* Vernon Smith, Kathleen Gifford, Sandy Kramer and Linda Elam, *The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation, Results from a 50-State Snapshot*, Kaiser Commission on Medicaid and the Uninsured, February 2006, Publication No. 7467.

Fiscal Impact of the Clawback

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003[38] (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 dual eligibles in 2003, trended forward and multiplied by the number of dual eligibles 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 February 2006, CMS made downward formula adjustments that had the effect of reducing state clawback obligations for FY 2006 compared to the projections released the previous fall. Despite this adjustment, a number of states reported that the clawback formula still resulted in a negative state fiscal impact rather than a savings – even as the phase-down percentage is applied. Compared to what Medicaid would have paid if drugs were still covered by Medicaid for dual eligibles in FY 2007, officials in 15 states reported that their FY 2007 clawback obligation was more costly, 15 states said the clawback was less costly and 20 said it was "about the same" and one state responded that it "did not know". Also, 18 states did not expect cost savings in future years, despite the scheduled partial phase-down of the clawback (Figure 29).



A number of states reporting a negative fiscal impact cited the annual inflation factor used in the clawback formula as being significantly higher than the growth that would have occurred in the Medicaid pharmacy program in the absence of Part D.

[38] Pub. L. 108-173

Comments of State Medicaid Officials on the Clawback:

"We're funding a federal program and that's not right. The payments are a little less than projected, but it's still inherently unfair on its face."

"[We] anticipate that inflation will offset the benefit of the reduced clawback."

"CMS is using 2003 [for the base year], which is the year we went from accrual to cash. So we had only three quarters of [drug] rebates, and so per capita costs are too high. It's not saving us."

"We expect a five percent savings in FY 2007, but less in future years as clawback inflation exceeds expected inflation in our program."

"[It] was not near as costly as expected."

Enrollment Impacts

Prior to the implementation of Part D, states were concerned that federal outreach efforts to enroll low-income Medicare beneficiaries into the Part D low-income subsidy program would result in Medicaid enrollment increases as well – often referred to as the "woodwork effect." Few states, however, reported seeing evidence of a woodwork effect with most reporting either no increase in enrollments related to Part D (27 states) or that the state did not know whether an increase had occurred (13 states). Eleven states reported a Part D-related Medicaid enrollment increase.

Also, few states reported experiencing a Part D-related decrease in Medicaid enrollments in eligibility categories where individuals "spend-down" to meet an income eligibility threshold (e.g., the Medically Needy eligibility group). Twenty states reported no decrease, 18 reported that the state did not know whether a decrease had occurred and eight reported that a decrease had occurred. (Five states responded that their state did have not have a spend-down eligibility program.)

Wrap-around Coverage for Part D Copayments

Part D imposes copayments of $1 to $5 for non-institutionalized dual eligibles. These amounts are higher than those imposed by some states. The MMA, however, does not allow states to receive federal Medicaid matching funds if a state chooses to cover Part D copayment obligations. Despite this funding prohibition, twelve states reported providing wrap-around coverage for Part D copayment obligations for dual eligibles.

Medicare Demonstration Plan Reimbursements

In response to the transition problems experienced by many dual eligibles when the Part D benefit took effect, CMS created a demonstration program to reimburse states for the costs they incurred for temporary drug coverage programs for dual eligibles after January 1, 2006. Of the 43 states that reported applying for reimbursement under the demonstration program, 14 reported having recently received full or partial reimbursement as of the date of the survey and 29 states reported that they had not yet received any reimbursement. Seven states had not yet applied for reimbursement, and in some cases, Medicaid officials indicated that the amounts involved were relatively small and they were not concerned about the delay in reimbursement.

Future Issues

State officials were also asked to identify other issues with regard to Part D that they expected to affect Medicaid in FY 2007. This was an open-ended, non-structured question. Responses were grouped into five categories: administrative impacts, beneficiary impacts, fiscal impacts, CY 2007 contract issues and impacts on pharmacies.

- ***Administrative Impacts.*** Twenty states raised concerns over administrative issues – especially ongoing data exchange issues between the states and CMS that impact the ability of CMS to identify and enroll dual eligibles in Part D in a timely manner. Some states also cited the ongoing concerns with the treatment of retroactive Medicaid eligibility segments and the ongoing staffing requirements to field Part D-related telephone calls. Finally, one state official expressed concern over who at CMS would take responsibility for Medicaid-related Part D issues after the current Part D implementation team is redeployed.

- ***Beneficiary Impacts***. Ten states raised concerns over beneficiary impacts including continuity of care issues, the impact of new copayment requirements, mental health-related and long-term care-related coverage and utilization issues, access to non-formulary drugs, gaps in coverage and beneficiaries that may continue to "fall through the cracks."

- ***Fiscal Impacts.*** Seven states cited ongoing fiscal concerns related to the clawback, impacts on supplemental rebate programs from the loss of drug claims volume and increasing pressure on the state to "fill the donut hole."

- ***CY 2007 Contract Issues.*** Eight states expressed concerns relating to the plan transitions that will be required for some dual eligibles in 2007 due to changing low-income subsidy benchmark amounts and other plan changes.

- ***Pharmacy Impacts.*** A few states (three) expressed concern over the impacts of Part D on pharmacies and pharmacy access due lower Part D reimbursements (compared to Medicaid).

8. Outlook for the Future

The majority of states face some uncertainty about the future of their Medicaid programs because directions and policies could change or be affected by the outcome of the elections in the fall and the health care priorities of a new governor. Thirty-six states have gubernatorial races and a number of state officials acknowledged the uncertainty created by the fact that there will be a new governor in January.

While total program spending and enrollment growth slowed dramatically, states officials continued to express concerns about exogenous program pressures such as overall health care costs. Medicaid officials also raised significant concerns about continued federal scrutiny targeted at state financing for Medicaid. As described by one Medicaid director, there is a feeling among many states that the federal government is seeking "to limit or cost-shift legitimate costs to the states." States often expressed frustration over increased administrative burdens associated with this federal oversight and inconsistencies in the application of federal policies in this area of financing.

Medicaid officials said they will continue to search for strategies to control Medicaid costs in light of the changes in the federal-state partnership around Medicaid financing as well as program demands related to the growing number of uninsured, continued declines in employer sponsored coverage and the aging population's demand for long-term care services. However, states will also focus on other initiatives that could improve quality and program integrity. States reported that going forward they will look to use better care management strategies, additional pay for performance reimbursement approaches, and new electronic health records. An increasing number of states are beginning to look for opportunities they may have to use given their status as a major health care purchaser to improve quality and improve health outcomes.

Looking ahead, a few states are moving forward with major Medicaid reform using waiver authority (like Florida and Vermont), some states have plans to evaluate more options made available in the DRA and a number of states look to expand health coverage to new populations. Major reform efforts in states like Massachusetts or Illinois relied on a strong Medicaid base of coverage and financing. Medicaid will undoubtedly continue to be a major foundation for state health reform efforts.

Conclusion

After a period of intense fiscal stress, state revenues are rebounding in most areas of the country and Medicaid spending slowed to near record levels. However, because states continue to face Medicaid pressures related to general health care cost inflation, increasing numbers of uninsured, the growing numbers of elderly and disabled, and the shift in program costs from the federal government to the states, officials indicated that they will remain focused on strategies to be effective purchasers and to control Medicaid costs. States continued to implement policies to freeze provider rates, trim benefits, control prescription drug spending and to cut eligibility, but as revenues improved there was also some relief from the pressure to implement changes that would generate substantial and immediate savings. States were able to turn more attention to initiatives that hold promise for longer-term cost and quality benefits such as disease management, new pay for performance programs and program integrity enhancements. Some states were able to restore or expand eligibility and benefits or enhance provider payments. Many states dedicated some investment directed at expanding home and community based long-term care services in an effort to redirect care away from institutional providers.

State Medicaid programs were busy with the implementation of the new Medicare Part D program and with some new requirements included in the Deficit Reduction Act, such as changes to the asset transfer rules and new citizenship documentation requirements. Few states have plans to use the new flexibility around benefits and cost sharing in FY 2007, but some states are still evaluating these options. More states appeared to be interested in some of the new options and grant programs included in the DRA in the long-term care area. An increasing number of states are talking about major health insurance coverage initiatives. The major reform passed in Massachusetts last year reinvigorated a discussion about state strategies that might move toward more universal health coverage. Illinois has a plan to extend health coverage to all residents and a number of other states have plans to expand coverage to all children. A strong base of Medicaid coverage and financing is a common thread to some of these coverage efforts.

FY 2007 may be another important turning point for Medicaid and with new options available to states to redesign programs, the direction for Medicaid will be affected by the elections in the fall, the on-going tension in the federal-state partnership for the program and possibly the recommendations of Secretary Leavitt's Medicaid Commission expected by the end of the calendar year. The decisions and the directions that states take will have critical implications for the availability and affordability of health care for the millions of low-income individuals who rely on health coverage through their state Medicaid program.

Appendix A: State Survey Responses

Appendix A-1a: Cost Containment Actions Taken in the 50 States and District of Columbia FY 2006

States	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Initiatives	DM/CM	Fraud and Abuse	LTC
Alabama	X						X	X	X
Alaska	X	X							X
Arizona	X								
Arkansas	X	X					X		
California	X		X						
Colorado	X					X			
Connecticut	X			X					
Delaware	X	X							
District of Columbia	X								
Florida	X	X		X				X	X
Georgia	X		X	X	X	X	X		X
Hawaii	X								
Idaho	X	X		X					
Illinois	X		X					X	
Indiana	X	X							X
Iowa		X					X	X	
Kansas		X				X	X		
Kentucky	X	X	X		X		X		
Louisiana	X							X	
Maine	X	X	X						
Maryland	X	X			X			X	X
Massachusetts		X				X		X	
Michigan	X			X	X				
Minnesota	X	X	X	X		X			X
Mississippi	X	X	X	X					
Missouri	X	X	X	X	X			X	X
Montana	X			X					
Nebraska	X	X				X			
Nevada	X								
New Hampshire	X							X	
New Jersey	X						X	X	
New Mexico	X	X		X					
New York	X	X	X	X	X	X		X	
North Carolina	X	X	X	X	X		X	X	X
North Dakota		X							
Ohio	X	X	X	X	X	X		X	X
Oklahoma	X	X							
Oregon	X			X			X		
Pennsylvania	X	X	X	X	X	X		X	
Rhode Island	X							X	X
South Carolina	X					X		X	X
South Dakota		X							X
Tennessee	X	X	X	X			X		X
Texas	X		X						X
Utah	X								
Vermont	X	X	X	X		X			X
Virginia	X					X	X		
Washington	X							X	X
West Virginia	X	X		X		X	X		
Wisconsin	X	X				X			
Wyoming	X	X							
Total	**46**	**29**	**15**	**18**	**9**	**14**	**12**	**17**	**17**

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

States	Provider Payments	Pharmacy Controls	Benefit Reductions	Eligibility Cuts	Copays	Managed Care Initiatives	DM/CM	Fraud and Abuse	LTC
Alabama	X	X					X	X	X
Alaska	X	X						X	
Arizona	X								
Arkansas	X	X						X	
California	X					X	X	X	
Colorado	X			X		X	X		
Connecticut									
Delaware	X	X					X		
District of Columbia	X	X				X	X		
Florida	X	X				X	X	X	
Georgia	X					X			X
Hawaii	X								
Idaho	X	X	X	X			X		
Illinois	X					X	X	X	
Indiana	X	X							
Iowa						X	X		X
Kansas		X				X			X
Kentucky	X		X		X		X		
Louisiana	X							X	X
Maine	X	X				X	X		X
Maryland	X		X						
Massachusetts		X						X	
Michigan	X	X			X		X		
Minnesota	X	X				X			
Mississippi	X								
Missouri	X	X							
Montana	X	X							
Nebraska	X	X						X	
Nevada	X						X		X
New Hampshire	X						X	X	
New Jersey	X							X	
New Mexico		X							
New York	X	X				X	X	X	
North Carolina						X	X	X	
North Dakota		X					X		
Ohio	X					X	X	X	
Oklahoma	X	X					X	X	
Oregon	X		X						
Pennsylvania	X	X						X	
Rhode Island	X	X		X	X		X		
South Carolina	X		X	X		X		X	X
South Dakota									
Tennessee	X	X	X			X	X		
Texas	X					X			X
Utah	X	X	X				X	X	
Vermont	X	X	X	X			X		
Virginia	X						X	X	X
Washington	X						X	X	
West Virginia	X		X				X		
Wisconsin	X	X				X		X	
Wyoming	X	X							
Total	**43**	**27**	**9**	**5**	**3**	**17**	**26**	**21**	**10**

Appendix A-2a: Positive Policy Actions Taken in the 50 States and District of Columbia FY 2006

States	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Long Term Care Expansions
Alabama	X			
Alaska	X	X		X
Arizona	X	X		
Arkansas	X		X	
California	X	X	X	X
Colorado	X		X	
Connecticut	X		X	
Delaware	X			
District of Columbia	X		X	X
Florida		X	X	
Georgia				X
Hawaii	X			
Idaho	X		X	X
Illinois	X		X	X
Indiana	X			X
Iowa	X		X	X
Kansas	X	X	X	X
Kentucky	X			
Louisiana	X			
Maine	X		X	
Maryland	X		X	X
Massachusetts	X	X	X	X
Michigan	X	X	X	X
Minnesota	X	X		X
Mississippi				
Missouri	X			
Montana	X			X
Nebraska	X			X
Nevada	X	X		X
New Hampshire				X
New Jersey	X			
New Mexico	X			
New York	X			
North Carolina	X	X	X	
North Dakota	X		X	X
Ohio	X			X
Oklahoma	X	X	X	
Oregon	X		X	
Pennsylvania	X		X	X
Rhode Island	X			X
South Carolina	X	X		X
South Dakota	X			
Tennessee	X			
Texas		X	X	X
Utah	X		X	X
Vermont	X		X	X
Virginia	X			X
Washington	X		X	X
West Virginia	X		X	
Wisconsin	X		X	X
Wyoming	X		X	X
Total	**46**	**13**	**26**	**29**

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

States	Provider Payment Increases	Benefit Expansions	Eligibility Expansions	Long Term Care Expansions
Alabama	X			
Alaska	X	X		X
Arizona	X			
Arkansas	X			X
California	X		X	X
Colorado	X		X	X
Connecticut	X		X	X
Delaware	X			X
District of Columbia	X	X	X	
Florida		X	X	X
Georgia	X	X		X
Hawaii	X		X	
Idaho	X	X	X	
Illinois	X			X
Indiana	X		X	X
Iowa	X	X	X	X
Kansas	X		X	X
Kentucky	X			X
Louisiana	X		X	X
Maine	X			
Maryland	X		X	X
Massachusetts	X		X	X
Michigan	X			X
Minnesota	X			X
Mississippi				
Missouri	X	X		X
Montana	X		X	X
Nebraska	X			X
Nevada	X		X	X
New Hampshire	X			
New Jersey	X			X
New Mexico	X	X	X	X
New York	X			X
North Carolina				X
North Dakota	X			X
Ohio	X			X
Oklahoma	X	X	X	X
Oregon	X		X	
Pennsylvania	X		X	
Rhode Island	X			X
South Carolina	X	X		X
South Dakota	X		X	
Tennessee	X		X	X
Texas			X	X
Utah	X		X	X
Vermont	X	X	X	X
Virginia	X			X
Washington	X			X
West Virginia	X		X	
Wisconsin	X		X	
Wyoming	X	X		X
Total	**47**	**12**	**26**	**38**

Appendix A-3a: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2006

State	Eligibility, Premium and Application Changes
Alabama	
Alaska	
Arizona	
Arkansas	**Aged & Disabled:** Expansion: Removal of Income Cap for income trusts (<.5%, 8/15/05) **Application:** ARKids First Telephone Renewals - Completed if original renewal form was not returned in order to prevent case closure.
California	**Application:** Made changes to the Medi-Cal annual redetermination form to decrease program turnover and increase the rate at which the form is complete and returned subsequently resulting in more individuals remaining on the program.
Colorado	**Application:** Presumptive Eligibility
Connecticut	**Parents:** Restored eligibility for parents to 150% FPL (7/1/05) **Application:** Eliminated self-declaration of income (7/1/05).
Delaware	
District of Columbia	**Application:** Implemented a simplified application and allowed customers to recertify by phone; In addition, all recent mailings include both English and Spanish versions.
Florida	**Aged & Disabled:** Eliminated MEDS-AD coverage for individuals covered by Medicare (70,000, 1/06) **Application:** The department continues to move forward with its "modernization" efforts which began in 2003. These changes include the increased use of a web based application, use of community partners to act as intake points for applications and adjustments to verification requirements as needed.
Georgia	**Application:** Citizenship verification through a state plan. Income verification is now required for family Medicaid programs. Resource verification also for Low-Income Medicaid.
Hawaii	
Idaho	**All:** Remove asset test (4/06) **Aged & Disabled:** Remove asset test & added asset transfer restrictions Mandate Medicare coverage for Medicaid recipients who are Medicare qualified (4/06)
Illinois	**Parents:** Increased level from 133% to 185% FPL (56,000, 1/1/06) **Aged/Disabled:** Increased asset disregard from $12,500 to $17,500 for senior community care waiver **Other:** Ticket to Work for adults w/ CP (450, 7/1/05) **Application:** Passive redetermination for kids (4/1/06) Web-based application for kids, FamilyCare, pregnant women.
Indiana	**Medically Needy:** spend down automation (not counted as a restriction or expansion)
Iowa	**Parents:** IowaCare - 1115 waiver expansion to 300% of FPL for pregnant women (16, 7/1/5) **Adults:** IowaCare - 1115 Waiver Expansion up to 200% (17,000, 7/1/05) **Other:** Implemented Iowa Family Planning - 1115 Waiver (14,649, 2/1/06) **Application:** For IowaCare 1115 Waiver population ONLY, used a simplified application and self-declaration of income
Kansas	**Aged & Disabled:** Increase LTC standard $50 **Application:** Created short application for Medicare Savings & Subsidy D. Relaxed administrative processes for these applicants. Added presumptive eligibility for parents and kids.
Kentucky	
Louisiana	
Maine	**Adults:** Reopening of childless adult waiver ("unfreezing enrollment") (10,000, 4/06)
Maryland	**Aged & Disabled:** The Employed Persons with Disabilities Program will provide full Medicaid coverage to disabled individuals with incomes up to 300 percent FPL and is scheduled to begin April 2006. (400, 4/1/06)
Massachusetts	**Aged & Disabled:** Program of All-Inclusive Care for the Elderly (PACE) increased the income level to 300% of the SSI federal benefit rate (FBR) for an individual. This same change was approved for the income eligibility level for the Frail Elders Home - and Community-Based Services Waiver.

State	Eligibility, Premium and Application Changes
Michigan	**Children:** New asset test for Group 2 persons ages 19 & 20 **Parents:** New asset test for Caretaker Relatives (5/1/06) **Aged & Disabled:** LTC changes to annuity exclusion (10/1/05) **Other:** Family planning waiver ("Plan First!") (7/1/06)
Minnesota	**Application:**, In MA (the "regular Medicaid program): Eligibility for all pregnant women is redeterimined at the end of the postpartum period, replacing a policy that allowed a delay until the regularly recurring renewal if the woman had been on MA or part of an MA-eligible family; verification of all assets is required at application and renewal, instead of only when assets were within $300 of the limit; verification of a reported change in earned income is required immediately if it adversely affects eligibility. (10/1/05) For the MInnesotaCare program (Medicaid waiver expansion group): Verification of all income sources is required at renewal, instead of verifying only earned income; changes to premiums due to changes in income between renewal take effect immediately, instead of delaying premium increases until renewal. (10/1/05) For MinnesotaCare: employer contact information is required at application and renewal to determine access to employer-sponsored insurance. (4/01/06)
Mississippi	**Aged & Disabled:** Eliminated Poverty Level Aged & Disabled optional category of eligibility (66,000, 12/31/05) **Application:** Face to face application/renewal
Missouri	**Parents:** Reinvestigations for medical assistance for families eligibility (10,617, 9/1/05) Eliminates extended transitional medical assistance (part of the 1115 waiver) (1,150, 7/1/05) Reduction of income limit from 75% FPL to 1996 AFDC level for medical assistance for families, adults (46,104, 7/1/05) **Aged & Disabled:** Reduction of income limit from 100% to 85% FPL for elderly and disabled eligibles (8,660, 9/1/05) Eliminate Medical Assistance for Employed Disabled Persons (MAWD) (9,529, 9/1/05) Institutionalized spouse applying for Medicaid shall divert income to community spouse to raise the community spouse's income before diverting assets (180, 9/1/05) Limits investments in annuities for purposes of Medicaid eligibility (12, 9/1/05) Requires DMS to enforce TEFRA liens on all institutionalized individuals (9/1/05) Reinvestigations for medical assistance eligibility (2,990, 9/1/05) **Application:** Reverification rate to 95% from 70%. Multiple check status instead of just one. Emphasis on annual reinvestigations
Montana	**Medically Needy:** Begin to count annuities owned by ineligible and community spouses/parents as resources (10/6/06) **Application:** Eliminated the uniform Medicaid/SCHIP simplified application.
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	**Application:** Moved from 12 months to 6 months for recertification. (7/1/05)
New York	**Children:** 6-18 (between 100% and 133% FPL) moved to SCHIP **Parents:** Family Health Plus - No eligibility for government employees and their family members that have access to employer sponsored coverage. A resource test was also added. **Medically Needy:** Income standard for household of two reduced from $975 to $900 as of 1/1/06 (to comply with federal limits)
North Carolina	**Children:** children ages 0-5 from 133% to 200% FPL moved from SCHIP to Medicaid (1/1/06) **Application:** Required paper verification of state residency
North Dakota	**Children:** technical change of calculation for medically needy **Aged & Disabled:** Increased burial allowance from $3,000 to $5,000 (8/1/05) **Application:** Simplification to joint application for MA & SCHIP
Ohio	**Parents:** Reduced income eligibility for parents from 100% to 90% FPL (25,000, 1/1/06)
Oklahoma	**Children:** TEFRA implementation (10/05) **Parents:** OEPIC; enhanced eligibility for working poor, TMA, etc. (12/05) **Adults:** OEPIC (12/05)
Oregon	**Parents:** Restriction: Implemented 3 of last 6 month eligibility requirement and income reporting requirements for Transitional Medical Assistance (TMA) (4/1/06) **Adults:** For the adult Medicaid expansion (OHP Standard) program, clients with incomes at or below 10% of the federal poverty level (approximately 8,800 clients) are exempt from premiums. Clients with incomes greater than 10% of the federal poverty level (approximatly 12,500) are no longer disqualified for six months for failing to pay monthly premiums on time. Clients must pay all

State	Eligibility, Premium and Application Changes
	past-due premiums at the time they reapply for benefits. (21,300, 6/1/06) **Application:** Eligibility staff were trained to review eligibility based on the most current application instead of requiring the client to submit a new application. Started sending applications automatically to children aging off programs and to women whose pregnancies have ended.
Pennsylvania	**Aged & Disabled:** LTC: a)Changed methodology to determine spousal share for married individuals applying for Medicaid/LTC; b) Implemented partial month penalty periods for transfers for less than Fair (10/3/05) **Application:** New application or renewal form is not required when an application is denied or ongoing benefits are discontinued and the client reapplies within 60 days of denial or closing. Added semiannual reporting requirement for parents and children.
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**Other:** Expansion population adults reduced. (171,000)
Texas	**Application:** Implemented New Eligibility System pilot. Reduced face-to-face interview requirement to only done if requested by the client.
Utah	**Application:** Ability to submit application on-line.
Vermont	**Aged & Disabled:** Conversion of 1915(c) long term care waiver to an 1115(a) waiver. The waiver approval included a $3,000 resource disregard for single individuals who own their own homes. (10/7/05) Elimination of resource test for QMB, SLMB, and QI-1. (1/1/06) **Application:** We are requesting additional verification of third-party liability by requiring individuals to send in a copy of their insurance information. **Premium:** Vermont increased premiums for adults above 50% FPL, pregnant women and children above 185% FPL. The amounts of the premium increases were between $1 and $10 per month.
Virginia	
Washington	**Children:** Began 12 month continuous eligibility for children (7/1/05) **Aged & Disabled:** Spousal resource transfer maximum increased for LTC (7/1/05) Categorically needy income level increased, allowing waiver standards to increase and LTC SIL to Increase (1/1/06) Medicare part D began (1/1/06) **Medically Needy:** Income methodology changed for 1 person MN - effectively increasing standard (1/1/06) **Application:** Changed from a 6 month review for children to 12 month continuous eligibility (7/1/05)
West Virginia	**Aged & Disabled:** Medicare as requirement for Medicaid eligibility (11/05) **Medically Needy:** Medicare as a condition of eligibility (11/05) **Application:** Electronic signature process for children's Medicaid. Pregnant women
Wisconsin	**Aged & Disabled:** Implement a less restrictive policy related to dividends or interest earned on resources. (9/2/05) **Application:** all simplifications: ESS-Check My Benefits: An online public facing web application allowing recipients to query benefits was implemented 9/29/2005. (This was an addition to the existing ACCESS application containing the Medicaid self-screener application called 'Am I Eligible'.) ACCESS –Apply For Benefits: On 6/2/2006, the capability for individuals to submit applications online for family Medicaid was added to ACCESS. This data transmits to the CARES Worker Web system inbox for automation assisted application processing. CARES Worker Web (CWW) Medicaid Mail-in Streamlining: CWW is the web system used by income maintenance workers to determination Medicaid eligibility. Along with functionality to apply online in ACCESS on 6/2/2006, a streamlined Medicaid mail-in process was also implemented. New CWW pages were added to allow for streamlined data entry of applications. This utilizes the same inbox for automation assisted application processing. CARES Worker Web enhancements: Throughout fiscal year 2006, multiple enhancements were added to the CARES Worker Web system to streamline application processing. These include items such as moving more screens from mainframe to CWW, streamlining program request drivers, streamlining person add and delete processes, and scheduling summary pages in place of detail pages. Electronic Case File: Throughout fiscal year 2006, the electronic case file project continued to roll out through counties in Wisconsin. This allows for case files to be scanned and maintained as electronic copies, thus streamlining case transfers, QA activities and document retrieval.
Wyoming	**Other:** Implemented a Family Planning Waiver

Appendix A-3b: Eligibility and Premium Related Actions Taken in the 50 States and District of Columbia FY 2007

State	Eligibility, Premium and Application Changes
Alabama	
Alaska	
Arizona	
Arkansas	
California	**Children:** Implement one extra month of Medicaid eligibility for SSI eligible children based on the later of the month of the SSI application or the month SSI eligibility is determined as per section 6065 of the DRA. (790/month, 2/1/07)
Colorado	**Children:** Removal of Medicaid Asset test will shift clients from CHP to Medicaid. (12,045, 7/1/06) **Parents:** Removal of Medicaid Asset Test. (2,891, 7/1/06) Increased income threshold for parents from 31% to 60% of FPL. (3,223, 7/1/06) **Application:** Requirement to verify that an individual is legally in the USA
Connecticut	**Parents:** TMA 24 to 72 months (7/1/06) **Application:** Self-declaration of income, Presumptive Eligibility for pregnant women & children.
Delaware	
District of Columbia	**Children:** Add 19-20 year olds to Medicaid through SPA; Change eligibility from 200% to 300% FPL (1,000, 10/1/06)
Florida	**Application:** continued 'Modernization efforts'. Plan to implement a web-based renewal process in 2007.
Georgia	
Hawaii	**Adults:** Allow adults that were previously left out of managed care due to enrollment cap to 100% FPL, childless adults limited benefits, removed cap (4,500, 10/1/06)
Idaho	**Application:** Will use an on-line application to speed up the process. Obtain health status information at enrollment in order to properly designate which group recipient falls in (Basic, Enhanced, Elderly/Advantage) Connect individual with primary care physician at time of enrollment **Premiums:** Buy-in for aged and disabled workers with disabilities up to 250% FPL with $10/month premium
Illinois	
Indiana	**Aged & Disabled:** Increase income standard for HCBS waiver to 300% of SSI. **Application:** RFS for outsourcing which will begin 2007. Goal to be more accurate, make process easier.
Iowa	**Children:** Expanded coverage to children aging out of foster care (550, 7/1/06)
Kansas	**Aged & Disabled:** State determined disability (800, 9/1/06) **Other:** expansion of family planning waiver **Application:** Presumptive Eligibility for children & pregnant women eligible for managed care, presumptive disability determination for SSI. 9/06 implementation. Application modifications to support DRA-LTC issues.
Kentucky	
Louisiana	**Other:** Family Planning Waiver Services (75,000, 10/06)
Maine	
Maryland	**Aged & Disabled:** Employed Individuals with disabilities (1,500) **Adults:** Under the Maryland Primary Adult Care program, adults up to 116 percent FPL who are ineligible for Medicaid and Medicare will receive primary care, outpatient mental health, and pharmacy services. Implementation: July 2006.
Massachusetts	**Other:** Insurance Partnership Expansion (4,000, 7/1/06)
Michigan	
Minnesota	
Mississippi	
Missouri	
Montana	**Children:** Increase asset test from $3,000 to $15,000 (3,000, 7/1/06)
Nebraska	
Nevada	**Parents:** Pregnant women - HIFA: 133% to 185% awaiting CMS approval (2,000, 10/06) **Other:** ESI expansion - premium assistance to 200% for parents – HIFA (8,000, 10/06)

State	Eligibility, Premium and Application Changes
New Hampshire	
New Jersey	
New Mexico	**Children:** While eligibility standards remain the same, income disregards have been increasing. Deductions were increased for the children's category. (7,800, 8/1/06) **Parents:** While eligibility standards remain the same, income disregards have been increasing for pregnant women. (9/1/06) **Application:** All Medicaid recipients on the assistance programs (Food Stamp, TANF, etc.) may recertify for all programs at the same time using one (1) application; changed 6-month recertification back to 12-month / automatic closure continues from FY05 (only for income based population; not disabled individuals).
New York	
North Carolina	
North Dakota	
Ohio	
Oklahoma	**Children, Parents:** 12 month eligibility (up from 6) (8/06) **Other:** Expanding Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program to provide funds to match employer and employee contributions for adults who work for small employers and have incomes above Medicaid Standards but below 185% FPL. (12/05) **Application:** 6 month to 12 month re-certification
Oregon	**Application:** Pending approval - no earlier than Jan. 1, 2007. Exploring the possibility for clients to apply for medical assistance through an on-line application process.
Pennsylvania	**Application:** Automated Renewals- All forms needed for renewal will be mailed centrally from Harrisburg. This function is currently completed by individual workers at local County Assistance Offices. This function will reduce workload for caseworkers and standardize the types of forms that are sent to clients.
Rhode Island	**Children:** Established resource test (7/1/06) **Parents:** Resource test added - The whole 1115 waiver group impacts parents (250, 7/1/06) **Application:** Verification of residency for children and parents
South Carolina	**Children, Parents:** Added asset limit (7/1/06)
South Dakota	**Aged & Disabled:** Buy in for working disabled adults. (1/07)
Tennessee	**Medically Needy:** TN has requested to reopen MN program from CMS (40,000)
Texas	**Aged & Disabled:** Adopt BBA Working Disabled Option (500-1,500, 91/06) **Other:** family planning (1/07)
Utah	**Children:** covered 19 & 20 yr olds in foster care. (360, 7/1/06)
Vermont	**Aged and Disabled:** Possible increase of income standard for QMB, SLMB, and QI-1 **Premiums:** Vermont pharmacy premiums increased to $20 for VScript and $42 for VScript expanded (7/1/06)
Virginia	
Washington	
West Virginia	**Application:** Children's Medicaid groups, QMB, SUM. QI-1's. Pickle amendment coverage (PAC) can submit redeterminations online. (7/1/06)
Wisconsin	**Medically Needy:** The Spousal Impoverishment Community Spouse Income Allowance Minimum Allocation, Shelter Base Amount, and the Spousal Impoverishment Family Member Income Allowance increased effective July 1 (12/06) **Application:** ACCESS –Report My Changes: On 9/5/2006 the ability for clients to report changes in earned income via the web for Medicaid will be implemented. These changes will transmit to the CARES Worker Web system for automation assisted change report processing. SeniorCare Process Improvement: An enhanced verification and error prone case profiling system is being implemented 7/7/2006 which will streamline the existing central office processing of SeniorCare Prescription Drug program applications and renewals. Healthy Birth Outcomes – Presumptive Eligibility: For the Spring/Summer of 2007, functionality will be added to ACCESS to allow for collection of applications for Presumptive Eligibility for Family Planning Waiver and Presumptive Eligibility for Newborns via the web. Eligibility determinations will be done real-time and the data transferred to the appropriate Medicaid eligibility systems. ACCESS and CARES Worker Web (CWW) Enhancements: For fiscal year 2007, enhancements are being explored for both ACCESS and CARES Worker Web. These include items such as adding more types of reportable changes to ACCESS, adding a Spanish text version of ACCESS, online review processing, adding the ability to submit EBD applications online, and moving more mainframe screens to CWW.
Wyoming	

Appendix A-4a: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2006

State	Benefit Change
Alabama	
Alaska	**Children:** Added an infant learning targeted case management program for children from birth to age three (200)
Arizona	**Children:** As a result of a court decision, EPSDT coverage added for incontinence briefs
Arkansas	
California	**Children and Pregnant Women**: Addition of fluoride varnish for teeth provided by a physician for young children and providers who routinely see pregnant women. **All Adults:** Imposed $1,800 annual dental cap (6,800).
Colorado	
Connecticut	
Delaware	
District of Columbia	
Florida	**Adults**: A 4-script limit on monthly prescriptions lifted.
Georgia	**Other:** Emergency Medical Assistance services restricted; additional medical review for most services added (3,000)
Hawaii	
Idaho	
Illinois	**Adults**: Imposed a 3-script limit on monthly prescriptions
Indiana	
Iowa	
Kansas	**Other:** Added coverage of vagal nerve stimulators and Baclofen pumps
Kentucky	**Adults**: Imposed a 4-script limit on monthly prescriptions
Louisiana	
Maine	**Aged & Disabled:** Imposed a 5-script limit on monthly prescriptions for brand drugs for persons in supervised settings **Expansion Adults**: Reduced benefit package including cuts in vision, OT, PT, podiatry, DME and outpatient mental health services; also imposed a 5-script limit on monthly prescriptions (20,000)
Maryland	
Massachusetts	**Parents:** Dental benefits added for pregnant women and women with children under 3.
Michigan	**Children:** Expanded Healthy Kids Dental contract (45,000) **Parents, Aged & Disabled, Medically Needy:** Reinstated Adult Dental (600,000)
Minnesota	**Children:** Eliminated coverage for circumcision unless medically necessary (8,400) **All Adults**: Eliminated $500 dental cap **Aged and Disabled:** Eliminated coverage of sex reassignment surgery (3).
Mississippi	**Adults**: Imposed a 5-script limit (3 generic, 2 brand) on monthly prescriptions
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 (370,000)
Montana	
Nebraska	
Nevada	**Children, Adults:** Expansion of mental health services; new provider types added
New Hampshire	
New Jersey	

State	Benefit Change
New Mexico	
New York	**All Adults:** Eliminated coverage of erectile dysfunction drugs **Expansion Adults**: Limits imposed on Family Health Plus vision benefit.
North Carolina	**Non-institutionalized Adults:** Imposed new limits on the number of prescriptions per month **Aged & Disabled:** Increased the number of hours of personal care in special care units (Alzheimer's)
North Dakota	
Ohio	**All Adults:** Reduced dental benefits
Oklahoma	**Children**: Added hospice benefit **All Adults**: Added smoking cessation and removal of benign skin lesion benefits
Oregon	
Pennsylvania	**Medically Needy**: Limits imposed on inpatient medical rehab, visits to outpatient providers (n/a to pregnant women), inpatient psychiatric hospital days, hours of psychiatric partial hospitalization services and hours of psychiatric outpatient clinic services **Adults Without Children**: Limits imposed on inpatient medical hospital, inpatient medical rehab, inpatient psychiatric hospital days, hours of psychiatric partial hospitalization services and hours of psychiatric outpatient clinic services
Rhode Island	
South Carolina	**Children:** Expanded the Pediatric Sub-Specialty program to include a broader array of services
South Dakota	
Tennessee	**All Adults:** Prescription limit imposed (5 per month – 2 brand, 3 generic)
Texas	**Adults:** Limited PCCM clients to 3 prescriptions per month. Coverage restored for hearing aids and eyeglasses and the following provider types restored for all adults: podiatry, chiropractor, marriage and family therapist, licensed master level social worker and psychologist
Utah	
Vermont	**All Adults:** reduce dental cap
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

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

State	Benefit Change
Alabama	
Alaska	**All adults:** Expanded dental benefits to include a capped preventative & restorative services; benefit sunsets after 3 years **Other** Targeted Case Management services added for tribal populations. (40,000)
Arizona	
Arkansas	
California	
Colorado	
Connecticut	
Delaware	
District of Columbia	**Adults:** Added dental benefits for adults (60,000)
Florida	**All adults:** Restored adult hearing and vision and implemented adult partial dentures **Other:** Benefit flexibility allowed through Medicaid Reform in Duval & Broward counties
Georgia	**Parents:** Expanded dental benefits for pregnant women (60,000)
Hawaii	
Idaho	**All:** Used DRA authority to create "Basic: benefit package for healthy low-income children and adults (effective July 2006). Also includes some enhanced wellness and prevention benefits "Enhanced" Benchmark Benefit Package for individuals with disabilities and special health care needs (effective July 2006), and "Coordinated Benchmark Benefit Package for dual eligibles (effective January 2007) that will enhance Medicaid and Medicare integration. Participation is voluntary – beneficiaries may "opt-out" if they wish to retain standard Medicaid. Basic Benchmark Plan excludes long-term care benefits, limits mental health services, and restricts some provider specialties (such as rehab mental health services, speech and hearing clinics, independent practical and registered nurse services, mental health and personal care case management) to diagnostic and evaluation services only.
Illinois	
Indiana	
Iowa	**All:** Added coverage for smoking cessation prescription drugs, over-the-counter nicotine replacement and cessation counseling, coverage for a preventive medical exam, health risk assessment and personal health improvement plan
Kansas	
Kentucky	**All**: Implemented four redesigned benefit packages (under DRA authority) with new "soft" service limits that vary by package including limits on audiometric services, chiropractic services, dental services, home health, occupational and physical and speech therapies and ultrasound services. New dollar limits apply to hearing aids, prosthetic devices and vision hardware.
Louisiana	
Maine	
Maryland	**Other:** Eliminating payment for non-emergency treatment in the ER (10% less visits)
Massachusetts	
Michigan	
Minnesota	
Mississippi	
Missouri	**All adults:** Coverage restored for wheelchair accessories and batteries, and eyeglasses for adults (370,000)
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	

State	Benefit Change
New Mexico	**Children, Aged & Disabled:** Expand comprehensive dental exams to 2 times per year
New York	
North Carolina	
North Dakota	
Ohio	
Oklahoma	**Children**: Added environmental assessment for children with high blood lead levels. Private duty nursing. **Parents:** Additional ultrasounds covered for high-risk pregnancies
Oregon	**Children:** Limiting over-the-counter drugs. (190,000) **Parents, Aged & Disabled:** Eliminating routine vision coverage and glasses for adults (except pregnant women); limiting dental coverage for adults (except pregnant women); limiting over-the-counter drugs; imposing a hospital day limit for adults in fee-for-service. (45,000 – vision & dental, 10,000 – hospital day limit) **Adults in OHP Standard Program:** Limiting over-the-counter drugs and imposing a hospital day limit for adults in fee-for-service. (21,400)
Pennsylvania	
Rhode Island	
South Carolina	**Children:** Delete Targeted Case Management as a covered service (5,000) **Aged & Disabled:** Expanded Cancer Screening coverage to include screening colonoscopies **Adults:** Delete Targeted Case Management as a covered service (800)
South Dakota	
Tennessee	**Other:** Removed adult dental emergency services (500,000)
Texas	
Utah	**Parents, Medically Needy, Adults:** eliminated dental and vision benefits **Aged & Disabled:** eliminated vision benefits
Vermont	**Parents:** Increased dental cap **All Adults:** Eliminated coverage of drugs used to treat erectile or sexual dysfunction (500)
Virginia	
Washington	
West Virginia	**Children and Parents:** Implemented an alternative benefit package (under DRA authority) for healthy adults and children that restricts benefits for persons that do not sign or fail to comply with a Member Medicaid Agreement. Benefits restricted or excluded include diabetes care, mental health care, podiatry, and chiropractic services. Also includes a four script per month limit.
Wisconsin	
Wyoming	**Adults:** Increased dental benefits **Other:** Translator Services (79,000)

Appendix A-5: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia FY 2006 and FY 2007

State	Reduce Dispens. Fee		AWP Greater Discount		Preferred Drug List		More Drugs/ Prior Auth		Supp. Rebates		Multi-State Purch. Coalition		New/ Lower State MAC		Other Actions	
Fiscal Year:	‘06	‘07	‘06	‘07	‘06	‘07	‘06	‘07	‘06	‘07	‘06	‘07	‘06	‘07	‘06	‘07
Alabama				X												
Alaska							X	X						X	X	
Arizona																
Arkansas							X	X					X	X		
California																
Colorado																
Connecticut																
Delaware					X				X	X	X					
D.C.						X				X		X				
Florida					X				X				X	X		
Georgia																
Hawaii																
Idaho				X	X		X		X		X				X	
Illinois																
Indiana			X										X			X
Iowa											X					
Kansas					X	X			X	X			X			X
Kentucky			X								X					
Louisiana																
Maine											X		X		X	X
Maryland											X					
Massachusetts															X	X
Michigan				X												
Minnesota			X		X	X	X	X					X			
Mississippi					X											
Missouri															X	X
Montana				X												
Nebraska							X	X								
Nevada																
N. Hampshire																
New Jersey																
New Mexico					X		X			X			X			
New York			X	X		X	X	X		X		X		X	X	
N. Carolina							X								X	
N. Dakota							X	X								
Ohio			X		X				X							
Oklahoma					X	X										X
Oregon																
Pennsylvania			X		X		X			X			X			
Rhode Island				X		X				X		X				
S. Carolina																
S. Dakota							X									
Tennessee							X	X			X					
Texas																
Utah														X		
Vermont				X	X		X				X					X
Virginia																
Washington																
West Virginia	X		X								X		X			
Wisconsin					X	X					X					X
Wyoming								X					X			
Total	**1**	**0**	**7**	**7**	**12**	**7**	**13**	**8**	**5**	**7**	**10**	**3**	**10**	**5**	**7**	**8**

Appendix A-6: DRA Related Changes

States	Make Copayments Enforceable	LTC Partnership Program	HCBS Alternatives to PRTF for Children	Money Follows the Person	Self-Directed Personal Assistance Services	Medicaid Buy-in for Disabled Children	Medicaid Transformation Grants	Health Opportunity Account Demonstration
Alabama		X		X	X		X	
Alaska								
Arizona							X	
Arkansas			X	X			X	
California				X				
Colorado								
Connecticut				X			X	
Delaware							X	
District of Columbia								
Florida		X						
Georgia		X						
Hawaii								
Idaho		X			X		X	
Illinois		X		X	X		X	
Indiana				X			X	
Iowa		X	X		X	X	X	
Kansas		X		X	X			
Kentucky	X			X	X		X	
Louisiana				X				
Maine		X						
Maryland		X	X	X			X	
Massachusetts								
Michigan				X	X		X	
Minnesota		X						
Mississippi							X	
Missouri							X	
Montana		X			X			
Nebraska		X			X	X	X	
Nevada			X		X			
New Hampshire				X			X	X
New Jersey		X	X	X	X		X	
New Mexico				X	X	X		
New York								
North Carolina		X		X			X	
North Dakota		X						
Ohio		X					X	
Oklahoma							X	X
Oregon							X	
Pennsylvania		X		X	X			
Rhode Island	X				X		X	
South Carolina								X
South Dakota		X						
Tennessee							X	
Texas								
Utah								
Vermont		X						
Virginia		X						
Washington		X			X			
West Virginia							X	
Wisconsin				X			X	
Wyoming		X		X	X		X	
Total	**2**	**22**	**5**	**18**	**16**	**3**	**26**	**3**

Appendix B: Profiles of Selected State Medicaid Policy Changes:

- **Idaho**
- **Michigan**
- **New York**

Profile of Medicaid Policy Changes: Idaho

On May 26, 2006, Lt. Governor Jim Risch became Idaho's 31st Governor succeeding Governor Dick Kempthorne who was confirmed by the U.S. Senate as Secretary of the Interior that day. Governor Risch inherited a thriving state economy – among the best in the nation – and a healthy state budget experiencing record revenue growth. In July 2006, the State of Idaho Division of Financial Management described FY 2006 state revenue performance as "spectacular" increasing by 7.2 percent over FY 2005 even after a decrease in the state sales tax from six percent to five percent on July 1, 2005. Without the sales tax cut, state revenue growth for FY 2006 would have been 16.2 percent. With a state general fund balance on June 30, 2006 that was just over $200 million higher than was projected when the Legislature adjourned in April 2006, Governor Risch called for a special session of the Legislature to be held on August 25, 2006 to consider property tax relief totaling $260 million statewide. Governor Risch proposed to replace those revenues by adding one-cent to the sales tax and by using $50 million of the state general fund surplus. The Legislature overwhelmingly approved the Governor's proposal and the property tax relief legislation was signed into law on August 31, 2006.

Governor Risch also took over responsibility for implementing the "Idaho Medicaid Simplification Act" proposed by Governor Kempthorne and adopted by the Idaho Legislature in March 2006. While originally conceived as a Section 1115 waiver proposal, the state changed course at the recommendation of CMS and instead used the newly available Deficit Reduction Act of 2005 (DRA) flexibility provisions to accomplish program reforms. On May 25, 2006, Idaho became the third state to receive CMS approval to implement alternative benefit packages pursuant to the DRA. Idaho's plan is intended to simplify eligibility and better match benefits to enrollees' needs by offering three alternative benefit plans:

- The "Basic" Benchmark Benefit Package for healthy low-income children and adults (effective July 2006);
- The "Enhanced" Benchmark Benefit Package for individuals with disabilities and special health care needs (effective July 2006), and
- The "Coordinated Benchmark Benefit Package for dual eligibles (effective January 2007) that will enhance Medicaid and Medicare integration.

Participation is voluntary – beneficiaries may "opt-out" if they wish to retain standard Medicaid. The Enhanced and Coordinated Benchmark Plans include the full range of Medicaid services covered under the regular Medicaid plan, while new restrictions and limitations apply to the Basic Benchmark Plan including:

- The exclusion of long-term care benefits,
- Limits on mental health services, and
- Restrictions on some provider specialties (such as rehab mental health services, speech and hearing clinics, independent practical and registered nurse services, mental health and personal care case management) to diagnostic and evaluation services only.

EPSDT benefits are preserved for all children: those that are found to have special health care needs may receive those benefits through either the Enhanced Benchmark plan or as

"wrap-around services" to benefits covered under the State plan for children who do not opt-in to an Enhanced Benchmark Benefit Package.

Beginning in October 2006, the Basic and Enhanced Benchmark plans will include a Personal Health Account (PHA) component targeting individuals who use tobacco or who are obese. The state will issue vouchers to targeted individuals who have earned credits which may be used to purchase goods and services related to tobacco cessation and weight loss (e.g., nicotine replacement therapies, fitness program memberships, and bicycle helmets). Additional credits can be earned through complying with recommended preventive services and can also be used to pay premiums where families are subject to premium payments. The benchmark plans will also include other new preventive services including an initial health risk assessment (comprised of an initial health questionnaire and a well child screen or an adult physical) and nutrition services.

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

Provider Rates:
• In FY 2006 rates increased for physicians (1.3%) and nursing homes (approximately 7.5%). Rates for other providers remained unchanged. • In FY 2007 rates increased for physicians (2.4%), dentists (2.4%) and home and community-based waiver providers (1.9%). Nursing home rate increases are also planned with the amount yet to be determined at the time of the survey. Rates for other providers remained unchanged.
Eligibility Changes:
• In July 2005, enrollment began in the Idaho Access Card premium assistance program for adults with incomes up to 185% FPL employed by small businesses and their spouses. Enrollment is capped at 1,000 adults. • Removed asset test for low-income children effective April 2006. • Effective January 1, 2007, will implement a Medicaid Buy-in/Ticket to Work Program for disabled workers
Benefit/Service Changes:
(See discussion of benchmark plans above.)
Prescription Drug Controls and Limits:
• Joined a multi-state purchasing pool in April 2006. • In FY 2006, implemented a maximum daily dose edit to prevent pharmacies from circumventing monthly quantity limits by altering days supply. • Number of drug classes included on PDL increased in FY 2006.
Long-Term Care Policy Changes:
• Increased number of HCBS waiver slots in FY 2006. • Repealed ICF/MR bed moratorium in FY 2006. • Implementing a new estate recovery initiative in FY 2007. • Implementing a Long-Term Care Partnership Program in FY 2007.
Other Cost Containment and Policy Changes:
• In FY 2007: ▪ Implementing a pay-for-performance pilot initiative with two residency programs and voluntarily participating FQHCs designed to promote best clinical practices; ▪ Implementing a diabetes management program; ▪ Outsourcing dental benefits by contracting with one or more dental benefit administrators; ▪ Establishing a non-emergency medical transportation brokerage program, and ▪ Implementing a new mental health provider credentialing initiative.

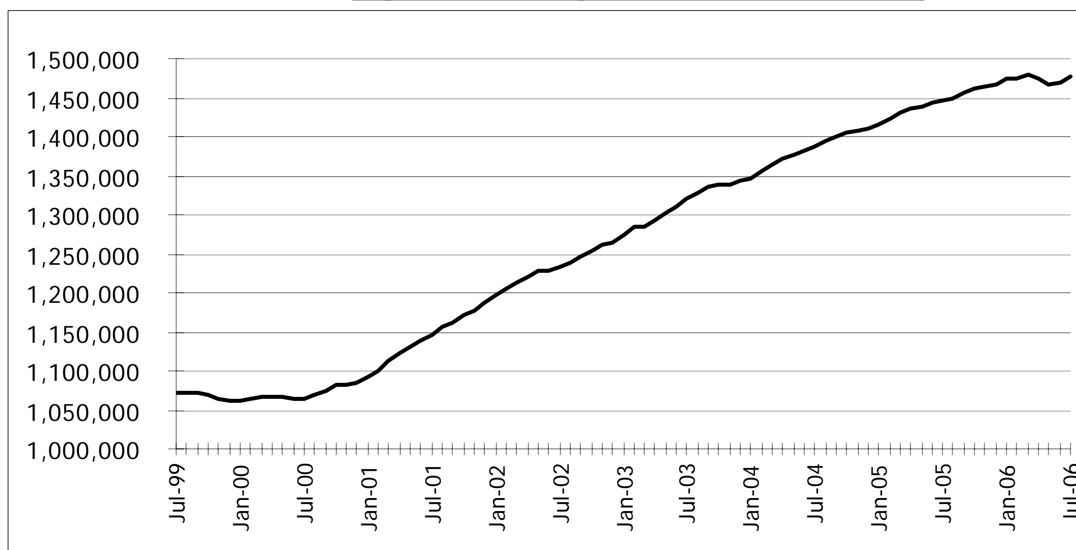
Profile of Medicaid Policy Changes: Michigan

Michigan's economy remains weaker than those of most other states. With a job market that has been heavily tied to the manufacturing sector, most recessions are deeper in Michigan and the state is usually among the last to recover. Manufacturing employment in Michigan dropped by 26% from July 1999 to November 2005. Only Mississippi had a higher unemployment rate in July 2006.[40] Michigan also ranks next to last in personal income growth from the first quarter of 2005 to the first quarter of 2006.[41]

State revenues have been impacted not only by the weak economy but also by decisions to reduce several key taxes. As a result, the state's general fund revenues in fiscal years 2003 through 2005 were below the actual revenues in fiscal year 1995 and also below the inflation adjusted general fund revenue level in fiscal year 1972.[42] Given this situation, Medicaid special financing was a key component of the balancing of the state's budget in recent years.

The increase in unemployment and the transition from a manufacturing economy to a service economy has resulted in a reduction in employer-based health insurance in Michigan. Enrollment of children in Medicaid was also impacted by the eligibility expansion that occurred in 1999 with the implementation of SCHIP and several simplifications of the Medicaid enrollment processes for children. As a result total Medicaid enrollment in Michigan increased by more than 40% from July 2000 to July 2006. The state projects an additional 3.2% enrollment increase in fiscal year 2007.

Figure 1 - Michigan Medicaid Enrollment



Source: Michigan Department of Human Services.

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[40] Source: Bureau of Labor Statistics report on August 18, 2006.
[41] Source: Bureau of Economic Analysis, US Department of Commerce.
[42] Source: *Michigan's Budget Crisis and the Prospects for the Future,* Citizen's Research Council of Michigan; March 23, 2006.

Despite the budget challenges faced by the state, Michigan has made very limited reductions in its Medicaid program. There has been bi-partisan support for health care coverage for children through Healthy Kids and MIChild, the state's Medicaid and SCHIP programs for low-income children. Michigan continues use of free media to promote enrollment in these programs and has maintained one of the most streamlined enrollment processes in the nation. Families can apply for health coverage for children by mail or on-line and may self-declare their income. Enrollment of income eligible children in Medicaid has increased by nearly two-thirds from July 2000 to July 2006.

Michigan has relied extensively on managed care through HMOs to contain the costs of Medicaid. In almost every county enrollment in Medicaid HMOs is mandatory for most Medicaid beneficiaries, including the disabled. (Excluded groups include those enrolled in Medicare, those that must meet a deductible[43], or those in long term care.) As a result, about two-thirds of all Michigan Medicaid enrollees are served by an HMO. Michigan indicates that from FY 1995 to FY 2005 the average per enrollee cost more than doubled for those in fee-for service, while the per enrollee cost for those in HMOs increased by less than 20 percent.

With increasing caseloads and limited state revenues, the state has generally been unable to fund Medicaid provider rate increases. Michigan has primarily used provider taxes on all nursing homes, hospitals, community mental health agencies, and those HMOs that participate in the Medicaid program as a vehicle to support payment increases for these categories of Medicaid providers. Beyond these providers, Michigan has targeted its limited resources to rate increases for providers that provide key Medicaid services and for which there are concerns about adequate access to care. In FY 2006 rates for obstetrical services were increased by 20%. For FY 2007 rates paid to physicians for preventive care visits will be increased by 47%. (This represents only a 2% increase in the total cost of physician services.)

There was significant dialogue between the legislature and the executive branch in recent years over Medicaid coverage for 19 and 20 year old individuals that are not disabled or parents, and for "caretaker relatives" (individuals such as grandparents that are raising children and meet Medicaid income criteria). At one point the legislature eliminated eligibility for these individuals. Advocates successfully blocked this action under the provisions of existing state law. Ultimately the decision was to implement an asset test for these groups as of May 1, 2006. Enrollment in the affected category dropped by only 13,000 persons between April 2006 and July 2006.

In her 2006 State of the State message Governor Granholm proposed an extensive Medicaid waiver – *Michigan First Health Care*. This waiver, with a proposed implementation on April 1, 2007, shares many characteristics with the recently approved Massachusetts waiver. While the details of the waiver are not yet available, the goal is to use a private sector model, including provider payments at private sector rates, for fully or partially subsidized coverage for up to 500,000 of Michigan's 1.1 million uninsured. The waiver would rely on managed care savings to meet federal budget neutrality requirements. Most of the state share of the waiver funding would come from existing expenditures for health services for non-Medicaid clients (also known as "costs not otherwise matchable" or CNOM.). In addition to the efforts described above, Michigan has implemented or plans to implement the policy changes noted below:

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[43] This category was previously described as the "spend-down" category.

Other Changes in Provider Rates:

- In FY 2006:
  - A previous 1.85% cut in all nursing facilities rates was restored effective 10/1/05.
  - A previous 4% cut in rates for public nursing facilities was also restored effective 10/1/05.
  - Nursing facilities and hospitals received increased rates to the extent that the Medicare Upper Payment Limit increased.
  - Existing HMO rates were deemed actuarially sound based on HMO financial reports and not increased.
- In FY 2007:
  - HMO base rates were increased by 5%. The HMO rates will be further increased as the state counts ALL of the Medicaid fee-for-service hospital payments in setting the HMO rates. Hospitals are expected to receive significantly higher payments from the HMOs.
  - Nursing home and hospital rates will increase to the extent that the Medicare Upper Payment Limit increases.

Other Eligibility Changes:

- On October 1, 2005 Michigan implemented changes to the annuity exclusion rules for long term care eligibility.
- On July 1, 2006 Michigan Implemented "Plan First", its family planning waiver.

Benefit/Service Changes:

- Adult dental services were reinstated on 10/1/05, affecting 600,000 beneficiaries.
- Effective May 1, 2006 the Healthy Kids Dental program was expanded from 37 counties to 59 counties, affecting 45,000 children. This program increases access to dental care through a capitated arrangement.

Beneficiary Copayments

- In FY 2006 Michigan added new copayments for adults. Previously there were only copayments for pharmacy, podiatry, vision, chiropractic and dental services. The new copayments are:
  - $2 for physician office visits,
  - $3 for emergency department visits for non-emergent conditions,
  - $50 for the first day of an inpatient hospital stay, and
  - $1 for an outpatient hospital visit.
- In FY 2007 the copayment for emergency department visits for non-emergent conditions is scheduled to increase to $6.

Prescription Drug Controls and Limits:

- The state participates in multi-state purchasing, use of a PDL and supplemental rebates.

Long Term Care Policy Changes:

- In FY 2007 Michigan implemented pilot Single Point of Entry programs for long-term care services in four regions of the state.
- Legislation for estate recovery is pending in the state legislature. Such legislation has been introduced but not passed many times.

Other Cost Containment and Policy Changes:

- In FY 2007 Michigan is implementing a program of care management for high cost beneficiaries with mental health diagnoses, high prescription drug costs, chronic diseases, and neonates. The program will apply to the fee-for-service Medicaid population and will provide payment incentive for physicians.

Profile of Medicaid Policy Changes: New York

Entering the 2006-2007 budget cycle, the State estimated a budget imbalance of $751 million in 2006-2007 and gaps in the range of $3 billion to $4 billion in future years. Governor George Pataki, entering his twelfth and final year as Governor of the State of New York, proposed a budget in January 2006 that, if enacted, would have eliminated the 2006-2007 imbalance and reduced the gaps in FY 2008 and FY 2009 to $1.9 billion and $3.9 billion, respectively, by (a) restraining spending in the fastest-growing programs in the State Budget, particularly Medicaid, (b) setting aside the entire $2.0 billion from the expected 2005-06 surplus to help reduce the potential gaps in 2007-08 and 2008-09, and (c) financing $250 million in reserves that will be used in the future to lower State debt.

After failing for 20 years to meet the April 1st deadline to adopt a state budget (New York's fiscal year begins April 1 and ends March 31), the legislature succeeded for the second year in a row in adopting an on-time budget on March 31, 2006. This budget eliminated the FY 2007 imbalance but widened future budget gaps to over $6 billion. In mid-April, Governor Pataki vetoed over 200 spending items worth $2.1 billion, including vetoes of 39 items worth $1.5 billion that the Governor found to be "unconstitutional" and therefore not subject to being overridden by the Legislature. Although the legislature overrode most of the vetoes, Governor Pataki refused to enforce what he called "unconstitutional overrides." In late June, the Governor and the legislature ended the budget stalemate by reaching agreement on a number of revised budget measures that, included, among other things, a revised Medicaid cost containment package. Some of the changes included the following:

- Automatic FY 2007 rate increases for hospitals and nursing homes vetoed by the Governor were restored at lower levels;
- Hospital funding for graduate medical education, volume adjustments and inpatient detoxification were restored to pre-veto levels and rate increases were approved for emergency services and displaced workers;
- Certain nursing home "add-on" payments were restored to pre-veto levels;
- A physician override provision (related to the PDL) was eliminated;
- Part D wrap-around coverage for dual eligibles (a state-only expense) was limited to four drug classes beginning in January 2007; and
- Legislation was enacted to enhance Medicaid anti-fraud efforts, including creating the Office of the Medicaid Inspector General in statute (that was previously established by executive order).

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

Provider Rates:
• In FY 2006 increased rates by 2% for inpatient and outpatient hospital services, nursing facilities and home health services. • In FY 2007, increased rates for inpatient hospital (2.25%), emergency room clinic rate (rate increased from $95 to $150), emergency room physicians, managed care organizations (8.5% for Medicaid and 2.8% for Family Health Plus), nursing homes

(2.25%) and home health services (2.25%).
Eligibility Changes:
• Children aged 6-18 in families with incomes between 100% and 133% FPL shifted from the more comprehensive Medicaid program to Child Health Plus (SCHIP) in FY 2006. • In FY 2006, restricted Family Health Plus for adults by prohibiting government employees and their family members (who have access to employer sponsored coverage) from enrolling and by imposing a resource test. • Medically Needy income standard for a household of two reduced from $975/mo to $900/mo. effective January 1, 2006 (to comply with federal limit).
Benefit/Service Changes:
▪ Effective August 1, 2005, brand-name drug copays increased from $2 to $3, generic drug copays increased from $0.50 to $1 and the annual copayment maximum increased from $100 to $200 per recipient per year. ▪ Effective September 1, 2005, added copayment requirements for Family Health Plus adults including inpatient hospital ($25 per stay), non-urgent ER ($3 per visit), brand drugs ($6 per script and each refill), generic drugs ($3 per script and each refill), over-the-counter drugs ($0.50 per medication), physician and clinic ($5 per visit), dental ($5 per visit up to a total of $25 per year), radiology ($1 per service), medical supplies ($1 per supply) and lab ($0.50 per test).
Prescription Drug Controls and Limits:
• In FY 2006, reduced ingredient cost reimbursement from AWP-12% to AWP-12.75% for brands and from AWP-12% to AWP-16.5% for generics. Effective July 15, 2006, ingredient cost reimbursement was further reduced to AWP-13.25% for brands and AWP-20% for generics. • Implemented Phase I of a preferred drug list on June 28, 2006. • Implemented supplemental rebate program in June 2006. • Implementing a State Maximum Allowable Cost program September 5, 2006. • Joined a multi-state purchasing pool in June 2006. • Eliminated coverage of erectile dysfunction drugs in June 2006. • Effective January 1, 2007, restricting state-funded wrap-around coverage for non-formulary/restricted Part D covered drugs for dual eligibles to only four drug classes: antipsychotics, antidepressants, antiretrovirals and transplant drugs.
Long Term Care Policy Changes:
• In FY 2007: o Implement a new Nursing Home Transition and Diversion Home and Community Based Services Waiver in FY 2007 with the intention of serving at least 5,000 persons during the initial three years of the waiver. o Implement Phase I of a local "Point of Entry " for accessing long term care services in FY 2007. o Continue the planning process with a goal of submitting a Section 1115 Medicaid waiver request to restructure long term care services.
Managed Care Policy Changes:
• In FY 2006: o Expanded managed care to additional counties. o In New York City and nine counties, changed from voluntary to mandatory managed care for physical health services for disabled beneficiaries. • In FY 2007: o Expand managed care to additional counties. o In five additional counties, change from voluntary to mandatory managed care for physical health services for disabled beneficiaries.

○ Extend managed long-term care to dual eligibles by integrating with Medicare Advantage plans.
Other Cost Containment and Policy Changes:
• A .35% provider assessment imposed on hospitals in FY 2006. • Increased nursing facility provider tax (to 6%) in FY 2006. • In FY 2007, implement six (state-funded) disease and care management demonstration programs to test innovative strategies and technologies. • In FY 2006, established an independent office of the inspector general to address Medicaid fraud and abuse.

Appendix C: Survey Instrument

Medicaid Budget Survey
For Fiscal Years 2005, 2006 and 2007

State ______________ **Name** ______________________________

Phone ______________ **Email** ______________________ **Date** __________

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

Return Completed Survey:

Email preferred: Vsmith@healthmanagement.com

Or mail or FAX to: Vernon K. Smith, Ph.D.
Health Management Associates
120 N. Washington Square, Suite 705
Lansing, MI 48933
FAX: (517) 482-0920

Section I. Medicaid Expenditure Growth: State Fiscal Years 2005, 2006 and 2007

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

	Percent Change for Each Source of Funds			
	State Funds	**Local or Other Funds**	**Federal Funds**	**Total: All Fund Sources**
FY 2005 1. Percentage change: FY 2005 Medicaid Expenditures over FY 2004 Expenditures	%	%	%	%
FY 2006 2. Percentage Change: Estimated FY 2006 Medicaid Expenditures over FY 2005 Expenditures	%	%	%	%
FY 2007 3. Percentage Change: FY 2007 Medicaid Appropriations over FY 2006 Expenditures	%	%	%	%

Comments: ____

____

B. Was FY 2006 spending greater than the *original* appropriation? ☐ Yes ☐ No

C. Has your legislature enacted the Medicaid budget for FY 2007? ☐ Yes ☐ No

D. **Potential FY 2007 Medicaid Budget Shortfall:** When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2007 for Medicaid, how likely would you say it is that your state will experience a Medicaid budget shortfall in FY 2007?

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

E. Considering all factors that impact Medicaid (e.g., spending and enrollment trends, state budget and policy priorities, etc.), do you believe the overall pressures on your state Medicaid program are now (*check one*): ☐ Growing ☐ Remaining constant ☐ Subsiding

Comments: ____

____

Section II. Medicaid in State Fiscal Year 2006 and 2007

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 2006? What factors do you expect to be the principal drivers of Medicaid expenditure changes in FY 2007?

	FY 2006	FY 2007
a. Most significant factor?		
b. Second most significant factor?		
c. Other significant factors?		

2. **Medicaid Enrollment Changes**:
   i. Overall % enrollment growth/decline (+/–), FY 2006 over FY 2005: _____%
   ii. Overall % enrollment growth/decline (+/–), projected for FY 2007 over FY 2006: _____%
   iii. What do you believe are the *key factors* that contributed to increases or decreases in enrollment in FY 2006, and will do so in FY 2007? (e.g., eligibility expansions or cuts, changes in the application or redetermination process, economy, etc.)?

	FY 2006	FY 2007
a. Most significant factor?		
b. Second most significant factor?		
c. Other significant factors?		

3. **Provider Payment Rates**: For each provider type, please indicate any rate increases (including COLA or inflationary increases) or decreases *implemented* in FY 2006 or to be implemented in FY 2007. (Please indicate % increase, % decrease, or no change in appropriate column.)

Provider Type	FY 2006	FY 2007
a. Inpatient hospital		
b. Outpatient hospital		
c. Doctors		
d. Dentists		
e. Managed care organizations		
f. Nursing homes		
g. Home health		
h. Home and community-based waiver providers		

4. **Provider Taxes/Assessments**: Please list any provider taxes and indicate for each if it was or will be new in FY 2006 or 2007, or if changes were made or will be made to existing provider taxes in FY 2006 or 2007.

Provider Group Subject to Tax	New (Yes or No)		Discont'd (Yes or No)		Increased, Decreased or Unchanged (+, -, or 0)	
	In FY '06?	In FY '07?	In FY '06?	In FY '07?	In FY '06?	In FY '07?
a.						
b.						
c.						
d.						
e.						
f.						

5. **Changes in Medicaid Eligibility Standards:** Please describe any expansion, reduction, restriction, restoration or other change in ***eligibility standards*** (e.g., income standards, asset tests, retroactivity, treatment of asset transfer or income) *implemented* during FY 2006 or to be implemented in FY 2007.
Do not include SCHIP funded or DRA mandated changes related to long term care eligibility.

Eligibility Category	Year	Nature of Eligibility Change: Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Estimated No. of People that Gain or Lose Eligibility
a. Children	FY '06			
	FY '07			
b. Parents/ Pregnant Women	FY '06			
	FY '07			
c. Aged/ Disabled (including duals)	FY '06			
	FY '07			
d. Medically Needy	FY '06			
	FY '07			
e. Adults Without Children	FY '06			
	FY '07			
f. Other	FY '06			
	FY '07			

6. **Changes in Application/ Renewal Process:** Did your state make any changes to the ***application or renewal process*** (e.g., changes in verification or face to face interview requirements, application, renewal process, etc.)?

Do not include DRA mandated changes regarding citizenship documentation.

i. In FY 2006? ☐ Yes ☐ No If "Yes," please describe those changes:

____

____

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

____

____

7. **Changes in Benefits:** Please describe below any expansion, reduction, restriction, restoration or other change in benefits or services *implemented* during FY 2006 or to be implemented in FY 2007.

Populations Affected	Year	Nature of Benefit, Expansion, Reduction, Restriction, Restoration or Other Change	Effective Date	Under DRA Authority?	Est. No. of People Gaining or Losing Benefits
a. Children	FY '06			☐	
	FY '07			☐	
b. Parents/ Pregnant Women	FY '06			☐	
	FY '07			☐	
c. Aged/ Disabled (including duals)	FY '06			☐	
	FY '07			☐	
d. Medically Needy	FY '06			☐	
	FY '07			☐	
e. Adults Without Children	FY '06			☐	
	FY '07			☐	
f. Other	FY '06			☐	
	FY '07			☐	

8. **Changes in Cost Sharing**:

i. ii. For FY 2007, does your state plan to make copayments enforceable for any eligibility group (as allowed by the DRA)? ☐ Yes ☐ No ☐ Don't know

ii. Does your state charge copays? (*Check one*) ☐ Yes ☐ Yes, but only for drugs ☐ No

Comments: ____

____

iii. Please describe any beneficiary cost sharing that was *newly implemented, increased* or *decreased* in FY 2006 or will be implemented, increased or decreased in FY 2007:

Populations Affected	Year	New, Higher or Lower Beneficiary Copays or Premiums by Service (e.g., for prescription drugs, dental, ER, inpatient hospital, etc.)	Under DRA Authority?
a. Children	FY '07		☐
b. Parents/ Pregnant Women	FY '06		☐
	FY '07		☐
c. Aged/ Disabled (including duals)	FY '06		☐
	FY '07		☐
d. Medically Needy	FY '06		☐
	FY '07		☐
e. Adults without Children	FY '06		☐
	FY '07		☐
f. Other	FY '06		☐
	FY '07		☐

9. DRA Long Term Care Changes:

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

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

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

ii. Indicate whether your state intends to take any of the actions listed below in FY2007.

DRA State Options:	Yes	No	Don't Know
a. Establish a Long Term Care Partnership Program	☐	☐	☐
b. Apply for any of the following Demonstration Projects or Grants:			
i. HCBS Alternatives to Psychiatric Residential Treatment Facilities for Children	☐	☐	☐
ii. Money Follows the Person Rebalancing Demonstration	☐	☐	☐
c. Establish HCBS State Plan Option	☐	☐	☐
d. Take advantage of new options related to Self-Directed Personal Assistance Services (Cash & Counseling)	☐	☐	☐

10. Long Term Care Policy Changes: Briefly identify the long term care reductions, restrictions or expansions (described below) that were implemented during FY2006 or will be implemented in FY2007. (Please *exclude* rate and tax changes reported under questions 3 and 4). Where applicable, please indicate if the change was made possible by the DRA.

Program or Policy Actions	Actions Implemented in FY 2006	Actions to be implemented in FY 2007
a. Eligibility restrictions (e.g., tighten level of care, etc.)		
b. Eligibility expansions (e.g., liberalize level of care; adopt "special income level", etc.)		
c. Community Service Restrictions (e.g., restrict waiver slots/services, state plan personal care services, etc.)		
d. Community Service Expansions (e.g., establish/ expand waiver slots/services, state plan personal care services, PACE sites, nursing home diversion/transition programs, etc.)		
e. Institutional reductions (e.g., bed-hold policy changes, reduced Medicare cross-over payments, bed moratoriums, etc.)		
f. Institutional expansions/ increases (e.g., bed moratorium repeal, quality enhancement initiatives, etc.)		
g. Estate Recovery Initiative		
h. LTC Managed Care Initiative		
i. Other		

11. Prescription Drug Policy Changes:

i. **Impact of DRA FUL Changes:** The DRA made changes to the Federal Upper Limit (FUL) program to reduce Medicaid payments for certain multi-source drugs. For your state in FY2007, do you expect these changes to produce (check one):

☐ None/insignificant savings ☐ Some or modest savings ☐ Significant savings

ii. **Program or Policy Actions:** What *new prescription drug policies* were *implemented* during FY 2006? What *new* actions will be implemented for FY 2007? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2006	Actions to be Implemented in FY 2007	Was policy in place in FY 2006? (check all that apply)
a. Change in dispensing fees			
b. Change ingredient cost (i.e., AWP – x%; ASP, WAC or AMP + x%)			
c. Preferred Drug List (PDL)			☐
d. More/fewer drugs subject to prior authorization w/out PDL			☐
e. Supplemental rebates			☐
f. Multi-state purchasing coalition			☐
g. Limits on number of Rx per month imposed or lifted			☐
h. Changes to State MACs (update frequency, lower rates, new contract administrator, etc.)			☐
i. Other			

12. Pay for Performance or other Quality Incentive:

Was a quality incentive in place before FY 2006. ☐ Yes ☐ No

Program or Policy Actions	Actions Implemented in FY 2006	Actions to be implemented in FY 2007
a. Pay for performance with financial bonuses & penalties		
b. Other quality incentive programs		

13. Other Policy Changes or Cost Containment Measures: What other program or policy actions were *implemented* during FY 2006, or will be implemented in FY 2007 to slow the growth in Medicaid expenditures *or* to restore previous cuts? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented in FY 2006	Actions to be implemented in FY 2007
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. Other actions:		

Comments: ____

14. Section 1115 Waivers:

i. Is your state currently planning to implement a new Section 1115 comprehensive Medicaid reform waiver or waiver amendment in FY 2007? ☐ Yes ☐ No

ii. If yes, has it been approved? ☐ Yes ☐ No

iii. Did your state have plans to move forward with an 1115 waiver that changed in light of the new options in the DRA? ☐ Yes ☐ No

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

A. Increase the number of persons with health coverage by:

- i. ☐ Expanding eligibility
- ii. ☐ Increasing private or employer-sponsored coverage
- iii. ☐ Other: Please describe ________________

B. Encourage personal responsibility:

- iv. ☐ Through premiums or cost sharing
- v. ☐ Through personal health accounts
- vi. ☐ Other: Please describe ________________

C. Reduce or improve predictability of state costs by:

- vii. ☐ Shifting from defined benefit to defined contribution approach
- viii. ☐ Limiting federal funds to an agreed amount
- ix. ☐ Modifying benefits for specific groups
- x. ☐ Preserving federal funds for health programs
- xi. ☐ Other: Please describe ________________

D. ☐ Rebalance Long Term Care

15. Medicare Prescription Drug Benefit:

i. **Woodwork effect:** Has your state experienced increased Medicaid enrollments that you believe have resulted from outreach and enrollment efforts for the Part D Low-Income Subsidy?

☐ Yes ☐ No ☐ Don't Know

Comments:____

ii. Medically Needy/Spend-down Enrollment: Has your state experienced a decrease in Medicaid enrollments in eligibility categories where individuals "spend-down" to meet an income eligibility threshold that you believe has resulted from the implementation of the Part D benefit?

☐ Yes ☐ No ☐ Don't Know

Comments:____

iii. **Clawback:**

a. Compared to what your state would have paid if Medicaid still covered drugs for dual eligibles, do you expect your state's clawback obligation in FY 2007 to be:

☐ More costly ☐ Less costly ☐ About the same

b. Does your state expect cost savings in future years (as the clawback percentage phases down)? ☐ Yes ☐ No

Comments: ____

iv. **Wrap-around Coverage:** In FY 2007, will your state provide:

a. Wrap-around coverage for dual eligibles' copay requirements? ☐ Yes ☐ No

b. Drugs not covered under the plan formulary? ☐ Yes ☐ No

v. **Medicare Demonstration Plan Reimbursements:** Has your state received reimbursement under the Medicare Demonstration Plan established to repay states for costs incurred during the Part D transition to ensure dual eligibles had continued access to prescription drugs?

☐ Yes ☐ No ☐ Not applicable (state did not apply for the demonstration)

vi. **Future Part D Issues:** Are there other issues with regard to Part D implementation that you expect to affect Medicaid in FY 2007?

____

____

16. Other Deficit Reduction Act of 2005 State Options: Indicate whether your state intends to take any of the actions listed below in FY 2007.

DRA State Options:	Yes	No	Don't Know
a. Create a Medicaid Buy-in Program for Disabled Children	☐	☐	☐
b. Apply for any of the following Demonstration Projects or Grants:			
i. Medicaid Transformation Grants	☐	☐	☐
ii. Health Opportunity Account Demonstration	☐	☐	☐
c. Establish Non-Emergency Medical Transportation Brokerage Program	☐	☐	☐

17. DRA Citizenship Documentation Requirement:

i. **Administrative Impact:** Do you expect that your state will incur greater administrative costs to comply with the new DRA citizenship documentation requirements? ☐Yes ☐No ☐ Don't Know

ii. **Enrollment:** Do you expect Medicaid enrollment in your state to be impacted by the new documentation requirements? ☐ Yes ☐ No ☐ Don't Know

If yes, please describe the expected impact. ____________________

iii. **Acceptable Documentation:** Will your state accept all types of documentation deemed acceptable according to {ADD CITE TO CMS GUIDANCE]?

☐ Yes ☐ No ☐ Don't Know

Comments: ____________________

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

____

____

This completes the survey. Thank you very much.

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