kaiser commission on medicaid and the uninsured

Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009

Prepared by
Vernon Smith, Ph.D., Kathleen Gifford and Eileen Ellis
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and
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Kaiser Commission on Medicaid and the Uninsured
Kaiser Family Foundation

September 2008

THE HENRY J. KAISER FAMILY FOUNDATION

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.

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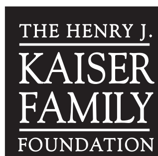

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Table of Contents

Executive Summary 7

Introduction 11

1. Medicaid Today 11
2. Current Issues 15
   a. Medicaid and the Economy 15
   b. Recent Legislative and Regulatory Action 17
   c. State and Federal Coverage Issues 19

Methodology 21

Survey Results for Fiscal Years 2008 and 2009 23

1. Medicaid Spending and Enrollment Growth Rates 23
   A. Total Medicaid Spending Growth 24
   B. State General Fund Spending Growth for Medicaid 26
   C. Medicaid Enrollment Growth 27
2. Medicaid Policy Initiatives for FY 2008 and FY 2009 29
   A. Changes in Provider Reimbursement 30
   B. Eligibility and Enrollment Process Changes 33
   C. Premium Changes 37
   D. Copayment Requirements 38
   E. Benefits Changes 40
   F. Long-Term Care and Home and Community–Based Services 43
   G. Prescription Drug Utilization and Cost Control Initiatives 46
   H. Managed Care and Care Management 48
   I. Quality and Health Information Technology 50
3. Key Medicaid Issues 54
   A. Access to Providers 54
   B. Behavioral Health 56
   C. Impact of Federal Oversight Activities 58
   D. Federal Medicaid Regulations 59
   E. Medicaid and SCHIP Reauthorization 62
   F. Medicaid 1115 Waivers 63
   G. Initiatives to Reduce the Number of Uninsured 64
   H. Looking Ahead: Perspectives of the Medicaid Directors 65

Conclusion 66

Appendix A: State Survey Responses 67

Appendix A-1: Positive Policy Actions Taken in the 50 States and District of Columbia FY 2008 and FY 2009 ... 68
Appendix A-2: Cost Containment Actions Taken in the 50 States and District of Columbia FY 2008 and FY 2009 ... 69
Appendix A-3a: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2008 ... 70
Appendix A-3b: Eligibility, Premium and Application Renewal Process Related Actions Taken in the 50 States and District of Columbia FY 2009 ... 73
Appendix A-4a: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2008 ... 76
Appendix A-4b: Benefit Related Actions Taken in the 50 States and District of Columbia FY 2009 ... 78
Appendix A-5: DRA Options ... 80
Appendix A-6a: Pharmacy Cost Containment Actions in Place in the 50 States and District of Columbia in FY 2008 ... 81
Appendix A-6b: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia FY 2008 and FY 2009 ... 82
Appendix A-7: Medicaid Care Management Taken in the 50 States and District of Columbia FY 2008 and 2009 ... 83
Appendix A-8: Medicaid Quality Measures in Place in the 50 States and District of Columbia FY 2008 and 2009 ... 84
Appendix A-9: Provider Taxes in Place in the 50 States and District of Columbia FY 2008 and FY 2009 ... 85

Appendix B: Profiles of Selected State Medicaid Policy Changes: ... 86

Profile of Medicaid Policy Changes: Florida ... 87
Profile of Medicaid Policy Changes: Michigan ... 90
Profile of Medicaid Policy Changes: New Mexico ... 93

Appendix C: Survey Instrument ... 96

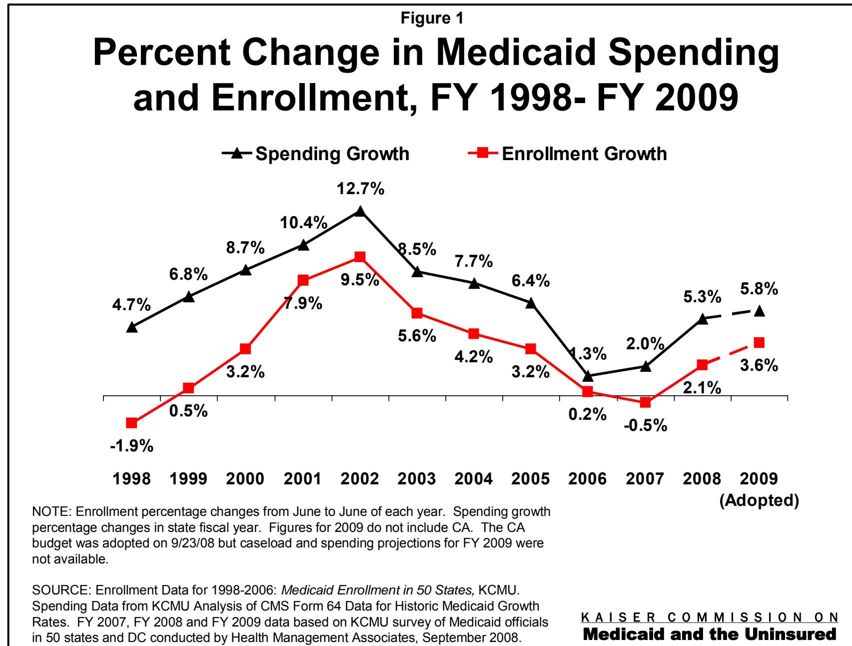
Executive Summary

As states finalized Medicaid policy decisions for fiscal year 2009, they faced a dramatically different situation than the prior year. At the start of state fiscal year 2008, the economy was generally strong and many states were restoring cuts from the last economic downturn and moving forward with Medicaid improvements and expansions to cover more low-income uninsured individuals. A year later, over half of all states faced significant budget shortfalls and slower than anticipated state revenue growth. For some states, plans to expand Medicaid were put on hold as states struggled to allocate funding and balance their budgets. Despite the budget crunch, few states took significant actions to cut Medicaid. During the last economic downturn from 2001 to 2004, most of the major Medicaid restrictions came later in the downturn cycle, not at the very beginning.

The Medicaid program provides health coverage and long-term care support services to 59 million individuals. Medicaid is administered by the states within broad federal guidelines, but financing is shared by the states and the federal government. During an economic downturn, unemployment rises and puts upward pressure on Medicaid enrollment and therefore Medicaid spending, as individuals lose employer sponsored coverage and incomes decline. At the same time, increases in unemployment have a negative impact on state revenues making it even more difficult for states to pay for Medicaid spending increases.

For the eighth consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. This report presents findings for state fiscal years 2008 and 2009.

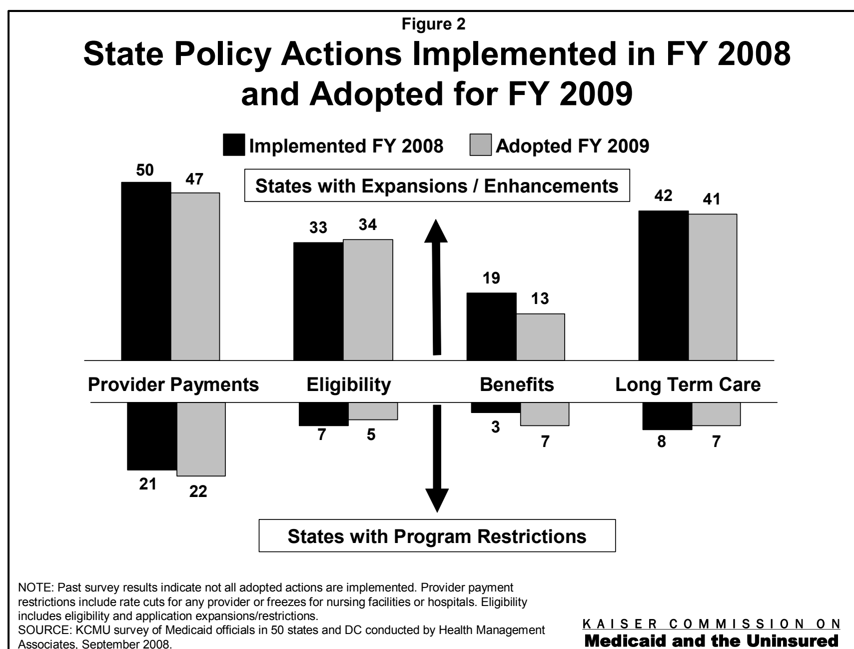
After hitting low points in 2006 and 2007, Medicaid spending and enrollment growth increased in 2008 and is projected to grow faster in 2009. The implementation of Medicare Part D and an improving economy were the primary factors contributing to record low Medicaid spending growth of just 1.3 percent in 2006. Medicaid spending growth reached 5.3 percent in 2008 due to a combination of program restorations and enhancements (particularly for provider payment rates) as well as enrollment increases related to the economy and policy changes to expand eligibility, simplify enrollment or implement marketing or outreach campaigns to enroll more individuals. Looking ahead to FY 2009, states legislatures appropriated spending growth for FY 2009 that averaged 5.8 percent (Figure 1). However, the initial appropriation for Medicaid may understate actual growth in total Medicaid spending in FY 2009. Medicaid directors in two-thirds of states indicated that the likelihood of a Medicaid budget shortfall in their state this year was at least 50-50. One reason is an expected increase in the number of persons enrolled in the program. For FY 2009, Medicaid officials projected growth in Medicaid enrollment that would average 3.6 percent across all states. Medicaid directors primarily attributed the higher enrollment growth projections in FY 2009 to the worsening economy. The FY 2009 California budget was adopted on September 23, 2008 but estimates for California spending and enrollment growth were not available and therefore not included in the national averages. The report reflects the Medicaid policy actions that were included in the FY 2009 budget for California.



NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentage changes in state fiscal year. Figures for 2009 do not include CA. The CA budget was adopted on 9/23/08 but caseload and spending projections for FY 2009 were not available.

SOURCE: Enrollment Data for 1998-2006: *Medicaid Enrollment in 50 States,* KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2007, FY 2008 and FY 2009 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.

In both FY 2008 and FY 2009, states made more Medicaid restorations, enhancements and expansions than cuts despite the change in the economy. The economy was generally favorable as states prepared their budgets for fiscal year 2008. This enabled them to implement an array of positive changes for Medicaid including provider payment rate increases, eligibility expansions and simplifications, targeted benefit improvements or restorations of cuts, community-based long-term care expansions as well as continued strategies to improve quality of care. Even in a favorable economic climate, Medicaid directors remained focused on efforts to control Medicaid spending growth. For FY 2009, despite the economic downturn, states moved cautiously with respect to Medicaid. States adopted more positive policy changes than restrictions related to provider payments, eligibility, benefits and long-term care, but there were fewer and smaller expansions compared to FY 2008 (Figure 2). This response was similar to the experience in the last economic downturn when states did not immediately implement widespread actions to cut Medicaid as the economy faltered; significant cuts to Medicaid came further into the downturn cycle.



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Eligibility includes eligibility and application expansions/restrictions.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008.

States continued to report negative implications related to the citizenship and identity documentation requirements imposed by the Deficit Reduction Act (DRA). Thirty states reported that the new citizenship and identity requirements moderately or significantly increased the time needed to determine eligibility; 24 states reported increased backlogs of applications and 22 states reported an increase in the number of applications denied. More than half of states saw enrollment dip in June 2007 compared to the previous year as they implemented the new requirements and then increase as delayed applications were processed or individuals returned after being dropped from coverage. The citizenship documentation requirement was the most frequently cited reason for drops in enrollment in 2007. Medicaid directors in one-quarter of states indicated that the requirements continued to have a significant impact on enrollment in 2008. Overwhelmingly, Medicaid directors indicated the new requirements were cumbersome, burdensome and that they pose new barriers for those applying for benefits.

A few more states opted to use new DRA options around benefits and cost sharing, but overall adoption has remained low. The DRA allowed states new options to alter benefit packages, impose or eliminate cost sharing and make copays enforceable (meaning that providers or pharmacists could deny services for individuals who could not pay their copay at the time of service) for certain groups. By FY 2008, eight states were using DRA authority related to benefit changes, four states were using DRA authority to make at least some copays enforceable and Wisconsin was using DRA authority to extend nominal copayment requirements to certain parents and children in managed care. For FY 2009, Nevada plans to use the DRA to implement new copayment requirements for adults and to make these copays enforceable. Two states, Oregon and Pennsylvania also used DRA authority to eliminate co-pays.

Again this year, most states reported taking steps to expand or enhance home and community-based service options for long-term care. In FY 2008, 42 states took actions that expanded long-term care services (primarily expanding HCBS programs), and a similar number (41 states) planned expansions in long-term care for FY 2009. While the DRA included new provisions intended to give states increased flexibility to deliver long-term services and supports, only nine states thus far have reported implementing or adopting plans to implement the DRA self-directed personal assistance services option (cash and counseling) and only five states have reported implementing or adopting plans to implement the HCBS State Plan option. However, a total of 38 states are moving forward with Long Term Care Partnership programs.

States continue to develop managed care delivery systems and implement strategies to improve quality. In FY 2008, nearly one-third of states expanded their use of managed care by including persons with disabilities in managed care, expanding managed care service areas and requiring enrollment into managed care when it had previously been voluntary. Managed care continues to be a vehicle for quality improvement initiatives in Medicaid through the use of performance measures and reporting the results for health plans. There is a clear trend towards pay for performance arrangements, with three-fourths of states using some form of P4P in FY 2009, compared to less than half three years earlier. States continue to develop new generation disease management and care management initiatives to assure better care for persons with chronic conditions and disabilities whose care tends to be the highest cost. Almost a third of states implemented new or expanded care management initiatives in FY 2008, and over a quarter of states did so in FY 2009. More states are also moving forward to encourage new technologies such as e-prescribing and electronic health records to improve health care quality.

Overall, Medicaid programs provide access to quality health services, but Medicaid officials recognized access problems for dental care and some specialists and they raised concerns about behavioral health care. A large body of research has shown that low provider rates are a primary factor affecting provider participation in Medicaid and access to services for Medicaid beneficiaries. This survey gauged Medicaid directors' perceptions about access to care for primary care physicians, specialists and dentists. Access to primary care physicians was generally regarded as favorable, but 39 states reported some or significant problems accessing dental care and two-thirds of states reported access issues for specialty physician services. Medicaid officials noted that access issues for Medicaid often parallel those that exist for the general population. On the positive side, Medicaid officials frequently indicated that access improved in the past year, largely due to state initiatives to improve provider rates and specifically to address dental access. Medicaid plays a critical role in delivering and financing mental health services, but nearly all states indicated moderate or significant issues with the growing cost of behavioral health care, behavioral health drug utilization, mental health related emergency room use and inpatient hospital admissions for mental health services.

A majority of states mentioned a strained federal-state relationship as a significant current challenge for Medicaid. States continue to express frustration over the administrative burden imposed by various federal audits and oversight activities. Of 50 states responding, 41 states reported that the administrative burden was ranked as a 4 or a 5 on a scale of one to five, including 23 states that described the administrative impact as a "5." Most states indicated that a series of proposed federal regulations would have significant fiscal and beneficiary implications in their states. Directors noted that state and federal elections and the prospect of national health reform could have implications for the currently strained federal-state partnership and they were hopeful that the future would bring a more collaborative partnership that would help states accomplish key program goals.

Looking ahead, federal policy actions, as well as the downturn in the economy, are likely to hinder state efforts maintain current Medicaid coverage and to cover more uninsured. Medicaid officials indicated that they continue to look at strategies to control costs as they also focus on improving quality and health care outcomes for Medicaid beneficiaries, and on strategies to reduce the number of persons without health coverage. Federal issues including SCHIP policy limits and the uncertainty of ongoing funding due to the temporary nature of the current authorization of SCHIP resulted in a number of states limiting their coverage expansions for children, including some expansions already approved by the state legislature. While some states continue to explore options to address the issue of the uninsured, the economic downturn has caused some states to proceed more slowly or to scale back plans. Given rising health care costs and a growing uninsured problem, coupled with state requirements to balance their budgets and the economic downturn, there is heightened state concern about Medicaid financing. A new Administration and Congress, the potential for large-scale health reform, as well as uncertainty about the direction of the economy all have important implications for the immediate future of the Medicaid program nationally and across all fifty states.

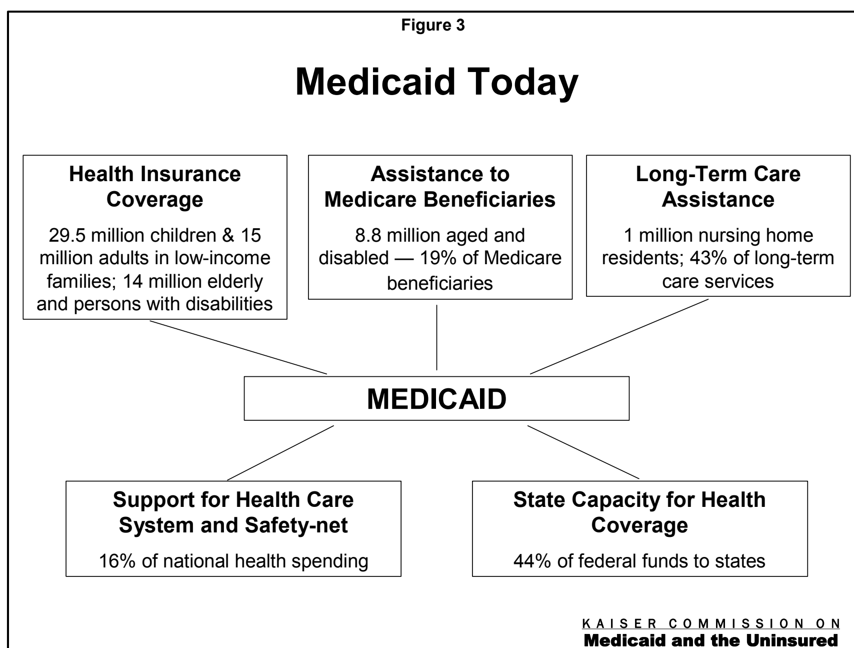
Introduction

In 2008, state fiscal situations turned from a period of economic recovery to another economic downturn. During the last downturn that started in 2001 (not even a decade earlier), Medicaid enrollment and spending growth peaked in 2002 and every state implemented an array of measures to control Medicaid spending growth to meet state budget shortfalls. Federal fiscal relief in the form of an enhanced FMAP was given to states for 15 months starting in April 2003 to stave off even deeper Medicaid cuts and preserve eligibility levels (which was required to receive the increased match). States began to climb out of the last economic downturn in 2005 and by 2007 many states were planning Medicaid program restorations, improvements and expansions in response to an improved fiscal climate and the need to address the growing problem of the uninsured. However, a year later, in mid-2008, states are in a dramatically different situation and than half of the states faced a budget shortfall going into budget deliberations for FY 2009.

For the eighth consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. This report presents findings for state fiscal years 2008 and 2009. This report also includes background on the Medicaid program today as well as current issues facing the program.

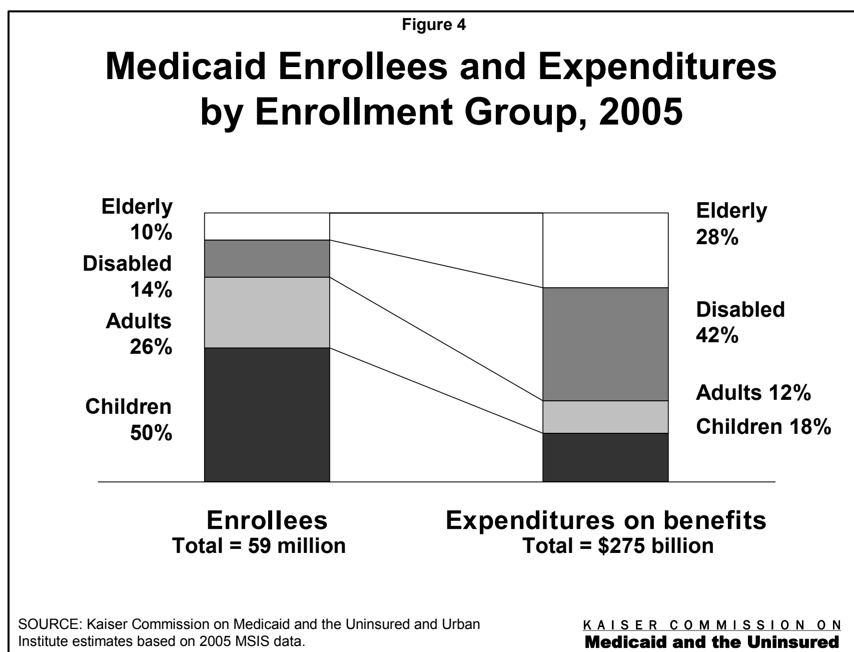
1. Medicaid Today

Medicaid serves multiple roles in the health care system. The program provides health coverage and long-term care assistance to about 45 million people in low-income families and nearly 14 million elderly and disabled people, including nearly 9 million low-income Medicare beneficiaries for whom it fills gaps in Medicare coverage. Medicaid provides critical funding for a range of safety-net providers. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all health care spending in the U.S. and nearly half of all nursing home care. Finally, Medicaid represents the largest source of federal revenue to states which provides a significant support for state capacity to finance health coverage (Figure 3).



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

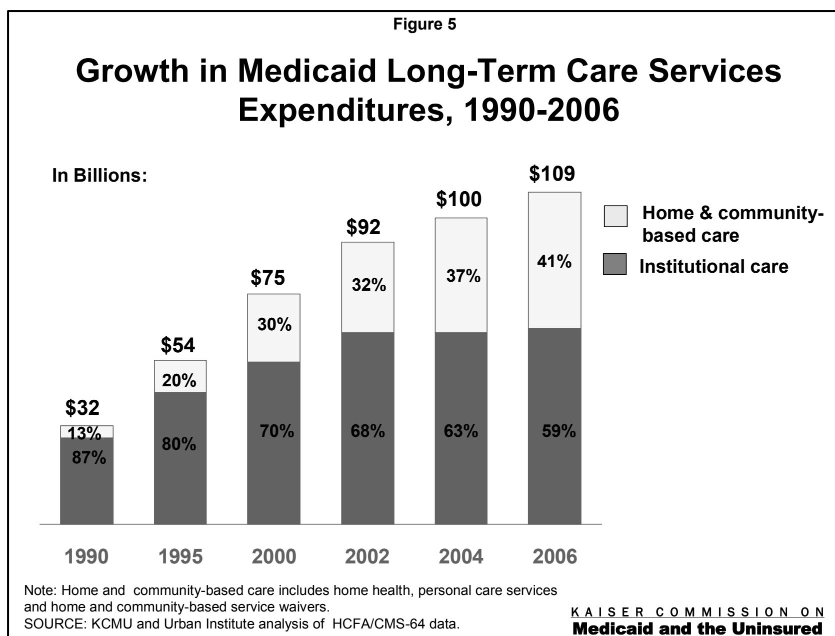
To be eligible for Medicaid, individuals must meet income and asset requirements and also fall into one of the categories of eligible populations. The federal government sets minimum eligibility standards, and states have the option to expand beyond these minimum levels or to cover optional groups. About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



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

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

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

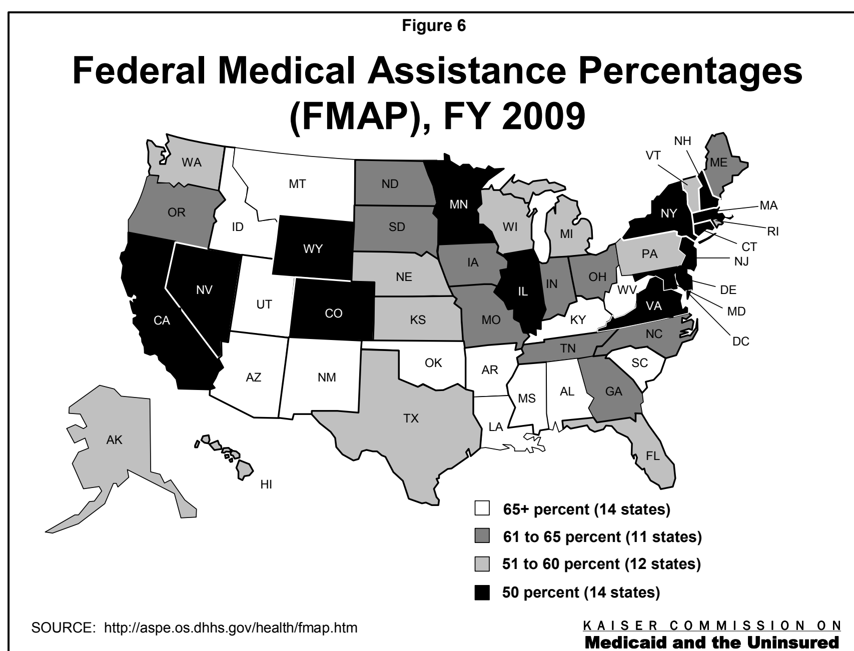


About 8.8 million elderly and persons with disabilities participate in both the Medicare and Medicaid programs. These "dual eligibles," accounted for only 15 percent of Medicaid enrollment, but just over 40 percent of Medicaid expenditures for medical service prior to the transfer of prescription drugs to Medicare. These same individuals account for over 25 percent of Medicare spending. The duals rely on Medicaid to pay Medicare premiums, cost sharing, and to cover critical benefits not covered by Medicare, such as long-term care. Because dual eligibles have significant medical needs and a much higher per capita cost than other Medicaid beneficiaries, they are a major issue for both Medicare and Medicaid and for both state and federal governments. Prescription drug coverage for the duals was transitioned from Medicaid to the Medicare Part D program on January 1, 2006 but states remain required to finance a portion of this coverage through a payment to the federal government, often referred to as the "Clawback." States have argued that all health care for the duals should be the responsibility of the federal government.

Medicaid Financing. The Medicaid program is jointly funded by states and the federal government. In 2006, total Medicaid expenditures exceeded $300 billion. The federal government guarantees matching funds to states for qualifying Medicaid expenditures, which include payments states make for covered Medicaid services provided by qualified providers to eligible 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 high of 76 percent[2] (Figure 6). On average across all states the FMAP is now approximately 55 percent. Each state's FMAP is calculated annually using a formula set forth in the Social Security Act. The FMAP is inversely proportional to a state's average personal income, relative to the national average. States with lower average

[2] In FY 2009, 13 states had an FMAP at the statutory minimum of 50.0 percent: CA, CO, CT, DE, MD, MA, MN, NH, NV, NJ, NY, VA and WY. The FMAP for IL in 2009 is 50.32. In addition, the FMAP is set in statute for the territories at 50 percent, with a cap on federal matching funds.

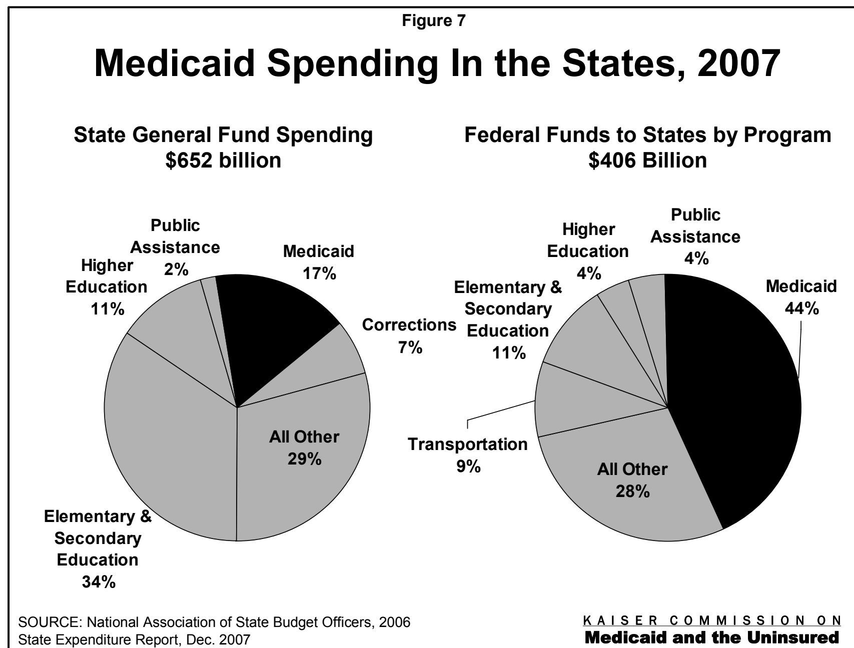
personal incomes have higher FMAPs. Personal income data is lagged so data used for FY 2009 is from the three years of 2004 to 2006.



In recent years, changes in average personal income occurred in a pattern that resulted in formula-driven FMAP reductions in a majority of states. Over the period FY 2005 – FY 2008, a total of 30 states had declines in their FMAP, including 19 states with drops of 1.0 percentage point or more. In 2009, the average federal Medicaid matching rate was about one percentage point less than it was in 2005.[3] These FMAP declines place pressure on states to allocate additional state general revenues to maintain current level programs. FMAP declines are particularly difficult to manage during economic downturns when states face other budget constraints.

Because of the matching formula, growth in state spending on Medicaid brings increased federal dollars to the state and provides an important economic incentive for states to maintain 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, accounting for an estimated 44 percent of all federal grants to states in 2007. On average, states spend about 17 percent of their own funds on Medicaid, making it the second largest program in most states' general fund budgets following spending for elementary and secondary education, which represented 34 percent of state spending in 2007 (Figure 7).

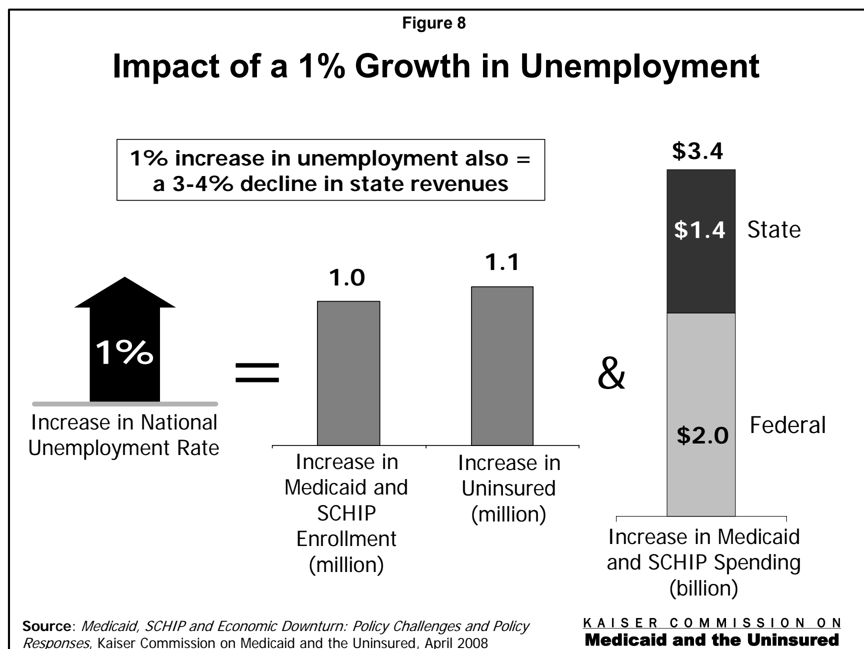
[3] For further discussion, see: Vic Miller, "Updated FY 2010 FMAP Projections," Issue Brief 08-16, Federal Funds Information for States, March 28, 2008.



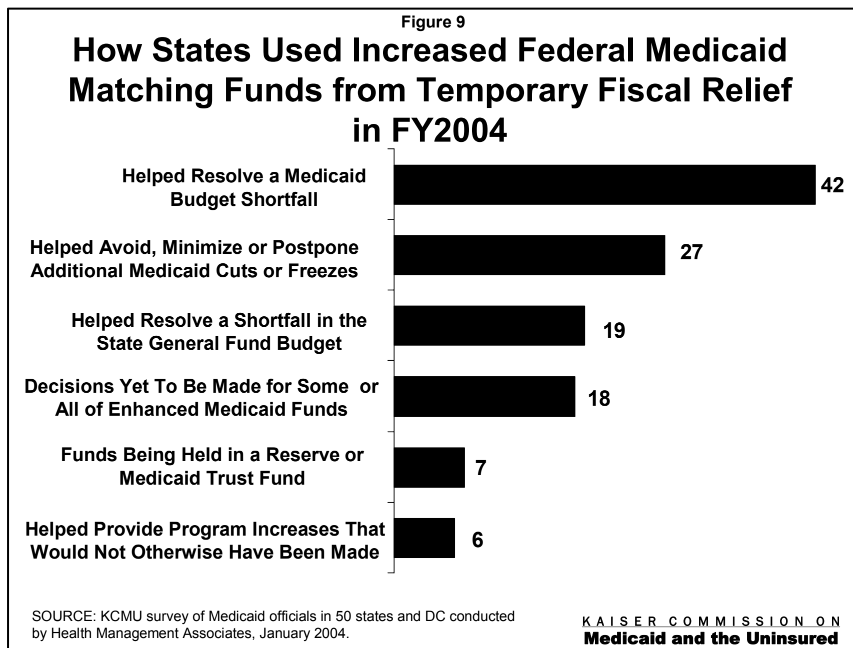
2. Current Issues

a. Medicaid and the Economy

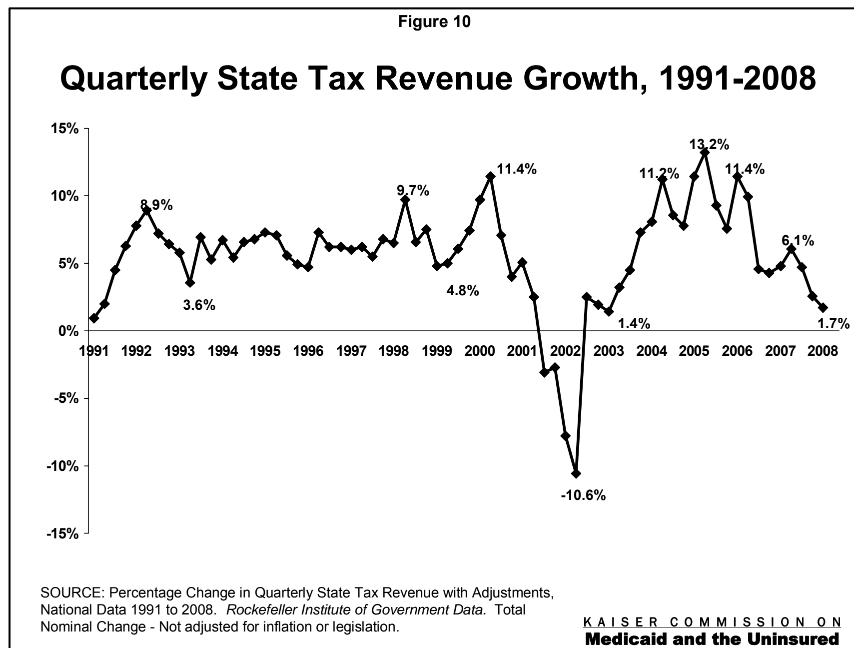
During an economic downturn, unemployment rises and puts upward pressure on Medicaid enrollment and therefore Medicaid spending, as individuals lose employer sponsored coverage and incomes decline. At the same time, increases in unemployment have a negative impact on state revenues making it even more difficult for states to pay for Medicaid spending increases (Figure 8). Beginning in 2001, the national economy worsened. From 2001 to 2004 cumulative state budget shortfalls exceeded $250 billion. In response to the fiscal crisis, states cut spending for services (including Medicaid), raised taxes or fees and used reserve funds to balance their budgets. Medicaid enrollment and spending growth peaked in 2002 in response to the economic downturn.



Recognizing the extraordinary state fiscal pressures, Congress passed the Jobs and Growth Tax Relief Reconciliation Act of 2003 that provided $20 billion in temporary federal fiscal relief to the states to ease budgetary pressures. Of the $20 billion total, $10 billion was provided through a temporary 2.95 percent FMAP increase. This fiscal relief (in effect for fifteen months from April 1, 2003 though June 30, 2004) proved instrumental in helping states to meet Medicaid and overall state budget shortfalls, to avoid making potentially larger Medicaid program cuts and to preserve eligibility (Figure 9).



FY 2005 marked the start of the fiscal recovery for many states that continued through FY 2006 when all states met or surpassed their revenue projections.[4] Nearly all states reported "stable" fiscal conditions in 2007 and the situation took a turn for the worse in 2008 when expenditures dropped to 5.1 percent (from 9.3 percent in 2007), thirteen states had to reduce enacted budgets (compared to three in 2007), revenue projections fell below expectations in 20 states (compared to 8 states in 2007) and year-end balances fell from a high of 11.5 percent of expenditures in 2006 to 10.5 percent in 2007 to 8 percent in 2008.[5] State revenues increased by only 1.7 percent from January to March of 2008 (mid-way through most state fiscal years) the lowest rate since 2003 when states were in the middle of the last economic downturn (Figure 10).



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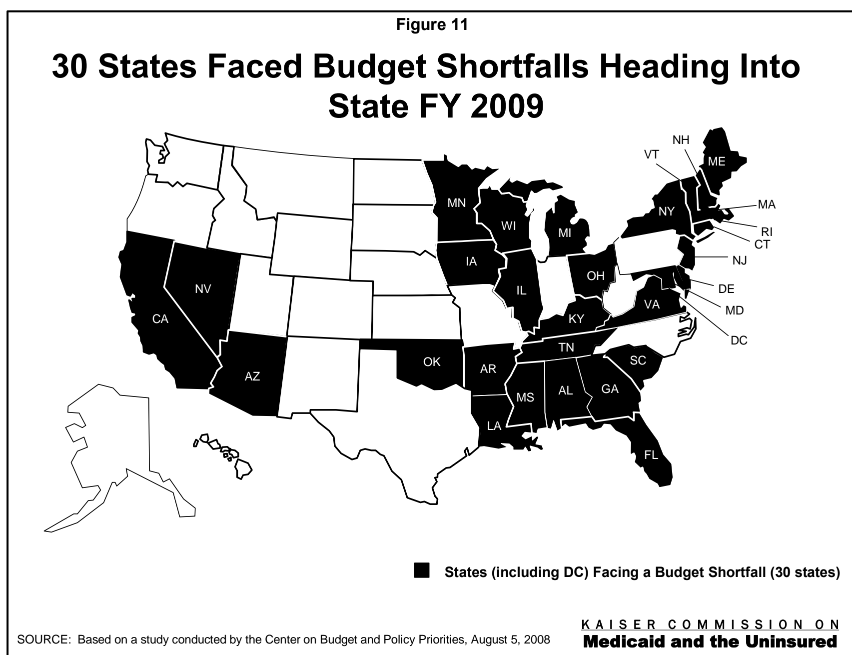
[4] Fiscal Survey of the States: June 2007. *National Governors Association and National Association of State Budget Officers.*

[5] Fiscal Survey of the States: June 2008. *National Governors Association and National Association of State Budget Officers.*

By all measures, the situation for spending, revenues and year-end balances were expected to worsen in 2009. Thirty states (including the District of Columbia) were projecting budget shortfalls for 2009 totaling at least $48 billion[6] (Figure 11). As with most downturns, the impact is not evenly distributed across states. States hit the hardest by the decline in the housing sector have fared worse than other states. After dealing with shortfalls when they adopted FY 2009 budgets, 13 states reported that they will face mid-year budget gaps of $4.4 billion.[7]



b. Recent Legislative and Regulatory Action

Deficit Reduction Act. The DRA, signed into law in February 2006, contained extensive Medicaid policy changes related to benefits, cost sharing, long-term care services, program integrity and eligibility. When the DRA was passed, the Congressional Budget Office (CBO) estimated that the Act would generate $26.1 billion in savings to the federal government over the next ten years. A few states that were in the midst of developing Medicaid reform Section 1115 waiver proposals (Kentucky, West Virginia and Idaho) were poised to take advantage of the new flexibility around benefit design instead of going through the waiver process. A few other states have used the new options but in fairly limited ways. In addition to the new options, the DRA included several mandatory provisions, including changes related to reimbursement for Medicaid prescription drugs, asset transfer rules that could affect eligibility for nursing home services, and documentation requirements for citizens applying for Medicaid. The DRA also included several other provisions including the creation of the Medicaid Program Integrity Program and a number of grant and demonstration programs. Thirty-five states, plus the District of Columbia and Puerto Rico were awarded Medicaid Transformation Grants (to fund research, design and implement new systems to

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[6] Elizabeth McNicol and Iris Lav. "29 States Faced Total Budget Shortfall of at Least 48 Billion." *Center on Budget and Policy Priorites.* Updated August 5, 2008.
[7] Elizabeth McNicol and Iris Lav. "State Budget Troubles Worsen." *Center on Budget and Policy Priorites.* Updated September 8, 2008.

enhance quality and efficiency of care) and 31 states were awarded Money Follows the Person Grants (to help move individuals from institutional to community based long-term care settings).

Medicare Part D. As part of the Medicare Modernization Act, prescription drug coverage for the duals was transitioned to the Medicare Part D program on January 1, 2006, however, states are now obligated to finance a portion of this Medicare coverage through a payment referred to as the "clawback" to the federal government. Most states continue to include the clawback payments as part of the state Medicaid budget, but these payments are not matched with federal funds and they are not included in calculations of federal Medicaid spending. The federal government accounts for these payments as Medicare revenue. States paid $5.5 billion to the federal government for the clawback in calendar year 2006 and $6.6 billion in 2007. Projections for clawback payments are $6.8 billion in 2008, and for 7.2 billion in 2009.[8]

Medicaid Regulations. Since 2007, the Administration has moved forward with changes to the Medicaid program via rule making that have implications for states, providers, beneficiaries and federal spending. The regulations would affect federal Medicaid reimbursement for government providers, rehabilitation services, case-management services, school-based administration and transportation services, provider taxes, graduation medical education and outpatient services. The Office of Management and Budget estimated that the regulations would reduce federal spending by over $15 billion over five years, but a report using state estimates projected a loss in federal Medicaid financing of nearly $50 billion. The Administration maintains that "each of these rules is vitally important to ensure the integrity of the Medicaid program," but members of Congress, states, beneficiaries and providers have raised concerns that these changes could have serious negative consequences, shift costs to states and may be inconsistent with Medicaid policies enacted by the Congress. Congress imposed a moratoria on six of the regulations (excluding the outpatient regulation) until April of 2009.

SCHIP Reauthorization. SCHIP was established as a block grant program in 1997 and authorized for ten years. The program was designed to expand health coverage to children not eligible for Medicaid but who could not afford or access private insurance. Congress passed two versions of the Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) to expand and extend SCHIP with bi-partisan support. Both bills (HR 976 and HR 3963) were vetoed by the President and there were insufficient votes in the House to override the veto. In December 2007, Congress passed S 2499 which extended SCHIP through March 2009 with additional funds to help states maintain current coverage levels. This extension fell short of the SCHIP reauthorization efforts which would have significantly increased SCHIP funding and reached nearly 4 million children who otherwise would have been uninsured. Issues around the income eligibility limit for coverage of children, crowd-out, and the treatment of immigrants, parents and childless adults as well as tobacco tax financing and politics were the key stumbling blocks for more comprehensive efforts to reauthorize the program.

The failure to pass the SCHIP reauthorization legislation left guidance issued by the Administration on August 17, 2007 intact. This guidance, referred to as the August 17th Directive essentially limits states' ability to expand SCHIP coverage to children with family incomes above 250 percent of poverty. The directive had a direct impact on 23 states (10 that had already implemented coverage expansions beyond 250 percent of poverty and another 14 that had plans to do so with Washington

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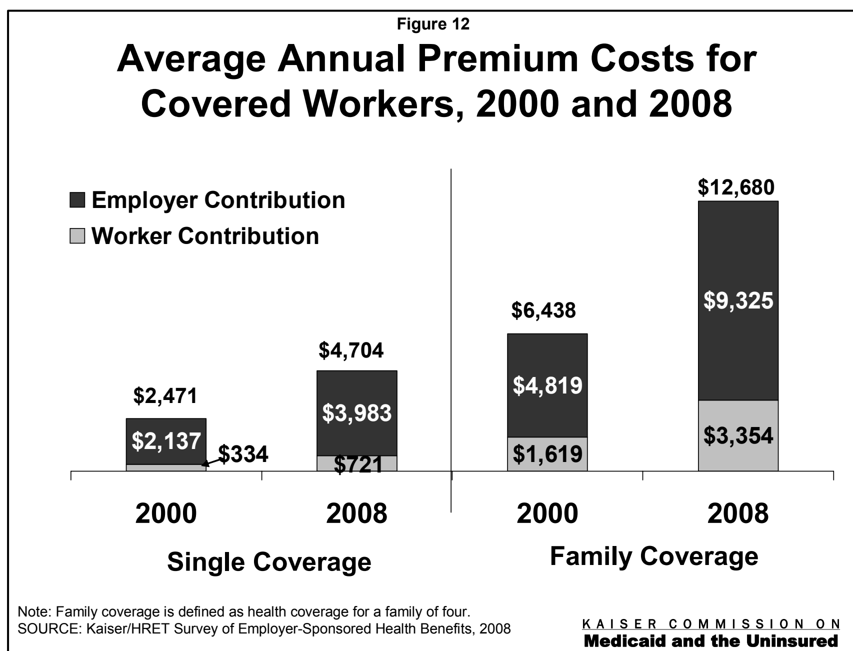
[8] Vic Miller, Federal Funds Information for States, Issue Brief 07-24, May 3, 2007 and Issue Brief 08-20, April 17, 2008.

falling into both categories). The directive forced many states to scale back planned coverage expansions. While CMS indicated that they will not take compliance actions against states if they fail to meet the requirements put forth in the directive, the guidance has not been rescinded leaving states with a great deal of uncertainty about how to proceed.

c. State and Federal Coverage Issues

The number of non-elderly uninsured Americans fell slightly from 46.5 million to 45 million from 2006 to 2007. Most of the uninsured are non-elderly adults, but there are about 8.9 million uninsured children. After the enactment of SCHIP in 1997, states expanded eligibility, increased outreach efforts and worked aggressively to make the application, enrollment and renewal processes for Medicaid and SCHIP easier in both SCHIP and Medicaid. The result was a decade of significant progress in reducing the uninsured rate for children, especially low-income children; however, an increase in the number of uninsured children was reported for both 2005 and 2006. Census data for 2007 shows a slight reduction in the number of uninsured children of about 500,000 largely due to increases in public coverage.

Despite the small decline in the last year, the number of uninsured has increased by eight million since 2000 which is largely tied to a decline in employer-sponsored coverage for both children and adults. While the growth in the cost of health insurance premiums has moderated somewhat in recent years, the cumulative growth in health insurance premiums for workers from 2000 to 2008 was 97 percent, compared to an increase in workers wages of just 29 percent over the same time period. The result has been an increasing problem of affordability for health care coverage particularly for low-income workers. Average worker premiums for a family were $12,680 in 2008 which is roughly equal to the earnings of a minimum wage worker (Figure 12).



Bolstered by an improved fiscal situation and anticipation of a robust SCHIP reauthorization bill, many states enacted or proposed plans to expand health coverage to a growing number of uninsured residents, particularly for children. Three states have universal coverage plans in place (Massachusetts, Maine and Vermont) and others had proposals to achieve universal coverage. Both comprehensive and incremental coverage plans used Medicaid and SCHIP as a foundation to expand coverage and rely extensively on federal Medicaid financing. Using Medicaid as a base for additional coverage is efficient because systems are in place and because on a per person basis, Medicaid spending has been growing slower than private health spending or premiums for employer

sponsored coverage. However, the failure of SCHIP reauthorization, new federal limits for using SCHIP to expand coverage and the change in the economy has forced states to delay or limit the scope of some planned expansions.

The final outcome of SCHIP reauthorization, the directive and the course of the economic downturn will have implications for how far states can go to expand public coverage programs. Certainly, the ideological debate around SCHIP is a foreshadowing of the debate that could ensue over the next year as the new Congress and President engage in a discussion about broader health reform. Issues around health insurance affordability and accessibility and the appropriate role of public coverage will certainly keep Medicaid in the mix during the discussion about health reform.

Methodology

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

The KCMU/HMA survey on which this report is based was conducted in July and August 2008. The survey was designed to document the policy actions states had taken in the previous year, state FY 2008, and new policy initiatives that they had implemented or expect to implement in state FY 2009, which for most states had begun on July 1, 2008.[10] Legislatures had adopted the FY 2009 Medicaid budget at the time each survey was finalized in all states. The California budget was signed on September 23, 2009. This report reflects the Medicaid policy decisions included in the signed budget, but revised spending and enrollment estimates were not available and not included in the national estimates used in the report.

The 2008 survey instrument was designed to provide information that was consistent with previous surveys. As with previous surveys, specific questions were added to reflect current issues. For this survey, new questions were included about: access to providers; behavioral health; the fiscal and enrollment implications for Medicaid of the federal extension of State Children's Health Insurance Program (SCHIP); and the impact of certain proposed federal Medicaid regulations.[11]

The data for this report were provided directly by Medicaid directors and other Medicaid staff in response to a written survey and telephone interview. The survey was sent to each Medicaid director in June 2008. Personal telephone interviews were scheduled for July and August 2008. 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. Completed surveys were received from all 50 states and the District of Columbia.

As has been the case in each annual survey, the focus of the 2008 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 actually implemented in FY 2008 or would be implemented in FY 2009. Policy changes under consideration for which there was not yet a definite decision to implement in FY 2009 were not recorded in this survey. It is important to note that some actions that were adopted or planned for implementation in FY 2009 at the time the survey

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[9] For previous survey results, see the following links: http://www.kff.org/medicaid/7569.cfm; http://www.kff.org/medicaid/7392.cfm; http://www.kff.org/medicaid/7001.cfm; http://www.kff.org/medicaid/kcmu4137report.cfm; http://www.kff.org/medicaid/4082-index.cfm; http://www.kff.org/medicaid/7699.cfm.

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

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

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. Policy changes sometimes are not implemented within the original timelines, or policy makers reconsider previous decisions as the impacts become better understood.

This report also includes case studies of three states (Florida, Michigan and New Mexico) that were profiled as illustrative examples of policy changes in states in FY 2009. Every state is unique in its Medicaid policy making, and these case studies show how these states are using Medicaid in innovative ways to expand coverage to the uninsured, taking steps to improve the quality and cost-effectiveness of care and managing their programs within tight fiscal constraints. These profiles are included as Appendix B in the report.

Where possible, the results from previous surveys are referenced to provide trends, context and perspective for the results of this survey. For example, in addition to showing the number of states implementing specific Medicaid cost containment in FY 2008 and FY 2009, information from previous surveys was used to chart the number of states adopting these actions over the seven-year period from fiscal years 2003 to 2009.

For FY 2008 and FY 2009, annual rates of growth for Medicaid spending and enrollment were calculated as weighted averages across all states (except that California projections for spending and enrollment growth were excluded from the calculations of national averages for FY 2009 because estimates were not available due to the late passage of their FY 2009 budget.) 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*, December 2007. 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 2007. For years prior to the periods covered by the KCMU/HMA surveys, Medicaid spending and enrollment data are based on estimates prepared by the Urban Institute using data from Medicaid financial management reports (CMS Form 64), adjusted for state fiscal years.

Survey Results for Fiscal Years 2008 and 2009

1. Medicaid Spending and Enrollment Growth Rates

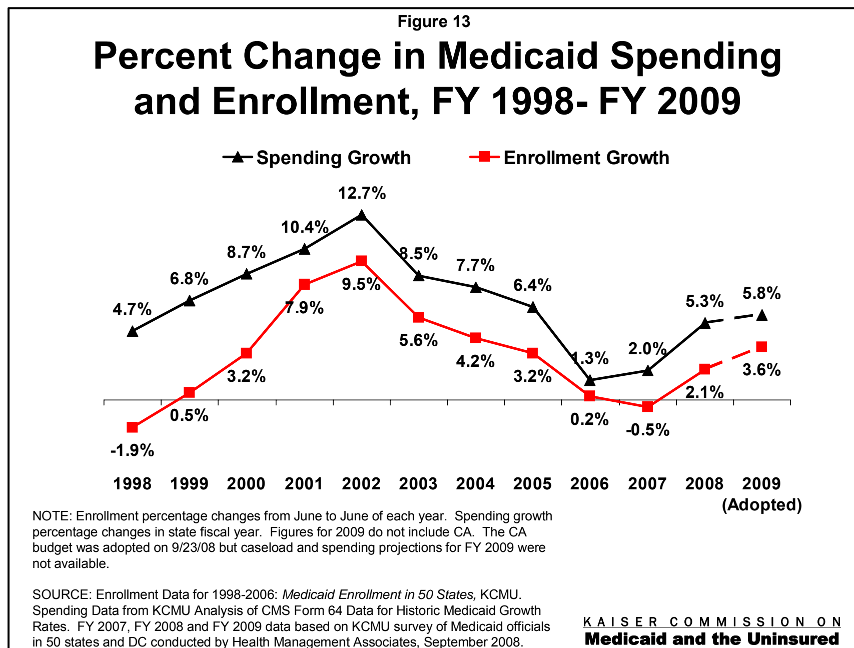
Key Section Findings:

- After two years of very low growth, total Medicaid spending growth increased by 5.3 percent in FY 2008 and was expected to increase by 5.8 percent in FY 2009. Medicaid directors attributed the higher growth rates to increases in provider rates, higher service utilization and increases in enrollment.

- State general fund spending for Medicaid grew by 5.4 percent in FY 2008 and was expected to increase by 6.0 percent in FY 2009. States spending growth is slightly higher than total spending in part because of formula driven declines in the federal matching rate for Medicaid which can shift spending to states to maintain current programs.

- After an actual enrollment decrease nationally in FY 2007, Medicaid enrollment increased by 2.1 percent in FY 2008 and states expected enrollment to increase by 3.6 percent in FY 2009. Medicaid officials attributed higher growth rates to a downturn in the economy as well as specific policy actions designed to address the uninsured and expand Medicaid.

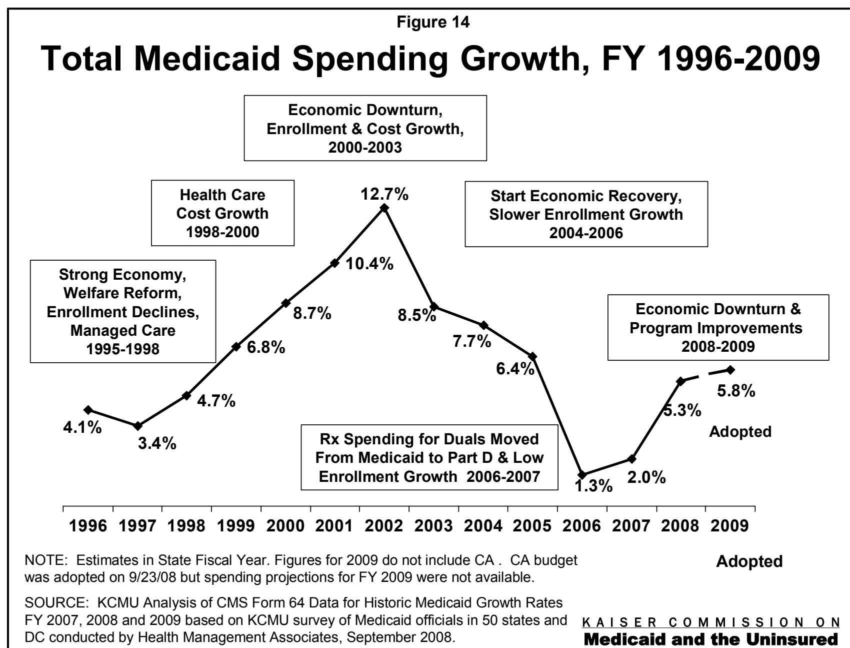
- Medicaid officials reported the new citizenship and identity documentation requirements imposed by the Deficit Reduction Act played a big role in suppressing enrollment in FY 2007 and this continued into 2008 for some states.



A. Total Medicaid Spending Growth

Total Medicaid spending represents all payments to Medicaid providers for services for Medicaid beneficiaries. It also includes "disproportionate share" (DSH) payments to hospitals that qualify for special payments to cover part of the costs of care for persons on Medicaid or that are uninsured. Total spending does not include Medicaid administrative costs.[12] Total Medicaid payments are financed by a combination of federal and state funds, and in some states local funds.

In state fiscal year 2008, total Medicaid spending increased by 5.3 percent.[13] Two years earlier, Medicaid spending grew at the record low rate of 1.3 percent as a result of two primary factors: the strong economy which contributed to slow enrollment growth and the implementation of Medicare Part D that transferred financial responsibility for prescription drugs for dual Medicare - Medicaid enrollees from Medicaid to Medicare.[14] The 5.3 percent spending in FY 2008 was well below the recent historical high of 12.7 percent annual growth in 2002 as well as below the 15-year historical average annual growth of 7.1 percent (Figure 14).



[12] For this and previous surveys, Medicaid agencies were asked to use a consistent definition of expenditures from year to year in their calculation of annual rates of growth of total Medicaid spending. The definition was determined by each state and varied across states. In some states, for example, Medicaid-financed spending under the control of another agency such as mental health or public health agency may not have been included. The national rates of growth in Medicaid spending reported here are the weighted averages of growth rates reported by each state, with the weights based on actual expenditures for each state for 2006, the most recent year for which state-by-state national data were available.

[13] For this survey, Medicaid directors indicated percentage growth of legislative appropriations for Medicaid above actual spending for fiscal year 2008. FY 2008 spending levels were preliminary at the time of the survey, pending the actual closing of the fiscal year books.

[14] Medicare Part D transferred fiscal responsibility for payment for prescription drugs for dual eligibles from Medicaid to Medicare, effective on January 1, 2006. Federal law required states to continue to pay a maintenance-of-effort amount to the federal government, generally known as the "Clawback." The Clawback formula approximates what a state would have paid in state funds for the prescription drug expenditure transferred to Medicare, discounted over a ten-year period by ten percent phasing to 25 percent. By law the Clawback is classified not as a Medicaid expenditure but as a source of financing for Medicare, although many states continue to budget the Clawback payment as a part of Medicaid. For this survey, when calculating spending growth, Medicaid expenditures exclude state Clawback payments.

State officials cited three primary factors as contributing to the growth of Medicaid spending in fiscal year 2008. First, all but 10 Medicaid officials attributed spending growth to legislatively-adopted provider rate increases. Officials in several states indicated that rate increases occurred in 2008 for some providers for the first time in many years, representing a catch-up for previous years when rates had been frozen or actually reduced during the economic downturn that began in 2001. The second factor mentioned was increases in service utilization, particularly for mental health and inpatient hospital services. Finally, about half of states mentioned increasing rates of growth in the number of persons enrolled in Medicaid due to changes in the economy or policy decisions designed to increase Medicaid enrollment. State officials listed a number of factors that worked to constrain overall Medicaid spending in FY 2008 such as the ongoing impacts of cost containment, enhanced program integrity initiatives, a range of care and disease management efforts, utilization management tools and a shift to community-based services for persons needing long-term care.

For FY 2009, legislatures adopted Medicaid appropriations that averaged 5.8 percent above total expenditures for fiscal year 2008. State legislatures deliberated and adopted Medicaid budgets for fiscal year 2009 as the economic picture worsened and state revenue growth slowed, coming in at less than projected rates. Most states were starting to feel fiscal pressure, but a few states including California, Arizona, Nevada, Florida, New York and Rhode Island were facing more severe budget crises. At the same time state revenue growth slowed, Medicaid caseload started to grow in almost all states putting additional pressure on state budgets. Medicaid officials in almost two-thirds of states – almost double the number at the beginning of FY 2008 – indicated that the likelihood of a budget shortfall in FY 2009 was at least 50 – 50. The implication is that actual spending growth may turn out to exceed the 5.8 percent average increase reflected in initial legislative appropriations for FY 2009.

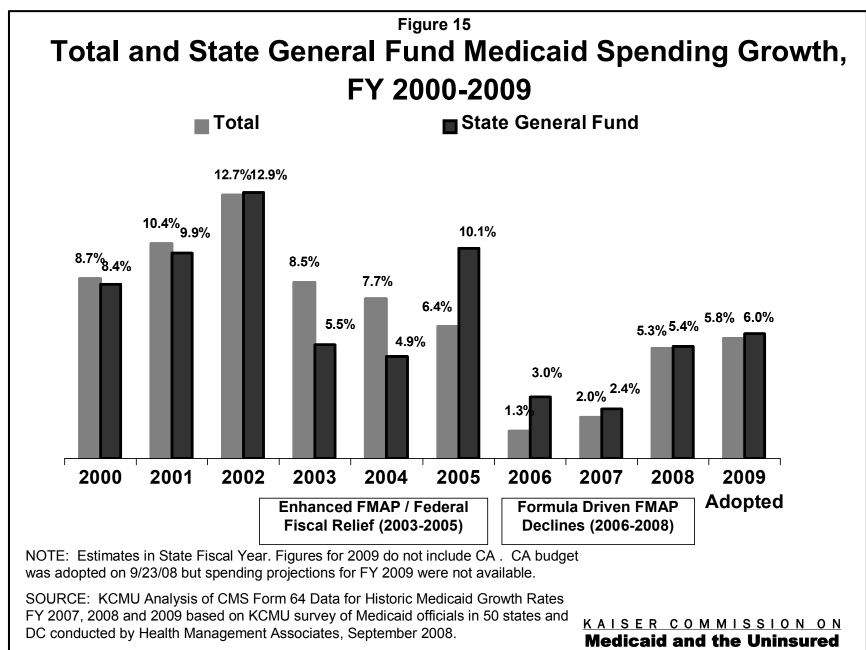
Medicaid directors anticipated that provider rate increases, enrollment growth and increasing utilization would be the primary drivers of Medicaid spending growth in 2009. These were the same factors driving Medicaid spending in FY 2008, except that for FY 2009 officials expected the significance of each factor to change. Increasing Medicaid enrollment was expected to play a much greater role in FY 2009, although provider rate increases were still cited as the most significant factor in Medicaid spending growth.

Unlike the past three years, Medicaid officials in several states indicated that they faced a real possibility of mid-year budget adjustments in state fiscal year 2009, due to overall state revenue and budget shortfalls. Officials in these states clearly communicated the specter of a difficult budget year across the board for state programs in general and in particular for Medicaid.

B. State General Fund Spending Growth for Medicaid

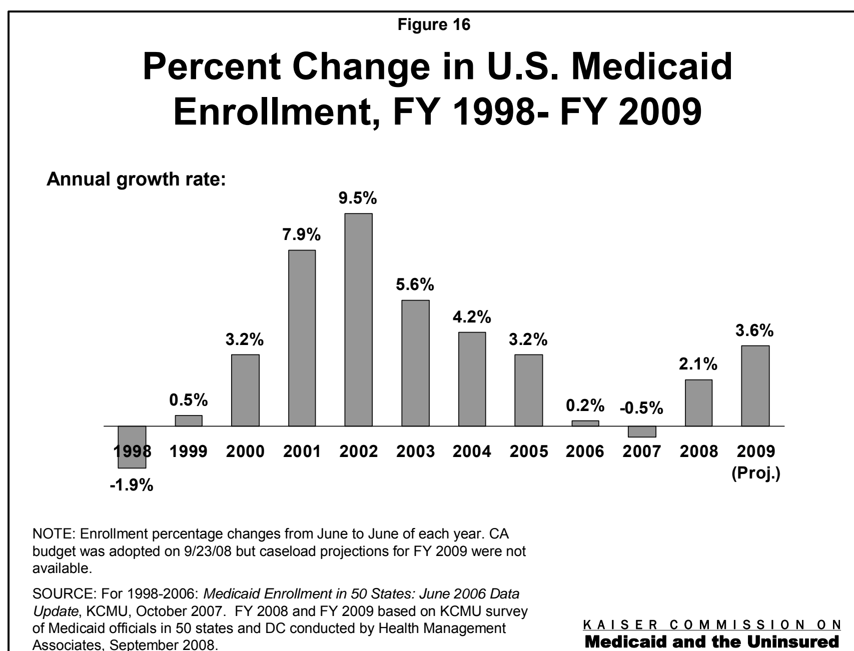
Medicaid costs are shared by the states and the federal government. State spending is matched with federal dollars at the federal matching rate (FMAP) which is determined by a formula that relies on states' relative per capita income. State policy makers must consider how Medicaid spending affects state general fund dollars and federal revenues to states as a result of the match. Total Medicaid spending and state Medicaid spending typically grow at about the same pace; however, differences can result from changes in the FMAP, contributions from local governments, tobacco tax funding, special financing arrangements and provider tax revenues. For example, during the last economic downturn, federal fiscal relief in the form of an increased Medicaid match rate resulted in total Medicaid spending growth outpacing state general fund growth. More recently, formula driven declines in the FMAP have resulted in the reverse. When the FMAP drops, states must pay more from state general fund dollars just to maintain their Medicaid program at the same level. For example, a state with Medicaid total spending near the median of about $4 billion, with a one percent drop in FMAP, would see a drop in federal Medicaid matching funds of $40 million and would need to increase its general fund spending by $40 million to maintain the same program level.

In state fiscal year 2008, state general fund spending increased on average by 5.4 percent across all states, slightly greater than the average 5.3 percent increase in total Medicaid spending. For FY 2009, state legislatures appropriated general fund spending growth that averaged 6.0 percent to achieve a growth of 5.8 percent on average in appropriated total Medicaid spending. This rate exceeds projected growth in state revenues and growth authorized by legislatures for most other state programs (Figure 15). It is the fourth consecutive year that growth in state Medicaid spending would exceed growth in federal Medicaid spending.



C. Medicaid Enrollment Growth

After two years of essentially flat enrollment growth in Medicaid, enrollment growth increased in 2008 by 2.1 percent on average across all states. Medicaid caseload increases occurred in 38 states and the District of Columbia, and generally modest declines occurred in 12 states. FY 2008 marked the first year since FY 2002 that the rate of growth in Medicaid enrollment was greater than in the previous year (Figure 16). For FY 2009, state officials on average projected an increase in Medicaid enrollment of 3.6 percent.[15] Three states projected that the Medicaid enrollment would remain unchanged, and all others projected increases in Medicaid enrollment.



Medicaid officials in half of states in FY 2008 and in two-thirds of states in FY 2009 indicated the worsening economy was the primary factor contributing to caseload increases. The number of persons who qualify for Medicaid goes up during times of economic downturn as unemployment rises, individuals lose employer sponsored coverage and incomes decline and more individuals become eligible for the program. Children and adults tend to drive economy driven Medicaid enrollment changes. Several states indicated that depending on the path of the economic downturn, enrollment could grow faster than projections which would have implications for Medicaid spending. During the last economic downturn, Medicaid enrollment increased nationally by 40 percent from 2000 through 2005 with annual growth of nearly ten percent in FY 2002. Since FY 2002 the pace of enrollment growth had decelerated for five consecutive years until the growth trend reversed in 2008.

At the same time, about half of the states indicated that the enrollment growth in 2008 and 2009 was also related to specific eligibility expansions, policy changes or program marketing campaigns. Several states mentioned expansions designed to cover specific population groups and outreach initiatives designed to find low-income uninsured children and families who were eligible but not

[15] California data are excluded in the projected average increase in enrollment of 3.6 percent for FY 2009 because estimates were not available due to the late passage of the California FY 2009 budget.

enrolled in Medicaid. As discussed later in this report, many states took steps to ease the application process, adopt continuous eligibility or expand eligibility.

The Deficit Reduction Act, implemented in FY 2007, imposed new citizenship and identity documentation requirements for Medicaid for all enrollees and applicants. While the requirements did not change the rules regarding citizenship for Medicaid, three-quarters of states indicated that implementing the citizenship documentation requirements exerted a downward pressure on enrollment, usually due to difficulty applicants or beneficiaries had in obtaining the necessary documentation in a timely manner. States reported that the new requirements were the most significant factor contributing to low or declining growth in Medicaid enrollment for FY 2007. Some states indicated that enrollment in FY 2007 was artificially low due to the citizenship and identity documentation requirements and the recovery or catch-up from application backlogs contributed to the enrollment increases in FY 2008. However, officials in about one-quarter of states indicated that the requirements continued to have a significant impact on enrollment in FY 2008.

2. Medicaid Policy Initiatives for FY 2008 and FY 2009

Key Section Findings:

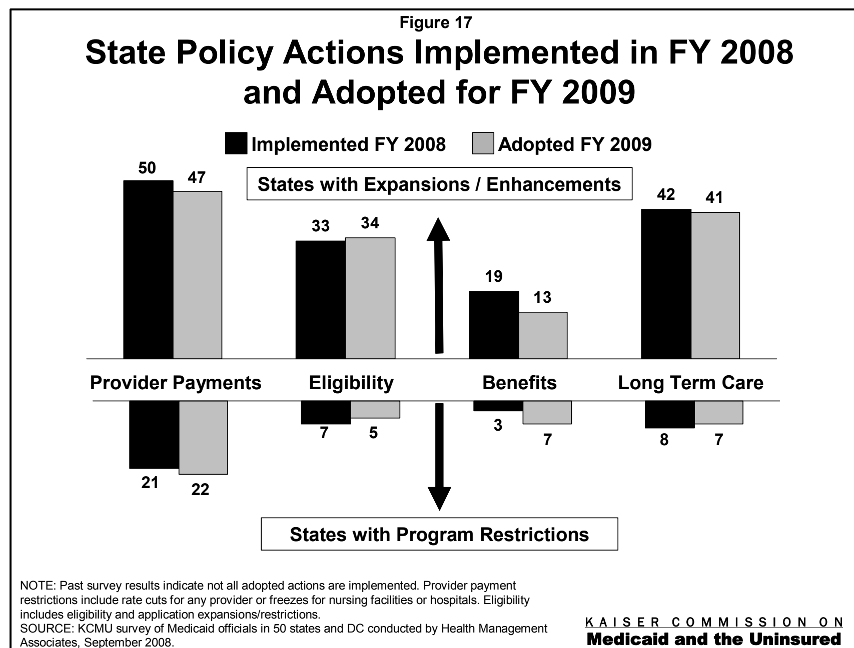
- Every state implemented at least one positive Medicaid initiative in FY 2008 and FY 2009. States adopted policies that were more positive than restrictive for provider rates, eligibility, benefits, and long-term care. In FY 2008, a total of 47 states implemented at least one new Medicaid policy change to control Medicaid costs and 43 states planned to do so in FY 2009. Most of these cuts were targeted and without a major impact on beneficiaries. A few states with severe budget shortfalls adopted more significant program reductions.

- Many states reported that DRA requirements for citizenship and identity documentation increased the time needed to determine eligibility and increased application backlogs and application denials. Overwhelmingly, Medicaid directors reported that the new requirements imposed new administrative burdens and barriers for those applying for benefits.

- By 2009, 8 states were using the DRA authority related to benefit changes, 5 states were using or planning to use DRA authority to make at least some copays enforceable, 2 states were using DRA authority to extend nominal copayment requirements and 2 states used DRA authority to eliminate co-payment requirements.

- In FY 2008, 42 states expanded LTC services (primarily for HCBS programs), and 41 states planned similar expansions for 2009. Few states are using DRA flexibility to deliver long-term services. Thirty-eight states have Long Term Care Partnership programs authorized by the DRA.

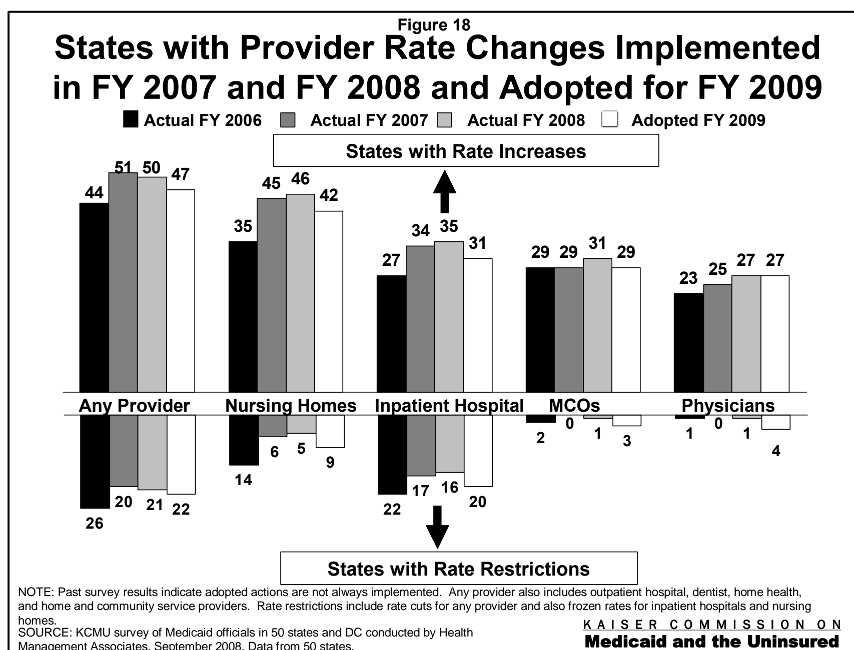
- In FY 2008, states continued to expand their managed care programs, develop new disease and care management programs for high cost individuals with chronic conditions, and implement health information technology and quality initiatives such as electronic health records and pay-for-performance.



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

A. Changes in Provider Reimbursement

Rate Changes. Provider payment rates are an important determinant of provider participation and access to services for Medicaid beneficiaries. Medicaid typically pays providers less than Medicare or commercial insurance and providers often cite low reimbursement rates as their primary reason for not participating in the program. These issues were exacerbated during the last economic downturn when all states reduced or froze provider payments to help curb Medicaid spending growth, sometimes for multiple years. As the economy started to improve, states were less likely to cut provider rates and more likely to increase provider rates with more states reversing payment cuts or increasing rates. In FY 2007, all states increased rates for at least one group of providers and in FY 2008 all but one state (New Hampshire) increased payment rates for at least one group of providers. For FY 2009, even though state finances again are becoming tighter, almost all states are increasing provider rates. In state budgets for FY 2009, only four states have no provider rate increases, namely California, Florida, New Mexico and Oklahoma[16] (Figure 18).



Nursing facilities were the most likely to have payment rates increased for FY 2008 and FY 2009, followed by inpatient hospital providers and managed care organizations. Reimbursement methodologies for hospitals and nursing facilities often include automatic adjustments based on an index relating to the cost of services and states are required to maintain actuarially sound

[16] Just before Labor Day, Georgia adopted a plan to delay Medicaid rate increases in order to balance the state's budget. These rate increases may be implemented later in the fiscal year.

reimbursement to HMOs. As a result, these three provider groups are more likely than others to show increases.[17]

Many states have experienced declining physician participation and are using enhanced payment rates as part of their strategy to improve participation and patient access. In FY 2008, a total of 27 states reported increases in physician payment rates (six fewer than the 33 that had planned to do so at the time of last year's survey). One state noted that the planned increase was "rolled back" in FY 2008 because it was necessary to cut either rates or benefits to balance the budget in FY 2008.[18] For FY 2009, 27 states indicated specific plans to increase physician rates. Some states noted that they were attempting to increase Medicaid rates to be on par with Medicare rates and others were targeting rate increases to specific physician types with access issues (i.e. certain pediatric specialists).

Not only are states increasing more provider rates, fewer are restricting payments by reducing or freezing payments than in years prior to FY 2007. In FY 2008, 21 states restricted payments for at least one provider category (including three states that cut rates) and in FY 2009, 22 states plan to restrict payments (including five that plan to cut rates) for at least one provider category.[19]

Of the more significant rate reductions planned for FY 2009, some are mid-year adjustments states are making after the original Medicaid budget was adopted. Significant rate reductions include:

- ***California*** implemented across-the-board provider ten percent rate reductions on July 1, 2008, that had been previously adopted by the legislature. The final budget adopted on September 23, 2008, provides for a restoration in March 2009 for a "significant portion" of the rate cuts.

- The ***New York*** budget agreement reached on August 20th includes mid-year rate cuts for hospitals, nursing homes and managed care organizations. (The New York fiscal year begins on April 1.)

- The ***Florida*** budget for FY 2009 included specified reductions in HMO rates and the monthly primary care case management fee. In addition, the budget reduced funding for inpatient and outpatient hospital services, nursing homes, and other provider categories not tracked by this survey. The budget required that rates for these providers be reduced if they would otherwise exceed the unit cost assumptions in the budget.[20] As a result, inpatient and outpatient hospital rates are also being reduced, but no budget-based rate reduction was necessary for nursing facilities.

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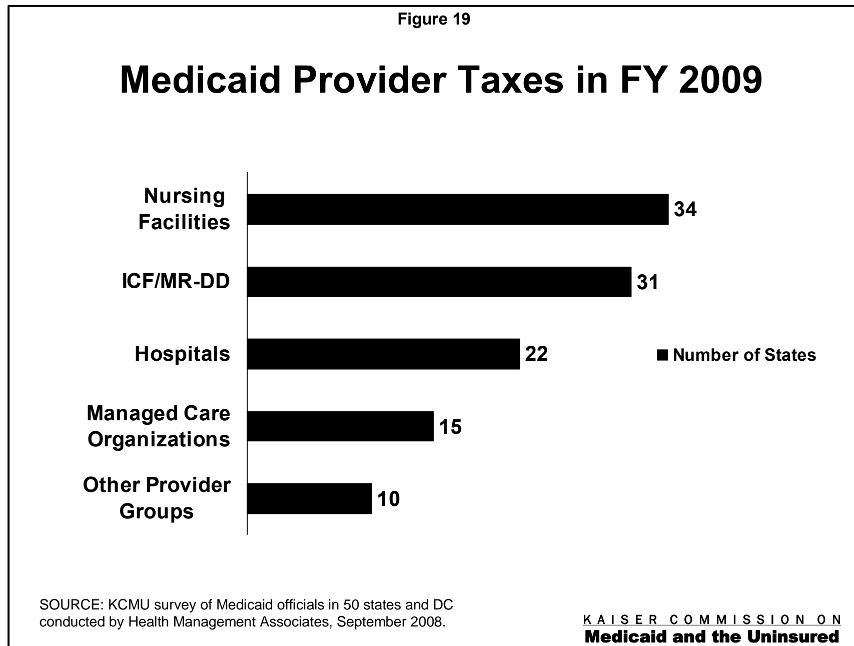
[17] When hospital and nursing facility home increases are tied to new or increased provider taxes the real rate increase net of the provider tax could be less than the nominal increase.
[18] One additional state reported an increase for FY 2008 that had not been noted in their FY 2008 survey.
[19] For this report the definition of payment restrictions includes rate freezes for institutional providers that typically have had annual cost of living adjustments (inpatient hospital and nursing facilities) or actual reductions in rates for any provider. By policy some states do not make annual changes to rates for physicians, dentists, and other non-institutional providers, but rather make periodic rate changes designed to cover multiple years.
[20] Health and Human Services Appropriations Committee Conference Report, Fiscal Year 2008-2009, Florida State Senate, accessed at http://edr.state.fl.us/conferences/medicaid/medsession.pdf with specific appropriation detail at: http://www.myfloridahouse.gov/FileStores/Adhoc/Appropriations/gaa/2008-House/bill/pdf/confreprt08.pdf

- In August 2008, ***Nevada*** announced mid-FY 2008 reductions in payments to hospitals, among other program reductions necessitated by a billion dollar state budget shortfall.

- In September 2008, ***South Carolina*** announced Medicaid reimbursement cuts as part of a three percent across-the-board cut in all state budgets. As of October 1, 2008, rates will be cut for physicians and dentists, as well as many other providers of ambulatory services. Hospitals will not be impacted at this time. Nursing homes will have a delay in their rate increase until the end of 2008. MCOs will not be impacted at this time.

Provider Taxes. In the early part of the current decade there was rapid growth in the use of taxes on health care providers as a mechanism to raise the non-federal dollars to support Medicaid programs. States are continuing the use of provider taxes to generate revenue to support their Medicaid programs, although the number of states and the number of taxes has not changed much in recent years. The number of states taxing at least one provider category reached 44 at the end of FY 2007, was unchanged for FY 2008 and will increase to 45 states in FY 2009. Thirty of these states taxed more than one category of providers in FY 2008 and 32 states will have more than one provider tax in FY 2009. (See Appendix A-9 for state-specific information on provider taxes.)

Two states implemented new provider taxes in 2007. For FY 2008, two states each implemented one new provider tax: ICF/MR-DD in South Dakota and Nursing Facilities in Maryland. For FY 2009 there are six states with proposed new provider taxes: hospital taxes in Idaho, Maryland and Pennsylvania; ICF/MR-DD taxes in the District of Columbia and Missouri, and a Nursing Facility tax in Colorado. Figure 19 shows the distribution of Medicaid provider taxes for FY 2009 among the various types of providers.



The most common change in the level or size of Medicaid provider taxes in FY 2008 was the federally mandated reduction in upper limit on these taxes from 6 percent of provider revenue to 5.5 percent of provider revenues. States reported that 34 taxes were affected by this limit – generally in FY 2008. The mandate resulted in reductions in three hospital taxes, 14 ICF/MR-DD taxes, 11 nursing facility taxes, and six HMO or other MCO taxes. Two other provider taxes were reduced for

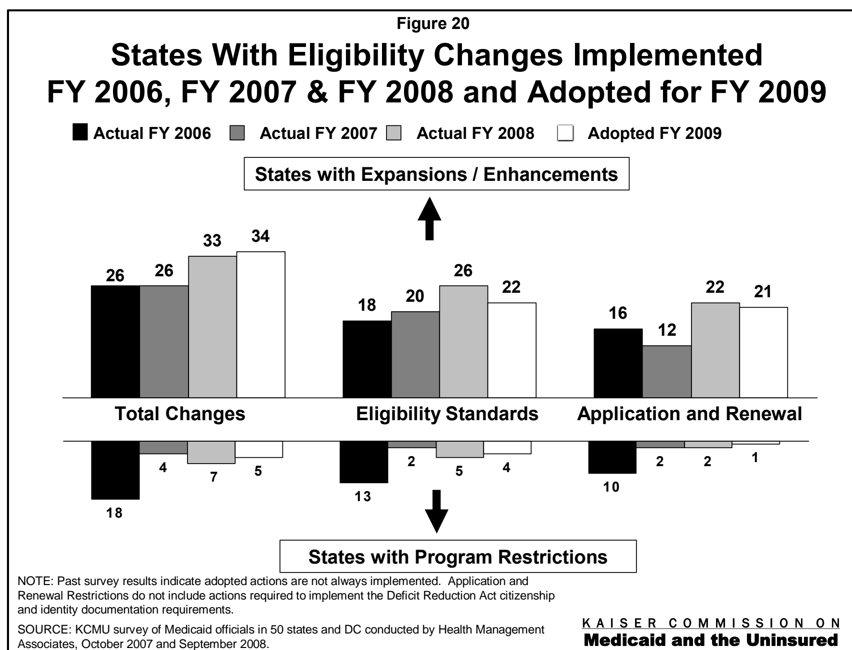
a total of 36 provider tax reductions in FY 2008. However at the same time, 11 provider taxes were increased in FY 2008, including two hospital taxes, two ICF/MR-DD taxes, four nursing facility taxes, one HMO tax and two taxes on other provider groups.

For FY 2009, in addition to the six new provider taxes noted above, there are more increases than decreases in existing Medicaid provider taxes. Twelve of the provider taxes are being increased in 2009 (six hospital taxes, three nursing facility taxes, one ICF/MR-DD tax and two other taxes), while only seven provider taxes are being reduced (three hospital taxes, three nursing facility taxes, and one ICF/MR-DD tax).

B. Eligibility and Enrollment Process Changes

Medicaid eligibility standards determine who can qualify for the program. The application and renewal processes impact how hard or easy it is to comply with program requirements, and therefore affect the likelihood that those who are eligible will apply or follow through on their application. Changes in eligibility standards or processes may result in either expansions or restrictions of the number of individuals covered by the program. Examples of changes to eligibility standards include increasing or reducing the income eligibility thresholds, adding or eliminating groups of individuals that are eligible for coverage, adding or changing asset tests, and implementing presumptive eligibility or 12-month continuous eligibility. A state can also affect enrollment by making changes in its Medicaid application and renewal processes. Examples would include changes in state policies for face-to-face interview requirements, simplifying the application form or instituting an online application process.

During the 2002 economic downturn, almost all states enacted some policy changes to restrict eligibility. As the economy recovered, states started to restore or roll back these eligibility restrictions. At the start of FY 2008, many states were interested in expanding their programs and only a few states took action to restrict eligibility. In FY 2008, 33 states implemented expansions of eligibility or improved application processes compared to seven states that implemented restrictive policies. Despite the faltering economy, in FY 2009, 34 states adopted plans to expand Medicaid compared to five states with plans to limit eligibility or enrollment (Figure 20). Many states reported that the new citizenship documentation requirements included in the DRA that were effective in FY 2007 also had significant implications for eligibility and enrollment.



Eligibility Standards. In FY 2008, 26 states expanded Medicaid by raising eligibility levels or by extending coverage to new populations and 22 states planned to do so in FY 2009. For FY 2008 and FY 2009, the most common eligibility expansions included changes to financial eligibility criteria – fifteen states increased income standards or income disregards and another four states increased asset limits. Expansions to newly eligible population groups occurred as nine states expanded Medicaid to cover 19 to 20 year old youths who were covered by Medicaid while in foster care and eight states implemented or expanded programs for disabled individuals who return to work, allowing them to continue coverage under Medicaid through a Medicaid buy-in program or the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). Six states are implementing or expanding a family planning waiver and five states are implementing 12-month continuous eligibility. Additionally, four states reported that they were implementing programs under the Family Opportunity Act (FOA), an option established in the DRA to allow children with disabilities with family income up to 300% FPL to "buy-in" to the Medicaid program.

The programs for persons aging out of foster care, working persons with disabilities, and the Medicaid buy-in for disabled children are expansions to generally high cost groups that typically cannot access affordable or adequate private health insurance. Some of the expansions to new population groups offer limited benefits.

Eligibility Expansion	States in FY 2008	States in FY 2009	States in Either FY 2008 or FY 2009
Increase an Income Limit or Earned Income Disregard	AK, AZ, CT, DC, IA, IN, LA, MO, MT, OH, WI	KY, MD, MT, NY, OR, WI	15
Cover Youth Aging out of Foster Care	MO, NC, OH, WA, WI	CO, FL, GA, NY	9
New or Expanded Coverage for Working Disabled	CT, GA, KY, MO, OH	DE, IL, MD	8
Implement or Expand a Family Planning Waiver	PA, VA	IN, MO, MT, VA, WY	6
12 Month Continuous Eligibility	IN, ND, TX	IA, NY	5
Family Opportunity Act (DRA Option)	LA, ND	IA, IL, LA	4
Presumptive Eligibility	CO, WI	IN, MO	4
Increasing Asset Limits or Eliminate Asset Test	AK	MD, MN, NY	4
Premium Assistance/ESI Initiatives	NY, OK, VT	OK	3
Buy-in Option (other than working disabled)		IN	1
Add New Eligibility Group		NE	1
Other Expansion	AL, IN, MS, OK, OR, TX	AL, FL, MN, MT, TN	10
Any Expansion	**26**	**22**	**34**

While most eligibility changes affected a small number of beneficiaries, some of the larger expansions were in Wisconsin and Maryland.

- ***Wisconsin.*** In FY 2008, Wisconsin expanded eligibility through its newly streamlined public health care program, BadgerCare Plus, providing universal coverage for children and increasing eligibility thresholds for pregnant women, parents, and caretaker relatives, using a combination of Medicaid, SCHIP and state-only funding streams. BadgerCare Plus extended eligibility to children with family incomes up to 300 percent FPL; children with family incomes above 300 percent FPL may also enroll, but are required to pay the full cost of coverage (around $1,100 per year). Under BadgerCare Plus, pregnant women with incomes up to 300 percent FPL and parents and caretaker relatives with incomes up to 200 percent FPL are eligible. The state also plans to expand coverage to childless adults with incomes up to 200 percent FPL in FY 2009.[21]
- ***Maryland.*** In FY 2009 Maryland is increasing the earned income disregard to change the effective income standard for parents and caretaker relatives from 30 percent to 116 percent of FPL. The state is also using the same earned income disregard to expand eligibility for childless adults to 116 percent FPL in it Primary Adult Care Program (Note: the asset test is also being eliminated for these groups.)

For FY 2008, five states implemented eligibility cuts and four states adopted cuts for FY 2009. Examples include eliminating continuous eligibility, reducing income eligibility or implementing a waiting list for selected population groups, and enacting more restrictive income disregard policies. Some of the more significant cuts included:

- ***Rhode Island.*** Income level for extended family planning & parents reduced from 185% to 175% of FPL for FY 2009 (estimate of 1,000 individuals).
- ***Maine.*** Implemented a waiting list and ultimately an enrollment freeze for childless adults in Maine (estimate of 8,000 in FY 2008 and an additional 1,000 in FY 2009).
- ***California.*** The adopted budget would eliminate continuous eligibility for children in FY 2009, and institute six month eligibility reviews and reporting requirements. Caseload estimates of this change were not available.

Details on these changed to eligibility standards, along with information about application process and premium changes for FY 2008 and FY 2009 are described in Appendices A-3a and A-3b.

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[21] The Medicaid component of BadgerCare expansion included an increased income limit for infants from 185% to 250% FPL and use of presumptive eligibility for children under age 19 in families with incomes below 150% FPL. In addition Medicaid coverage for parents and caretaker relatives was extended from the AFDC standard (approximately 40% FPL) to 200% FPL and for pregnant women from 185% FPL to 250% FPL. The expansions noted above that exceed these income limits use either SCHIP or state-only funding. While using a variety of funding sources, Wisconsin has created a seamless program of coverage for low-income individuals.

Application and Renewal Process Changes. States were asked whether they had made changes to their application and renewal process. In FY 2008, 22 states implemented changes that would streamline or simplify the application and renewal process (nearly double the number of states taking such actions in 2007). Twenty-one states indicate plans for simplification in FY 2009.

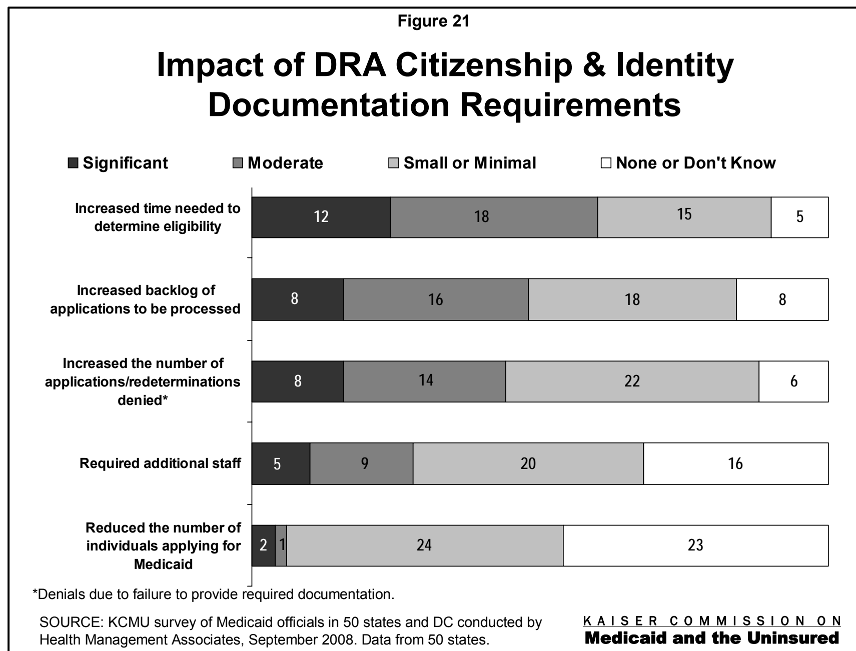
The most common changes reported were simplification of application forms (fourteen states), expansion or implementation of the ability to submit applications on-line (twelve states), elimination of face-to-face interview requirements (six states), e-signature options (six states), and telephone application or renewal options (four states). Other application related changes for FY 2008 and 2009 include initiatives to work with other agencies to verify application information, increasing the number of application sites, expanding the options for submitting applications and renewing coverage (mail-in, phone, internet), increasing the re-certification period from 6 months to 12 months, and improving coordination between Medicaid and SCHIP.

Only three states reported restrictive application changes in either FY 2008 or FY 2009. These changes included increased income documentation, re-instatement of a face-to-face interview, and more frequent re-determinations. Many states in 2007 and 2008 were further modifying their application processes in order to comply with the DRA requirements.

Impact of the DRA Citizenship and Identity Documentation Requirements. Many states reported that the new citizenship documentation requirements included in the DRA had significant implications for eligibility and enrollment in their state. The Deficit Reduction Act (DRA) of 2005 required that all Medicaid recipients and future applicants prove their citizenship and identity when applying for Medicaid or at the first subsequent redetermination. While this federal change was effective in FY 2007, states had little time to prepare for the new requirements. In addition, the federal guidance on the actual requirements changed several times subsequent to the effective date of the regulations. As a result, few states implemented the requirements on the effective date of July 1, 2006. The impact of these changes continued into FY 2008 as a result of both the gradual implementation that occurred and the ongoing impact of the new requirements.

Medicaid directors were asked to assess the impact of the DRA citizenship and identity documentation requirements on their eligibility process and on applicants and beneficiaries. Fifty states provided quantitative assessments of the impact of the DRA. One state indicated that they were still assessing the impact.

State officials indicated the greatest impact was on the time needed to determine eligibility with thirty states reporting a significant or moderate increase. About half of states indicated significant or moderate increases in the backlog of applications to be processed or in the number of applications or re-determinations that were denied due to failure by the beneficiaries or applicants to provide the required documentation. Only three states indicated that they had observed a significant or moderate negative impact on the number of individuals applying for Medicaid, but many states indicated that they had no way to gauge the impact on applications. Over one-quarter of states reported increasing their staff to address the increased administrative burden associated with implementing the documentation requirement. However, some states indicated that adding staff was not possible within their budget, or that staff were redirected from other agency activities (Figure 21).



Impact of DRA Long-Term Care Eligibility Changes. The use of asset sheltering techniques by some to qualify for Medicaid long term care services (with the help of financial planners and attorneys) has long been a concern of Medicaid policy makers. For that reason, the DRA included several provisions designed to discourage the use of certain "Medicaid planning" techniques including an extension to the "look-back" period for asset transfers, changes to the treatment of home equity, and changes in how penalty periods are applied.

This year's survey asked states to comment on the impacts of the mandatory DRA long-term care eligibility changes on Medicaid costs and Medicaid beneficiaries. State officials provided mixed responses suggesting that it is still too soon to fully assess the impact of these provisions. One official stated "These changes required much administrative time to make (policy revisions, code changes, etc.) and retraining of staff required substantial time, however, it does not seem to have had an adverse effect on those eligible for coverage." Another stated, "Medicaid beneficiaries are more confused which has resulted in more hearings and hardship requests."

C. Premium Changes

Historically, states have been prohibited from charging Medicaid enrollees premiums or enrollment fees outside of a Section 1115 waiver or various Medicaid "buy-in" programs that have been introduced for working individuals with disabilities who do not have access to affordable employer based insurance. The DRA gave states additional flexibility to impose premiums, and three states report that they are using this option to implement four different premium initiatives. In all, 35 states reported on 58 different Medicaid premium programs, of which 41 had been in place since FY 2007 or before.

- Twenty-four of the premium programs were for the working disabled under the authority of either the Balanced Budget Act (BBA) of 1997 or the Ticket to Work and Work Incentive Improvement Act (TWWIIA) of 1999, both of which included this type of program. Three of these premiums programs for the working disabled were introduced in FY 2008 and another two are new in FY 2009.

- Twenty-three other premium programs applied to higher income recipients and were implemented under waiver authority. The income ranges varied, but most premium programs apply to individuals with incomes above 150 percent of the FPL.
- Four states (Illinois, Iowa, Louisiana, and North Dakota) are using the Family Opportunity Act within the DRA to implement premium-based Medicaid programs for disabled children that would not otherwise meet Medicaid income eligibility criteria.
- Three states report that they are using the DRA option (beyond the Family Opportunity Act) to impose premiums. These programs apply to optional low-income populations as follows: caretakers 150 percent to 200 percent of FPL and infants 200 percent to 250 percent of FPL in Wisconsin[22]; optional low-income children in Maryland (families with incomes between 200 percent and 250 percent of FPL); and "Katie Beckett" enrollees in Maine.[23]
- Three states reported on non-waiver premium programs. Two of these were for extensions of Temporary Medical Assistance (TMA) for low-income families that lose Medicaid eligibility due to increased income, and one was for a Medicaid spend-down population.

Two states reported that they had eliminated premiums for three Medicaid programs in FY 2008. Massachusetts eliminated premiums for MassHealth enrollees at or below 150 percent of FPL and for Commonwealth Care parents with family income at or below 300 percent of FPL. Tennessee eliminated the premium for children enrolled in TennCare Standard.

Additional information on specific premium changes is reported in Appendix A-3a and A-3b.

D. Copayment Requirements

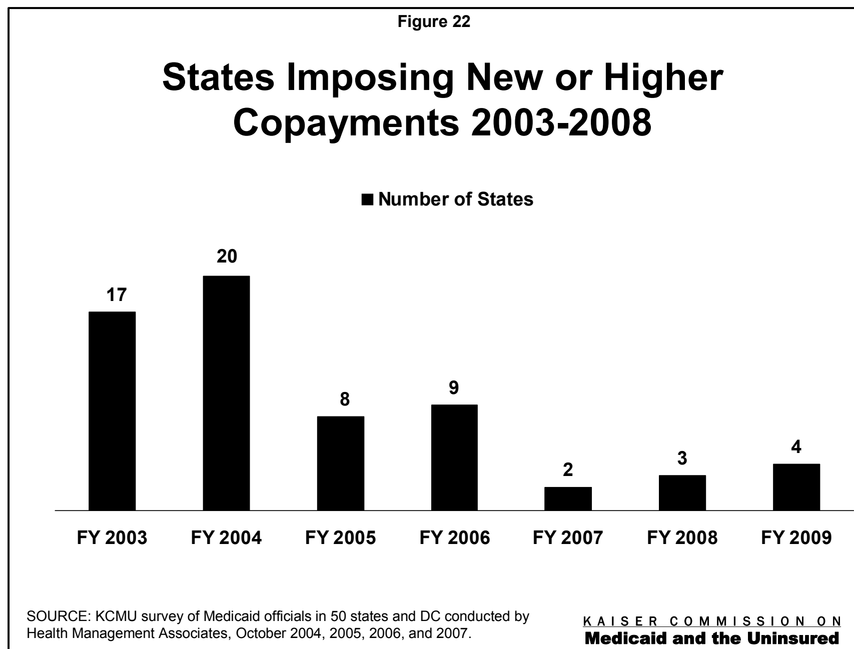
Imposing new or higher copayment requirements is a common Medicaid cost containment tool and the vast majority of states impose co-pay requirements on one or more services. According to the results of this year's survey, a total of 45 states (one more than last year) impose copayments, including five states that impose copayments only on drugs. Only six states (Connecticut, Hawaii, New Jersey, Nevada, Texas, and Washington) responded that they had no copayment requirements at all.

Prior to the DRA, federal law limited Medicaid copayments to nominal amounts, generally defined as $3.00 or less per service, and also prohibited states from applying co-payments to certain services (e.g., emergency room visits) or certain eligibility groups (children and pregnant women). Subject to certain limits and exemptions, however, the DRA now provides new authority for states to charge greater than nominal cost-sharing on certain eligibility groups and most services. States may also vary the cost-sharing requirements by eligibility group.

In FY 2008, three states imposed new or higher copayments. These copays were generally targeted to specific services (i.e. new copays for prescription drugs in Maine, outpatient hospital services in Mississippi, and the extension of pharmacy copays to the aged and disabled population in Wisconsin). In FY 2009, four states (Illinois, Massachusetts, Mississippi, and Nevada) plan to increase their copayment amounts or to introduce new copays for specific populations. Included in

[22] Wisconsin has 2 DRA premium programs.
[23] Katie Beckett option covers children who don't otherwise qualify for Medicaid eligibility that require hospital or ICF/MR level of care services but can be cared for at home.

these totals, two states (Wisconsin in FY 2008 and Nevada in FY 2009) used DRA authority to extend nominal copayment requirements (Figure 22).



Four states reduced or eliminated copayments in FY 2008. Minnesota exempted mental health services from copayment requirements and South Carolina eliminated copayments for persons in its primary care case management program. Also, two states used DRA authority to reduce co-pays. Oregon eliminated copayments for preferred generic drugs and drugs on its preferred drug list (PDL) and reduced copayments for certain non-preferred generics, and Pennsylvania eliminated copayments for all services for persons in a Personal Care Home or a Domiciliary Care Home.

Three states are reducing or eliminating copays in FY 2009. Minnesota is decreasing the monthly cap for pharmacy and emergency room copayments, New York is decreasing copayments for brand name drugs on the state's PDL, and South Dakota is removing copayment requirements for persons aged 19 and 20 (consistent with the policy for children).

Prior to the DRA, federal law required providers to render services regardless of whether the copayment was collected, although beneficiaries remained liable for the amounts. Under DRA authority, states may now elect to make cost-sharing enforceable – that is, allow a provider to deny rendering services if the copayment requirement is not met.

Four states (Delaware, Kentucky, Minnesota, and Wisconsin) reported that copayment requirements were enforceable in FY 2008 for at least one eligibility group as allowed by the DRA (up from only one state — Kentucky — in FY 2007). One state (Nevada) reported plans to take advantage of the DRA authority to make co-payments enforceable in FY 2009. Oklahoma also reported that copayment requirements were enforceable for a waiver expansion population in 2008, but noted that the state relied on a waiver rather than the DRA authority for this requirement.

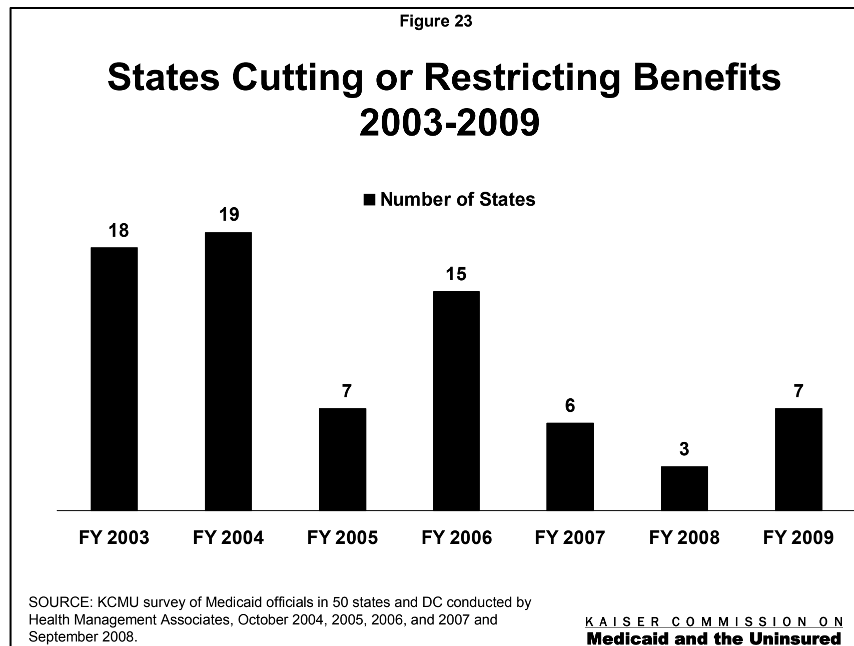
DRA Health Opportunity Accounts

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

As was reported in last year's survey, South Carolina was the first state to receive an HOA demonstration grant and remains the only state taking up this DRA option. In FY 2008, South Carolina implemented two one-county pilots each limited to 1000 beneficiaries: a voluntary HOA demonstration for healthy adults and children and a voluntary "Health Savings Account" plan using DRA benefit flexibility (discussed in the benefits section). Once a beneficiary's HOA has been depleted, the member will have out-of-pocket responsibility for 10 percent of costs up to a maximum of $250 for an adult or $100 for a child. No additional cost-sharing is applied thereafter. South Carolina reported that although both pilots were implemented as planned in FY 2008, the state had not yet enrolled any beneficiaries into either pilot as of July 2008.

E. Benefits Changes

FY 2008 marked both the high point for expansions and the low point for cuts since 2003. A total of 19 states reported benefit expansions and only three states reported cuts or restrictions in FY 2008. In FY 2009, the difference between expansions and cuts was smaller. Thirteen states planned to expand benefits while a somewhat higher number, seven, reported plans for cuts or restrictions. These results are similar to FY 2007 (when 16 states reported expansions and six states reported restrictions) but reflect a sharp decrease from FY 2006 when 15 states implemented benefit cuts or restrictions (Figure 23).



Of the three states reporting cuts or restrictions for FY 2008, two states made targeted cuts: Michigan eliminated coverage of school-based services for persons ages 21 to 26 and Minnesota restricted coverage for circumcisions. The third state, West Virginia, reported the statewide expansion of its redesigned Medicaid benefit package using the DRA benefit flexibility provisions (described below). Of the seven states reporting benefit cuts or restrictions in FY 2009, two states reported new utilization controls (for therapy services in Florida and for mental health services in Virginia), one state (Arizona) cut dental benefits, one state (Tennessee) limited the scope of benefits for home health and private duty nursing services and the following three states reported broader actions impacting more than one service:

- ***Maine*** is eliminating day treatment services for children, eliminated coverage of certain durable medical equipment (DME), such as over-the-counter orthotics, for adults, and is adding prior authorization requirements for other DME and podiatry services;
- ***Nebraska*** is limiting dental benefits to $1,000 per year; occupational, physical and speech therapy services to 60 visits per year; hearing aids to one every four years; eyeglasses one every 24 months; and chiropractic services to 12 visits per year;
- ***Nevada*** is restricting allowable personal care service (PCS) hours, eliminating PCS exercise coverage and eliminating adult coverage for eyeglasses and related supplies.

In contrast to the limited number of states that reported benefit cuts or restrictions, a total of 19 states in FY 2008 and 13 states in FY 2009 adopted benefit restorations and expansions. These totals include five states in both FY 2008 and FY 2009 restoring, expanding or adding mental health or substance abuse services, four states in FY 2008 and two states in FY 2009 that are restoring or expanding dental benefits and three states in FY 2008 that added telemedicine services. Of the two states expanding dental benefits in FY 2009, one state (Kansas) is using the DRA benefit flexibility provisions to do so. (See Appendices A-4a and A-4b for more detail on benefit related actions.)

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

Three states (West Virginia, Idaho and Kentucky), used the DRA to do comprehensive benefits restructuring in FY 2007. West Virginia's restructuring ("Mountain Health Choices") was initially implemented on a pilot basis in three counties, but was expanded statewide in FY 2008.

West Virginia Mountain Health Choices

Under its DRA state plan amendment, non-disabled, non-pregnant adults and children in West Virginia receive a scaled back "Basic" Medicaid benefit package, unless they sign, submit, and conform to a "Medicaid Member Agreement." Those that sign and submit the Agreement, which outlines certain health care responsibilities, receive the "Enhanced" benefit package. The Enhanced plan provides the state's full Medicaid benefits. The "Basic Plan" includes all mandatory and some optional services, but is more limited than the full Medicaid benefit package, excluding, for example, diabetes care and imposing limits on mental health care and prescription drugs. However, under the state plan amendment, the state is required to provide the EPSDT benefit to children in both the "Basic" and "Enhanced" plans. To date, the large majority of children are enrolled in the Basic plan.[24]

Virginia and Washington also used DRA benefit authority in a more targeted way in 2007. Virginia converted its voluntary "opt-in" disease management program to a voluntary "opt-out" DRA benchmark program, and Washington implemented a chronic care management pilot program that uses predictive modeling to identify high-risk clients. For FY 2008, three additional states obtained state plan amendments to utilize DRA benefit flexibility: Kansas, South Carolina, and Wisconsin.[25]

- ***Kansas*** began offering Personal Assistance Services (PAS) and related services to beneficiaries eligible for the "Work Opportunities Reward Kansans (WORK)" program, the state's Medicaid buy-in program.
- ***South Carolina*** implemented a voluntary one-county pilot "Health Savings Account" plan (limited to 1,000 beneficiaries) using the State Employee High Deductible Health plan as the benchmark plan. The pilot is open to all beneficiaries except duals, foster care and persons in institutions. (This initiative is noted for this report as a new option for beneficiaries and was not counted as a benefit or copayment restriction or expansion.)
- ***Wisconsin*** used DRA benchmark authority to offer a modified benefit package to the BadgerCare Plus expansion population. The comprehensive benchmark plan was adapted from Wisconsin's largest commercial, low-cost health care plan which is provided by United Healthcare. (This action has not been counted as a benefit restriction or expansion.)

In FY 2009, ***Kansas*** has plans to again use the DRA benefit flexibility provisions to add dental services for pregnant women.

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[24] According to a report released in August 2008 by the Center for Children and Families at Georgetown University's Health Policy Institute, more than 93% of West Virginia children participating in Medicaid do not receive the Enhanced benefit plan. Joan Alker,"West Virginia's Medicaid Redesign: What is the Impact on Children?," August 2008, accessed at http://ccf.georgetown.edu/index/west-virginia-s-medicaid-redesign-what-is-the-impact-on-children.

[25] In January 2008, Missouri had a state plan amendment to add a benchmark benefits package and mandate enrollment of parents and caretaker relatives age 19 and older who either became eligible through a new earned income disregard up to 100% FPL or who are eligible under Section 1925 of the Act into the benchmark plan. This was part of Insure Missouri but it did not pass in the state legislature.

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

Over the last decade, states have made significant progress in shifting the proportion of Medicaid long-term care dollars towards more home and community-based service (HCBS) options and away from institutional service settings. Expansions or cost containment actions in long-term care may be the result of changes related to community-based long-term care services or changes related to nursing homes and ICFs/MR-DD. In FY 2008, 42 states took actions that expanded LTC services (primarily expanding HCBS programs), and a similar number (41 states) planned expansions in LTC services for FY 2009. This compares to 35 states taking actions to expand LTC services in FY 2007. Conversely, a total of eight states in FY 2008 and seven states in FY 2009 took action to constrain LTC services (compared to ten in FY 2007).

The following section details state actions to both expand and control long-term care services in both institutional and community-based settings.[26] This section also includes results from survey questions about certain new DRA-related long-term care state options.

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

By far, the most commonly reported LTC expansion change in both years was adopting new HCBS waivers or expanding existing waivers, including the implementation of DRA "Money Follows the Person"[27] and Psychiatric Residential Treatment Facility (PRTF) Demonstration Grant[28] initiatives. Other examples of LTC expansions include adding additional services to an existing HCBS waiver and expanding PACE programs[29] (Figure 24).

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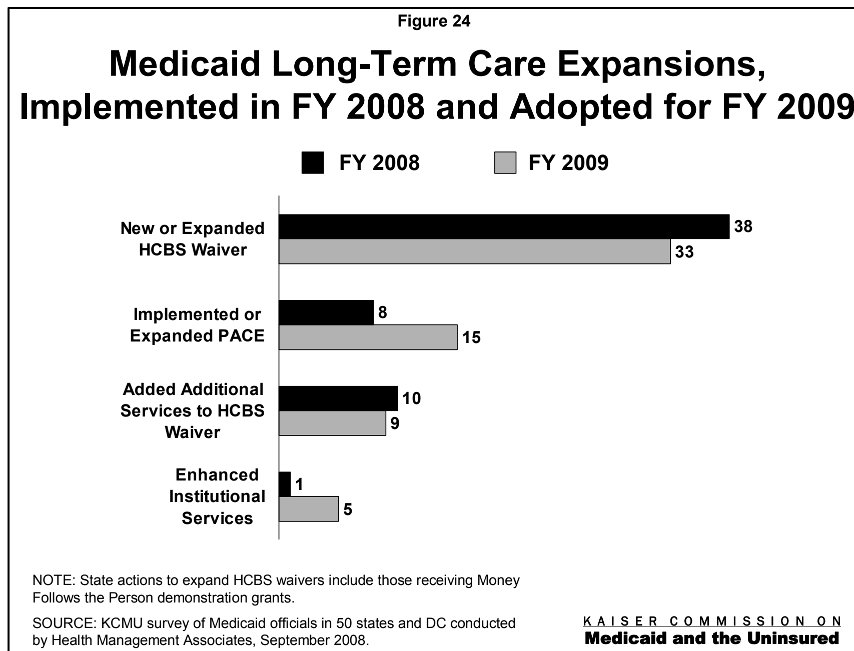
[26] Changes reported in this section exclude changes in financial LTC eligibility criteria which were reported under the "Eligibility section" of this report.

[27] A total of 31 states were awarded MFP grants in 2007 totaling $1.4 billion to reduce reliance on institutional care by transitioning individuals from institutions to the community. The demonstration program provides an enhanced FMAP (75-90%) for an individual's costs for 12 months from the date of institutional discharge. State grant proposals included plans to transition nearly 38,000 individuals into the community over the five-year demonstration period.

[28] The PRTF Demonstration Grant program, created by the DRA, allows states to create home and community-based service alternatives for children with serious emotional disturbances who would otherwise be institutionalized in a PRTF. In December 2006, CMS announced grant awards to ten states: Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Montana, South Carolina, Virginia and Mississippi.

[29] 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.



Only two states in FY 2008 and again two states in FY 2009 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 three states imposed utilization controls and placed lower limits on certain waiver or targeted case management services, and one state made changes to its level of care (LOC) criteria making it more difficult to qualify for HCBS services.[30]

Institutions. One state in FY 2008 and five states in FY 2009 took positive action to remove restrictions on, or enhance institutional services. Oklahoma implemented a tiered reimbursement structure providing for enhanced funding for nursing facilities based on quality indicators. Florida approved reimbursement for Medicare coinsurance costs for private institutions for mental disease (IMDs). (Previously, the state did not cover Medicare cross-over payments for services it did not cover as a primary payer.) Colorado is planning to convert some HCBS waiver service settings into ICF/MR beds. Maryland will liberalize its nursing home level of care criteria.[31] North Carolina plans to expand the types of services covered in institutions (including geropsychiatric services). Finally, Wyoming reported that because statewide nursing facility occupancy now exceeds 85 percent, its moratorium policy on new nursing facilities no longer applies.

In FY 2008, seven states implemented cost controls related to nursing homes and ICFs/MR-DD, and seven states are planning reductions in FY 2009. Examples include:

- efforts to reduce the size of or close state-owned Mental Health/Mental Retardation facilities (California, Nebraska and Texas);
- policies designed to reduce the number of nursing home beds (e.g., through tightening of a certificate of need program) (Indiana);

[30] Nebraska reported that it planned to implement an objective nursing facility LOC process for three of its waivers to harmonize the waiver and institutional LOC determinations through the use of a standardized waiver tool.
[31] This action was counted as an expansion for both institutional and community-based services.

- reductions in reimbursement for Medicare nursing home coinsurance costs (Florida);
- reductions in payments for bed holds (Massachusetts and Louisiana);[32]
- other nursing facility formula changes to incentivize providers to serve lower acuity patients (Indiana and Washington);
- new procedures for nursing facility continuous stay reviews (Massachusetts); and
- increases in the number of community service transition providers (Colorado).

Other LTC Actions. A few states also reported other LTC policy initiatives underway to improve the delivery of LTC services and increase community-based alternatives. These initiatives are not counted as institutional or community-based expansions or restrictions in this survey, but were additional LTC actions reported by the states. State policies included the implementation of long term care options counseling, establishment of "single points of entry," implementation of a common pre-admission screening process for waiver and nursing facility eligibility, and the consolidation of multiple HCBS programs. Also, two states in FY 2008 and five states in FY 2009 implemented or expanded LTC managed care programs.

Finally, Rhode Island indicated its plan to submit to CMS in FY 2009 a Section 1115 waiver request (the "Rhode Island Consumer Choice Global Compact Waiver") which, among other things, would cap federal funding for all Medicaid spending, including long-term care, and would include provisions to rebalance the long term care system by enhancing home and community-based alternatives to institutional care. Specifically, Rhode Island noted the waiver would include a request to disregard certain living expenses beyond the current need standard for beneficiaries who choose to obtain services in the community and who are in need of a high level of care. More detail on the Rhode Island waiver request is included in the Medicaid 1115 Waivers section of this report.

DRA Long-Term Care Options. The DRA included new provisions intended to give states increased flexibility to deliver long-term services and supports. The survey asked states to report on programs in place in FY 2007, actions taken in FY 2008 and plans for FY 2009 regarding three DRA LTC-related options. As in last year's survey, this year's survey results indicate widespread adoption of Long-Term Care Partnership Programs but little take up, thus far, of the cash and counseling or the HCBS State Plan options.

- ***Long-Term Care Partnership Programs.*** Thirteen[33] states reported having in place a Long-Term Care Partnership Program in FY 2007; eight states reported implementing a program in FY 2008 and 17 states indicated that they were planning to implement a program in FY 2009, which would bring the total to three-fourths of all states. LTC Partnership programs are designed to increase the role of private long-term care insurance in financing long-term services by allowing persons who purchase qualified long-term care insurance policies to shelter some or all of their assets when they apply for Medicaid after exhausting their policy benefits.

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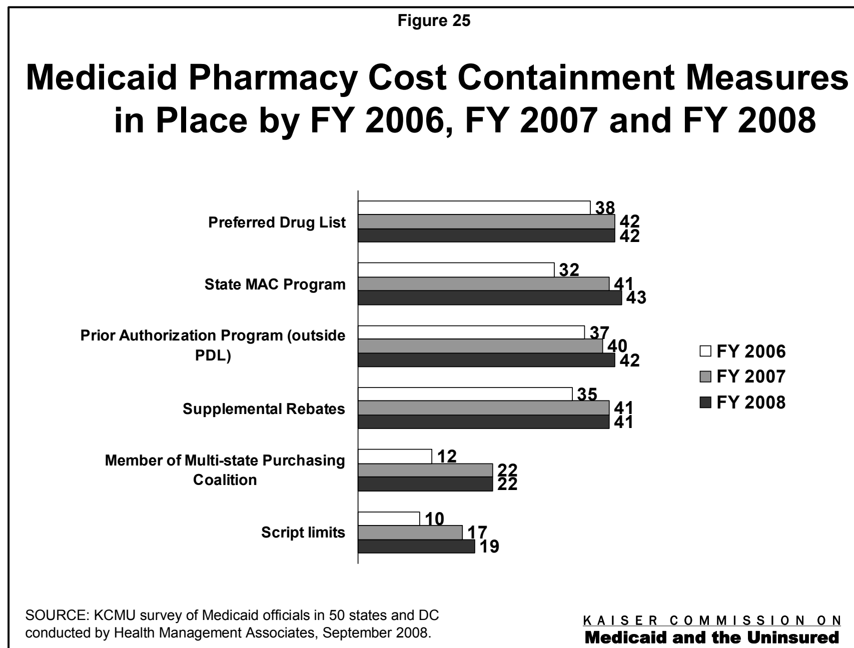
[32]A bed hold day is defined as a day when the resident is not in the facility and has exhausted the allowable Medicaid leave days and the facility holds the bed for their return.
[33] Four of the 13 states that reported having plans in place in FY 2007 (California, Connecticut, Indiana and New York) have had demonstration model programs underway since 1992 and did not utilize DRA authority.

- ***Self-Direction of Personal Services.*** In FY 2007, only one state (Alabama) reported having in place the DRA option to allow for self-direction of personal assistance services, sometimes referred to as the "cash and counseling option." Four states (Arkansas, Colorado, Oregon and Wisconsin) reported implementing this option in FY 2008 and another four states (Connecticut, Kentucky, Louisiana, and Minnesota) reported plans to implement this option in FY 2009. A number of states noted that they already had cash and counseling options in place under existing state waivers and therefore were not considering the DRA option.
- ***HCBS State Plan Option.*** Only one state (Iowa) reported having taken advantage of the HCBS State Plan option in FY 2007. This new option allows states to offer HCBS services as a state plan option rather than through a 1915(c) waiver. Iowa used the option to add case management and habilitation services to a targeted population – persons with a history of mental illness who also meet certain risk factor criteria and have ongoing needs. One state (Colorado) reported implementing this DRA option in FY 2008 and three additional states reported plans to implement the HCBS State Plan option in FY 2009 (Connecticut, Nevada and Texas).

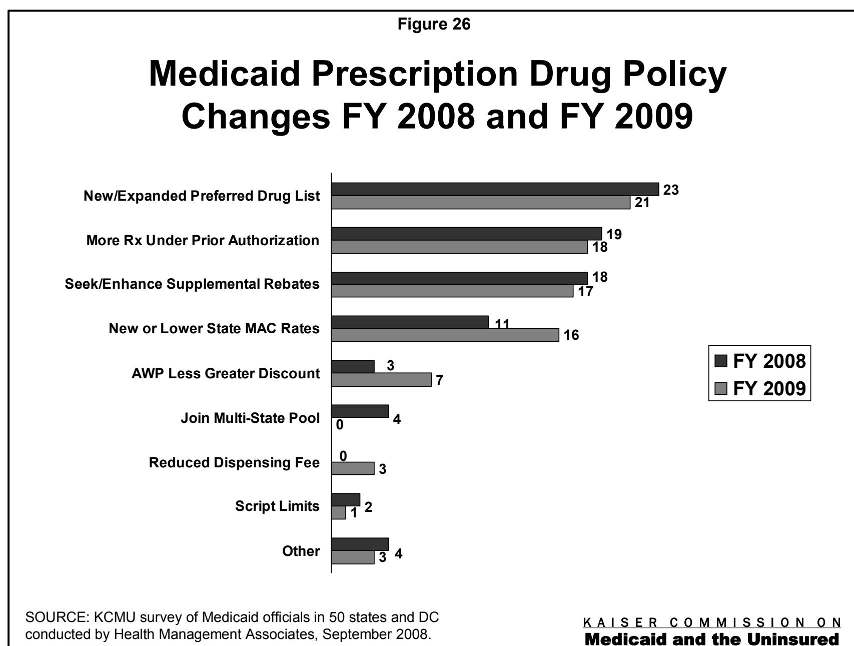
G. Prescription Drug Utilization and Cost Control Initiatives

Driven by the need to better control spiraling drug costs, the vast majority of states reformed their pharmacy benefit programs between 2001 and 2005 to adopt or enhance preferred drug lists (PDLs), prior authorization programs, supplemental rebate programs, state maximum allowable cost ("state MAC") programs and other cost containment measures. Since then, states have continued to maintain and refine these programs, but report fewer new activities and initiatives. While the pharmacy controls implemented in the past continue to operate to contain cost growth, it is significant that prescription drug coverage for dual eligibles shifted from Medicaid to Medicare Part D in 2006. This decreased direct state Medicaid drug spending by almost half and possibly decreased the incentive for states to focus on this area.

For the third year, the survey identified the number of states that had certain pharmacy cost containment measures in place at the beginning of the survey period. At the beginning of FY 2008, there were no changes from the previous year in the number of states that reported having PDLs and supplemental rebate programs or being a member of a multi-state purchasing pool. For the other categories, only incremental increases were reported (Figure 25).



Thirty-three states in FY 2008 and 32 states in FY 2009 implemented cost-containment initiatives in the area of prescription drugs, comparable to the number in FY 2007 and FY 2006 (30 and 29 respectively), but fewer than the numbers reported for FYs 2002 – 2005. Given the large number of states with prior authorization programs, PDLs, supplemental rebate programs, and state MAC programs already in place, it is not surprising that the majority of actions reported were described as additions, expansions or refinements to these programs. The most commonly implemented cost containment efforts include establishing or enhancing a preferred drug list, and expansions of prior authorization programs (Figure 26). No state in FY 2008 and three states in FY 2009 reported decreasing pharmacy dispensing fees, while six states in FY 2008 and six states in FY 2009 increased dispensing fees.



Several states reported other types of pharmacy cost containment measures for FY 2008 and FY 2009 including:

- two states (Connecticut and Wisconsin) that carved pharmacy benefits out of their managed care contracts;
- two states (Kentucky and New York) that implemented enhanced retrospective drug utilization review programs;
- two states (Pennsylvania and Virginia) implementing efforts that focus on specialty pharmacy products; and
- one state (New Jersey) that reduced the frequency of its pharmacy pricing updates from weekly to monthly.

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

DRA Federal Upper Limit (FUL) Changes. Since 2007, a few states have reported taking actions to change pharmacy dispensing fees or ingredient cost reimbursement formulas. In 2007, states were awaiting the publication in December 2007 of new federal upper limits (FULs) on reimbursements for multi-source drugs as mandated by the DRA. The new FULs were to be based on a new drug pricing formula specified in the DRA – Average Manufacturer Price (AMP). A number of states indicated having plans to adjust their pharmacy reimbursement policies once CMS began publishing the new AMPs. On December 19, 2007, however, a U.S. District Court Judge issued a preliminary injunction blocking CMS from implementing the new AMP-based FULs and publishing the new AMPs. Uncertainty about federal actions caused states to refrain from making changes in this area. During this year's survey, a number of states reported that they were waiting for the resolution of this litigation before moving forward with related pharmacy reimbursement changes.

H. Managed Care and Care Management

Managed Care. Managed care has become the most common health care delivery system for Medicaid programs. Managed care usually refers to health maintenance organizations (HMOs), but in Medicaid also includes state-operated primary care case management programs (PCCMs).[34] The number of Medicaid beneficiaries in some form of managed care increased dramatically in the 1990s, from less than ten percent in 1990 to over half – 54 percent – in 1998. Since 1998, growth has occurred at a slower pace. According to CMS reports, the proportion of all Medicaid beneficiaries (including families and children, elderly and disabled groups) in any form of managed care was 64 percent in 2007, with growth in recent years primarily in Medicaid HMO enrollment. Only Alaska and Wyoming reported no form of Medicaid managed care.[35]

In fiscal years 2008 and 2009 states continued to implement expansions, improvements or policy changes in their managed care programs, including expansions to new geographic areas, additional populations in managed care, a new requirement to enroll in managed care or expansion or implementation of long-term care managed care. A total of sixteen states had one of these managed

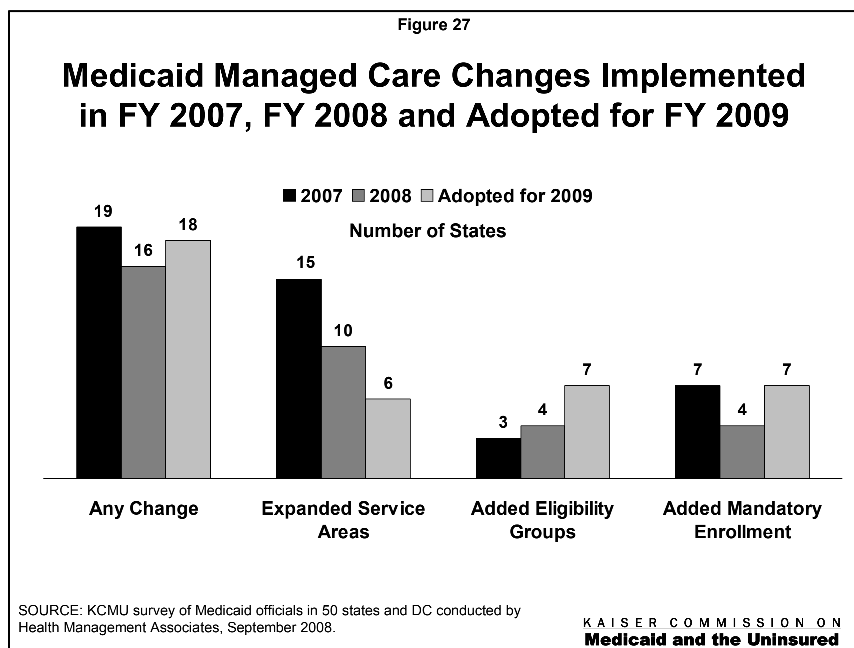
[34] A few states operate limited benefit prepaid ambulatory health plans or prepaid inpatient health plans that CMS includes in its definition of Medicaid managed care.
[35] CMS, Medicaid Managed Care Enrollment Reports, various years.

care policy changes in FY 2008, and eighteen in FY 2009 (Figure 27). Additional detail is in Appendix 7.

In FY 2008, a total of ten states expanded managed care geographic service areas, usually to rural areas. In FY 2009, six states plan to implement geographic expansions. In both years, these geographic expansions occurred both for states using health plans and those with PCCM programs. Connecticut is implementing a new PCCM program in 2009, and Illinois is planning to complete the statewide implementation of its PCCM in 2009.

All states with Medicaid managed care enroll families and children, and an increasing number now enroll eligibility groups that in the past were excluded from Medicaid managed care, such as persons with disabilities, pregnant women, and children in foster care. In FY 2008, four states enrolled additional Medicaid eligibility groups into managed care, including three enrolling persons with disabilities and one adding children and youth in the conservatorship of protective services. Altogether, a total of 23 states indicated that they enrolled aged or disabled eligibility groups into managed care in FY 2008. In FY 2009, an additional seven states plan to begin enrollment of new eligibility groups, including six adding adults with disabilities and one adding foster children and pregnant women. With these changes for the upcoming year, the total number of states with aged or disabled enrollees in managed care will increase by five to 28 states in FY 2009.

Medicaid is able to require enrollment in a managed care plan when beneficiaries have a choice of plans. New mandatory enrollment requirements were implemented in four states in FY 2008, and are to be implemented in seven states in FY 2009. In general, these changes reflect mandatory enrollment for groups (such as persons with disabilities) where other groups were already required to enroll in a plan, or a previously exempt group now is required to be in managed care. For example, in one state persons who are HIV positive and in another state special needs children who were previously exempt from managed care, will not be exempt in 2009.



Disease and Care Management Programs. A key focus of Medicaid programs in recent years has been on special care management programs for persons with disabilities and chronic illness. In part, this focus is related to recent research that indicates that the likelihood of a person receiving exactly the right care at the right time is only about 56 percent for adults with chronic conditions, and just 47 percent for children.[36] Given the perennial fiscal pressure on Medicaid, officials want to ensure that Medicaid is not paying for any unnecessary care. To improve care for persons with chronic illness, most states have adopted formal disease management or care management programs. States are now directing considerable attention at developing programs for coordinated care management for persons with complex, high cost conditions, both to improve care and to achieve savings in costs.

In this survey, states described new disease management or care management initiatives (including new programs or enhancements to existing programs) that they implemented in FY 2008 and had plans to implement in FY 2009. A total of 16 states indicated that new disease management initiatives were implemented in FY 2008 (note that 35 states in last year's survey indicated they planned new programs or enhancements to existing programs in FY 2008); and 14 states had adopted plans for new disease management initiatives in FY 2009. States continued to focus on the most prevalent chronic conditions, including diabetes, asthma, congestive heart failure and high risk pregnancies. Expansions included additional counties and inclusion of additional chronic conditions. Examples of new initiatives included a special pilot project implemented for HIV/AIDS and a tele-health initiative for a state's rural areas. For FY 2009, three states mentioned that they would be replacing the existing disease management program to a more comprehensive program with new features such as health coaches and care managers for participants. New programs are focused on a broad range of conditions and population groups, including high utilizers of emergency rooms, weight management, medical care management and home visits to coordinate care for the elderly, and care coordination for children with serious emotional disturbances. In general, the new programs are more likely to focus on high-cost situations, regardless of a specific diagnosis, and to include predictive modeling to identify individuals who would benefit from care coordination and assistance for their conditions to improve health care outcomes.

I. Quality and Health Information Technology

Quality improvement is now among the highest priorities of state Medicaid programs. Many state officials would say that among major purchasers in their states, Medicaid has taken a leading role in fostering health care quality improvement. Medicaid officials see quality as an important component of their efforts to secure the best possible value for the dollars expended through the program. Some states have adopted a formal process for "value-based purchasing," where the value of health care takes into account all aspects of quality, including processes and outcomes, and relates quality to the costs associated with the health care outcomes achieved.

The focus on health care quality improvement has been assisted by the increasing availability of useful data on quality measures. All health care purchasers now have high expectations relating to accountability and performance. It is now routinely expected, for example, that health plans will provide valid encounter data on which their performance can be measured. This has made it more

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[36] Elizabeth A. McGlynn, et al, "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine*, June 26, 2003; and Rita Mangione-Smith, *et al.,* "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine,* October 11, 2007.

feasible for Medicaid to participate in system-wide initiatives, and to obtain the data needed to measure performance that relates to care paid for by Medicaid (Figure 28).

Health Plan Performance (HEDIS). Most states use some type of performance measures. The standard set of benchmarks are those included in the Healthcare Effectiveness Data and Information Set (HEDIS®) developed by the National Committee on Quality Assurance (NCQA). These measures were developed primarily for an employed population and not specifically for a Medicaid population. States generally choose a subset of specific measures considered most applicable to Medicaid populations. These might include measures for children such as up-to-date immunizations and well-care visits at specific ages, measures for pregnant women relating to timely prenatal care, or measures of care for adults such as timely Hemoglobin A1c tests for persons with diabetes.

A total of 45 states reported that they used at least some HEDIS® or similar state-developed measures in fiscal year 2008, and these same 45 states also reported they would do so in 2009. All state Medicaid programs that contract with capitated, at-risk managed care organizations now expect those health plans to provide data on their performance. States that operate a primary care case management (PCCM) managed care program generally also use such measures, and some states indicated they were working on applying these measures to their fee-for-service system.

Consumer Surveys (CAHPS). Another measure of quality is how patients assess their own experience and satisfaction with the health care they received. Obtaining this information is the purpose of patient surveys, the most common of which is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), a standardized survey of patient experiences with ambulatory and facility-level care. Often such surveys are conducted on a periodic schedule rather than each year, and they are adapted by the state to address specific issues. In fiscal year 2008, a total of 43 states indicated that they used CAHPS®or a similar survey to assess patient satisfaction. For fiscal year 2009, one additional state indicated that it would be using a CAHPS® survey for the first time, bringing the total number using CAHPS® or similar surveys to 44 states.

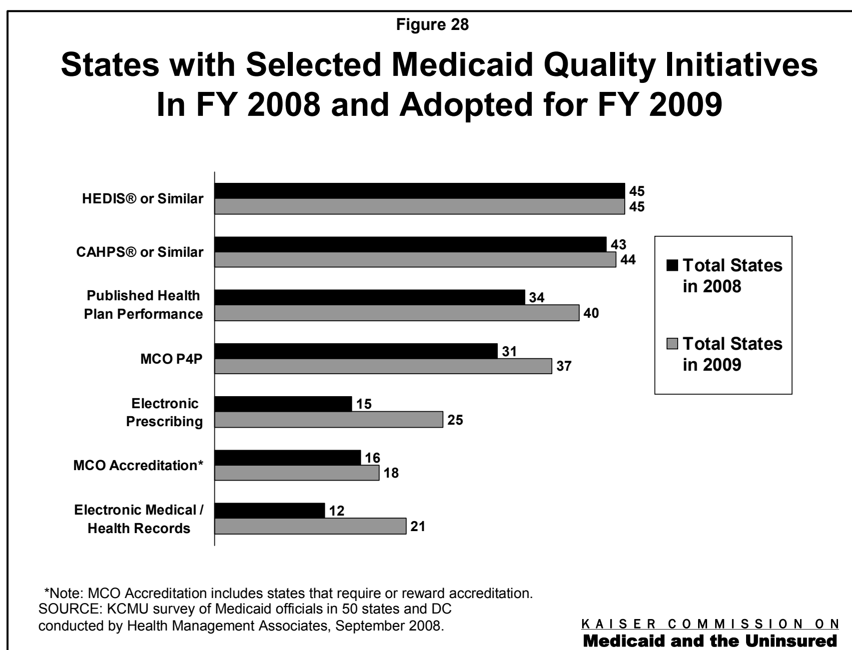
Reporting Health Plan Performance. Increasingly, state Medicaid programs are making available the data they collect on HEDIS®, CAHPS® or other measures of health plan or provider performance. Performance data may be in a formal report or a brief report card, usually available on the agency web site or in a published report. An important purpose is to provide beneficiaries with easily understood information that can help them chose a health plan. In addition, publishing the data often is regarded as an incentive for improvement in provider performance in delivering care for Medicaid beneficiaries. Significantly, these performance data also can be used for reimbursement incentives under pay-for-performance methodologies. In fiscal year 2008, a total of 34 states reported that they publicly made available at least some data on provider performance. An additional six states reported they would do so in fiscal year 2009, bringing the total to 40 states.

Pay For Performance. Increasingly, state Medicaid programs have begun to identify key measures, to set standards and benchmarks and to develop reimbursement methods that financially reward high performance on specific measures of quality. These pay-for-performance systems are in place now for managed care organizations and for specific provider groups such as hospitals, nursing homes and physicians. For managed care organizations, performance on specific measures often is used both for financial incentives and for automatic enrollment in higher-performing health plans (when beneficiaries don't respond to the opportunity to choose a health plan). In some states, health plans can earn incentive payments in addition to the monthly capitation payments; or in other states, earn back what was withheld from the capitation payments.

The number of states with a Medicaid pay-for-performance arrangement for at least one provider group almost doubled in the three years from 2006 to 2009. In fiscal year 2006, a total of 20 states indicated they had Medicaid pay-for-performance incentive payment methodologies in place, based on our previous survey. In FY 2007, Medicaid officials in 25 states indicated they had pay-for-performance systems in place and in FY 2008, the number increased to 31 states. For FY 2009, a total of 37 states indicated they would use a pay-for-performance reimbursement methodology.

Increasingly, states are also examining how they pay when care is not acceptable, or whether to pay at all for outcomes that should not have occurred, which are known as "never events." Following the lead of Medicare, Medicaid programs in at least three states – Maine, Pennsylvania and South Carolina – indicated specifically that they were planning to deny payment entirely when "never events" occur during an inpatient stay.

Health Plan Accreditation. One approach states use to better assure quality is to require health plans to be accredited by a national standard-setting organization such as by the NCQA. In fiscal year 2008, a total of 16 states either mandated accreditation, or in the case of three states, included an incentive to be accredited. In Pennsylvania, for example, a state with strong and comprehensive emphasis on health care quality, health plans are not required to be accredited, but accredited plans are favored through incentive payments in the reimbursement system. The result is that all Medicaid health plans in Pennsylvania are accredited, even though it is not mandated. For fiscal year 2009, two additional states indicated they would require accreditation, bringing the total for 2009 to 18 states.



Use of New Technologies: Electronic Prescribing and Electronic Health Records. New technologies continue to facilitate the ability of Medicaid programs to improve health care quality. States reported a number of health information technology initiatives underway in fiscal year 2008 and planned for 2009, including health information exchanges, reporting of information in an effort to improve "transparency" in pricing and performance, electronic health records and electronic prescribing. Often, these initiatives are broader than Medicaid, involving both public and private sectors, employers and purchasers.

This survey asked specifically about two initiatives, electronic prescribing and electronic health records, that have the potential to improve quality, reduce medical errors and improve the efficiency of the health care system. In FY 2008, a total of 15 states indicated that Medicaid was participating in an electronic prescribing initiative, including eight states where the initiative began in 2008. An additional ten states indicated they would begin an e-prescribing initiative in FY 2009, which would bring the total to 25 states.

In many states, Medicaid is also participating in statewide initiatives to encourage the development or use of electronic medical records (EMR) or electronic health records (EHR). In FY 2008, a total of twelve states indicated that Medicaid was participating in an initiative for an EMR or EHR, including eight states that indicated they had begun an initiative in 2008. Nine additional states indicated they would implement an EMR or EHR initiative in FY 2009, bringing the total number to 21 states in FY 2009.

See Appendix A-8 for more detail on Medicaid quality measures.

3. Key Medicaid Issues

Key Section Findings:

- Access to primary care physicians was generally regarded as favorable for Medicaid beneficiaries. However, most officials recognized access problems for dental care and some specialists in Medicaid but noted that these are issues for the general population as well. Some directors noted specific actions their state had taken to improve access, particularly for dental care. Medicaid directors also reported issues with the growing cost of behavioral health care, behavioral health drug utilization, as well as emergency room and inpatient hospital utilization for mental health issues.

- A majority of states mentioned a strained federal-state relationship as a significant issue or challenge. States continue to express frustration over the administrative burden imposed by various federal audits and oversight activities. Of 50 states responding, 41 states reported that the administrative burden was ranked as a 4 or a 5 on the scale of one to five, (including 23 states that described the administrative impact as a "5.") Most states indicated that a series of proposed regulations would have significant fiscal and beneficiary implications.

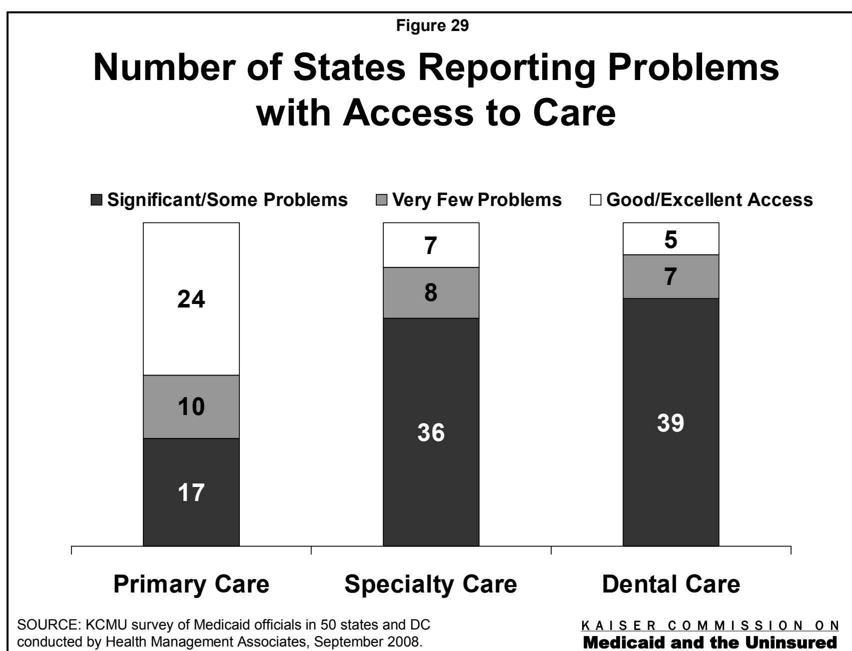
- Looking ahead, states raised concerns about Medicaid financing, the federal-state partnership and key Medicaid initiatives to improve quality or expand coverage to the low-income uninsured. A number of states reported that they limited their expansion of coverage of children due to the new federal SCHIP requirements or the uncertainty of ongoing funding due to the temporary nature of the current federal authorization of SCHIP.

A. Access to Providers

A substantial body of research has long demonstrated that Medicaid coverage significantly improves access to needed care. Medicaid enrollees have far better access to preventive and primary health care than uninsured individuals. Compared to the uninsured, Medicaid beneficiaries are more likely to receive care, have a usual source of care, and have a pap test. Access across these measures is comparable to the privately insured. Children covered by Medicaid also are less likely to have postponed getting needed care and are more likely to have contact with a physician and dentist than uninsured children. While the research demonstrates Medicaid's positive impacts on access to care, there have been longstanding concerns about provider participation in the program. Inadequate provider participation can limit enrollees' ability to access needed services even if they are covered for the care. There has been increased focus on the issue of provider participation in recent years, particularly as all states have turned to reductions or freezes in provider payment rates as a way to limit program costs during the last economic downturn. Further, national attention was focused on this issue after the death of twelve year old Deamonte Driver in 2007 due to a brain infection he developed from untreated tooth decay after his mother was unable to locate a dentist accepting Medicaid patients that was willing to treat him.

A new question was added to the survey to gauge the perception of state Medicaid officials regarding the ability of Medicaid enrollees to access health care services from three categories of providers: primary care physicians, specialty care physicians and dentists. Medicaid directors generally perceive that Medicaid enrollees have much better access to primary care than to specialty care or dental care. Dental access is especially problematic with 39 of 51 Medicaid directors indicating that there are either significant problems or some problems with access. Thirty-six states

also indicated some or significant problems with access to specialty care physicians, but the degree of the problem was generally not as great for specialty care physicians as for dentists (Figure 29).



One director commented that, "We spend a lot of time talking about coverage, but it doesn't mean anything without access. My long term concern is workforce – both physicians and dentists. Our workforce is not near where it needs to be." Several Medicaid directors noted that the use of HMOs or other managed care organizations contributed positively to access since the MCOs were responsible to assure access to care. Another director commented that they were expanding access by using mid-level practitioners, noting that "without the mid-levels we'd have a big problem."

The survey questions did not ask whether the access issues were either unique to Medicaid or greater for Medicaid enrollees than for the population at large. However, many Medicaid directors indicated that both specialty care physician access and dental access were problems for privately insured individuals as well. Some Medicaid directors also noted regional variations in the supply of providers, with access issues most acute in rural areas.

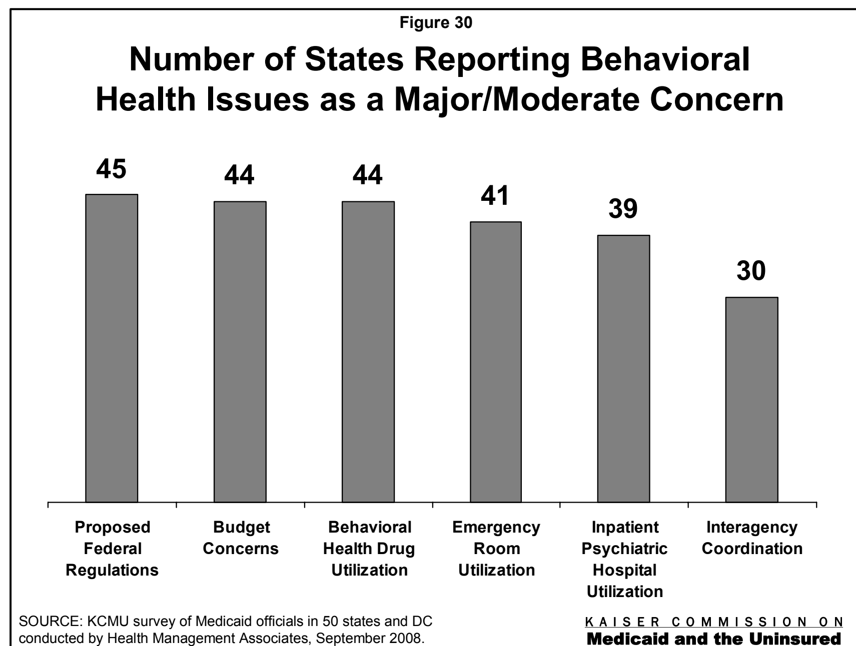
The survey also asked whether in the past year access to these providers had improved, gotten worse, or stayed about the same. In general, access had stayed about the same. Access to dental care has been a focus of state officials and was most likely to have improved, with one-third of Medicaid directors reporting improvement. Several of these states have increased rates or contracted with dental managed care providers to improve dental access. Other states were using rate increases to expand access to specialists. Many state officials said they would continue efforts to improve access within Medicaid, but that there is more work to be done to improve access across the entire health system.

B. Behavioral Health

Historically, public mental health services were separate from Medicaid, often delivered in an institutional setting and financed primarily with state and local funding. Over the past two decades, significant changes have occurred in the delivery and financing of behavioral health services. Gradually, as services shifted from an institutional setting into the community, many state institutions closed and community mental health capacity developed. De-institutionalization was reinforced by Medicaid reimbursement policy for mental health services. Title XIX of the Social Security Act expressly forbids Medicaid payment for services in "Institutions for Mental Disease." However, mental health services provided in the community often qualify for Medicaid funding, and the shift to community-based services was accelerated by the opportunity to use Medicaid to help pay for them. As Medicaid became the dominant payer for behavioral services, concerns began to surface among Medicaid officials about the impact of these services on the Medicaid budget.

Medicaid now pays for over half of all publicly financed mental health services and 26 percent of total mental health expenditures. About 13 percent of beneficiaries rely on Medicaid for mental health services, including children who qualify for coverage based on income and individuals who become eligible as a result of a disability. Medicaid mental health services include coverage for inpatient and outpatient care, treatment in residential centers, rehabilitation services, case management, prescription drugs, counseling and clinician visits, as well as transportation and some outreach activities. For children, mental health services are covered under EPSDT, which mandates that access to services must be granted for all medically necessary conditions.

For this survey, Medicaid directors were asked to indicate the extent to which various potential Medicaid behavioral health issues in their states were concerns, with a ranking of "5" indicating a significant or major concern and a ranking of "1" indicating a small or non-issue. Without question, from a Medicaid perspective, behavioral health issues are currently of great significance (Figure 30).



In particular, Medicaid officials were concerned about the impact of increasing costs to Medicaid for behavioral health services, with 44 states indicating that budget issues were at least a moderate to significant concern. Some states indicated that behavioral health was now the most significant driver of Medicaid spending. In some cases, mental health services are being expanded while other Medicaid funded services are constrained. The issue was reflected in the related concerns about inappropriate use of emergency rooms, prescription drugs and inpatient hospitalizations. One director said, "Mental health is going to be a continuing challenge. You see it everywhere. It shows up in physician offices, in hospitals, and in pharmacies. Mental health services are the largest area of growth in Medicaid."

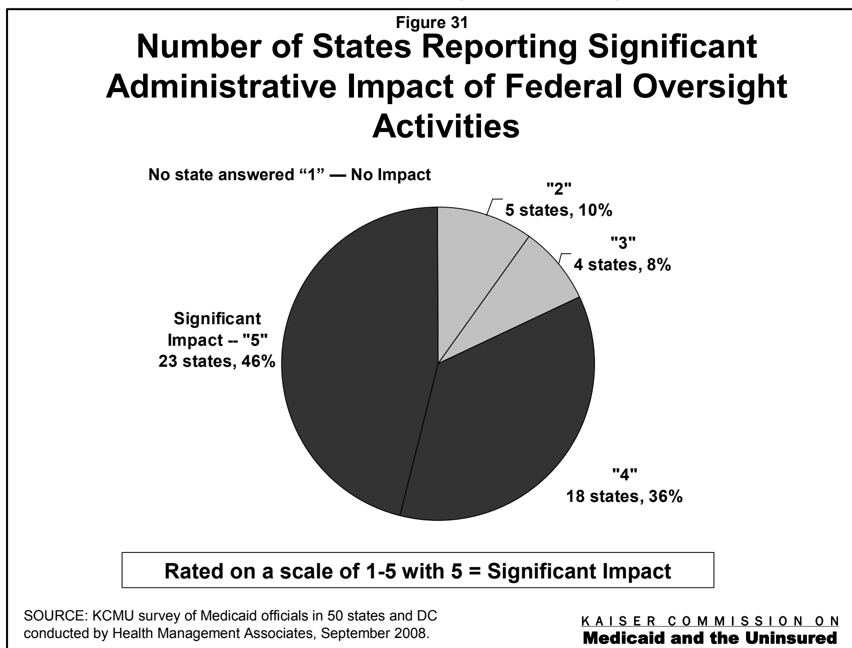
Over half of states indicated that interagency coordination is a moderate or significant concern. This is clearly an area of focus administratively across state agencies. Medicaid officials indicated that considerable effort has been directed at improving interagency coordination, and as one Medicaid director said, reducing the effects of "organizational silos." Many states indicated that through a focused effort, including organizational changes and special collaborative initiatives, the relationships with their mental health sister agency were improving and they were jointly addressing the key issues. One issue of mutual concern is the appropriate use of prescription medications. One state indicated that of the top five prescription medications paid for by Medicaid, four were drugs for mental health diagnoses. The issue is of particular concern for children. One state indicated it had identified hundreds of children under the age of five with prescriptions for antipsychotic medications but without an associated diagnosis, and they were working together with the mental health department to address this issue. In other states, the agencies are working collaboratively on accrediting and credentialing, so providers will meet all Medicaid standards. Several states indicated they were working on ways to achieve better integration of mental health and physical health services for this population. Integration of services is often an issue for states using managed care, where managed care organizations are expected to deliver behavioral health services.

Another key issue for both mental heath and Medicaid relates to proposed federal regulations for rehabilitation services and targeted case management. These services have been central to care for children in foster care, for example, and Medicaid directors expressed significant concern about the potential impact if these regulations were to go into effect. Some states indicated that they had changed the way some services are delivered to comply with federal rules. Other states were concerned about proposed federal regulations that would impact community health clinics where a large share of these services are delivered.

C. Impact of Federal Oversight Activities

In 2003, the GAO added Medicaid to its list of high-risk federal programs[37] because the program's size, growth, and diversity put it in danger of waste, abuse, and exploitation. CMS responded in a number of ways to increase federal oversight such as: hiring 90 funding specialists to examine and eliminate high-risk state funding practices; creating the Division of Reimbursement and State Financing (DRSF) to review state plan amendments related to payment methodologies; using focused financial reviews and OIG audits to identify inappropriate state claims for federal reimbursement; implementing the Medicare-Medicaid ("Medi-Medi")[38] data match project; and implementing the Payment Error Rate Measurement (PERM) project.[39] The DRA also included a new Medicaid Integrity Program to increase the government's capacity to prevent, detect, and address fraud and abuse in Medicaid. For the second year in a row, the survey included questions exploring the administrative impact on state Medicaid programs of these enhanced CMS oversight activities.

There is widespread support for efforts to enhance Medicaid program integrity and many states have multiple efforts under way to improve fiscal and operational oversight of various program areas. Most states, however, expressed a strong belief that the federal administrative oversight activities were being carried out in a way that was burdensome to states. This year's survey asked state officials to describe the expected administrative impact of federal audits, reviews and other oversight activities (including PERM) on a scale of 1 to 5 (with "1" meaning "no impact" and "5" meaning "a significant impact."). Of 50 states responding to this question, a total of 41 states indicated that for them, the administrative burden was ranked as a 4 or a 5 on a scale of one to five, (including 23 states that described the administrative impact as a "5.") No state said there was no impact (Figure 31).



[37] GAO, *Major Management Challenges and Program Risks: Department of Health and Human Services*, GAO-03-101 (Washington, D.C.: January 2003).
[38] The Medi-Medi data match project matches Medicare and Medicaid claims information on providers and beneficiaries to identify potential improper billing and utilization patterns which could indicate fraudulent schemes.
[39] GAO, Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts, GAO-06-705 (Washington, D.C., June 2006).

Just over half of the states said that they needed to add new administrative resources or redirect administrative resources from other purposes to respond to ongoing federal audits and reviews, and other federal oversight activities in FY 2009.[40] In many cases, states commented that tight administrative budgets would prevent the state from adding new staff and instead staff would need to be redirected from other priorities to respond to oversight requests. In other cases, however, states responded that new staff and/or contractor resources were being added and that sometimes these additional costs (particularly related to PERM contracts) were significant. Medicaid officials in smaller states seemed less likely to be able to obtain additional staff to address the increased administrative burden related to the additional federal reviews.

Some state officials commented regarding the apparent lack of coordination between the various oversight efforts (e.g., PERM, the Medicaid Integrity Program, CMS audits, OIG audits, GAO audits, etc.). One official noted that a general federal suspicion of states had led to a depth of scrutiny "without a real sense of what they are looking for" which in turn resulted in an additional state administrative burden. Another director commented that "the [Department] generally has around 5-7 active audits at any given time…the audits require a significant amount of personnel time throughout the Department. There are numerous data requests which require significant staff hours in addition to the cost of programming a system to obtain the necessary data."

Others officials expressed concern about the possible impact on provider participation of increased federal provider audits. One director said, "Our concern is on the provider impact. I hope it doesn't overburden providers, some of whom are just itching for a reason not to participate in Medicaid." Finally, a number of officials suggested that states were as interested in fiscal integrity as is the federal government, that the cumulative cost of the audits exceeded the benefits, and that it was a lot of work with minimal positive results for a state.

D. Federal Medicaid Regulations

In 2007, CMS moved forward with a number of major regulatory initiatives intended to promote the integrity of the Medicaid program by closing perceived "loopholes" used by states to engage in excessive claiming of federal Medicaid funds. However, members of Congress, states, beneficiaries and providers raised concerns that these changes would constitute an unprecedented reversal of long-standing Medicaid policy that would have serious negative consequences. As a result of these widespread concerns, Congress and the Bush Administration ultimately agreed at the end of June 2008 to a one-year moratorium on six of the new Medicaid regulations that were included in the supplemental war appropriations bill (HR 2642). In the absence of future congressional action, these regulations could take effect as early as April 2009.

The survey included questions regarding six of the seven controversial regulations. These rules are described in the box on the following page.

[40] Mississippi did not respond.

Federal Medicaid Regulations

Regulation	Description
Case Management	Rule would restrict the scope of case management services and targeted case management (TCM) and specifies that federal Medicaid is not available for TCM if there are other third parties liable to pay for those services.
School-based Administration and Transportation	Rule would prohibit Medicaid payments for administrative activities (including outreach, enrollment and support in gaining access to EPSDT services) performed by schools and transportation of school-age children to and from school.
Public Provider Cost Limit	Rule would limit reimbursement for government providers to cost; narrow the definition of a unit of government and require providers to retain all Medicaid payments.
Graduate Medical Education (GME)	Rule would eliminate Medicaid reimbursement for GME (cost of medical residents).
Rehabilitation (Rehab) Services	Rule would restrict the scope of rehab services that are eligible for federal Medicaid matching payments and eliminate coverage for day habilitation services for people with developmental disabilities.
Provider Taxes	Rule would reduce allowable provider taxes from 6% to 5.5% (change was part of the Tax Relief and Health Care Act of 2006) of revenues and tightens the hold-harmless test.
Outpatient Services	Rule would restrict the scope of Medicaid outpatient hospital services and clarify the outpatient upper payment calculation. (not subject to the moratoria until April 2009)

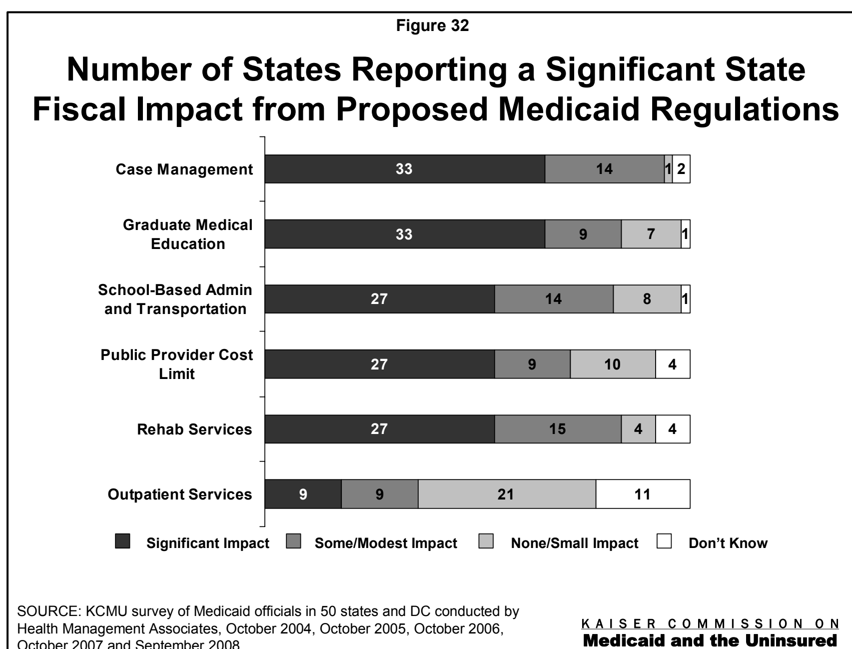
The federal regulatory estimates prepared by the Office of Management and Budget (OMB) projected federal savings of over $15 billion over the next five years if six of the regulations were implemented. However, a report issued by the House Committee on Oversight and Reform that surveyed states about the impact of the regulations showed a fiscal impact of about $49.7 billion in reduced federal payments to states.[41] The impacts of the regulations varied widely across states. According to the state estimates, the public provider cost limit regulation had the largest fiscal impact by far, however, the impact was concentrated in fewer states.

This survey asked Medicaid directors to describe both the expected state fiscal impact and the expected impact on beneficiaries as "none or small," "some or modest," "significant," or "don't know" assuming the proposed regulatory initiatives are ultimately implemented in their proposed form in 2009.

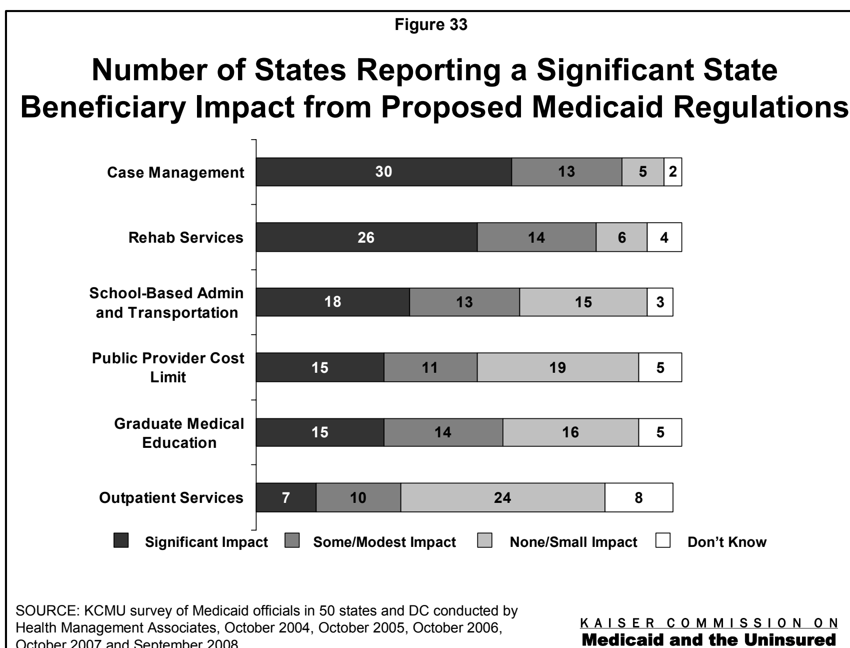
Regarding the state fiscal impact of the regulations, the vast majority of states indicated that the regulations would have a real and significant impact on states and beneficiaries. Over 40 states indicated the impact would be moderate to significant for the proposed rules on case management, GME, rehabilitation and school-based administration and transportation. The only proposed rule for which fewer than half the states indicated a likely significant fiscal impact was the outpatient services rule. (The outpatient rule is the only rule that was never issued as final and was not subject to the moratoria.) Only nine states indicated that the outpatient services rule would have a significant state fiscal impact. The impact of this proposed rule was less certain for Medicaid officials, with 11 states indicating that they did not know yet what the impact would be. However,

[41] Committee on Oversight and Government Reform. "The Administration's Medicaid Regulations: State-by-State Impacts." March 2008.

one state commented that it expected to be particularly hard-hit by the outpatient rule due to that state's heavy reliance on outpatient clinics to deliver primary care in urban areas (Figure 32).



State officials were also asked to indicate the anticipated beneficiary impact of the regulations. Compared to the expected state fiscal impact, a smaller number of states indicated that the regulations would have a significant impact. The rules of greatest concern for their potential impacts on beneficiaries were the case management and rehabilitation (rehab) services rules, with 43 and 40 states, respectively, expecting a modest to significant impact. For example, one state official expressed concern that these two rules could result in more persons ending up in hospital and nursing home placements who could have been served in the community. Again, states expressed the most uncertainty regarding the outpatient services rule with eight states indicating that they did not know yet what the impact on beneficiaries would be. At least one state official indicated that the state intended to absorb any impacts so they would not fall on beneficiaries (Figure 33).



E. Medicaid and SCHIP Reauthorization

Fiscal year 2008 was a time of challenge and uncertainty for the State Children's Health Insurance Program (SCHIP). For states, two significant actions at the federal level created uncertainty. The first action related to the way Congress temporarily reauthorized SCHIP, and the second to a federal directive that affected states pursuing expansions of coverage for children.

The initial ten-year federal authorization for SCHIP and its funding expired on September 30, 2007. Agreement on the terms of reauthorization proved to be politically difficult. Congress first allowed the program to operate on a continuation basis, then twice adopted five-year reauthorization bills that were vetoed by the President. Finally, on December 29, 2007, the President signed into law temporary reauthorization with funding to maintain current programs through February 2009. The second significant action for states was a federal directive on August 17, 2007, that essentially limited SCHIP coverage above 250 percent of the federal poverty level (FPL). Twenty-three states were affected by the directive (10 that had already expanded coverage beyond 250 percent of poverty and another 14 that planned to do so with Washington falling into both categories).

Medicaid and SCHIP are closely linked. The SCHIP program includes a Medicaid expansion component in 33 states, including 14 states in which a Medicaid expansion is the entire SCHIP program. Only 18 states rely entirely on a separate stand-alone SCHIP program. Inevitably, policies in the SCHIP program affected Medicaid in some states. In this survey, state Medicaid officials were asked whether there had been any Medicaid budget, policy or enrollment impacts in their state as a result of the way SCHIP was temporarily reauthorized, or as a result of the new requirements of the August 17th letter.

In states considering expansions of coverage for children, the uncertainty of SCHIP reauthorization made states wary of taking action until the funding situation was resolved. The temporary nature of the reauthorization until February 2009, the middle of state fiscal year, made it extremely difficult for states to make policy decisions for FY 2009, due to the uncertainty about future federal funding, especially given the downturn in state economies. Without question, the temporary reauthorization created uncertainty that caused some states to put off discussions of proposed expansions until they knew the details of a permanent SCHIP reauthorization.

Secondly, the August 17th letter had a chilling effect on proposed expansions of coverage for children. A number of states had authorized an expansion of coverage for children to at least 300 percent of the FPL, but some did not implement the SCHIP expansion for reasons specifically related to the requirements of the August 17th letter. Some states implemented coverage expansions for children using state-only funds for coverage above 250 percent of poverty including New York, Wisconsin and Iowa.

F. Medicaid 1115 Waivers

Even with the new DRA options, some states are continuing to seek to make changes in their programs beyond the flexibility provided under federal law. 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. Federal guidelines require these waivers to be "budget neutral" for the federal government.

CMS indicates that just over half of states had a Section 1115 waiver relating to family planning coverage and about a dozen states had Section 1115 waivers relating to Medicaid reform or other more comprehensive initiatives. For example, Florida implemented a comprehensive reform demonstration under Section 1115 in 2006. In FY 2008, Florida expanded its Medicaid reform pilot project from the original two pilot counties (Broward and Duval) to three new rural counties (Baker, Clay, and Nassau). As part of the 2008-2009 budget negotiations, the state legislature debated expanding the waiver into additional counties, including the heavily populated area of Miami-Dade. However, the final budget did not include any expansions to other areas of the state. The legislature must approve expansion of the waiver to additional areas of the state. In 2007, the state OIG recommended that the state delay expansion into additional areas until certain improvements were made.

Hawaii, Maryland, Massachusetts and Montana were among the states seeking waiver extensions or renewals in FY 2009. Some potential waivers include plans in: Iowa to adopt a "Disaster Relief Medicaid" program, an initiative relating to Medicaid coverage during recent floods; New York to add twelve-month continuous coverage for most adults; Pennsylvania to implement a demonstration for benchmark coverage for uninsured adults; Wisconsin to expand its BadgerCare Plus coverage to childless adults uninsured for at least twelve months; and Texas to improve health infrastructure and coordination to reduce uncompensated care with a new catastrophic care program for parents and caretakers and health insurance subsidies for adults. The most comprehensive waiver currently under review at CMS is for Rhode Island.

Rhode Island Global Consumer Choice Compact Waiver

On August 8, 2008, Rhode Island Governor Donald L. Carcieri announced the submission of a Section 1115 Medicaid demonstration waiver request to CMS to radically restructure Rhode Island's Medicaid program, driven in large part by fiscal pressures. As of September 2008, the waiver is pending an approval decision from CMS. Some of the most significant changes proposed in the waiver are around program financing. Under the proposed waiver, the state would accept a global cap on federal funding for all Medicaid spending (excluding only disproportionate share hospital payments, payments to local educational agencies and administrative costs); the state would also limit its own Medicaid spending to a fixed percentage of the state budget.

In exchange for accepting the global cap on federal funds, the state is seeking greater flexibility to make program changes without additional federal approval, including the ability to reduce benefits and increase benefit and cost sharing levels. Additionally, one of the state's central goals of the waiver is to rebalance the long-term care delivery system. The state plans to achieve this by establishing three levels of long-term care based on need in order to increase access to community-based services and reduce use of institutional services.

G. Initiatives to Reduce the Number of Uninsured

A significant number of states are undertaking special initiatives to address the uninsured, including some initiatives outside of Medicaid. In this survey, Medicaid officials in 32 states indicated that there were plans for new measures to reduce the number of uninsured in their states, including Section 1115 and other coverage expansions. In three-fourths of these states, Medicaid had a clear role in the financing of these initiatives, although the role was regarded by state officials only as "some or modest' in about one-third of these states.

The worsening state budget situation has had an effect on the scope of these initiatives in some states. Of the 32 states indicating that they planned initiatives to reduce the number of uninsured in FY 2009, officials in ten states said that the measures had been reduced in scope or significance from previous plans due to budget concerns. Initiatives to address the number of persons without health coverage included: tax credits for small businesses and employers who provide health insurance; insurance market reforms; offering limited benefit coverage for adults through Medicaid; SCHIP expansion for children; outreach to enroll eligible children in public health insurance programs; continuous eligibility for children; expanding Medicaid coverage for parents; adding Medicaid coverage for uninsured adults without children; adding a state-only funded children's buy-in program, and premium assistance for low-income uninsured.

H. Looking Ahead: Perspectives of the Medicaid Directors

There are a myriad of operational issues involved with running a large public program that serves millions of individuals such as: ensuring that individuals get the services that they need, providers get claims paid and administrative systems are functioning on a daily basis. Beyond these issues that Medicaid officials deal with daily, Medicaid directors were asked to step back and identify the key issues they expect Medicaid to face in their state over the next one or two years, through 2009 and 2010. Most directors mentioned issues around financing, the status of the state and federal partnership, quality of care and Medicaid's ability to meet the needs of the uninsured.

Two-thirds of states cited the Medicaid budget and state fiscal pressures as key issues for the program. Almost a quarter of states specifically mentioned the impact of the economy on the program as state revenue growth slowed and programs have come under greater budget pressure. Directors were concerned that the economic downturn might result in a return to the budget-driven program cutbacks that occurred in the last recession. For some states, this was described as an immediate concern, with a looming possibility of program cuts in mid-fiscal year 2009 or fiscal year 2010. The fact that Medicaid is counter-cyclical and tends to grow faster in periods of economic downturn increases state financing challenges. Longer term, officials expressed a concern that states do not have the fiscal capability to continue to finance Medicaid from the state revenue base, particularly as Medicaid demands grow and the program is called upon to serve ever-increasing numbers of persons without health coverage.

The second most cited issue was related to the federal – state partnership for Medicaid. Over half of states mentioned a strained state relationship with the federal government as a significant issue or challenge. In many instances, states described how they were frustrated by the federal government when they wanted to implement a policy change, including changes in coverage, reimbursement methodologies or comprehensive Medicaid reform. Officials indicated that the federal rules often were not clear, consistent, practical or effective. State Medicaid officials expressed a desire for more cooperative federal partners who might assist states in program improvements in the future.

The third key issue that state Medicaid directors said they would be addressing over the next year would be the implementation of new program initiatives. States mentioned strategies to improve health outcomes, to encourage primary and preventive care, to develop and use health information technology, implement new MMIS systems, to move toward integration of acute and long term care, to improve chronic care management, to develop value-based purchasing strategies, and to reduce the number of uninsured children. Policy developments are on the horizon in the majority of states.

States have come to recognize the critical role Medicaid plays in the health care marketplace, and the opportunity Medicaid has to improve the system and expand coverage to persons without health insurance. As one Medicaid director said: "We are a major player. We are not just at the table, we are leading the discussion on reforming health care in the U.S. We are ahead of the curve. We in Medicaid need to hold our head high and beat the drum loudly. We are proud of what we do here, and we are excited." Finally, Medicaid directors often mentioned that the outcome of the election in November 2008 would have important implications for the future of Medicaid. There were two key messages. One was a feeling that the election would impact the discussion about the role of Medicaid in addressing the issue of coverage for the uninsured. The second was that a new administration regardless of party would have an opportunity to improve the federal – state partnership, and perhaps repair the relationship that has become so strained.

Conclusion

After a brief recovery from the last economic downturn, states once again faced an increasingly challenging fiscal environment in state fiscal year 2009. Despite the fiscal challenges and a worsening economic outlook, states are planning to make positive changes to their Medicaid programs that are partially offset by a limited number of restrictions. Across the states, Medicaid programs would like to enhance provider payments, expand eligibility, work to balance their long-term care delivery systems and implement new quality initiatives but face significant budget realities. A few states with the most dire budget issues already made extensive Medicaid cuts to help balance their budgets. More states may be faced with hard Medicaid policy choices because no easy choices remain to scale back the program to achieve cost savings. Provider payment rates are already low and policies are in place to control prescription drug costs leaving states few options but to turn to core program cuts if states must achieve Medicaid budget savings.

Medicaid remains a critical program in addressing the coverage and long-term care needs for low-income individuals with few or no other options. Fiscal challenges will remain a perennial issue for Medicaid due to state budget constraints, limits to the state revenue base, the countercyclical design of the program which causes expenditures to increase during economic downturns, and the nature of the shared financing between the federal and state governments. The new Administration and Congress will immediately face the issues of SCHIP reauthorization, pending Medicaid regulations, state waiver requests, and the state-federal relationship around Medicaid. The resolution of these issues, in addition to a discussion about broader health reform will inevitably impact Medicaid and the role it will play in the future within the nation's health care system.

Appendix A: State Survey Responses

Appendix A-1: Positive Policy Actions Taken in the 50 States and District of Columbia FY 2008 and FY 2009

States	Provider Payment Increases		Benefit Expansions		Eligibility Expansions		Simplification to Application/ Renewal		Decreased Co-Payments		Long Term Care Expansions	
	2008	**2009**	**2008**	**2009**	**2008**	**2009**	**2008**	**2009**	**2008**	**2009**	**2008**	**2009**
Alabama	X	X			X	X	X	X			X	
Alaska	X	X			X						X	X
Arizona	X	X	X		X		X	X			X	X
Arkansas	X	X		X				X				
California	X		X					X			X	X
Colorado	X	X			X	X	X				X	X
Connecticut	X	X			X							X
Delaware	X	X				X					X	
District of Columbia	X	X	X		X							X
Florida	X					X					X	X
Georgia	X	X			X	X					X	X
Hawaii	X	X		X							X	X
Idaho	X	X	X	X				X			X	
Illinois	X	X				X					X	X
Indiana	X	X			X	X	X	X			X	X
Iowa	X	X	X		X	X	X	X			X	X
Kansas	X	X	X	X			X	X			X	X
Kentucky	X	X			X	X					X	X
Louisiana	X	X	X	X	X	X	X	X			X	X
Maine	X	X									X	X
Maryland	X	X				X	X	X			X	X
Massachusetts	X	X					X	X			X	X
Michigan	X	X					X				X	X
Minnesota	X	X	X	X		X	X	X	X	X	X	X
Mississippi	X	X			X			X			X	
Missouri	X	X			X	X		X			X	X
Montana	X	X			X	X					X	X
Nebraska	X	X		X		X					X	X
Nevada	X	X					X				X	
New Hampshire		X	X									
New Jersey	X	X										X
New Mexico	X		X	X			X	X				X
New York	X	X		X	X	X	X	X		X	X	X
North Carolina	X	X		X	X		X				X	X
North Dakota	X	X			X						X	X
Ohio	X	X	X	X	X			X			X	X
Oklahoma	X		X		X	X	X				X	X
Oregon	X	X	X		X	X	X		X		X	
Pennsylvania	X	X	X		X		X	X	X		X	X
Rhode Island	X	X										X
South Carolina	X	X							X		X	X
South Dakota	X	X	X							X		
Tennessee	X	X				X					X	X
Texas	X	X	X	X	X		X				X	X
Utah	X	X	X								X	X
Vermont	X	X	X	X	X		X	X			X	X
Virginia	X	X	X		X	X					X	X
Washington	X	X			X		X	X			X	
West Virginia	X	X									X	X
Wisconsin	X	X			X	X	X	X			X	X
Wyoming	X	X				X						X
Total	**50**	**47**	**19**	**13**	**26**	**22**	**22**	**21**	**4**	**3**	**42**	**41**

Appendix A-2: Cost Containment Actions Taken in the 50 States and District of Columbia FY 2008 and FY 2009

States	Provider Payments		Pharmacy Controls		Benefit Reductions		Eligibility Cuts		Changes to Application and Renewal		Copays		LTC	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Alabama		X	X	X			X							
Alaska			X	X										
Arizona	X	X				X				X				
Arkansas	X													
California		X		X				X					X	
Colorado			X	X									X	
Connecticut	X	X	X											
Delaware			X	X			X							
District of Columbia	X	X	X	X										
Florida	X	X	X			X							X	
Georgia	X		X	X										
Hawaii							X							
Idaho														
Illinois	X											X		
Indiana	X	X	X	X									X	X
Iowa	X	X	X	X										X
Kansas	X												X	
Kentucky				X									X	
Louisiana														X
Maine			X	X		X	X	X			X			
Maryland														
Massachusetts		X	X	X								X	X	X
Michigan			X		X									
Minnesota	X	X	X	X	X									
Mississippi		X	X								X	X		
Missouri	X	X												
Montana			X	X										
Nebraska						X							X	X
Nevada	X	X				X	X	X				X		
New Hampshire	X	X												
New Jersey			X	X										
New Mexico		X		X										
New York		X	X	X										
North Carolina			X	X										
North Dakota			X	X										
Ohio	X	X		X										
Oklahoma	X	X	X	X										
Oregon			X	X										
Pennsylvania		X	X	X										
Rhode Island			X	X				X						
South Carolina		X	X	X										
South Dakota			X	X										
Tennessee	X	X		X		X								
Texas	X		X	X					X					X
Utah			X	X										
Vermont	X													
Virginia	X		X	X		X								
Washington			X	X										X
West Virginia			X		X									
Wisconsin	X	X	X						X		X			
Wyoming			X	X										
Total	**21**	**22**	**33**	**32**	**3**	**7**	**5**	**4**	**2**	**1**	**3**	**4**	**8**	**7**

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

State	Eligibility, Premium and Application Changes
Alabama	**Aged & Disabled:** Suspended the QI1 group (Medicare premium payments). (15,557, 6/30/08). **Other:** New eligibility group - Iraqi/Afghan refugees. (no enrollees yet, 12/2007) **Application & Renewal:** Online application with e-Signature option as of July 2008. Also online "change form" for enrollees report changes implemented in August 2008.
Alaska	**Pregnant Women:** Increased income standard to 175% of FPL for Alaska. (218, 7/1/07) **Working Disabled**: Increased asset limit from Medicaid levels to $10,000 for individuals and $15,000 for couples. (50, 8/1/07)
Arizona	**Pregnant Women:** Increased income limit to 150% of FPL from 133%. (547, 10/1/07) **Application & Renewal:** Change in face-to-face interview requirement went statewide 03/08. Applications and documentation accepted by phone, e-mail and mail. For some client groups renewal can be conducted by phone or a paperless renewal.
Arkansas	
California	**Application & Renewal**: Implement continuing Presumptive Eligibility coverage until Healthy Families determination to replace one month Medi-Cal to Healthy Families Bridge (Title XXI) and when Medi-Cal application is screened to exceed Medi-Cal income/resource requirements (replaces Accelerated Eligibility--Title XXI). Not counted in totals.
Colorado	**Children:** Presumptive eligibility. (unknown, 1/1/08) **Application & Renewal:** Created a single purpose application (Medicaid and Financial), available on the Internet, that clarified benefits for estate recovery and lowered reading level.
Connecticut	**Parents:** Increased parent eligibility from 150% to 185% of FPL. (8,600, 7/1/07) **Pregnant Women:** Increased eligibility from 185% to 250% of FPL. (4,200, 10/1/07) **Working Disabled**: new TWWIIA program.
Delaware	**Family Planning:** Income standard reduced from 300% to 200% of FPL. (unknown, 1/1/08)
District of Columbia	**Children:** Expanding income level for 19-20 year olds from 50% to 200% of FPL. (750; 10/1/07)
Florida	
Georgia	**Working Disabled:** Implemented TWWIIA Medicaid buy-in program under DRA state plan option. (200; 12/07) **Application & Renewal:** Add external data validation vendor for assets and income. (credit reports etc). Not counted in totals. **Premiums:** New Ticket to Work buy-in program has premiums.
Hawaii	**All:** Limiting retroactive Medicaid coverage to 30 days from date of application. (2/1/08) **Premiums:** Decreased premiums for recipients 250% of FPL and above.
Idaho	
Illinois	
Indiana	**Children:** Continuous eligibility for 0 -3 year olds. **Pregnant Women:** Increased pregnancy coverage to 200% FPL from 150% FPL. (1,900, 1/1/08) **Parents & Adults Without Children:** Healthy Indiana Plan covers parents and adults to 200% of FPL. (50,000 & 34,000, 1/1/08) **Application & Renewal:** Continued roll-out to counties of the Modernized solution which established call centers and the ability to apply via the internet and by telephone. **Premiums:** Parents and Childless Adults under 200% of FPL under new Healthy Indiana Plan.
Iowa	**Parents:** Increased earned income disregard for parents (effectively expanding eligibility to 58% of FPL). (6,400, 8/1/07) **Aged & Disabled:** Increased personal needs allowance for residents of all medical facilities from $30 to $50 per month. **Application & Renewal:** Eliminated face-to-face interview requirement. All IM forms are electronic. Many forms have been and are being simplified and available in Spanish. **Premiums:** IowaCare Premiums for Medicaid Employed Persons with Disabilities (MEPD) now reviewed annually rather than every six months. The sliding scale for premiums for persons above 150% of FPL was adjusted with small premium increases.
Kansas	**Application & Renewal:** Multi-program applications implemented. (09/07)
Kentucky	**Working Disabled:** Implemented a Ticket to Work program. (100, 11/07) **Premiums**: New Ticket to Work program.
Louisiana	**Children with Disabilities:** Implement Family Opportunity Act (ages 0 through 12). (175, 10/1/07) **Pregnant Minors:** Disregard parental income. (25, 4/30/08) **Application & Renewal:** Migration from paper renewal form to renewal by telephone and internet

State	Eligibility, Premium and Application Changes
	application and renewals; administrative renewal of cases meeting certain characteristics. **Premiums:** New Family Opportunity Act buy-in program ages 0-12.
Maine	**Adults without Children:** Waiting list and ultimately an enrollment freeze. (8,000, 07/07) **Premiums:** New "Katie Beckett" option with premiums.
Maryland	**Application & Renewal:** Implemented on-line application. **Premiums:** for optional low-income children were increased slightly to adjust for inflation.
Massachusetts	**Application & Renewal:** The capacity to submit a streamlined electronic renewal was piloted in June 2008. Providers are able to assist some enrollees in submitting their renewal information on-line. **Premiums:** Eliminated premiums for: MassHealth enrollees at or below 150% of FPL & for Children (133% to 150% of FPL) if the parents are enrolled in the Commonwealth Care program. **Premiums:** were increased for Commonwealth Care.
Michigan	**Application & Renewal:** Application & Renewal form was simplified.
Minnesota	**Application & Renewal:** New shortened application implemented statewide 1/1/08. Application & Renewal assistance program also implemented.
Mississippi	**Other:** New category of eligibility for Serious Emotional Disturbance waiver. (none in FY 08, 11/1/07)
Missouri	**Children:** Expanded coverage for children aging out of foster care, up to age 21. (970, 7/1/07). **Working Disabled:** Implemented Ticket to Work Medicaid category. (3,240, 09/01/07) **Aged & Disabled:** Sheltered workshop income disregarded. (1,227, 9/1/07) **Premiums:** New Ticket to Work program.
Montana	**Pregnant Women:** Increased pregnant women income limit to 150% of FPL. (248, 7/1/07) **Aged & Disabled:** Increased personal needs allowance from $40 to $50. (7/1/07) **Medically Needy:** Added a $50 general income deduction. (5,972, 8/1/07)
Nebraska	
Nevada	**Children:** Change in income disregard policies (more restrictive). **Application & Renewal**: eliminated all face-to-face interviews for Medicaid.
New Hampshire	
New Jersey	
New Mexico	**Application & Renewal:** Implemented re-certifications by phone, fax, on-line or e-mail for low-income families and children. No face-to-face required unless there is an unresolved situation.
New York	**Parents:** Implement Employer Sponsored Insurance Initiative. (1,000; 1/1/08) **Adults without Children:** Implement Employer Sponsored Insurance Initiative. (2,000; 1/1/08) **Application & Renewal:** Eliminated the face-to-face interview for the Medicare Savings Program (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individual-1, and Qualified Disabled and Working Individual) effective 1/1/08. Eliminated documentation of income and residency at renewal. Also, individuals moving from county to county are no longer required to submit a new application or have a face-to-face interview.
North Carolina	**Children:** Expanding coverage for children aging out of foster care, up to age 21. (1200, 10/1/07) **Application & Renewal**: Forms changed and minor process improvements.
North Dakota	**Children:** Implement 12-month continuous Medicaid eligibility for children. (6,314, 6/1/08) **Children with Disabilities:** Implement Family Opportunity Act – Buy in for children. (400, 4/1/08) **Premiums:** New Family Opportunity Act buy-in program.
Ohio	**Children:** Expanded coverage for children aging out of foster care, up to age 21 (940 by June 2009, 1/1/08). **Pregnant Women:** Expand coverage from 150% of FPL to 200% of FPL. (estimate of 5,917 by June 2009; 1/1/08) **Working Disabled:** Implement coverage for working people with disabilities up to 250% of FPL. (TWWIIA) (estimated 5,831 by June 2009; 4/1/08) **Parents:** Removed a time limited disregard for low-income families to allow adults to continue their Medicaid coverage uninterrupted. **Premiums**: New Medicaid Buy-in for workers with disabilities.
Oklahoma	**Children:** Extend Medicaid eligibility to Native American children in Bureau of Indian Affairs/Tribal children dorms (boarding schools). **Other:** Expand coverage under O-EPIC to 200% FPL. **Application & Renewal:** Implementing electronic application for newborns – pilot began in April 2008.
Oregon	**Other:** OHP Standard reservation list was open from January 28, 2008 through February 29, 2008. OHP Standard is closed to new enrollment unless an individual's name is selected through the reservation list. (6,000, 1/29/08) **Application & Renewal**: Applications were shortened to 4 pages. Length of time for OHP applicants to return initial applications with documentation was increased from 30 days to 45 days.

State	Eligibility, Premium and Application Changes
Pennsylvania	**Family Planning Waiver:** Implement PlanSmart for Women. (no estimate, 2/1/08) **Applications**: Implemented an automated referral process between Medicaid and SCHIP, known as the 'Health Care Hand Shake (HCHS)' when a family or individual's application or renewal information makes the person eligible in the other's program. Data is transferred to the other agency through using the on-line application. Piloted in 9 counties starting in March 2008.
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**Application & Renewal:** Re-verification of the MNSD population was approved by CMS. Not counted in totals. **Premiums:** were eliminated for TennCare Standard Children.
Texas	**Children:** Newborns born to mothers receiving Emergency Medicaid at time of birth eligible for 12 months of continuous Medicaid coverage. (500 per year, 6/1/08) **Children, Parents & Medically Needy:** Updated policy to allow legal permanent residents (LPRs) with 40 qualifying quarters who entered after 8/22/96 to be eligible for Medicaid. (For individuals who were previously denied, Medicaid benefits were restored on the date the individual would have been eligible based on this criteria.) (unknown number, 4/16/08) **Application & Renewal:** Reinstated face-to-face interview for parents & caretakers. Implemented e-signatures for online applications. Application & Renewal reworded to collect information regarding migrant status, household members serving in armed forces and other absent parent information.
Utah	
Vermont	**Adults without Children:** Premium assistance program for adults at or below 200% of FPL. (1,423; 10/1/07) **Applications**: Changed from 6 month to 12 month recertification for most programs. **Premiums:** Reduced premiums for: children with household income greater than 185% of FPL, or pregnant women with household income greater than 185% of FPL, and expansion population adults with income greater than 50% of FPL.
Virginia	**Family Planning Waiver:** Coverage time limits were removed, no longer requires a Medicaid-covered pregnancy, and men were added. (no estimate, 1/1/08)
Washington	**Children:** Expanded coverage for children aging out of state or tribal foster care. (300 per year, 7/22/07) **Application & Renewal:** Implemented a renewal pilot project to evaluate methods of increasing timely renewal completion and reducing churn rates. The pilot consisted of 4 elements: 1) review completion on any client contact; 2) pre-calling to complete review early and by phone; 3) special 'Important' envelope sent; 4) simplified, modified form and tracked results of the 4 month project.
West Virginia	
Wisconsin	**Children:** Raised income limit for infants from 185% FPL to 250% of FPL. Started presumptive eligibility for children under age 19 with income at or below 150% of FPL. (8,200, 2/1/08) **Children:** Expanded coverage for children aging out of foster care. (500, 2/1/08) **Parents:** Expand coverage to parents and caretaker relatives from AFDC standard (approximately 40%) to 200% of FPL. (9,000 including pregnant women (below), 2/1/08) **Pregnant Women:** Expand coverage from 185% FPL to 250% of FPL (with state-funding up to 300%). (2/1/08) **Application & Renewal:** New application forms were introduced with the new BadgerCare Plus program. Also, changed verification policy for families to require that all types of income be verified. Streamlined income methodology, reduced change reporting policy and gross income test. **Premiums:** New premiums for caretaker adults between 150-200% of FPL, and infants 200% to 250% of FPL.
Wyoming	

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

State	Eligibility, Premium and Application Changes
Alabama	**Parents:** Extension of Temporary Medical Assistance (TMA) depending on re-authorization. **Application & Renewal:** New system to enhance interoperability between all HHS agencies.
Alaska	
Arizona	**Application & Renewal: -** The frequency of redetermination for Title XIX Waiver group adults without children will change from every 12 months to every 6 months. The revised multi-program application is scheduled to be released in FY 2009. Implementing an online application to allow applicants to apply online for Medicaid, SCHIP, Food Stamps, and TANF Cash. The user will also be able to submit changes and complete renewals online.
Arkansas	**Application & Renewal:** New funding for IT designed to improve access. **Premiums:** Premiums for ARHealthNet (HIFA Waiver) are being reduced.
California	**Children:** Elimination of 12-month continuous Medi-Cal eligibility for children. **Application & Renewal:** Implementing a revised joint Medi-Cal/Healthy Families Program application.
Colorado	**Children:** Expansion of eligibility through age 20 for children aging out of foster care. (201, 7/1/08)
Connecticut	
Delaware	**Working Disabled:** Implementation of a Ticket to Work program. **Premiums:** New Ticket to Work program has premiums.
District of Columbia	
Florida	**Children:** Extend Medicaid to youth up to age 21 who exit adoption subsidy at age 18 and meet certain criteria. (unknown number, 8/08) **Other Groups:** Clarify Florida residency criteria to cover non-citizens with temporary visas. (unknown number, 10/08)
Georgia	**Children:** Add "Chafee Option" eligibility for children that age out of foster care. (600, 07/08) **Premiums:** New Ticket to Work buy-in program has premiums.
Hawaii	**Application & Renewal:** Based on PERM requirements will be changing some passive renewals to require information. Not counted in totals due to involuntary nature of action. **Premiums:** Decreased premiums for recipients 250% of FPL and above. **Premiums**: Spend-down obligation for medically needy converted to a premium.
Idaho	**Application & Renewal:** new simplified "child only" application.
Illinois	**Children with Disabilities**: Family Opportunities Act. **Working Disabled:** Expansion of income limit from 250% to 300% of FPL and asset limit increased from $10,000 to $25,000, with unlimited retirement accounts and certain medical savings accounts. (540 persons) **Premiums:** New Family Opportunity Act buy-in program.
Indiana	**Parents & Adults without Children:** new buy-in option for Health Indiana Plan. Unknown, 7/1/08) **Other:** Family planning services for women 2 years postpartum, and presumptive eligibility for Pregnant Women up to 200 % FPL. **Application & Renewal:** Elimination of telephone interview requirement for renewals: can be done via mail.
Iowa	**Children:** Continuous eligibility for children. (175, 1/1/09) **Children with Disabilities:** A new coverage group for Disabled Children per the DRA FOA will be implemented for qualifying children in families with income be under 300% of the FPL. **Application & Renewal:** application and renewal forms will require only one adult signature even though two adults are in the household. The multi-application form will be able to be submitted electronically and the 'submit' button will serve as the applicant's signature. TPL language is being added to application and renewal forms. **Premiums:** Inflationary increase based on experience of state employee insurance. New Family Opportunity Act buy-in program.
Kansas	**Application & Renewal:** Implementation of on-line application with electronic signature. (01/2009)
Kentucky	**Pregnant Women:** Increase to 200% FPL. (400, est. 05/09) **Aged & Disabled:** For HCBS, PACE and Money Follows the Person participants, an increase in the personal needs allowance from $716 to $727. (07/08)
Louisiana	**Children with Disabilities:** Expansion of Family Opportunity Act to ages 13 to 18. (50, 10/1/08) **Application & Renewal:** Expansion of administrative renewal option for cases meeting certain characteristics. Reduction in procedural reasons that would result in denials or application rejections. **Premiums:** Family Opportunity Act buy-in program expansion ages 13-18.

State	Eligibility, Premium and Application Changes
Maine	**Adults without Children:** Continuation of waiting list for MaineCare. (1,000) **Premiums**: Increased premiums for "Katie Beckett" program.
Maryland	**Children & Parents:** Added an additional disregard to the section 1931 group to increase the effective income standard from 30% FPL to 116% of the FPL. We eliminated the asset test for the 1931 group. (10,609 children and 16,605 parents, 7/1/08) **Medically Needy:** Added an additional disregard to the AFDC-related groups to increase the effective income standard from 30% FPL to 116% of the FPL. (7/1/08) **Adults without Children:** Will be eliminating the assets test for Primary Adult Care program, which is for low income adults who do not otherwise qualify for Medicaid. The income standard is being adjusted so that it will equal 116% of the FPL for households with two adults as well as those with one adult (currently the standard is 116% for 1 adult and 100% for 2 adults). **Working Disabled:** Moving Employed Individuals with Disabilities (EID) program into the state plan using the TWWIIA groups. **Application & Renewal:** 1. Eliminated the face to face interview requirement and the asset test for low income families (the section 1931 eligibility group). 2. Created a new simplified application for 'Medical Assistance for Families, Pregnant Women, and Children' 3. Made income self-declatory (eliminated the verification requirement) for low income families. 4. Implementing electronic signature for the on-line application. **Premiums: f**or optional low-income children are increased slightly to adjust for inflation.
Massachusetts	**Application & Renewal:** Anticipate the expansion of Streamlined renewal tool (described above for FY 2008) to include additional caseload populations of Health Safety Net and MassHealth.
Michigan	
Minnesota	**Children:** Adding 2 months of Medicaid for children transitional from Medicaid to MinnesotaCare (household income exceeds 150% FPL) (10/01/08 or upon federal approval, whichever is later) **Children & Parents:** Eliminating add-back of depreciation and worker's compensation settlement as countable assets. (awaiting federal approval.) **Application & Renewal:** Children's only application to be implemented during this fiscal year, subject to federal approval. Application & Renewal assistance bonus increased from $20 to $25 per application, effective July 1, 2008. Effective January 1, 2009, state law allows enrollees who experience no change in circumstances to submit renewal forms to designated locations including community clinics and health care providers' offices. Authorizes DHS to establish criteria and timelines for sites to forward applications to DHS or to county agencies. **Premiums**: Decreased for MinnesotaCare caretaker adults (1115 expansion group).
Mississippi	**Application & Renewal:** Recertification by mail allowed for long term care cases.
Missouri	**Children:** Presumptive Eligibility expansion. (324, (07/01/08) **Other:** Expansion of Family Planning Waiver. (82,571, 07/01/08) **Application & Renewal:** Effective July 1, 2008, applications for Medicaid for Children, Pregnant Women, and Parents may be made via the Internet by visiting the Family Support Division's website.
Montana	**Medically Needy:** Increased general income deduction to $100. (6,054, 07/01/08) **Other:** Section 1115 Montana Plan First Family Planning Waiver. (1,950, 02/01/09) **Other:** Submission of Section 1115(a) HIFA/Basic Medicaid Waiver amendment extension revision to continue the Basic Medicaid waiver and add three new waiver populations. -– 2/1/09 implementation. This HIFA amendment extends the current waiver for 7,200 Able Bodied Adults with incomes at or below 33% of the Federal Poverty Level (FPL). This request also includes three additional populations; 1,600 Uninsured Mental Health Services Plan (MHSP) individuals with incomes at or below 150% FPL, 200 Uninsured Youth with a Serious Emotional Disturbance (SED) Formerly in Foster Care individuals with incomes at or below 175% FPL, and 150 additional Montana Comprehensive Health Association (MCHA) Premium Assistance Program individuals with incomes at or below 150% FPL. (target is 2/1/09) **Premiums:** If approved, the MHCA population in the HIFA waiver will be subject to 55% premium assistance.
Nebraska	**Children with Disabilities:** New 1915(c) autism waiver for kids under age 9. (50, 01/01/09) **Children with Disabilities:** Tightening of Disability Determination Process (A/D Waiver) - kids on HCBS disability waiver must demonstrate disability status. (-100, 01/01/09) Not counted in totals. **Premiums**: New autism waiver includes premiums.
Nevada	**Children:** Revert to more restrictive income disregard policy.
New Hampshire	
New Jersey	
New Mexico	**Application & Renewal:** Medicaid Renewal project (described for FY 2008) continues. Focus on reaching clients through providers.
New York	**Children:** Extending coverage to children aging out of foster care to age 21. Income and resources of children released from foster care at age 18 are exempt until age 21. (335, 01/09) **Parents, Aged, Disabled & Medically Needy:** Significant increase of income and resource eligibility levels for households of three or more, using the CPI as a major factor. (13,800, 04/08)

State	Eligibility, Premium and Application Changes
	Parents, Aged & Disabled: 12 months continuous coverage for non-institutionalized adults. (pending CMS approval) **Aged & Disabled Dual-Eligibles:** eliminated the resources test for OMB & SLMB. (5,000, 04/08) **Application & Renewal:** Maintain Medicaid eligibility for incarcerated individuals and reinstate coverage upon release until renewal, effective 4/1/08.
North Carolina	
North Dakota	
Ohio	**Application and Renewal:** Electronic eligibility and enrollment process will be fully implemented for Newborns. **Premiums**: Proposed expansion for children above 200% of FPL includes premiums.
Oklahoma	**Other:** Increase OEPIC employer group size to 250; add children to OEPIC and college kids to age 23 8/1/08. (If parent not enrolled in OEPIC, coverage delayed until systems changes made to delink) (Also this is Title 19). For nonprofits, leg authority to increase OEPIC employer group size to 500. (5,000 individuals)
Oregon	**Other:** Currently families who become ineligible for MAA/MAF due to an increase in earned income need 3 of 6 months MAA/MAF eligibility prior to being eligible for EXT (note: Transitional Medical Assistance) The revised rule excludes up to 3 months of earned income so the family is eligible for EXT. (1,683, 10/01/08)
Pennsylvania	**Application & Renewal:** Statewide implementation of "Health Care Hand Shake" (described for FY 2008) scheduled for 9/29/08.
Rhode Island	**Other:** Income limits for "Extended Family Planning" and for parents are reduced from 185% to 175% of FPL. (1,000, 10/01/08) **Premiums:** new premiums for children and families between 133% and 150% of FPL and increased premiums for those between 150% and 250% of FPL.
South Carolina	
South Dakota	
Tennessee	**Medically Needy:** Will open & begin enrollment in FY 2009 after re-verification of current enrollees. (20,000)
Texas	
Utah	
Vermont	**Application & Renewal:** On-line access and streamlined forms.
Virginia	**Other:** Expanding family planning waiver from 133% to 200% of FPL. (7/1/08)
Washington	**Application & Renewal:** Improving the online application form is in process. Requesting legislation to allow electronic signatures for Medicaid applications.
West Virginia	
Wisconsin	**Adults without Children:** Plan to make childless adults eligible up to 200% of FPL. (81,000, 1/1/09). **Application & Renewal:** Multiple process changes for the BadgerCare Plus expansion (4/1/09) will service as a test for the entire BadgerCare Plus program.
Wyoming	**Other:** New family planning wavier for women between the ages of 16 and 45.

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

State	Benefit Change
Alabama	
Alaska	
Arizona	**Aged & Disabled**: Added a $1000 dental benefit for LTC beneficiaries (previously only emergency service covered). Added hospice coverage.
Arkansas	
California	**All**: Added coverage for Human Papillomavirus Vaccine and home infusion therapy with tocolytic agents to control preterm labor and allowed all certified nurse practitioners to bill Medi-Cal independently
Colorado	
Connecticut	
Delaware	
District of Columbia	**Adults**: Added dental benefit.
Florida	
Georgia	
Hawaii	
Idaho	**All**: Added coverage for telemedicine services provided by a physician for pharmacological management, psychotherapy and psychiatric diagnostic interview examination. Also family therapy added to assist parents of children receiving mental health services.
Illinois	
Indiana	**Expansion Adults**: Implemented benefit package modeled on state employee plan with optional dental and vision coverage for additional cost-sharing. Beneficiaries will receive $500 annually in preventative care coverage (at no cost to the individual), a high deductible managed care plan and a $1,100 health savings account (called a "Power Account") funded by a combination of individual and state contributions.
Iowa	**All:** Added coverage for preventive medical exams and for comprehensive physical exam and health risk assessments.
Kansas	**Aged and Disabled:** Dental benefits added to Frail Elderly home and community-based services waiver. Also added personal assistance services for participants in the "Work Opportunities Reward Kansans (WORK)" program, the state's TWWIAA Medicaid buy-in program.
Kentucky	
Louisiana	**Children**: Expanded dental coverage to include a second dental preventive/screening visit and related services per 12 months. **All Adults:** Added coverage for adult immunizations.
Maine	
Maryland	
Massachusetts	
Michigan	**Adults:** Eliminated School Based Services coverage for 21-26 year olds.
Minnesota	**All:** Restricted coverage for circumcisions to only medically necessary indications. Added coverage for Community Health Worker services.
Mississippi	
Missouri	
Montana	
Nebraska	
Nevada	
New Hampshire	**All Adults:** Added coverage for incontinence supplies.
New Jersey	
New Mexico	**All Non-Pregnant Adults and Children:** Added coverage for Multisystemic Therapy and Comprehensive Community Support Services (mental health). **All**: Added coverage for Telehealth Services.
New York	
North Carolina	
North Dakota	

State	Benefit Change
Ohio	**All Adults**: Restored chiropractic and independent psychologist services.
Oklahoma	**Pregnant Women:** New high risk OB benefit for women screened as high risk including genetic counseling, lactation consulting and maternal and infant health enhanced ultrasounds.
Oregon	**Pregnant Non-Citizens**: Implemented a prenatal expansion pilot program in two counties. Individuals are eligible for the Plus Benefit package including prenatal.
Pennsylvania	**Children:** Childhood Nutrition and Weight Management services added. **Pregnant Women:** Telemedicine consults with OB specialists added. **Aged and Disabled:** Added telemedicine consults with psychiatrists (for mental health psychopharmacology).
Rhode Island	
South Carolina	**Other:** Implemented 2 one-county pilots each limited to 1000 beneficiaries: a voluntary DRA Health Opportunity Account Demonstration for healthy adults and children and a voluntary "Health Savings Account" plan using the State Employee High Deductible Health plan as the benchmark plan (done under DRA Benchmark plan authority and open to all beneficiaries except duals, foster care and persons in institutions).
South Dakota	**All Adults:** Added services of an occupational therapist.
Tennessee	
Texas	**Children:** Enhanced personal care services.
Utah	**Other:** Implemented a pain management program.
Vermont	**All Adults:** Added coverage for services provided by a naturopathic physician.
Virginia	**Children and Non-Pregnant Adults:** Adding coverage for substance abuse services (already covered previously for pregnant women).
Washington	.
West Virginia	**Children and Parents:** Statewide rollout of DRA Benchmark Plan 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, chiropractic and transportation services. Also includes a four script per month limit.
Wisconsin	**Other:** Implemented BadgerCare Plus expansion with a comprehensive benchmark plan adapted from Wisconsin's largest commercial, low-cost health care plan which is provided by United Healthcare. The benchmark plan is available to children and pregnant women with incomes above 200 percent of the FPL. Certain farmers and other self-employed parents will also be enrolled in the Benchmark Plan.
Wyoming	

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

State	Benefit Change
Alabama	
Alaska	
Arizona	**Aged & Disabled**: Eliminated $1000 dental benefit for LTC beneficiaries (added in FY 2008).
Arkansas	**Children:** New developmental and autism screens under EPSDT. **Adults**: Restored adult dental benefits.
California	
Colorado	
Connecticut	
Delaware	
District of Columbia	
Florida	**All:** Utilization controls imposed on fee-for-service therapy services by contracting with two prepaid therapy service vendors using waiver authority. **Premium Women:** Will establish a prior authorization program for elective cesarean sections.
Georgia	
Hawaii	**Aged & Disabled:** Care coordination and personal assistance level I services expanded through Quest Expanded Access integrated long term care managed care program.
Idaho	**All**: Partial hospitalization and outpatient mental health services added.
Illinois	
Indiana	
Iowa	
Kansas	**Pregnant Women:** Dental benefits to be added (using DRA authority).
Kentucky	
Louisiana	**Children:** Plan to implement multisystemic therapy for children aged 11-17 (a behavioral health service). **Pregnant Women:** Added coverage for gestational diabetes education.
Maine	**Children**: Eliminating day treatment (mental health) benefit. **Adults**: Coverage for some DME services, such as over-the-counter orthotics, will be eliminated. Prior authorization requirements will be added for other DME and podiatry services.
Maryland	
Massachusetts	
Michigan	
Minnesota	**Non-pregnant Parents and Caretaker Adults**: Remove $10,000 cap on inpatient hospitalization benefits for persons between 175% and 200% FPL. **Aged & Disabled and Medically Needy:** Added coverage for intensive outpatient treatment (a mental health service).
Mississippi	
Missouri	
Montana	**Expansion Adults:** Benefits for proposed 1115 waiver expansion groups: (1) Mental Health Services Plan (MHSP) individuals would receive same limited benefit package with same cost-sharing requirements as current 1115 Basic Medicaid waiver population *or* would receive premium assistance only (with no Medicaid wrap benefits) for an employer-sponsored plan or for private insurance. Also, a lifetime max cap of $1million. (2) Youth with a Serious Emotional Disturbance would receive same limited benefit package (but no cost-sharing requirements) as current 1115 Basic Medicaid waiver population *or* would receive premium assistance only (with no Medicaid wrap benefits) for an employer-sponsored plan or for private insurance. Also, a lifetime max cap of $1million. (3) Montana Comprehensive Health Association (MCHA) population will retain their current MCHA benefit package, premium and cost-sharing requirements. Waiver will allow Medicaid to fund the program's 45% premium subsidy for 150 new MCHA slots.
Nebraska	**Adults**: Dental benefits limited to $1,000 per year; OT/PT/speech therapy limited to 60 visits per year; hearing aids limited to 1 every 4 years; eyeglasses limited to 1 every 24 months; chiropractic limited to 12 visits per year. Also added coverage for tobacco cessation services.
Nevada	**Aged and Disabled:** Restricting allowable personal care service hours and eliminating PCS exercise coverage. **All Adults:** Will eliminate coverage for eyeglasses and related supplies.
New Hampshire	

State	Benefit Change
New Jersey	
New Mexico	**Aged and Disabled:** Added coverage for Intensive Outpatient services for substance abuse and removed restrictions on limited substance abuse treatment.
New York	**All**: Expanded mental health counseling in medical settings and asthma and diabetes education. **Expansion Adults**: Family Health Plus buy-in for union benefit funds and employers.
North Carolina	**All Adults**: Medical outpatient visit limits increased from 24 to 30.
North Dakota	
Ohio	**All Adults**: Restored dental benefits.
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	**Adults**: Limiting scope of benefits for home health and private duty nursing.
Texas	**All**: Bariatric Surgery for adults and children added as a Medicaid benefit on July 1, 2008. Clients 21 years and older must have a BMI greater than or equal to 35 kg. Clients under 21 years of age must have a BMI greater than or equal to 40kg. For a child to qualify, they must be at least 13 years of age and menstruating for girls and at least 15 years of age for boys that have reached a Tanner stage IV of physical development plus 95% of adult height based on bone age.
Utah	
Vermont	**All Adults:** Coverage for chiropractic services reinstated.
Virginia	**All**: Implementation of prior authorization for mental health services.
Washington	
West Virginia	
Wisconsin	**Expansion Adults**: Coverage expansion to childless adults provides a limited benefit package of basic health care services ("BadgerCare Plus Core Plan") including primary and preventative care plus generic drugs. With certain exceptions, an annual enrollment fee will apply in lieu of premiums. In addition, copays for services and drugs will apply. Also, employers can purchase additional coverage (called "Core Plus") for limited vision, dental, chiropractic, and outpatient mental health and substance abuse services.
Wyoming	

Appendix A-5: DRA Options

States	LTC Partnership Program (a)	PRTF Demo Grants (b)	Money Follows the Person (b)	HCBS State Plan Option	Self-Directed Personal Assistance Services	Family Opportunity Act	Medicaid Transformation Grants (b)	HOA Demo Grants	Benefit Changes	Cost Sharing Flexibility/ Co-Pay Enforceability
Alabama	X				X		X			
Alaska		X								
Arizona	X						X			
Arkansas	X		X		X		X			
California	X		X							
Colorado	X			X	X					
Connecticut	X		X	X	X		X			
Delaware			X				X			X
Columbia	X		X				X			
Florida	X	X					X			
Georgia	X	X	X				X			
Hawaii			X				X			
Idaho	X								X	
Illinois	X		X			X	X			
Indiana	X	X	X				X			
Iowa	X		X	X		X				
Kansas	X	X	X				X		X	
Kentucky	X		X		X		X		X	X
Louisiana	X		X		X	X				
Maine	X									X
Maryland	X	X	X				X			X
Massachusetts							X			
Michigan	X		X				X			
Minnesota	X				X		X			X
Mississippi		X					X			
Missouri	X		X				X			
Montana	X	X					X			
Nebraska	X		X							
Nevada	X			X			X			X
New Hampshire			X							
New Jersey	X		X				X			
New Mexico							X			
New York	X		X							
North Carolina	X		X				X			
North Dakota	X		X			X	X			
Ohio	X		X				X			
Oklahoma	X		X				X			
Oregon	X		X		X		X			X
Pennsylvania	X		X				X			X
Rhode Island	X						X			
South Carolina		X	X					X	X	
South Dakota	X									
Tennessee							X			
Texas	X		X	X			X			
Utah							X			
Vermont										
Virginia	X	X	X						X	
Washington			X				X		X	
West Virginia							X		X	
Wisconsin	X		X		X		X		X	X
Wyoming	X									
Total	**38**	**10**	**31**	**5**	**9**	**4**	**36**	**1**	**8**	**9**

(a) California, Connecticut, Indiana and New York had LTC Partneship model programs in place prior to the DRA.
(b) SOURCE: CMS. PRFT: http://www.cms.hhs.gov/DeficitReductionAct/20_PRTF.asp#TopOfPage
MFP: http://www.cms.hhs.gov/DeficitReductionAct/20_MFP.asp#TopOfPage
Transformation Grant: http://www.cms.hhs.gov/MedicaidTransGrants/ (Puerto Rico also received a Round 2 grant award.)

Appendix A-6a: Pharmacy Cost Containment Actions in Place in the 50 States and District of Columbia in FY 2008

States	Preferred Drug List	Prior Authorization Program	Supplemental Rebates	Multi-State Purchasing Coalition	Script Limits	State MAC Progam
Alabama	X	X	X		X	X
Alaska	X	X	X	X		
Arizona						
Arkansas	X	X	X		X	X
California	X	X	X		X	X
Colorado		X			X	X
Connecticut	X	X	X			X
Delaware	X	X	X	X	X	X
District of Columbia		X				
Florida	X	X	X			X
Georgia	X	X	X	X		X
Hawaii	X	X	X	X		X
Idaho	X	X	X	X		X
Illinois	X	X	X		X	X
Indiana	X	X	X			X
Iowa	X	X	X	X		X
Kansas	X	X	X	X	X	X
Kentucky	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X
Maine	X		X	X	X	X
Maryland	X	X	X	X		X
Masschusetts	X	X	X			X
Michigan	X	X	X	X	X	X
Minnesota	X		X	X		X
Mississippi	X		X		X	
Missouri	X	X	X			X
Montana	X	X	X	X		
Nebraska		X				X
Nevada	X	X	X	X		X
New Hampshire	X		X			X
New Jersey						
New Mexico	X		X			X
New York	X	X	X	X		X
North Carolina		X			X	
North Dakota		X				X
Ohio	X	X	X			X
Oklahoma	X	X	X		X	X
Oregon	X		X			X
Pennsylvania	X	X	X	X	X	X
Rhode Island	X	X	X			
South Carolina	X	X	X	X	X	X
South Dakota		X				X
Tennesee	X	X	X	X	X	X
Texas	X	X	X		X	X
Utah		X				X
Vermont	X	X	X	X		X
Virginia	X	X	X			X
Washington	X	X	X			X
West Virginia	X		X	X	X	X
Wisconsin	X	X	X	X		X
Wyoming	X	X				X
Total	**42**	**42**	**41**	**22**	**19**	**43**

Appendix A-6b: Pharmacy Cost Containment Actions Taken in the 50 States and District of Columbia FY 2008 and FY 2009

States	Impose Script Limits		Reduce Disp Fee		Reduce Ingredient Cost		Preferred Drug List		More Drugs/ Prior Auth.		Suplemental Rebates		Multi-State Purchasing Coalition		New/Lower State MAC		Other Actions	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Alabama						X	X	X	X	X	X	X				X		
Alaska							X	X	X	X						X		
Arizona																		
Arkansas																		
California				X		X						X						
Colorado							X	X		X	X	X				X		
Connecticut																	X	
Delaware							X	X	X	X	X	X			X	X		
District of Columbia							X		X		X		X			X		
Florida					X													
Georgia							X	X	X	X	X	X			X	X		
Hawaii																		
Idaho																		
Illinois																		
Indiana							X	X										
Iowa									X	X	X				X	X		
Kansas																		
Kentucky																		X
Louisiana																		
Maine	X											X						
Maryland							X				X							
Massachusetts							X	X	X	X	X	X						
Michigan																		
Minnesota						X	X	X			X	X			X	X		
Mississippi					X		X				X							
Missouri																		
Montana							X	X	X	X								
Nebraska																		
Nevada																		
New Hampshire																		
New Jersey				X		X											X	
New Mexico				X														
New York					X	X	X	X		X							X	X
North Carolina						X			X	X								
North Dakota									X	X					X			
Ohio								X				X						
Oklahoma							X	X	X	X	X	X						
Oregon							X	X							X	X		
Pennsylvania							X	X	X	X	X	X			X	X		X
Rhode Island							X	X	X		X	X	X					
South Carolina		X				X	X	X	X	X	X	X			X	X		
South Dakota									X	X						X		
Tennessee												X						
Texas							X	X	X	X	X	X			X	X		
Utah							X	X	X	X	X	X	X			X		
Vermont																		
Virginia							X	X							X	X		
Washington							X	X	X	X	X	X			X	X		
West Virginia	X																	
Wisconsin							X		X								X	
Wyoming								X			X		X					
Total	**2**	**1**	**0**	**3**	**3**	**7**	**23**	**21**	**19**	**18**	**18**	**17**	**4**	**0**	**11**	**16**	**4**	**3**

Appendix A-7: Medicaid Care Management Taken in the 50 States and District of Columbia FY 2008 and 2009

States	Managed Care Policy Changes: New Service Areas, Populations, Mandatory Groups or LTC		New Disease Management / Case Management Initiatives	
	2008	2009	2008	2009
Alabama			X	X
Alaska				
Arizona				
Arkansas				
California	X	X	X	X
Colorado			X	X
Connecticut		X	X	X
Delaware	X			
District of Columbia	X			X
Florida		X	X	X
Georgia				
Hawaii		X	X	
Idaho				
Illinois	X	X		
Indiana	X	X	X	
Iowa	X		X	
Kansas				
Kentucky				
Louisiana				X
Maine	X	X	X	
Maryland				
Massachusetts				
Michigan		X		
Minnesota	X			
Mississippi				
Missouri	X			
Montana				X
Nebraska				
Nevada				X
New Hampshire				
New Jersey	X	X		
New Mexico		X		
New York	X	X		X
North Carolina		X	X	X
North Dakota			X	
Ohio				
Oklahoma			X	
Oregon	X			X
Pennsylvania				
Rhode Island	X	X		
South Carolina				
South Dakota				X
Tennessee		X		
Texas	X		X	
Utah				
Vermont			X	
Virginia	X	X	X	
Washington		X	X	
West Virginia		X		
Wisconsin	X	X		X
Wyoming				
Total	**16**	**18**	**16**	**14**

Appendix A-8: Medicaid Quality Measures in Place in the 50 States and District of Columbia FY 2008 and 2009

States	Requires or Incentives for Accreditation		Use of HEDIS® or Similar Performance Measures		Use of CAHPS® or Similar Patient Surveys		Pay for Performance for MCOs		Public Reporting of MCO Performance		Electronic Health Records		Electronic Prescribing	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Alabama			X	X		X	X	X	X	X	X	X	X	X
Alaska														X
Arizona			X	X	X	X			X	X		X		X
Arkansas			X	X	X	X	X	X	X	X				X
California			X	X	X	X	X	X	X	X			X	X
Colorado	X	X	X	X	X	X	X	X	X	X				
Connecticut			X	X	X	X		X	X	X				
Delaware			X	X	X	X	X	X	X	X				X
District of Columbia	X	X	X	X	X	X	X	X		X				
Florida	X	X	X	X	X	X			X	X		X	X	X
Georgia	X	X	X	X	X	X	X	X		X				
Hawaii	X	X	X	X	X	X	X	X	X	X		X		
Idaho														
Illinois			X	X	X	X	X	X	X	X		X		X
Indiana		X	X	X	X	X		X	X	X	X	X		
Iowa	X	X	X	X	X	X	X	X	X	X	X	X		
Kansas			X	X	X	X	X	X		X	X	X	X	X
Kentucky			X	X	X	X			X	X				
Louisiana			x	x	X	X	X	X		X		X	X	X
Maine			X	X			X	X	X	X				
Maryland			X	X	X	X	X	X	X	X				
Massachusetts		X	X	X	X	X	X	X	X	X				
Michigan	X	X	X	X	X	X	X	X	X	X			X	X
Minnesota			X	X	X	X	X	X		X				
Mississippi													X	X
Missouri			X	X	X	X	X	X	X	X	X	X	X	X
Montana			X	X										X
Nebraska	X	X	X	X	X	X	X	X		X		X		
Nevada			X	X	X	X	X	X						X
New Hampshire					X	X		X					X	X
New Jersey			X	X	X	X		X	X	X		X		
New Mexico	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New York			X	X	X	X	X	X	X	X		X	X	X
North Carolina			X	X	X	X			X	X	X	X		X
North Dakota														
Ohio			X	X	X	X	X	X	X	X				X
Oklahoma			X	X	X	X	X	X	X	X				X
Oregon			X	X	X	X	X	X	X	X			X	X
Pennsylvania	X	X	X	X	X	X	X	X	X	X				
Rhode Island	X	X	X	X	X	X			X	X	X	X	X	X
South Carolina	X	X	X	X	X	X			X	X	X	X		
South Dakota											X	X		
Tennessee	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Texas			X	X	X	X	X	X	X	X	X	X		
Utah			X	X	X	X	X	X	X	X				
Vermont			X	X	X	X		X						
Virginia	X	X	X	X	X	X			X	X				
Washington			X	X	X	X	X	X	X	X				
West Virginia	X	X	X	X	X	X								
Wisconsin	X	X	X	X	X	X		X	X	X				
Wyoming			X	X	X	X	X	X				X	X	X
Total	**16**	**18**	**45**	**45**	**43**	**44**	**31**	**37**	**34**	**40**	**12**	**21**	**15**	**25**

Appendix A-9: Provider Taxes in Place in the 50 States and District of Columbia FY 2008 and FY 2009

States	Hospitals		ICF/MR-DD		Nursing Facilities		Managed Care Organizations		"Other"		Any Provider Tax	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Alabama					X	X			X	X	X	X
Alaska												
Arizona							X	X			X	X
Arkansas					X	X					X	X
California			X	X	X	X	X	X			X	X
Colorado			X	X		X					X	X
Connecticut					X	X					X	X
Delaware												
District of Columbia				X	X	X					X	X
Florida	X	X									X	X
Georgia					X	X	X	X			X	X
Hawaii												
Idaho		X										X
Illinois	X	X	X	X	X	X					X	X
Indiana			X	X	X	X					X	X
Iowa			X	X							X	X
Kansas	X	X									X	X
Kentucky	X	X	X	X	X	X	X	X	X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X	X	X	X	X			X	X	X	X
Maryland		X	X	X	X	X	X	X			X	X
Massachusetts	X	X	X	X	X	X					X	X
Michigan	X	X			X	X	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X					X	X
Missouri	X	X		X	X	X	X	X		X	X	X
Montana	X	X	X	X	X	X					X	X
Nebraska			X	X							X	X
Nevada					X	X					X	X
New Hampshire	X	X			X	X					X	X
New Jersey			X	X	X	X	X	X			X	X
New Mexico							X	X			X	X
New York	X	X	X	X	X	X			X	X	X	X
North Carolina			X	X	X	X					X	X
North Dakota			X	X							X	X
Ohio	X	X	X	X	X	X	X	X			X	X
Oklahoma					X	X					X	X
Oregon	X	X			X	X	X	X			X	X
Pennsylvania		X	X	X	X	X	X	X			X	X
Rhode Island	X	X	X	X	X	X					X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X							X	X
Tennessee			X	X	X	X	X	X			X	X
Texas			X	X			X	X			X	X
Utah			X	X	X	X					X	X
Vermont	X	X	X	X	X	X			X	X	X	X
Virginia												
Washington												
West Virginia	X	X	X	X	X	X			X	X	X	X
Wisconsin			X	X	X	X					X	X
Wyoming												
Total	19	22	29	31	33	34	15	15	9	10	44	45

*Kentucky, Maine, Minnesota, Vermont, and West Virginia all reported multiple "other" provider tax in both 2008 and 2009

Appendix B: Profiles of Selected State Medicaid Policy Changes:

- **Florida**
- **Michigan**
- **New Mexico**

Profile of Medicaid Policy Changes: Florida

Florida continues to struggle with a severe state budget crisis that began in FY 2007. The state has been particularly hard hit by the deterioration in the housing market and resulting losses in property values estimated at over $150 billion between 2007 and 2008. Worsening job losses and higher energy prices have also combined to undermine consumer and business spending. This, in turn, has lead to declining sales tax collections creating serious challenges for a state that does not impose a personal income tax and relies instead on sales taxes for almost three-quarters of its general fund revenues.

When the Florida legislature convened in early 2008 to write the FY 2009 state budget, they had only recently concluded a special session convened in October 2007 to reduce the FY 2008 budget by $1.1 billion. In March 2008, the legislature trimmed another $500 million from the FY 2008 budget and in May passed a $66 billion FY 2009 budget that was $4 billion lower than the *reduced* FY 2008 budget. Although the new budget relied somewhat on reserves, it still included funding cuts for nearly all state government functions including K-12 education, universities, health care and other social programs, prosecutors, public defenders, probation officers and environmental protection. Despite the widespread cuts, a few areas saw increases including higher funding to:

- enroll an additional 38,000 children in KidCare (Florida's SCHIP program);
- expand the Nursing Home Diversion program to 4,000 more seniors;
- fund repairs to senior centers, county health departments and domestic violence shelters;
- add 10,000 new prison beds;
- continue the Everglades restoration project; and
- enhance economic development efforts.

At the urging of Governor Crist, the Legislature also passed legislation creating the "Cover Florida Health Access" program to provide more health insurance coverage options to Florida's citizens. The program allows insurers to offer a variety of plans that are exempt from the mandated benefits that apply to conventional insurance coverage. It is intended that the products will provide limited benefits (some plans will not cover hospital care) designed to cost $150 per month or less and will be available to Floridians, regardless of income, who have been without insurance for at least six months. Cover Florida plans will not be considered to be insurance but are subject to oversight by the Florida Agency for Health Care Administration and the Office of Insurance Regulation. Also, Cover Florida plans may be required to demonstrate financial soundness, but will not be covered by an insurance or HMO guaranty association in the case of insolvency.

When the Florida Legislature passed the new budget for FY 2009 in May 2008, state revenue collections were already falling short of the reduced estimates prepared in March. Fearing the possibility of further deterioration in state revenues and wanting to avoid the need for another special legislative session, the Legislature authorized the Governor to tap into two reserve funds to cover any budget deficit in FY 2009: up to $1 billion from the Lawton Chiles Endowment — a health care fund created from the state's tobacco company settlement — and half of the funds in the Budget Stabilization Fund — about $600 million. The Governor also took action in June to hedge against a future deficit by ordering state agencies to hold back 4 percent of their FY 2009 budgets every month to save an estimated $1 billion.

On August 15, 2008, the Revenue Estimating Conference released the updated General Revenue forecast for FY 2009 which predicted that revenues would be $1.8 billion lower than predicted in the March 2008 forecast used to create the FY 2009 budget. According to the August 15th update, General Revenues are expected to decline for the third straight year in FY 2009, falling short of FY 2008 collections by $740 million, or 3.1 percent. This follows decreases of 8.7 percent in FY 2008 over FY 2007 and 2.5 percent in FY 2007 over FY 2006. While revenue growth is expected to return in FY 2010, the long term forecast predicts that state General Revenue collections are not likely to exceed FY 2006 levels until FY 2012. On September 10, 2008, the Florida Legislative Budget Commission unanimously approved Governor Crist's request to use $672 million in reserves from the budget stabilization fund to cover a portion of the projected FY 2009 deficit. The panel also agreed with the Governor to delay further action on the remaining $795 million shortfall until after the updated November state revenue forecast is released.

In addition to the measures described above, Florida has implemented, or planned to implement at the time of the survey, the Medicaid policy changes noted below.

Provider Rates:

- In FY 2008, increased rates for inpatient hospital services, nursing facilities and managed care organizations and decreased rates for outpatient hospital services.
- In FY 2009, the state will[42]:
  - reduce projected nursing home and hospice expenditures by 6.5%; (note: normal rate setting achieved rates low enough to meet this goal without further reductions);
  - reduce projected hospital inpatient expenditures by 7.5%;
  - reduce projected hospital outpatient expenditures by 7.3%;
  - reduce projected expenditures for Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) by 2.5%;
  - reduce capitated managed care rates by an average of 3%;
  - reduce fees to primary care case managers from $3 per member per month to $2 per member per month;
  - reduce the projected Medicaid county health department expenditures by 6.5%;
  - reduce Medicaid prepaid mental health plan expenditures by 4%;
  - reduce projected non-emergency transportation expenditures by 4%, and
  - reduce freestanding dialysis center rates from $125 per visit to $95 per visit.

Eligibility Changes:

- In FY 2009, the state will:
  - extend eligibility to youth up to age 21 who leave the adoption subsidy program at age 18 and meet certain other criteria, and
  - clarify state's residency criteria to allow coverage of non-citizens with temporary visas. (Individuals residing in-state on a temporary visa will only potentially be eligible for Emergency Medical Assistance, but their U.S. citizen children will be eligible for "regular" Medicaid.)

[42] Health and Human Services Appropriations Committee Conference Report, Fiscal Year 2008-2009, Florida State Senate, accessed at http://edr.state.fl.us/conferences/medicaid/medsession.pdf and Health and Human Services Appropriations Committee Conference Report, Fiscal Year 2008-2009, Florida State Senate, accessed at http://edr.state.fl.us/conferences/medicaid/medsession.pdf with specific appropriation detail at: http://www.myfloridahouse.gov/FileStores/Adhoc/Appropriations/gaa/2008-House/bill/pdf/confreprt08.pdf

Benefit/Service Changes:
▪ In FY 2009, the state will: o impose utilization controls on therapy services by contracting with two prepaid therapy service vendors using waiver authority, and o establish a prior authorization process for elective cesarean sections.
Prescription Drug Controls and Limits:
• In FY 2008, reduced ingredient cost reimbursement to AWP minus 16.4% and WAC plus 4.75%.
Long Term Care Policy Changes:
• In FY 2008: o imposed service and utilization controls on the waiver serving persons with developmental disabilities; o added 1,000 waiver slots to the nursing home diversion waiver; o added a new PACE site, and o eliminated nursing facility cross-over payments where Medicare payment equals or exceeds what Medicaid would have paid. • In FY 2009, the state will: o add 4,000 slots to the nursing home diversion waiver and 50 additional slots for existing PACE providers in two counties and one PACE provider in an additional county; and o begin paying Medicare cross-over claims for private institutions for mental disease. (Previously, cross-over claims paid only for state IMDs.).
Managed Care Policy Changes:
• In FY 2008, implemented a statewide Hemophilia disease management program. • In FY 2009, the state will: o implement Florida Senior Care (an integrated acute and long term care managed care program) pilot in one region, and o will change MediPass reenrollment policy to require beneficiaries to affirmatively choose MediPass (a PCCM program) during the 60-day open enrollment period or else be assigned to a managed care organization.
Other Quality and Program Improvement Initiatives
• In FY 2009, the state will: o implement an Electronic Health Record as part of the state's new Medicaid Management Information System, and o eliminate payment for preventable hospital errors (based on Medicare program standards). o In FY 2008, the state's Section 1115 Medicaid Reform waiver was expanded beyond the original two pilot counties (Broward and Dade) to three additional counties (Baker, Clay and Nassau). Further expansion is on hold pending results of evaluation efforts currently underway and pending receipt of additional legislative authorization to expand.

Profile of Medicaid Policy Changes: Michigan

By many measures Michigan has the worst economic situation of any of the 50 states. With a shift from away from a manufacturing-based economy, the state continues to suffer through a time of high unemployment and job loss. In recent years the Michigan unemployment rate has often been the highest in the country, as it was in August 2008 at 8.9 percent (seasonally adjusted) compared to a national average of 6.1 percent.[43] Manufacturing job loss including the auto industry has been particularly acute, with such jobs down by over one-third just in the past nine years.[44] Reflecting the loss of manufacturing jobs, Michigan ranked 50th among all states in personal income growth.

The non-partisan Citizens Research Council of Michigan summarized the fiscal situation in this way:

> "For seven years, Michigan has endured its worst financial crisis in more than 50 years. Cyclical and structural pressures have combined to produce both deteriorating revenue performance and escalating spending pressures. Although the State has successfully balanced budgets in each fiscal year, this has been accomplished by the use of reserves and through actions designed to minimize spending cuts. The fundamental issue of matching available on-going revenues with spending remains only partly addressed".[45]

Michigan has had to make substantial cuts in funding for higher education and revenue sharing with local government. It reduced the number of state employees by more than 15 percent since 2001. K-12 education spending growth was less than one percent over a six period, causing many school districts to make programmatic cuts.

Throughout this period, the Michigan Medicaid program was largely spared from cuts incurred in other parts of state government. Medicaid did make one across-the-board cut in provider rates, but did not change eligibility with the exception of an asset test for caretaker relatives, and made only a few minor benefit cuts that were all restored.

By the beginning of FY 2008, the state faced a projected budget deficit of $1.8 billion and revenue increases were unavoidable. The state first increased the personal income tax for 2007 from 3.9 percent to 4.35 percent (a rate still lower than the 6.35 percent rate two decades earlier.) A new Michigan Business Tax (MBT) replaced the Single Business Tax (SBT). A new 6 percent tax on services, parallel to the 6 percent sales tax, was enacted for implementation on January 1, 2008 but there were so many issues that it was almost immediately repealed and replaced with a 10 year surcharge on the Michigan Business Tax. These new revenues provided a balanced budget through FY 2009 without additional program reductions.

In spite of its difficult economic situation, Michigan has a high rate of health insurance coverage – ranking 10th best of states. Only 10.4 percent of Michigan residents were uninsured, fully one-third below the national average of 15.9 percent for 2005 and 2006.46 Michigan's story is even better for children. Michigan ranks 1st of among all states with only 5.3 percent of children uninsured versus a

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[43] Source: Bureau of Labor Statistics report on September 17, 2008.
[44] Source: Bureau of Labor Statistics.
[45] "Michigan's Fiscal Future", CRC Memorandum No. 1086, Citizen Research Council of Michigan, May 2008.
[46] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

national average of 12.1 percent for 2005 and 2006.[47] Michigan's heritage of employer-sponsored health insurance for dependents has been retained even in the most challenging of economic times.

The number of persons enrolled in Michigan Medicaid increased from 1.1 million in early 2000 to over 1.5 million in July 2008, an increase of nearly 45 percent over eight years. (Excluded are an additional 30,000 enrolled in a family planning waiver, PlanFirst!) Michigan's low rate of uninsured children and adults reflects both the economic situation and also specific efforts to make enrollment in Medicaid as simple as possible, including streamlined application forms and an option to use an electronic application process.

Given the growing Medicaid population and declining state revenues, it is noteworthy that Michigan's Medicaid program has been spared from major reductions. Some cuts have been considered but not adopted, such as elimination of coverage for 19 and 20 year-olds and for caretaker relatives. Minor benefit cuts were made but all were restored by FY 2007. Provider rates were cut across the board by 4 percent in 2004. Medicaid increased provider rates for hospitals, nursing facilities and HMOs in 2008 and 2009, but the 4 percent provider payment rate cuts in 2004 are not yet fully restored for other providers. The financing for these rate increases has depended primarily on provider taxes. For FY 2009 Michigan will be taxing hospitals, nursing facilities, HMOs and capitated behavioral health plans a total of nearly $1.1 billion.

In 2006 Governor Granholm proposed an extensive Medicaid waiver - Michigan First Health Care. As a result of dialogue with the federal government over the past two years, the waiver proposal has been significantly modified, but no agreement has been reached. The state no longer expects a positive response by the current administration. Michigan implemented its Adult Benefits Waiver five years ago, using unspent SCHIP funds to provide limited benefits to up to 62,000 adults without children. This waiver expires on January 31, 2009 so plans are underway for its renewal.

Provider Rates:

• In FY 2008:
  o Hospitals received rate increases funded by provider taxes. Nursing Facilities received rate increases based on cost trends.
  o HMOs received a rate increase required for actuarial soundness.
• In FY 2009:
  o Hospitals will receive rate increases funded by provider taxes.
  o Nursing Facilities will receive rate increases based on cost trends.
  o HMOs will receive a rate increase required for actuarial soundness.
  o Fees for preventive medicine visits and specific newborn care codes will be increased by 7.942% effective October 1, 2008.
  o Pharmacy dispensing fees are being increased by $0.25 for FY 2009. (LTC to $3 and non-LTC to $2.75.)

Eligibility Changes:
• In FY 2008 & FY 2009: Eligibility standards were not changed in Michigan.
Application/Renewal changes:
• In FY 2008: Application & Renewal forms were simplified.

[47] Ibid.

Benefit and Cost-Sharing Changes:

- In FY 2008: Eliminated Medicaid school-based services for individuals ages 21 to 26.

Long-Term Care Changes:

- In FY 2008:
    - MI Choice (HCBS waiver) slots were expanded due to the impact of the nursing facility transition program. Community Living Supports was added to the waiver service package and Participant Directed Care was implemented statewide.
    - Four Single Point of Entry pilot programs began providing Options Counseling and performing long-term care level of care determinations.
- In FY 2009:
    - Two new PACE sites are being implemented.
    - The state has submitted a traumatic brain injury (TBI) waiver application.
    - Michigan is also exploring a managed long-term care pilot initiative.

Prescription Drug Controls:

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

Managed Care Changes:

- In FY 2009:
    - Pregnant women will become a mandatory managed care population as of October 1, 2008.
    - Foster care children will become mandatory managed care population. The state is targeting implementation for April 1, 2009.

Other Quality and Program Improvement Initiatives

- In FY 2008:
    - Michigan implemented developmental screening in young children 0-3 (MI is one of the 18 states in NASHP Screening Academy).
    - Began an e-prescribing initiative.
- In FY 2009 Michigan will be re-procuring its managed care plans for FY 2010. State officials indicate that they will pick plans on the basis of quality and financial solvency.

Profile of Medicaid Policy Changes: New Mexico

Although growth has slowed since reaching its peak in 2006, New Mexico's economy is relatively strong compared with other states. While the state has not been immune from the negative economic forces impacting other areas of the country, resulting weaknesses in some state revenue sources (e.g. personal and corporate income taxes), have been more than offset by strong growth in taxes from crude oil and natural gas production.

At the beginning of the 30-day legislative session that began in January 2008, Governor Bill Richardson proposed legislation that would continue to build on previous efforts to expand healthcare coverage to the uninsured. Previous accomplishments included:

- implementation of the State Coverage Insurance (SCI) program in FY 2006 (an SCHIP waiver funded health care coverage expansion for parents and childless adults working for small employers in households with incomes at or below 200 percent FPL);
- increased Medicaid coverage for pregnant women and children aged 0-5 (using income disregards) to 235% FPL in FY 2007;
- establishment of a state-funded premium assistance program for children and pregnant women, whose family income is too high to qualify for Medicaid but do not have access to affordable coverage in FY 2007; and
- elimination of the SCI premium requirement for parents and childless adults up to 100 percent of the FPL in FY 2008.

Governor Richardson's 2008 health care reform proposal, the "HealthSOLUTIONS New Mexico Plan," called for universal health insurance by 2010 with individual and employer participation mandates. Specific components of the plan would have increased Medicaid coverage to 300 percent of the FPL, created new publicly supported coverage and assistance options, required major reforms within the commercial insurance industry, and created a single point of authority for the consolidation of all public sector programs and products.

Legislators, however, failed to pass the plan expressing concern that the HealthSOLUTIONS agenda was too ambitious for a short session and that there had been inadequate public deliberation of the issues. Richardson expressed his disappointment in part through extensive use of his line-item budget veto authority and in a very public late-session stand-off over a major capital outlay package. Calling the session the least productive since he took office, Richardson promised to call a special session to specifically address health care reform.

A special legislative session convened August 15, 2008 to consider health care reform and a number of other issues amidst apprehension over the unpredictability of state gas and oil tax revenues: a tax windfall from high oil and gas prices projected earlier in the summer had dwindled in more recent estimates from $400 million to just over $200 million. When the special session adjourned on August 19, 2008, legislators had passed a scaled back version of the Governor's health care agenda for children. The legislature rejected a proposed requirement that would have mandated health insurance coverage for all children and approved only $20 million of the $58 million requested to enroll more children in Medicaid and SCHIP. The legislature also appropriated $10 million to treat developmentally disabled children and $2.5 million for mental health services. Other significant measures passed included:

- a one-time tax rebate totaling $56 million to low- and middle-income taxpayers with adjusted gross incomes of $70,000 or less;
- funding for highway projects that were approved five years ago but stalled due to cost concerns totaling $200 million;
- a permanent increase in a tax credit for working class families totaling $7.6 million;
- $1.9 million to help pay heating and cooling costs for low-income citizens, and
- a $7.2 million child care assistance program.

During the earlier regular session, a small number of health care-related bills were also passed including the creation of a commission to address health issues of Native Americans in New Mexico, particularly those living off-reservations, as well as authority for a Healthy New Mexico Task Force to outline a five-year strategic plan for chronic disease prevention and management.

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

Provider Rates:

• In FY 2008, provider rates increased for nursing homes, inpatient hospital services physicians and dentists. In particular:
  ° Dental provider rates were increased by 10%, retroactive to July 1, 2007 and provider billing processes were improved to include electronic billing.
  ° Personal Care Option provider rates for consumer directed and consumer delegated care were increased by 1%, retroactive to July 1, 2007.
  ° A rate increase of less than 1% was made in the Salud! managed care contract.

Eligibility Changes:
• In FY 2008:   ° To facilitate enrollment, eligibility for Newborn Medicaid was expanded to infants born to mothers participating in the Emergency Medical Service for Undocumented Aliens program.
Benefit/Services Changes:

• In FY 2008:
  o Coverage added for telehealth services, including videoconferencing, internet, and store-and-forward imaging technology.
  o Coverage added coverage for Multisystemic Therapy and Comprehensive Community Support Services (mental health) for all non-pregnant adults and children.
• In FY2009:
  ° Will add coverage for intensive outpatient services for substance abuse and remove restrictions on limited substance abuse treatment for adults.

Long-Term Care Changes:

• In FY 2009:
  o Began phasing in the Coordinated Long-Term Services (CLTS) program to provide primary, acute and long-term Medicaid and Medicare services under a single integrated managed care program under a 1915(b) and 1915(c) waiver.
  o Will expand the developmental disabilities HCBS waiver program to serve an additional 430 people.

Prescription Drug Changes:
• Plan to reduce dispensing fees in FY 2009.
Other Actions in FY2008 and FY2009:
• In FY 2008: o Implemented re-certifications by phone, fax, on-line or e-mail for low-income families and children. No face-to-face required unless there is an unresolved situation. o Expanded the Pay for Performance initiative to include specific incentives for providers in order to increase child immunization rates. o Implemented an Electronic Health Record (EHR) initiative to connect clinicians treating Medicaid patients through a secure web portal that will display test results, diagnoses and dates of care. o Implemented an E-prescribing initiative to help reduce the possibility of errors related to the provision of prescription drugs to Medicaid beneficiaries. • In FY 2009: o Medicaid's current managed care program, Salud! and the State Coverage Insurance (SCI) program were combined under an integrated managed care umbrella, both for physical health services and separately for behavioral health services. o A Healthy New Mexico Task Force was established to devise a 5-year strategic plan for disease prevention and chronic disease management measures for public and private health care programs.

Appendix C: Survey Instrument

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2007, 2008 AND 2009

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
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1. Medicaid Expenditure Growth: State Fiscal Years 2007, 2008 and 2009

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

Fiscal Year (generally, July 1 to June 30)	Percent Change for Each Fund Source			
	State	Local or Other	Federal	All Fund Sources
FY ending in 2007 (FY 2007) 1. Percentage change: FY 2007 Medicaid Expenditures over FY 2006 Expenditures	%	%	%	%
FY ending in 2008 (FY 2008) 2. Percentage Change: Estimated FY 2008 Medicaid Expenditures over FY 2007 Expenditures	%	%	%	%
FY ending in 2009 (FY 2009) 3. Estimated Percentage Change: FY 2009 Medicaid Appropriations over FY 2008 Expenditures	%	%	%	%

Comments: ______________

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

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

	State	Total
FY 2007	%	%
FY 2008	%	%
FY 2009	%	%

d. Did FY 2008 spending exceed the *original* appropriation? ☐ Yes ☐ No

e. Has your legislature enacted the Medicaid budget for FY 2009? ☐ Yes ☐ No

f. Potential FY 2009 Medicaid Budget Shortfall: When you look now at the amount appropriated (or that you expect to be appropriated) for FY 2009 for Medicaid, how likely would you say it is that your state will experience a Medicaid budget shortfall in FY 2009 (check one)?

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

2. **Factors Driving Expenditure Changes:** What would you consider to have been *the most significant factors* contributing to increases or decreases in your Medicaid spending in FY 2008 and what factors do you expect to be the principal drivers in FY 2009 (e.g., enrollment, healthcare inflation, utilization, etc.)?

	FY 2008	FY 2009
a. Most significant factor that is an **upward** pressure on spending?		
b. Other significant factors that are **upward** pressures on spending?		
c. Most significant factor that is a **downward** pressure on spending?		
d. Other significant factors that are **downward** pressures on spending?		

3. **Medicaid Enrollment Changes**:

a. Overall % enrollment growth/decline (+/–), FY 2008 over FY 2007: ______%

b. Overall % enrollment growth/decline (+/–), projected for FY 2009 over FY 2008: ______%

c. What do you believe are the *key factors or pressures* that contributed to increases or decreases in enrollment in FY 2008, and will do so in FY 2009 (e.g., changes in eligibility or other policies, application or redetermination processes, the economy, etc.)?

	FY 2008	FY 2009
i. Most significant factor that is an **upward** pressure on enrollment?		
ii. Other **upward** pressures on enrollment?		
iii. Most significant **downward** pressure on enrollment?		
iv. Other **downward** pressures on enrollment?		

4. **Provider Payment Rate Changes**: Compared to the prior year, please indicate by provider type below any rate increases (including COLA or inflationary increases) or decreases implemented in FY 2008 or to be implemented in FY 2009 ("+" for an increase, " – " for a decrease and "0" for no change). Optional: if available, please indicate actual percentage change as well.

Provider Type	FY 2008	FY 2009
a. Inpatient hospital		
b. Outpatient hospital		
c. Doctors		
d. Dentists		
e. Managed care organizations		
f. Nursing homes		

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

5. **Access to Providers:**

   a. On a scale of 1 to 5 with 1 meaning "significant problems with access" and 5 meaning "excellent access," how would you describe Medicaid enrollee access to the following provider groups in your state over the past year?

	1 Significant problems	2 Some problems	3 Very few problems	4 Good Access	5 Excellent Access
i. Primary care physicians *(pick one):*	☐	☐	☐	☐	☐
ii. Specialty physicians *(pick one):*	☐	☐	☐	☐	☐
iii. Dentists *(pick one):*	☐	☐	☐	☐	☐

   b. Please indicate below whether access improved, got worse or stayed about the same over the past year for each of the provider groups listed below.

	Improved	Got worse	Stayed about the same
i. Primary care physicians *(pick one):*	☐	☐	☐
ii. Specialty physicians *(pick one):*	☐	☐	☐
iii. Dentists *(pick one):*	☐	☐	☐

Comments: ______________________________

6. **Provider Taxes/Assessments**: Please list any provider taxes and indicate for each if it was or will be new in FY 2008 or 2009, or if changes were made or will be made in FY 2008 or 2009.

Provider Group Subject to Tax	In place in FY 2007?	New in:		Discont'd in:		Increased, Decreased or No Change (+, -, or 0) in:		'08 Change Federally Mandated?
		FY 08?	FY'09?	FY '08?	FY '09?	In FY '08?	In FY '09?	
a. Hospitals	☐	☐	☐	☐	☐			☐
b. ICF/MR-DD	☐	☐	☐	☐	☐			☐
c. Nursing Facilities	☐	☐	☐	☐	☐			☐
d. Managed Care Organizations	☐	☐	☐	☐	☐			☐
e. Other:	☐	☐	☐	☐	☐			☐
f. Other:	☐	☐	☐	☐	☐			☐

7. **Changes in Application/ Renewal Process:**

   a. Please describe any changes to the ***application or renewal process*** (e.g., changes in forms, verification or face to face interview requirements, frequency of redeterminations or renewals, etc.) and indicate whether the changes were required by the DRA

In FY 2008:	
In FY 2009:	

   b. In FY 2008 did implementation of the DRA citizenship and identity documentation requirements have any of the following impacts in your state? *Check all that apply and for each checked item indicate whether the impact was small/minimal, moderate or significant*:

√	Impacts in FY 2008	Small or minimal impact	Moderate impact	Significant impact
☐	i. Increased the time needed to determine eligibility	☐	☐	☐
☐	ii. Increased backlog of applications to be processed	☐	☐	☐
☐	iii. Required additional staff	☐	☐	☐
☐	iv. Increased the number of applications or redeterminations denied due to failure to provide required documentation	☐	☐	☐
☐	v. Reduced the number of individuals applying for Medicaid	☐	☐	☐
☐	vi. Other (please specify)	☐	☐	☐

   c. Do you expect the impact in FY 2009 to: ☐ Increase, ☐ Ease, or ☐ Be about the same?

   Comments on application and renewal process changes and impacts: ______________________

8. **Changes in Medicaid Eligibility Standards:** Please describe any change in *eligibility standards*[1] (e.g. expansion, reduction, restriction or restoration) implemented during FY 2008 or to be implemented in FY 2009. (Do not include SCHIP funded changes or DRA mandated changes related to long term care eligibility.)

Eligibility Category	Fiscal Year	Nature of Eligibility Change*	Effective Date	Est. Number of People Affected	By Waiver Authority?
a. Children	'08				☐
	'09				☐
b. Parents/ Pregnant Women	'08				☐
	'09				☐
c. Aged/ Disabled (incl. duals)	'08				☐
	'09				☐
d. Medically Needy	'08				☐
	'09				☐
e. Adults Without Children	'08				☐
	'09				☐
f. Other:	'08				☐
	'09				☐

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

9. **Changes in Benefits:** Please describe below any expansion, reduction, restriction, restoration or other change in benefits or services *implemented* during FY 2008 or to be implemented in FY 2009.

Populations Affected	Fiscal Year	Nature of Benefit Change	Effective Date	By DRA Authority?	By Waiver Authority?
a. Children	'08			☐	☐
	'09			☐	☐
b. Parents/ Pregnant Women	'08			☐	☐
	'09			☐	☐
c. Aged/ Disabled (incl. duals)	'08			☐	☐
	'09			☐	☐
d. Medically Needy	'08			☐	☐
	'09			☐	☐
e. Adults Without Children	'08			☐	☐
	'09			☐	☐
f. Other:	'08			☐	☐
	'09			☐	☐

10. Changes in Cost Sharing:

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

b. Are copayments enforceable for any eligibility group as allowed by the DRA (*check one)*?
☐ Yes ☐ No ☐ Plan to implement in FY 2009 ☐ N/A

c. Please describe any *changes* in beneficiary cost sharing in FY 2008 and FY 2009 and indicate whether the cost sharing was *newly implemented, increased* or *decreased*.

Populations Affected	Fiscal Year	New, Higher or Lower Copays by Service (e.g., for drugs, ER, inpatient hospital, etc.)	By DRA Authority?	By Waiver Authority?
i. Children	'08		☐	☐
	'09		☐	☐
ii. Parents/ Pregnant Women	'08		☐	☐
	'09		☐	☐
iii. Aged/ Disabled (incl. duals)	'08		☐	☐
	'09		☐	☐
iv. Medically Needy	'08		☐	☐
	'09		☐	☐
v. Adults without Children	'08		☐	☐
	'09		☐	☐
vi. Other:	'08		☐	☐
	'09		☐	☐

11. Premiums: Please list any Medicaid eligibility group subject to a premium requirement and whether changes were made in FY 2008 or will be made in FY 2009.

Eligibility Group Subject to a Premium Requirement	In Place in FY 2007?	New, Increased, Decreased, Eliminated or No Change (New,+, -, Elim., or 0)		By DRA Authority?	By Waiver Authority?
		FY '08?	FY '09?		
a.	☐			☐	☐
b.	☐			☐	☐
c.	☐			☐	☐
d.	☐			☐	☐

12. DRA Long Term Care Changes:

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

	In Place in FY 2007		New in FY 2008		New in FY 2009	
i. Long Term Care Partnership Program	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
ii. HCBS State Plan Option	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
iii. Self-Directed Personal Assistance Service Options (Cash & Counseling)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

b. How would you describe the impacts of the mandatory DRA long term care eligibility changes (e.g., to asset transfer rules, treatment of home equity, application of penalty periods, etc.) on Medicaid costs or on Medicaid beneficiaries? ____

13. Long Term Care Changes: Briefly identify long term care reductions, restrictions or expansions implemented during FY 2008 or that will be implemented in FY 2009. (*Exclude* rate and tax changes reported under questions 4 and 6). Where applicable, indicate if the change was made possible by the DRA.

Program or Policy Actions	Actions Implemented in FY 2008	Actions to be implemented in FY 2009
a. Community service[1] restrictions		
b. Community service[1] expansions		
c. Institutional[2] reductions		
d. Institutional[2] expansions/ increases		
e. Other:		

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

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

14. Prescription Drug Policy Changes: What new prescription drug policies were *implemented* during FY 2008 or will be implemented for FY 2009? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented During FY 2008	Actions to be Implemented in FY 2009	Was policy in place at the end of FY 2007? (check all that apply)
a. Change in dispensing fees (indicate "+" or "-")			
b. Change in ingredient cost (indicate "+" or "-")			
c. Preferred Drug List (PDL) i. newly implemented? ii. enhanced? iii. eliminated or reduced?			☐
d. Prior authorization w/out PDL i. newly implemented? ii. enhanced? iii. eliminated or reduced?			☐
e. Supplemental rebates i. newly implemented? ii. enhanced? iii. eliminated or reduced?			☐
f. Joined a multi-state purchasing coalition?			☐
g. Limits on number of Rx per month i. adopted or increased? ii. reduced or lifted?			☐
h. State MAC program i. newly implemented? ii. enhanced? iii. eliminated or reduced?			☐
i. Other:			

Comments: ____________________

15. Behavioral Health

a. On a scale of 1 to 5 with 1 meaning a "small or non-issue" and 5 meaning a "significant concern," how would you describe the following Medicaid behavioral health issues in your state? *(Check one answer per row.)*

	Small or non-issue 1	2	3	4	Major concern 5	Don't know
i. Budget concerns	☐	☐	☐	☐	☐	☐
ii. Inter-agency coordination	☐	☐	☐	☐	☐	☐
iii. Behavioral health drug utilization	☐	☐	☐	☐	☐	☐

iv. Behavioral health drug utilization	☐	☐	☐	☐	☐	☐
v. Inpatient psychiatric hospital utilization	☐	☐	☐	☐	☐	☐
vi. Emergency room utilization	☐	☐	☐	☐	☐	☐
vii. Proposed federal regulations regarding targeted case management and rehabilitative services	☐	☐	☐	☐	☐	☐
viii. Other (please specify) _____	☐	☐	☐	☐	☐	☐

b. Did your state restrict Medicaid mental health services as a result of federal oversight actions in FY 2008 or do you anticipate doing so in FY 2009?
☐ Yes, in FY 2008 ☐ Yes, in FY 2009 ☐ No ☐ Don't know

Comments: ____

16. Quality Initiatives:

a. For each of the quality and health information technology (HIT) initiatives listed below, please indicate (with an "X" in the appropriate column) whether the measure was already in place in FY 2007, was newly implemented in FY 2008 or FY 2009, or was not in place or planned to be in place in your Medicaid program during the FY 2007 – FY 2009 period:

Quality and HIT Initiatives	In place in FY 2007	New in FY 2008	New in FY 2009	Not in place FY07-09	Not appli-cable
i. Require health plans to be NCQA accredited?	☐	☐	☐	☐	☐
ii. Use HEDIS (or similar) measures?	☐	☐	☐	☐	
iii. Conduct CAHPS (or similar) consumer surveys?	☐	☐	☐	☐	
iv. Report Provider performance (e.g. web-based report cards, reports, etc.) for acute or primary care quality measures? (*Do not include long term care reporting)*	☐	☐	☐	☐	
v. E-prescribing initiative?	☐	☐	☐	☐	
vi. Electronic health record (EHR)?	☐	☐	☐	☐	
vii. Pay for performance (P4P) initiative?	☐	☐	☐	☐	
A. If P4P in place in FY '08 or FY '09, please briefly describe approach and provider groups it applies to:					
viii. Other quality initiative?	☐	☐	☐	☐	
A. If in place in FY '08 or FY '09, please briefly describe:					

b. If any of the quality or HIT measures listed above was eliminated or discontinued in FY 2008 or FY 2009, please briefly describe what was eliminated or discontinued: ________________

Other Comments: ____

17. Managed Care Changes:

a. During FY 2008, were non-dually eligible aged or disabled populations enrolled in capitated managed care? ☐ Yes ☐ No

b. What managed care program or policy actions were *implemented* during FY 2008, or will be implemented in FY 2009? Please briefly describe those that apply.

Program or Policy Actions	Actions Implemented in FY 2008	Actions to be implemented in FY 2009
i. Expand/contract PCCM or MCO geographic service areas		
ii. Enroll new eligibility groups (please specify)		
iii. Change from voluntary to mandatory enrollment (specify by eligibility category)		
iv. Implement/expand long term care managed care		
v. Implement/expand a disease management or care management program (specify disease state if applicable)		
vi. Other actions:		

Comments: ________

18. SCHIP Reauthorization and Medicaid

a. In December 2007, Congress extended the expiring SCHIP program, adding funds for 2008 and 2009 to avert state SCHIP shortfalls otherwise projected through March 2009.

i. Were there any Medicaid budget, policy or enrollment impacts in your state in FY 2008 as a result of the timing, funding or other provisions of the SCHIP extensions?

☐ Yes ☐ No ☐ Don't Know

If yes, please briefly describe the impacts: ________

ii. Do you anticipate any Medicaid budget, policy or enrollment impacts in FY 2009 as a result of the timing, funding or other provisions of the SCHIP extensions?

☐ Yes ☐ No ☐ Don't Know

If yes, please briefly describe the impacts: ________

b. On August 17, 2007, CMS issued an SCHIP policy directive establishing certain "anti-crowd-out" policies (e.g., 250% FPL income limit policy, 12-month waiting period requirement, etc.).

i. Were there any Medicaid budget, policy or enrollment impacts in your state in FY 2008 as a result of the August 17th policy directive?

☐ Yes ☐ No ☐ Don't Know

If yes, please briefly describe the impacts: ________

ii. Do you anticipate any Medicaid budget, policy or enrollment impacts in FY 2009 as a result of the August 17th policy directive?

☐ Yes ☐ No ☐ Don't Know

If yes, please briefly describe the impacts: ________

Comments: ________

19. Section 1115 Waivers:

a. Is your state currently planning to implement a new Section 1115 comprehensive Medicaid reform waiver or waiver amendment in FY 2009? ☐ Yes ☐ No

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

c. If yes, please briefly describe any key waiver features not already described above: __________

20. Medicaid and Health Care Reform

a. In FY 2009, is your state implementing new measures to reduce the number of uninsured?
☐ Yes ☐ No

b. If "Yes",

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

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

iii. Were the new measures for FY 2009 reduced in scope or significance from previous plans due to budget concerns? ☐ Yes ☐ No

Brief description of measures or other comments: ____

21. Impact of Federal Medicaid Regulations and Oversight

a. Assuming the proposed federal Medicaid regulations identified below are finalized and implemented in their proposed form, how would you describe the fiscal impact you would expect in your state in FY 2009 to comply with the regulations, and any impact on beneficiaries?

	STATE FISCAL IMPACT				BENEFICIARY IMPACT			
	None/ Small	Some/ modest	Signi-ficant	Don't Know	None/ Small	Some/ modest	Signi-ficant	Don't Know
i. Case management rule	☐	☐	☐	☐	☐	☐	☐	☐
ii. School-based administration and transportation rule	☐	☐	☐	☐	☐	☐	☐	☐
iii. Public provider cost limit rule	☐	☐	☐	☐	☐	☐	☐	☐
iv. Graduate medical education rule	☐	☐	☐	☐	☐	☐	☐	☐
v. Rehabilitative services rule	☐	☐	☐	☐	☐	☐	☐	☐
vi. Outpatient hospital services rule	☐	☐	☐	☐	☐	☐	☐	☐

Comments: ____

b. On a scale of 1 to 5, with 1 meaning "no impact" and 5 meaning a "significant impact," please describe the expected *administrative* impact to your program in FY 2009 of federal audits and reviews and other federal oversight activities including the Payment Error Rate Measurement (PERM) initiative (*Check one*):

No burden 1	2	3	4	Significant burden 5
☐	☐	☐	☐	☐

c. In FY 2009, will your state add new administrative resources or redirect administrative resources from other purposes to respond to ongoing federal audits and reviews and other federal oversight activities?

☐ Yes ☐ No ☐ Don't Know

If yes, please briefly describe the impacts: ________________________________

Comments: ____

22. Outlook for Medicaid in the Future: What do you see as the most significant issues or challenges Medicaid will face over the next one or two years?________________________________

____

____

This completes the survey. Thank you very much.

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

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