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THE HENRY J. KAISER FAMILY FOUNDATION

Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012

Prepared by
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October 2011

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kaiser commission medicaid and the uninsured

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

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Acknowledgements

Medicaid staffs in virtually every state have seen administrative budgets trimmed and workloads increase as ongoing budget shortfalls have increasingly affected state governments. Especially in this year, we thank the public servants who administer the nation's Medicaid programs in all 50 states and the District of Columbia who completed the survey on which this study is based, provided information about their programs, participated in structured interviews and responded to our follow-up questions. Without the help of these Medicaid officials, this study could not be done. Given the challenges these staff are facing, we are truly grateful for their assistance.

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Executive Summary

The Great Recession continued to affect states at the end of state fiscal year (FY) 2011 and heading into FY 2012, although positive signs were beginning to emerge. State revenues were still below pre-recession levels, but were moving in a positive direction and Medicaid enrollment and spending growth were starting to taper. While Medicaid directors noted some positive signs of economic recovery, improvements remained fragile and slow in many states. State budgets for FY 2012 had to account for the expiration of the temporary federal fiscal relief provided through the American Recovery and Reinvestment Act of 2009 (ARRA). Thus, for FY 2012, nearly every state continued to focus on actions to control costs in Medicaid including restrictions on provider rates and benefits and new controls on prescription drug spending. At the same time, states also were moving forward with payment and delivery system reforms by expanding managed care programs and by continuing to re-orient long-term care programs to community-based care models. Eligibility for Medicaid remained stable due to the maintenance of eligibility (MOE) protections that were part of ARRA and health reform, and a number of states reported targeted eligibility expansions or simplified enrollment procedures.

Despite historically difficult budget conditions, states were also planning for the implementation of the Patient Protection and Affordable Care Act (ACA). Under the ACA, states will play key roles in implementing both Medicaid and private insurance coverage changes set to take effect in 2014. Medicaid is the foundation for the ACA coverage expansions for the low-income population, which will significantly reduce the number of uninsured. While the program is set to expand under the ACA in 2014, states worry about the implications of looming federal deficit reduction efforts and the policy and financing implications for Medicaid and states.

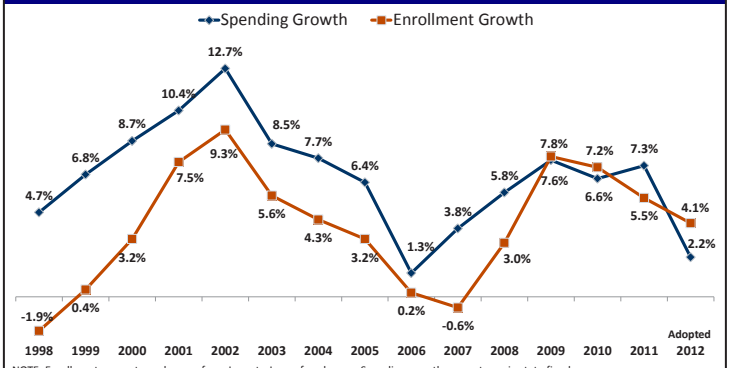
These findings are drawn from the 11th consecutive year of the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. The report provides detailed appendices with state-by-state information as well as a more in depth look through case studies of the Medicaid budget and policy conditions in Minnesota, New York and Tennessee. Key findings from the survey are highlighted below.

As a result of the recession, states experienced robust Medicaid spending and enrollment growth in FY 2011, but states are projecting lower growth for FY 2012 (Figure ES-1). Medicaid spending increased on average by 7.3 percent across all states in FY 2011 – very close to original projections of 7.4 percent growth. For FY 2012, legislatures authorized spending growth that averaged 2.2 percent, one of the lowest rates on record. Eleven states projected actual spending decreases. In some cases, these projections may understate actual spending increases for FY 2012 given that Medicaid officials in over half of the states reported a 50-50 chance of a Medicaid budget shortfall and almost one-quarter indicated a Medicaid budget shortfall was almost certain for FY 2012.

Enrollment growth, which drives spending growth, averaged 5.5 percent in FY 2011, somewhat lower than the 6.1 percent growth rate projected at the start of FY 2011. For FY 2012, states projected that the rate of enrollment growth, on average, would slow to 4.1 percent.

ES - 1

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2012

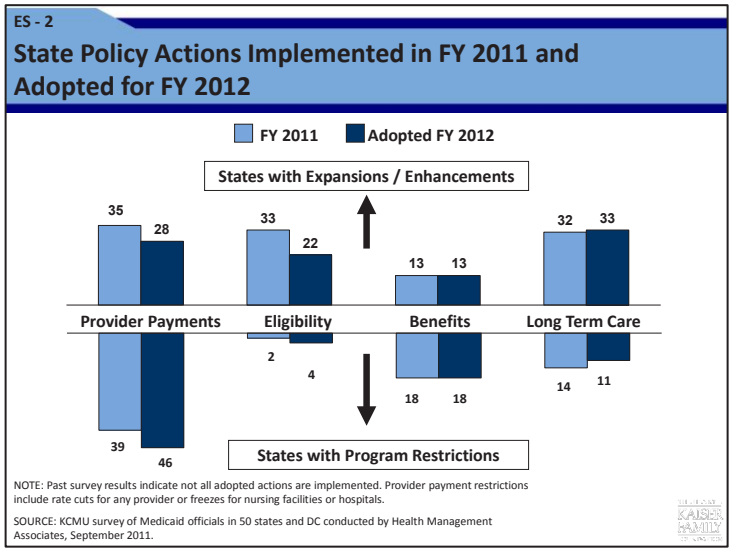


NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

SOURCE: *Medicaid Enrollment June 2010 Data Snapshot*, KCMU, February 2011. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

Increased federal assistance through the ARRA enhanced Federal Matching Percentage (FMAP) reduced the state share of Medicaid costs in FY 2009 and FY 2010, but the expiration of these funds means large increases in state funding for Medicaid in FY 2012. From October 2008 through June 2011 states received federal fiscal relief from ARRA in the form of an enhanced federal match rate for Medicaid. These funds helped states support state budgets and their Medicaid programs. The ARRA enhanced FMAP reduced the state costs for Medicaid by increasing the federal share, resulting in an average decline in state general fund spending for Medicaid of 4.9 percent in FY 2010, following a drop of 10.9 percent in FY 2009. These were the only two declines in state annual spending for Medicaid in the program's history. As the ARRA enhanced FMAP began to phase down over the final two quarters of the 2011 state fiscal year, state general fund spending increased on average by 10.8 percent for FY 2011. ARRA funds expired entirely as most states began FY 2012 when federal matching rates returned to statutory calculated levels. As a result, state spending had to be increased to replace the enhanced federal funds, contributing to large increases in state general fund spending for Medicaid of 28.7 percent in FY 2012.

Nearly every state implemented at least one new Medicaid policy to control spending in FYs 2011 and 2012, but many states also implemented some expansions in eligibility and home and community based long-term care (ES-2). In FY 2011, 47 states implemented at least one new policy to control Medicaid costs and 50 states planned to do so in FY 2012. Most states reported program reductions in multiple areas. Highlights of Medicaid policy changes for FY 2011 and FY 2012 include the following:



- ***The ARRA and ACA MOE provisions prevented states from restricting their Medicaid eligibility standards, methodologies or procedures, and despite tight budgets, many states reported eligibility expansions or enrollment simplifications.*** Thirty-three states in FY 2011 and 22 states in FY 2012 reported moving forward with positive eligibility changes. Minnesota joined Connecticut and the District of Columbia in implementing Medicaid coverage for childless adults under a new option in the ACA and several other states expanded coverage to this population through 1115 waivers. More states opted to cover legal immigrant children and pregnant women living in the United States for less than five years (the "ICHIA" option)[1] and several states also moved to expand coverage for family planning services (oftentimes using new authority in the ACA to do so through a state plan

[1] Taking its name from the earlier proposed Immigrant Children's Health Improvement Act (ICHIA).

amendment instead of a wavier). In addition, many states reported efforts to streamline their enrollment processes in FY 2011 and FY 2012. More states reported new or enhanced abilities to apply or renew Medicaid coverage through on-line applications, implementation or expansion of Express Lane Eligibility, and changes to administrative and passive renewals. A number of these changes help states qualify for performance bonus payments enacted as part of the Children's Health Insurance Program Reauthorization Act. Two states made notable eligibility restrictions that are allowed under MOE exceptions for expiring waivers (Arizona) and for coverage of adults with incomes above 133 percent of poverty in states with budget deficits (Hawaii, for January, 2012 pending approval).

- ***As in previous years, provider rate restrictions were the most commonly reported cost containment strategy.*** During economic downturns, states tend to freeze or reduce provider rates, but often restore or enhance them when conditions improve. A total of 39 states restricted provider rates in FY 2011 and 46 states reported plans to do so in FY 2012. A number of states, however, increased or imposed new provider taxes that mitigated provider cuts in some cases. States must balance the goal of controlling costs through provider rate cuts with the need to comply with the federal requirement to ensure that provider rates are sufficient to maintain adequate provider participation and access to services for enrollees. On October 3, 2011, the Supreme Court heard oral arguments in a group of cases from California that challenged reimbursement rate reductions. The court will be ruling on the narrower question of whether Medicaid providers and beneficiaries should be allowed to bring this lawsuit seeking to enforce federal Medicaid law. In May 2011, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would, for the first time, provide federal regulatory guidance regarding what states must do to demonstrate compliance with Medicaid's statutory access requirements.

- ***States continue to restrict benefits and implement cost containment strategies focused on prescription drugs.*** Eighteen states in both FYs 2011 and 2012 reported eliminating, reducing or restricting benefits. Elimination of, or limits on, dental, therapies, medical supplies and DME and personal care services were most frequently reported. Over the past decade, almost all state Medicaid programs have made substantial changes in their pharmacy programs by employing a variety of sophisticated pharmacy management tools including preferred drug lists (PDLs), supplemental rebates, prior authorization and other utilization management efforts. States continue to implement and refine these strategies. Many states are also looking at new reimbursement methodologies for prescription drugs and implementing initiatives that focus on specialty drugs which represent a large and growing share of prescription drug spending.

- ***There is a notable increase in the number of states raising or imposing new copayments on beneficiaries.*** Copayments are currently required by most state Medicaid programs for various services - particularly prescription drugs for adults. States are generally permitted to impose nominal copayments on services for certain beneficiaries, although the Deficit Reduction Act (DRA) allowed more flexibility under certain circumstances. Most children on Medicaid have been exempt from paying copayments under federal law. Five states in FY 2011 and 14 states in FY 2012 increased copayment amounts or imposed new copayments. In contrast, only one state did so in FY 2010. Most copayment changes were for pharmacy and emergency room visits, although a few states, including Arizona, California and Florida are requesting broader authority through waivers to impose copayments beyond nominal levels and to exempt populations. A recent Federal Court of Appeals decision questions the authority of the Secretary to use waiver demonstration authority to allow states to impose copayments, which may affect how CMS will rule on these pending waiver requests.

- ***States continue to re-orient the delivery of long-term care to shift care away from institutions and into community settings.*** Thirty-two states in FY 2011 and 33 states in FY 2012 took actions that expanded LTC services (primarily expanding home and community-based service (HCBS) programs). Conversely, a total of 14 states in FY 2011 and 11 states in FY 2012 took action to restrict LTC services. The ACA included a number of new long-term care options designed to increase community based long-term services and supports. Most states are still undecided as to whether to adopt these options, although four states were moving forward with the State Balancing Incentive Payment Program (Connecticut, Missouri, New Jersey and Rhode Island) and three states planned to implement the Community First Choice Option (Alaska, Rhode Island and Washington). By 2012, 43 states reported that they had implemented or plan to implement the Money Follows the Person Rebalancing Demonstration (with funding extended by the ACA).

States continue to adopt policies to expand managed care and enhance quality. Seventeen states in FY 2011 and nearly half (24 states) in FY 2012 reported that they were expanding their managed care programs primarily by expanding the areas and populations covered by managed care programs. Some states including Kentucky, Louisiana, New Jersey, New York and Texas are implementing either new or significant expansions of comprehensive managed care programs. States are also expanding the use of disease and care management programs and patient centered medical homes to help coordinate care and focus on high-cost and high-need populations. States are using managed care as a vehicle to implement quality and performance strategies such as tying payment or default enrollment to performance and adding quality measures for reporting.

New initiatives related to systems of integrated, coordinated care to serve dual Medicare – Medicaid eligibles were a top priority in FY 2011 and FY 2012. The ACA created two new offices (the Medicare-Medicaid Coordination Office and the Center on Medicare and Medicaid Innovation) that are working with states to facilitate new approaches to improve the care for this population. In April 2011, CMS awarded $1 million in planning contracts to each of 15 states for the development of integrated systems to serve dual eligibles. In July 2011, CMS released guidance that it would assist additional states in developing payment and delivery systems that would facilitate the coordination and integration of care for duals. Many states, including several of the 15 states who received contracts in April 2011, indicated that they had planned to submit proposals. Since the time of the survey, CMS has announced that 37 states have submitted letters of intent related to the opportunities announced by CMS in July 2011.[2] Tied to the grants and guidance and other state efforts, several states reported efforts to implement or expand managed long-term care programs for duals and other long-term care populations including New York, Tennessee, Texas, and California.

A number of states are pursuing Section 1115 Medicaid Demonstration Waivers to make program changes not otherwise allowable under federal Medicaid law. The majority of states with waiver plans reported significant delivery system and/or provider payment reforms for broad or targeted populations including duals or individuals with disabilities and special health care needs. Some states have approval from CMS for certain program changes or have applications pending; other states are still developing proposals and have not yet submitted formal applications to CMS.

Over the next few years, states will be required to implement significant health information technology (HIT) changes. Four major HIT initiatives are common across most states, with timelines for implementation that are driven by national deadlines: Medicaid Electronic Health Record (EHR) certification and incentive programs; major upgrades to claims payment systems; updates to the coding system for medical claims, and implementation of health reform in 2014, which requires major Medicaid IT development, particularly for Medicaid eligibility systems, and integration with new systems developed for state Health Insurance

[2] For more information, including a list of states that submitted letters of intent, see: http://www.cms.gov/medicare-medicaid-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf.

Exchanges. In addition, states are also using data systems to monitor for fraud and abuse to assure the highest level of fiscal and program integrity.

As states continue to grapple with historically difficult budget conditions, they must also plan for the implementation of the ACA which envisions new roles for Medicaid and for states. Under health reform, Medicaid will be expanded to cover nearly all individuals with incomes below 133 percent of poverty resulting in a large adult expansion in most states. Medicaid officials are playing a lead role in preparing for health reform implementation, in many cases alongside insurance commissioners. While reform presents the opportunity to dramatically reduce the number of uninsured, states identified a number of concerns related to ACA implementation including the fiscal impact of health care reform, tight implementation timelines, lack of clear federal guidance, limited staff and administrative resources, the need to streamline eligibility and coordinate with new exchanges, systems and IT issues, provider access issues, and political challenges in states with significant ACA opposition. State officials also discussed some of the issues and questions associated with transitioning to the new Modified Adjusted Gross Income (MAGI) eligibility methodology. (Concerns about MAGI were largely raised prior to the release of a proposed rule on these issues by CMS on August 4, 2011). To help develop new eligibility systems, three-quarters of the states indicated that they would take advantage of the new 90 percent federal match rate for eligibility systems made available under a final CMS regulation adopted in April 2011.

Looking to the future, Medicaid is poised to play a greater role in health care coverage, to lead the way in innovative payment and delivery models, and to remain front and center in state and federal budget discussions. Despite the intense focus on cost containment efforts due to unrelenting fiscal pressure, Medicaid directors pointed to a range of program improvements and strategies now underway particularly related to care delivery and payment systems. These initiatives are designed to improve the program in the near term and to better position the program for the ACA required eligibility expansions to cover more low-income Americans. However, as states take on the immediate challenges of running their programs and look to the implementation of health reform, they raised concerns that federal discussions related to debt and deficit reduction might achieve federal savings by shifting more Medicaid costs to states, thereby compromising their ability to move forward. In many ways, Medicaid programs have proven to be a resilient part of the nation's health care infrastructure, innovating and adapting to opportunities afforded by an evolving health care system and implementing new provisions of federal law while holding down cost increases. The current challenges may appear daunting, but Medicaid directors communicated that they and their programs are poised for a greater role in health care delivery and are committed to assuring access to high quality care delivered in the most effective manner possible.

Introduction

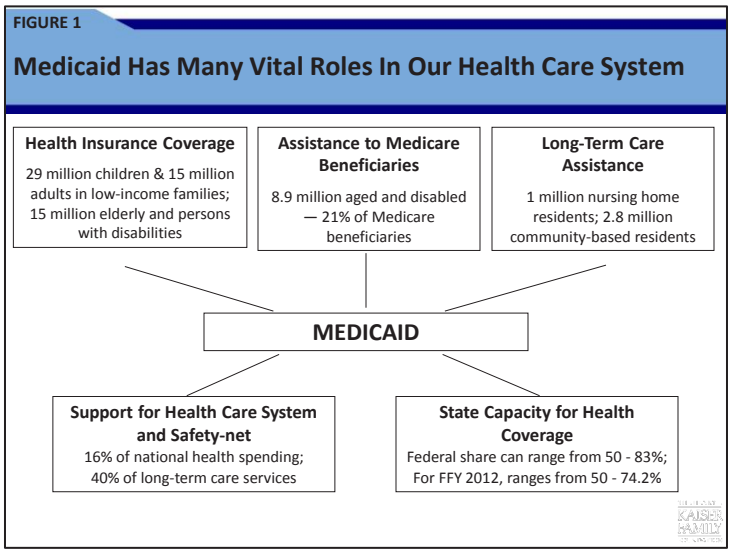
At the end of state fiscal year (FY) 2011 and heading into FY 2012, states were still experiencing the impact of the worst economic downturn since the Great Depression, although some positive signs were emerging. State revenues were still below pre-recession levels, but turning positive, and Medicaid enrollment and spending growth rates were starting to taper. Even with some positive indicators, states still struggled to pass balanced budgets for FY 2012, due in part to the expiration of the temporary federal fiscal relief provided through the American Recovery and Reinvestment Act of 2009 (ARRA) from October 2008 through December 2010 and then extended and phased-down through June 2011.

Even as states continue to grapple with historically difficult budget conditions, they are also planning for the implementation of the Patient Protection and Affordable Care Act (ACA). States are expected to play key roles in implementing both Medicaid and private insurance coverage changes. Medicaid will be the foundation for the ACA coverage expansion, which will significantly reduce the number of uninsured.

For the 11th consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. This report also includes background on the Medicaid program, as well as current issues facing the program including how states are preparing for the implementation of national health reform. Findings are presented for state fiscal years (FYs) 2011 and 2012. The report provides detailed appendices with state-by-state information as well as a more in depth look through case studies of the Medicaid budget and policy conditions in Minnesota, New York and Tennessee.

A. Medicaid Today

Medicaid serves multiple roles in the health care system. Medicaid provides health coverage and long-term care services and supports for nearly 60 million low-income Americans including 29 million low-income children, 15 million adults and 15 million elderly and people with disabilities. The program also provides assistance about 9 million low-income Medicare beneficiaries (dual eligibles) who rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all health care spending in the U.S., 40 percent of long-term care expenditures[3], and critical funding for a range of safety-net providers. Finally, Medicaid represents the largest source of federal revenue to states, which supports state capacity to finance health coverage (Figure 1).



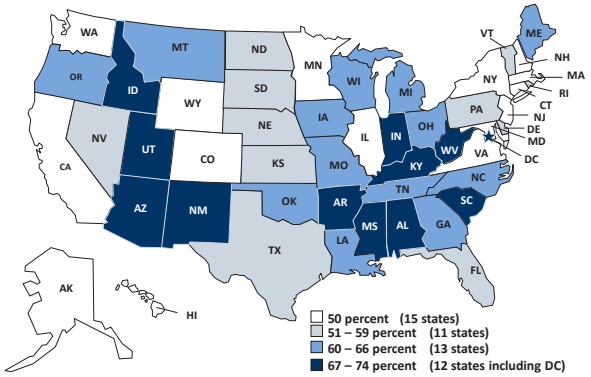
[3] KCMU estimates based on CMS National Health Accounts data, 2010. Total LTC expenditures include only spending on nursing home and home health services. Some community-based services financed primarily through Medicaid home and community-based waivers and delivered in other settings are not represented here.

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

Medicaid is financed by states and the federal government. The Medicaid program is jointly funded by states and the federal government. In FFY 2009, total Medicaid expenditures climbed to over $364 billion.[4] 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 FMAP is calculated annually using a formula set forth in the Social Security Act. The FMAP is inversely proportional to a state's average personal income relative to the national average. States with lower average personal incomes have higher FMAPs. Personal income data is lagged, so data used for FY 2011 is from the three years of 2007 to 2009. According to the statutory formula, for 2012, the FMAP varies across states from a floor of 50 percent to a high of 74.18 percent (Figure 2)[5]. States can claim federal matching funds after paying qualified providers for services for eligible beneficiaries.

FIGURE 2

Statutory Federal Medical Assistance Percentages (FMAP), FY 2012

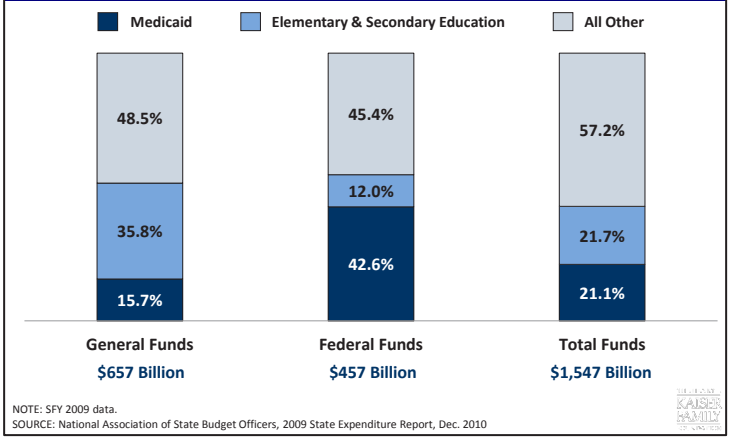


NOTE: Rates are rounded to nearest percent. These rates will be in effect Oct. 1, 2011 – Sept. 30, 2012.
SOURCE: Federal Register,, Nov, 10, 2010 (Vol. 75, No. 217), pp. 69082-69083.
http://edocket.access.gpo.gov/2010/pdf/2010-28319.pdf

Medicaid represents the largest share of federal revenues to states. Medicaid provides financing for a range of health care providers within communities across the country, supporting jobs, income and economic activity. The economic impact of Medicaid is magnified by the matching formula. At a minimum, states draw down $1 of federal money for every dollar of state funds spent on Medicaid; however, states must cut at least $2 in program spending to save $1 in state funds. Federal Medicaid dollars represent the single largest source of federal grant support to states, accounting for an estimated 43 percent of all federal grants to states in FY 2009. On average, states spent about 16 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 36 percent of state spending in FY 2009 (Figure 3).

FIGURE 3

Medicaid is a Budget Item and a Revenue Item in State Budgets



NOTE: SFY 2009 data.
SOURCE: National Association of State Budget Officers, 2009 State Expenditure Report, Dec. 2010

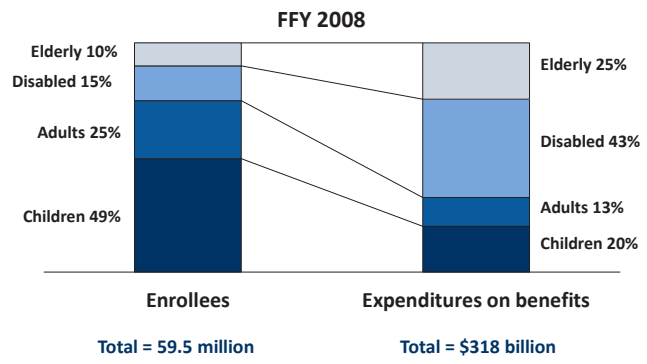
[4] Figure includes spending on services as well as DSH payments. Holahan, John et al. *Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009*. Kaiser Commission on Medicaid and Uninsured, February 2011. http://www.kff.org/medicaid/upload/8152.pdf.

[5] In FY 2012, 14 states have an FMAP at the statutory minimum of 50.0 percent: AK, CA, CO, CT, IL, MD, MA, MN, NH, NJ, NY, VA, WA, and WY. The FMAP for HI is 50.48 percent

Half of Medicaid enrollees are children, but most Medicaid spending is for the elderly and people with disabilities. About three-quarters of the beneficiaries served by the program are children and non-disabled adults, mostly parents. The elderly and people with disabilities represent just one-quarter of the share of program enrollees, but account for nearly 70 percent of program spending because these groups tend to have higher utilization of acute and may use long-term care services (Figure 4). In fact, Medicaid data show that just five percent of Medicaid enrollees account for more than half (57 percent) of program spending.[6]

FIGURE 4

The Elderly and Disabled Account for the Majority of Medicaid Spending

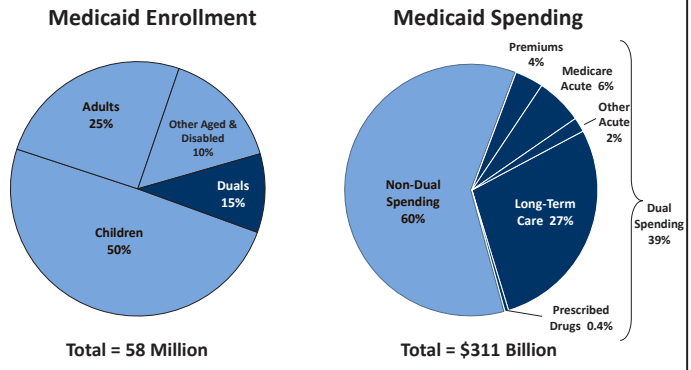


NOTE: Percentages may not add up to 100 due to rounding.
SOURCE: KCMU and Urban Institute estimates based on 2008 MSIS and CMS64 data.

Dual eligibles account for 15 percent of Medicaid enrollees, but account for 39 percent of costs. About 9 million elderly and persons with disabilities rely on both the Medicare and Medicaid programs to obtain needed health and long-term services. These "dual eligibles" accounted for only 15 percent of Medicaid enrollment, but 39 percent of Medicaid expenditures in federal fiscal year 2007 (Figure 5). These same individuals accounted for 21 percent of Medicare enrollment and over 34 percent of Medicare spending in federal fiscal year 2008.[7] These dual eligibles rely on Medicaid to pay Medicare premiums and cost sharing, and to cover critical benefits not covered by Medicare, such as long-term services and supports. Prescription drug coverage for the duals was transitioned from Medicaid to the Medicare Part D program on January 1, 2006, but states are required to finance a portion of this coverage through a payment to the federal government, often referred to as the "Clawback." Many states are focused on efforts to improve coordination between Medicare and Medicaid and across acute and long-term care services to achieve savings and better quality of care for beneficiaries.

FIGURE 5

Duals Account for 39% of Medicaid spending.



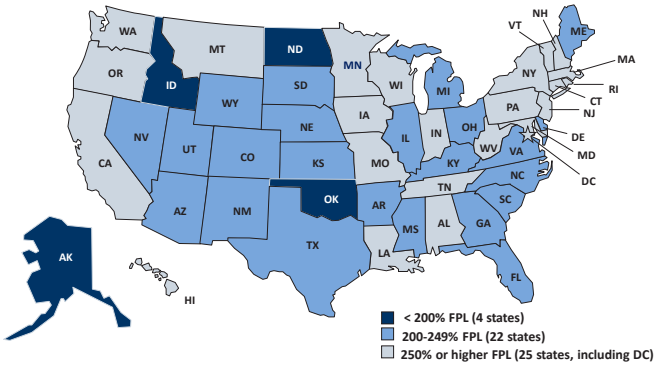
SOURCE: Urban Institute estimates based on FFY 2007 data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

[6] KCMU and Urban Institute estimates based on 2007 MSIS and CMS 64 data.
[7] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2008.

Eligibility levels vary significantly across states. To be eligible for Medicaid today, individuals must meet income and resource requirements and must also fall into one of the categories of eligible populations. The federal government sets minimum eligibility levels for coverage, and then states have the option to expand eligibility to higher incomes. As of December 2010, 46 states and the District of Columbia set the Medicaid/CHIP income eligibility level for children at or above 200 percent of the federal poverty level (FPL). However, Medicaid coverage for parents is more limited with 33 states setting levels below 100 percent of the FPL (Figures 6 and 7). Median coverage for the elderly and people with disabilities is about 75 percent of poverty (tied to the levels for Supplemental Security Income or SSI). Prior to the passage of health reform in March 2010, states could not cover adults without dependent children under Medicaid without a federal waiver. The ACA provides states the option to expand coverage to childless adults up to 133 percent of poverty without a waiver before such an expansion is required in 2014.[8] Low-income and high-need individuals covered by Medicaid generally do not have access to employer-based or other affordable private coverage.

FIGURE 6

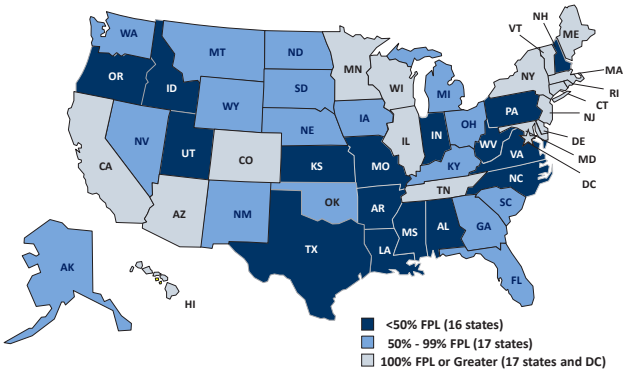
Children's Eligibility for Medicaid/CHIP by Income, January 2011



Notes: The federal poverty level (FPL) for a family of three in 2010 is $18,310 per year. IL uses state funds to cover children up to 300% of the FPL; OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Kaiser/Georgetown Medicaid Eligibility and Enrollment Survey, 2011.

FIGURE 7

Medicaid Eligibility for Working Parents by Income, January 2011



Notes: The federal poverty level (FPL) for a family of three in 2011 is $18,530 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid at higher income levels.
SOURCE: Kaiser/Georgetown Medicaid Eligibility and Enrollment Survey, 2011.

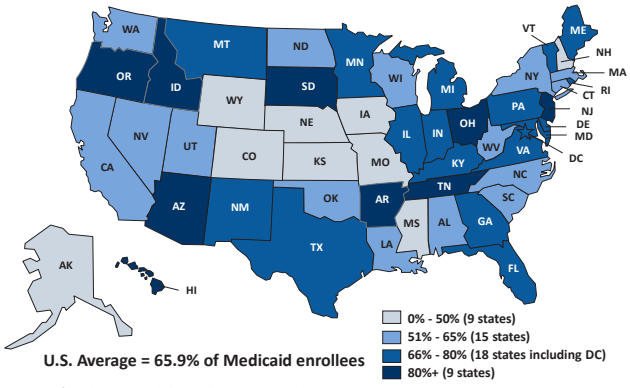
Medicaid provides affordable and comprehensive benefits reflecting the health and long-term care needs of the population it serves. Medicaid provides a comprehensive benefits package of acute and long-term care services that has been designed to meet the needs of the low-income and high-need populations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

[8] To date, three states have taken up this option – Connecticut, the District of Columbia and Minnesota.

Most Medicaid enrollees receive care through various types of managed care arrangements. Two-thirds of Medicaid enrollees receive care through managed care arrangements (Figure 8). States often contract with managed care organizations to provide comprehensive services and a provider network for beneficiaries. States have used managed care (fully capitated models and primary care management models) to secure better access to primary care services, restrain costs and to implement an array of quality improvement initiatives for Medicaid. Medicaid enrollees fare as well as the privately insured populations on important measures of access to primary care, even though they are sicker and more disabled (Figure 9). Accounting for the health needs of its beneficiaries, Medicaid is a low-cost program with lower per capita spending than private insurance.

FIGURE 8

Most Medicaid Enrollees Receive Care through Managed Care

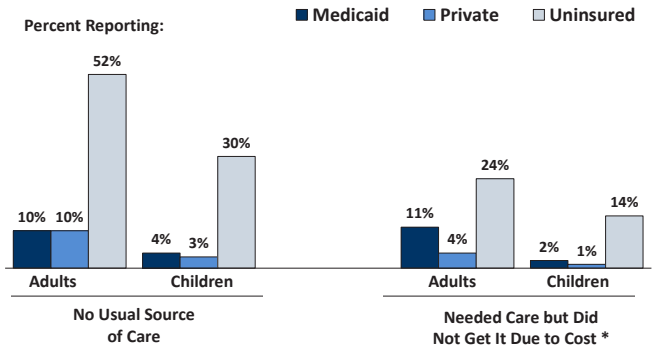


U.S. Average = 65.9% of Medicaid enrollees

NOTE: Data as of October 2010. Includes enrollment in MCOs and PCCMs.
SOURCE: Smith, V. et al. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September 2011.

FIGURE 9

Medicaid Provides Access To Care Comparable To Private Insurance and Far Better Than Access For The Uninsured

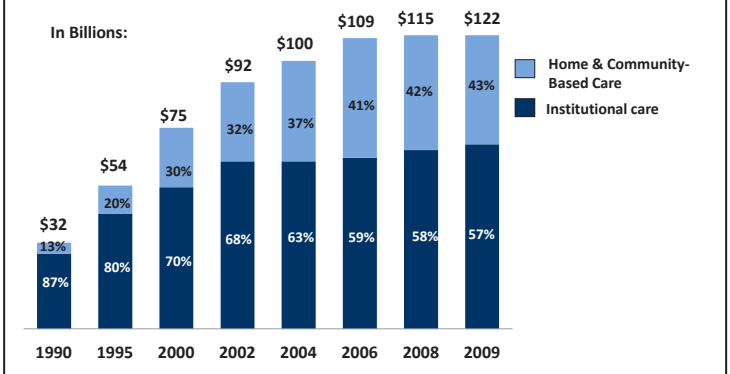


NOTE: *In the past 12 months
Respondents who said usual source of care was the emergency room were included among those not having a usual source of care
SOURCE: KCMU analysis of 2008 NHIS data

Medicaid is the dominant source of coverage and financing for long-term care services and supports. Medicaid plays a critical role for low-income people of all ages with long-term care needs. Unlike Medicare, which primarily covers physician and hospital-based acute care services, Medicaid covers long-term care services needed by people to live independently in the community such as home health care and personal care, as well as services provided in institutions such as nursing homes. Spending on long-term care services represents over a third of total Medicaid spending. Medicaid has evolved to become the primary payer for long-term care services and supports to low-income individuals. Over the past two decades, spending on Medicaid home and community-based services has been growing as more states attempt to reorient their long-term care programs by increasing access to home and community-based service options. In 2009, spending on home and community-based services accounted for 43 percent of total Medicaid long-term care spending, up from 13 percent in 1990 (Figure 10).

FIGURE 10

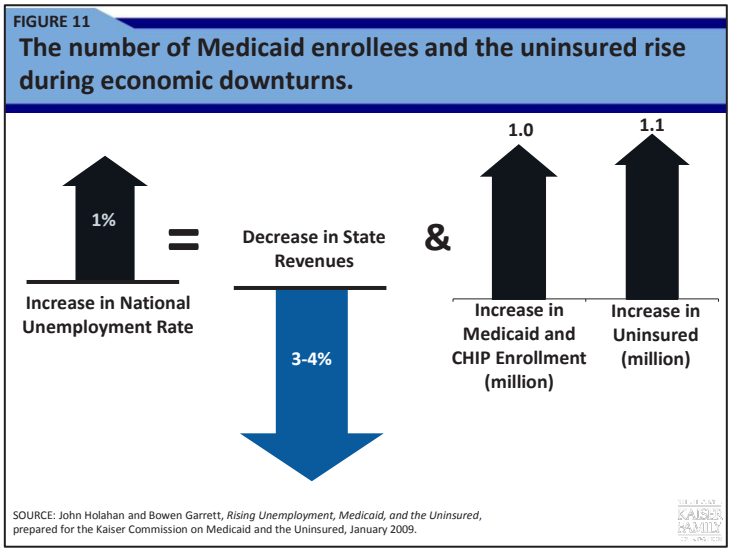
Growth in Medicaid Long-Term Care Services Expenditures, FFY 1990-2009



Note: Home and community-based care includes home health, personal care services and home and community-based service waivers. Institutional care includes intermediate care facilities for the mentally retarded, nursing facilities, and mental health facilities.
SOURCE: KCMU and Urban Institute analysis of HCFA/CMS-64 data.

B. Medicaid and the Economy

Headed into state fiscal year 2012, the national unemployment rate remained persistently high. State revenues remained depressed and states faced budget shortfalls of at least $149 billion for FY 2012 through 2013 on top of the $430 billion in shortfalls states have already closed in fiscal years 2009, 2010, and 2011.[9] During an economic downturn, high unemployment puts upward pressure on Medicaid. As individuals lose jobs and their incomes decline, more individuals qualify and enroll in Medicaid which increases program spending. At the same time, increases in unemployment have a negative impact on state tax revenues, making it even more difficult for states to pay their share of Medicaid spending increases. Specifically, research indicates that a one percentage point increase in unemployment is associated with one million more Medicaid and CHIP enrollees, an additional 1.1 million uninsured, and a drop in state revenues of three to four percent (Figure 11). Recent census data show that the number of nonelderly Americans without health insurance for 2010 now stands at 49.1 million, representing 18.5 percent of all nonelderly Americans.[10] Driven by the recession and the continued weakened economy, the recent census data show that the poverty rate in 2010 reached a near record high with 46.2 million Americans living in poverty.



C. Recent Legislative Action

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA, signed by President Obama on February 4, 2009, extended and expanded the Children's Health Insurance Program which was enacted as part of the Balanced Budget Act of 1997 (BBA).[11] CHIPRA provided fiscal incentives, new tools, and outreach funding for states to enroll children who are eligible but not enrolled in Medicaid and CHIP programs. The legislation included some new coverage options for states including allowing the use of Medicaid and CHIP to cover legal immigrant children and pregnant women during their first five years of residency, reversing a five year ban originally imposed in 1996 as part of welfare reform. CHIPRA phased out coverage for some adults that had been covered by CHIP through a waiver, giving states the option to transition these adults to

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[9] McNichol, Elizabeth, Nicholas Johnson, and Phil Oliff. *States Continue to Feel Recession's Impact*. Center on Budget and Policy Priorities. June 17, 2011. http://www.cbpp.org/cms/index.cfm?fa=view&id=711#_ftn1.
[10] *Five Facts About the Uninsured*. Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/uninsured/upload/7806-04.pdf.
[11] *State Children's Health Insurance Program (CHIP): Reauthorization History.* Kaiser Commission on Medicaid and the Uninsured. February 2009. http://www.kff.org/medicaid/upload/7743-02.pdf.

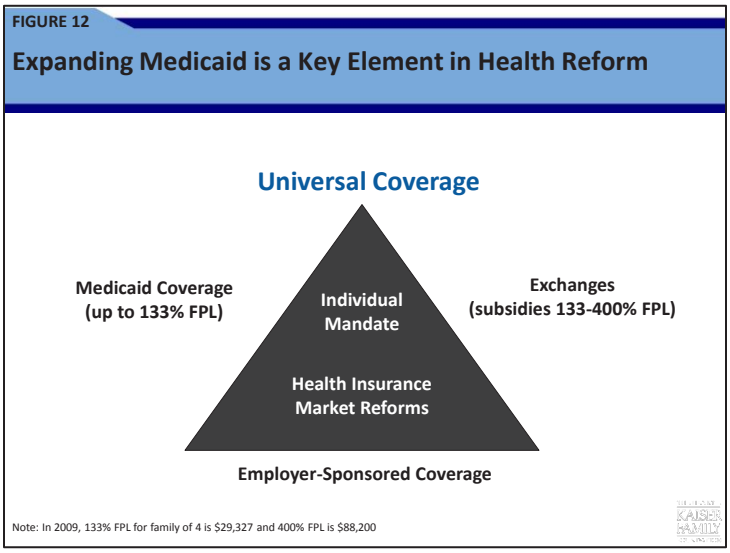
Medicaid. Additionally, CHIPRA focused on access and quality by establishing MACPAC, a new Commission to focus on access and payment policies in Medicaid and CHIP, and by funding initiatives related to quality measures and electronic health records.

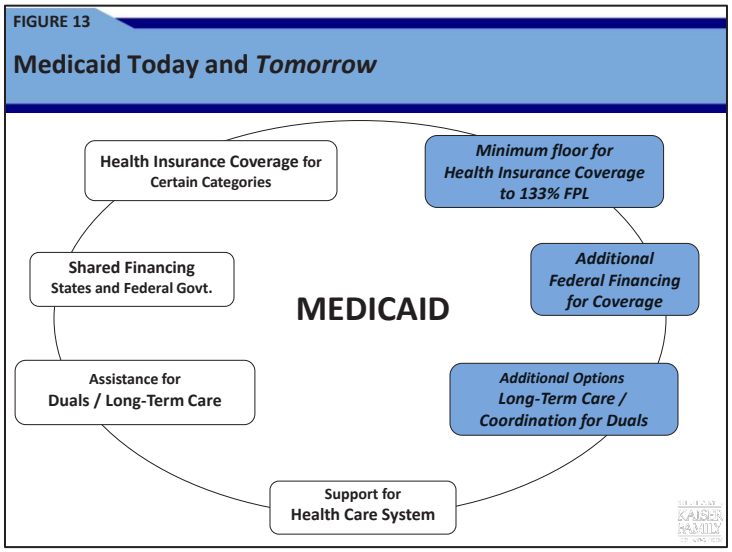
American Recovery and Reinvestment Act (ARRA). In an effort to boost an ailing economy, Congress enacted and President Obama signed the ARRA on February 17, 2009. The overall package, estimated to cost $787 billion, included significant funding for health care and state fiscal relief. Specifically, the Act included an estimated $87 billion for a temporary increase in the federal share of Medicaid costs from October 2008 through December 2010. This was the single most significant source of fiscal relief to states in the ARRA. Similar to relief provided in 2003 during the last economic downturn, these funds were designed to help support state Medicaid programs during a time of increased demand when states were least able to afford their share of the program. The FMAP increase included a "hold-harmless" clause, a base FMAP rate increase, and additional funding for states with significant increases in unemployment. ARRA was extended through June 2011 with lower levels of federal financing. To be eligible for these funds states could not restrict eligibility for Medicaid or tighten enrollment procedures to make it more difficult to obtain and retain coverage.

Budget Control Act. On August 2, 2011, President Obama signed the Budget Control Act of 2011 into law to raise the federal debt ceiling and to reduce federal spending with immediate and longer-term policies. The Act established the Joint Select Committee, also known as the "Super Committee," which is tasked with decreasing projected federal deficits by $1.5 trillion between FY2012 and FY2021. The Committee has broad authority to propose changes to meet its target, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the budget. The Super Committee may draw on proposals to cut Medicaid that were in the President's Plan for Economic Growth and Deficit Reduction released on September 19, 2011, or Medicaid proposals included in other deficit reduction commissions' recommendations. Some options that may be considered include limiting provider taxes, blending the federal match rates for Medicaid, CHIP and the new Medicaid match rates under the ACA to create a single federal match rate for each state, shifting duals to managed care, converting Medicaid to a block grant or capping federal health care expenditures. State officials expressed some concern that some proposals under consideration could shift costs to states, beneficiaries or providers.

D. National Health Reform and Medicaid

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA; Public Law 111-148), into law. The law will significantly expand options for affordable coverage through a Medicaid eligibility expansion and subsidies for low to moderate income individuals to purchase coverage through newly established Health Insurance Exchanges. Under the new law, employer sponsored coverage will remain the dominant source of coverage for most Americans. The ACA bolsters health coverage by requiring individuals to have health insurance and by making changes to the health insurance markets designed to protect consumers. In terms of Medicaid, health reform builds on many of Medicaid's current roles by expanding coverage with additional federal financing for the newly eligible population, and by adding additional options for providing long-term care supports and for coordinating care for dual eligibles (Figures 12 and 13).[12]





Coverage. More specifically, by January 1, 2014, Medicaid will be expanded to provide eligibility to nearly all low-income people under age 65 with incomes below 133 percent of the federal poverty level ($14,484 for an individual or about $29,726 for a family of four in 2011).[13] For most Medicaid enrollees, income will be based on modified adjusted gross income without an assets test or resource test.[14] As a result, millions of low-income adults without children who currently cannot qualify for coverage (except in a handful of states with waivers), as well as many low-income parents and, in some instances, children now covered by CHIP, will be made eligible for Medicaid (Figure 14). Due to increased outreach and program awareness, the health reform law is expected to result in more people who are already eligible for Medicaid under current rules learning about and signing up for coverage. In total, Medicaid, along with CHIP, is expected to cover an additional 16 million people by 2019.[15]

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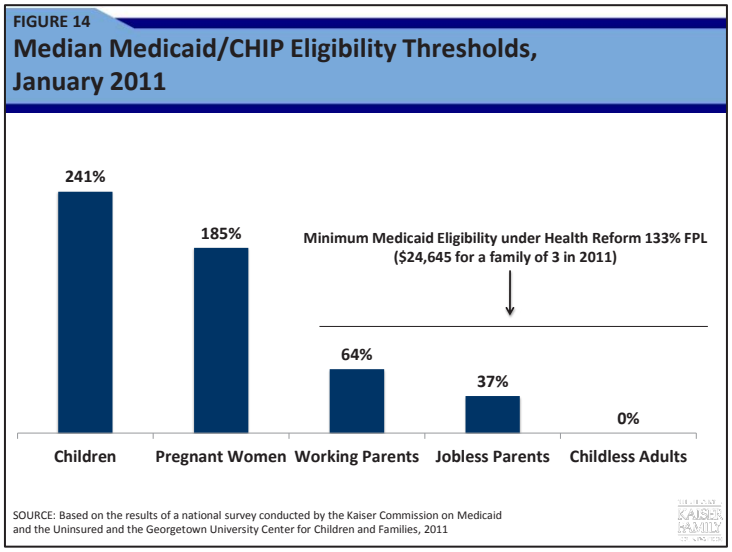
[12] *Medicaid and the Children's Health Insurance Program Provisions in the New Health Reform Law.* Kaiser Family Foundation, April 2010.

[13] As under prior law, undocumented immigrants will remain ineligible for Medicaid and CHIP, and only certain legal immigrants can secure coverage.

[14] There is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty. The legislation maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI).

[15] Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)" (March 20, 2010).



Financing. The new law provides full federal financing (100 percent federal) for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90 percent by 2020. States will receive their current match rates for individuals currently eligible for Medicaid. An expansion or transition matching rate is designed to provide federal funds to expansion states (those that had expanded coverage for adults to at least 100 percent of poverty prior to the enactment of health reform). These states will receive a phased-in increase in their federal match rate for childless adults so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults.[16] At the time the ACA was enacted, the Congressional Budget Office (CBO) estimated that the federal Medicaid/CHIP costs due to coverage related changes under health reform will be $434 billion from 2010 to 2019. The federal government is expected to finance about 95 percent of the costs of new coverage with the states paying the remaining five percent over the 2014 to 2019 period.[17]

Benefits and Access. The new law provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent package that meets the minimum essential health benefits available in the Health Insurance Exchange.[18] The ACA makes some other important changes to Medicaid benefits and access such as: increasing Medicaid payments for primary care to 100 percent of the Medicare payment rates for 2013 and 2014 with 100 percent federal financing for the increased payment rates; funding and broadening the scope of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all eligible individuals (not just children); establishing the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency; and funding pilot programs for medical homes and accountable care organizations.

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[16] Holahan, John and Irene Headen. *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL.* Kaiser Commission on Medicaid and the Uninsured. May 2010. For this analysis, AZ, DE, HI, ME, MA, NY and VT were assumed eligible for this transition match rate for current coverage of childless adults below any enrollment caps that may be in place.

[17] Ibid.

[18] *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries.* Kaiser Family Foundation, August 2010.

Long-Term Care. The ACA also includes new options to provide long-term care services and supports including the Community First Choice Option in Medicaid, which allows states to provide community-based attendant supports and services to individuals with incomes up to 150 percent of poverty who require an institutional level of care through a state plan amendment (SPA) and provides states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. The ACA extends funding for Medicaid Money Follows the Person Rebalancing Demonstration Programs through 2016. The law requires the Secretary to improve coordination of care for dual eligibles through a new office within the Centers for Medicare and Medicaid Services.[19] Other provisions provide demonstration opportunities for states to "rebalance" their long-term care system through use of home and community-based services, and to develop health homes for persons with chronic conditions.

Key State Responsibilities. The ACA will be implemented in large part by the states. Some key state responsibilities will be to expand Medicaid, transition to a new definition of income for Medicaid, develop adequate provider networks to serve Medicaid, coordinate systems between Medicaid and the Health Insurance Exchanges (new market places for coverage), provide for coordination in enrollment across Medicaid, CHIP and Exchange coverage, develop eligibility and enrollment systems that are consumer-friendly and technology enabled, and enforce new insurance market regulations.

[19] *Medicaid Long-Term Services and Supports: Key Changes in the Health Reform Law.* Kaiser Family Foundation, June 2010. http://www.kff.org/healthreform/upload/8079.pdf.

Methodology

The Kaiser Commission on Medicaid and the Uninsured (KCMU) commissioned Health Management Associates (HMA) to survey Medicaid directors in all 50 states and the District of Columbia to identify trends in Medicaid spending, enrollment and policy making. This report is based on the 2011 survey and structured discussions with Medicaid directors and staff based on each state's response to the survey.

This is the seventeenth KCMU/HMA survey of Medicaid officials to address these budget and policy issues. Eleven annual surveys have been conducted, at the beginning of state fiscal years 2002 through 2012, and six mid-year surveys were conducted in fiscal years 2002, 2003, 2004, 2009, 2010 and 2011, when many states made mid-year Medicaid policy changes due to shortfalls in state revenues.[20]

The KCMU/HMA Medicaid survey on which this report is based was conducted in July and August 2011. The survey documents policy actions states implemented in the previous year, state FY 2011, and new policy initiatives that they had implemented or expected to implement in the upcoming year, state FY 2012 (which began for most states on July 1, 2011.)[21] At the time each state survey was finalized, the FY 2012 Medicaid budget had been adopted by the Legislatures in all states.

The 2011 survey instrument was designed to provide information consistent with previous surveys.[22] As with previous surveys, specific questions were added to reflect current issues. For example, this survey includes additional questions on state activity relating to federal health reform implementation.

Medicaid directors and other Medicaid staff provided data for this report in response to a written survey and a follow up telephone interview. The survey was sent to each Medicaid director in June 2011. The surveys were completed and telephone interviews occurred in July and August 2011. The telephone discussions provided an opportunity to review the written responses or to conduct the survey itself. These interviews are an integral part of the survey and have proven to be invaluable to clarify responses, to ensure complete and accurate responses and to record the nuances of state actions. For most states, the interview included the Medicaid director along with Medicaid policy or budget staff. In a limited number of cases, the interview was delegated to a Medicaid policy or budget official. Survey responses were received from all 50 states and the District of Columbia.

Each annual survey focuses on policy directions, policy changes and new initiatives. The survey does not attempt to catalog all current policies. This survey asked state officials to describe policy changes that occurred during the previous fiscal year, and new policy changes that were implemented or would be implemented in FY 2012. It is important to note that the survey asks only for policy changes already implemented in FY 2011 or FY 2012, or for which there has been a definite decision to implement in FY 2012. Policy changes under consideration but for which a definite decision has not yet been made are not included, even though they may be implemented during FY 2012. Previous surveys have documented that some actions listed at the time of the survey as definitely planned for implementation might not be implemented in the upcoming year. Medicaid policy initiatives often involve complex administrative and computer system changes, specific advance notice

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[20] The previous annual budget survey report issued September 2010 is at: http://www.kff.org/medicaid/8105.cfm For previous survey results, see the following links: http://www.kff.org/medicaid/7985.cfm ; http://www.kff.org/medicaid/7815.cfm; http://www.kff.org/medicaid/7699.cfm; http://www.kff.org/medicaid/7569.cfm; http://www.kff.org/medicaid/7392.cfm; http://www.kff.org/medicaid/7190.cfm; http://www.kff.org/medicaid/kcmu4137report.cfm; http://www.kff.org/medicaid/4064-index.cfm; http://www.kff.org/medicaid/4020-index.cfm.

[21] 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.

[22] The survey instrument is in Appendix C of this report.

requirements and various political, legal and fiscal considerations. As a result, planned policy changes that are adopted and scheduled for implementation sometimes are delayed or reconsidered.

This report also includes case studies of three states (Minnesota, New York and Tennessee.) These state profiles provide concrete examples of state Medicaid policy changes, including program expansions and improvements and cutbacks, as well as the fiscal and political context in specific states in FY 2011 and FY 2012. The state case studies are included in Appendix B of the report.

Findings from previous surveys are referenced where possible to highlight trends and to provide perspective for the results of this survey. Data from previous surveys are reflected in trends in Medicaid spending and enrollment growth rates, and specific Medicaid cost containment actions.

Annual rates of growth for Medicaid spending and enrollment are calculated as weighted averages across all states. For FY 2011 and FY 2012, average annual Medicaid spending growth was calculated using weights based on the most recent available state Medicaid expenditure data, as reported by the National Association of State Budget Officers (NASBO) *State Expenditure Report,* December 2010. Average annual Medicaid enrollment growth is calculated using weights based on state enrollment data reported by state officials to HMA for the Kaiser Commission on Medicaid and the Uninsured for the month of June 2010. For years prior to the periods covered by the KCMU/HMA surveys, Medicaid spending and enrollment data are based on estimates prepared for KCMU by the Urban Institute using data from CMS Form 64 reports, adjusted for state fiscal years.

Survey Results for Fiscal Years 2011 and 2012

1. State Fiscal Conditions and Overall Impact of ARRA

Key Section Findings:

- States experienced the deepest economic downturn since the Great Depression in 2009 through 2011. Heading into FY 2012, states continued to face high unemployment, depressed revenues and high demand for public programs including Medicaid.
- All states used ARRA funds to address Medicaid and state budget funding shortfalls, to support Medicaid enrollment growth and to help avoid or mitigate program restrictions. Many states reported multiple uses of ARRA funds in 2011.
- State budgets for FY 2012 had to account for the expiration of the ARRA enhanced matching funds. The result was an unprecedented increase in the state costs of Medicaid to make up for the drop in federal Medicaid funding.

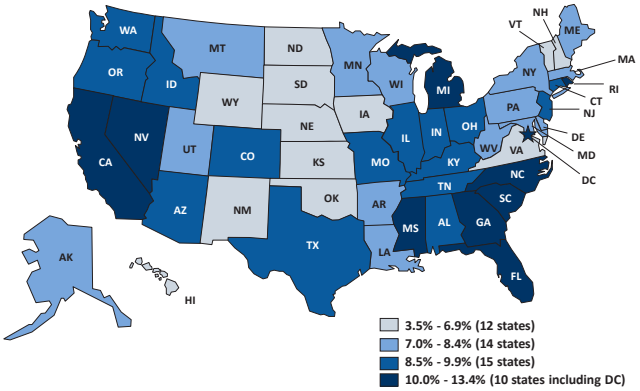
A. State Fiscal Conditions

States experienced effects of the deepest economic downturn since the Great Depression throughout FY 2009, 2010 and 2011. As states adopted their budgets for fiscal year 2012, most states were still experiencing the continued effects of the economic recession. While revenues were starting to rebound, levels were still far below pre-recession levels, unemployment remained persistently high and demands for public programs, including Medicaid, also remained high.

The national unemployment rate continued to hold at 9.1 percent in September 2011 having remained at this level since April 2011, but lower than last year's average of 9.6 percent. In August 2011, ten states including the District of Columbia had unemployment rates above ten percent (Figure 15). There are 6.7 million fewer jobs on non-farm payrolls since the start of the recession in December 2007 and an estimated 14 million unemployed. Of the 14 million unemployed in September 2011, the number of long-term unemployed (those jobless for 27 weeks and over) hit 6.2 million. Among those working, the number of people who want to work full-time but have had to settle for part-time employment rose from 8.8 in August 2011 to 9.3 million in September 2011.[23]

FIGURE 15

Unemployment Rates by State, August 2011



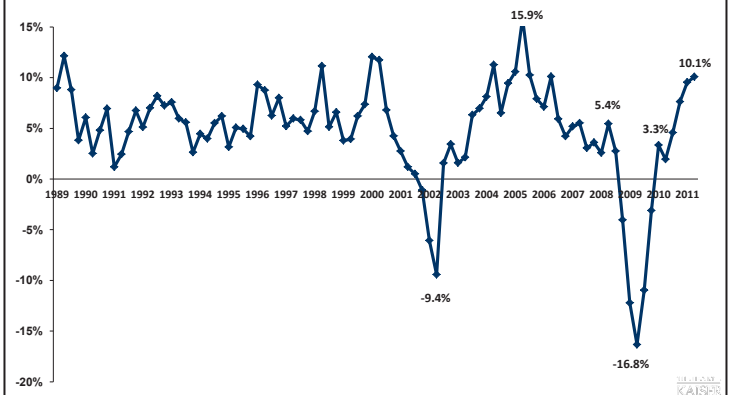
SOURCE: State figures from the Table 3, *Regional and State Employment and Unemployment: August2011,* Bureau of Labor Statistics. (Figures are preliminary).

[23] *The Employment Situation – September 2011.* Bureau of Labor Statistics, October 7, 2011.

States have had to close budget shortfalls in FY 2009, FY 2010, and FY 2011 totaling over $430 billion. At the start of FY 2012, 42 states faced a budget shortfall, collectively totaling $103 billion. Looking forward to 2013, 24 states already estimate budget gaps totaling $46 billion.[24] While tax revenue is starting to increase again for states, it is still far below pre-recession levels. Data for the second quarter of 2011 (April through June), show state tax revenue up by 10.1 percent from the same period in 2010, the sixth straight quarter of positive year-over-year growth and the strongest quarter of year-over-year growth since the second quarter of 2006.[25](Figure 16) In fact, at least 28 states reported higher than expected revenue collections for the second quarter of 2011. In 23 of these 28 states, gains in personal or corporate income tax collections were the primary drivers of higher than expected revenues as income for individuals and corporations are recovering faster than other sources of tax revenue for states. Higher than expected sales tax revenue occurred in a handful of states; however for the most part, sales tax revenue is recovering more slowly as consumer spending remains depressed.[26] For state FY 2011, every state except New Hampshire experienced overall revenue growth.[27]

FIGURE 16

State Tax Revenue, 1999 – 2011



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

Unlike the federal government, states are legally required to balance their budgets. States can use reserves or rainy day funds, increase taxes or cut spending to achieve a balanced budget during periods of economic stress. Nearly all states have reduced program spending to balance their budgets and in the large majority of states, some actions are expected to impact vulnerable residents. In responding to the fourth straight year of significant budget shortfalls for many states, at least 37 states enacted budgets for FY 2012 with spending below their FY 2008 levels. At least 38 states made significant cuts to core public services such as health care, K-12 education, and higher education.[28] At least 16 states have made cuts to state employees by reducing wages, reducing benefits, or proposing layoffs.[29] While a handful of states did balance these significant cuts with new tax measures, at least 12 states enacted significant tax cuts that further deepened budget shortfalls.[30]

In assessing the economic situation in their states, Medicaid directors in this survey noted that while there are some positive signs toward recovery, improvement remains fragile and slow in many states, and the fiscal pressure on Medicaid continues.

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[24] McNichol, Elizabeth, Phil Oliff and Nicholas Johnson. *States Continue to Feel Recession's Impact*. Center on Budget and Policy Priorities, June 17, 2011. Available at: http://www.cbpp.org/files/9-8-08sfp.pdf.

[25] *Table 3 of the Quarterly Summary of State and Local Government Tax Revenue*. Census Bureau, updated September 27, 2011. http://www.census.gov/govs/qtax/

[26] McNichol, Elizabeth, Michael Leachman and Dylan Grundman. *Better-Than-Expected State Tax Collections Highlight the Importance of Income Taxes*. Center on Budget and Policy Priorities, July 2011. http://www.cbpp.org/cms/index.cfm?fa=view&id=3530

[27] Lucy Dadayan, "Strong, Broad Growth in State Tax Revenues Continued in the Second Quarter of 2011," Rockefeller Institute of Government, September 1, 2011. http://www.rockinst.org/newsroom/data_alerts/2011/09-01.aspx.

[28] Williams, Erica, Micheal Leachman and Nicholas Johnson. *State Budget Cuts in the New Fiscal Year are Unnecessarily Harmful*. Center on Budget and Policy Priorities, July 2011. http://www.cbpp.org/cms/index.cfm?fa=view&id=3550.

[29] Ibid

[30] Ibid

B. Impact of ARRA

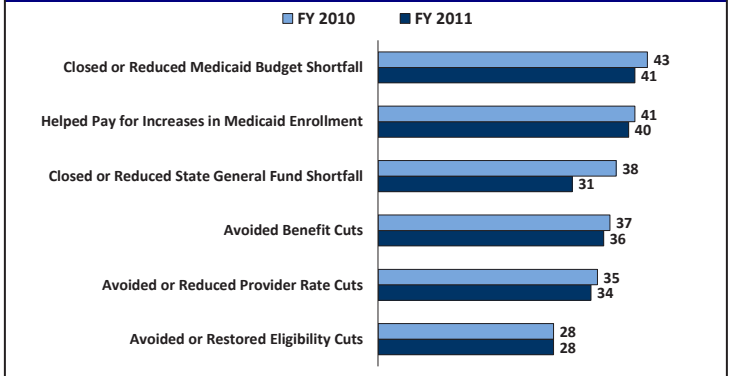
Recognizing that states were facing a fiscal emergency that would make it difficult to maintain essential services, including Medicaid, Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA), which the President signed into law on February 17, 2009. The largest component of state fiscal relief was provided through a temporary increase in the FMAP for states. Under ARRA, there were three factors included in the legislation that are used to calculate a state's FMAP increase. First, the legislation provided a "hold-harmless" clause to prevent states from receiving a formula-driven reduction in their FMAP. Second, all states received a 6.2 percentage point base increase in their FMAP. Third, states with significant increases in unemployment over a base rate received a 5.5 percent, 8.5 percent or 11.5 percent reduction in their state share of Medicaid costs, depending on the size of the increase in unemployment. The base rate was the lowest three month average of the state's unemployment rate since January 2006. Congress passed a partial extension that stepped down the ARRA enhanced FMAP. Instead of a continuation of the 6.2 percentage point base increase they received under ARRA, states received a 3.2 percentage point increase for the third quarter (January-March 2011) and a 1.2 percentage point increase for the fourth quarter (April-June 2011).

The ARRA funding provided immediate fiscal relief to states through Medicaid. Once the funds were earned through payments for qualified Medicaid expenditures to medical providers, the federal matching funds were available to use as determined by the state. To receive the enhanced federal financing, states had to comply with provider prompt payment requirements and could not restrict eligibility standards, methods or procedures beyond those in effect on July 1, 2008. The ARRA enhanced FMAP did not apply to payments for eligibility expansions implemented on or after July 1, 2008.

This survey addressed the question of how states used the ARRA funds that flowed through Medicaid. Based on responses to this survey, all states reported that they used the ARRA enhanced Medicaid funding as it was intended, both to address Medicaid funding shortfalls and to address budget shortfalls across state programs (Figure 17). The ARRA funds clearly assisted state Medicaid programs and helped them avoid or mitigate program restrictions that would have occurred otherwise. In FY 2011 most states reported multiple uses of the ARRA funds, meaning that in these states, a wide range of budget-driven restrictions likely would have occurred across state programs without these federal funds provided through Medicaid. The expiration of the ARRA funds at the end of FY 2011 meant a large increase in state general fund spending to replace the loss in federal financing. These results are discussed in the next section.

FIGURE 17

How States Used ARRA Enhanced Medicaid Funding in FY 2010 and FY 2011



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010 and September 2011.

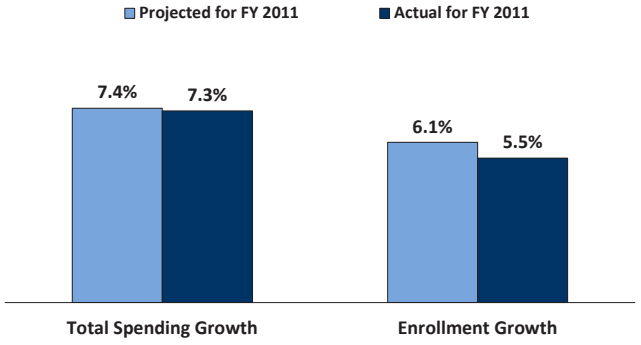
2. Medicaid Spending and Enrollment Growth Rates

Key Section Findings:

- Medicaid spending increased on average by 7.3 percent across all states in FY 2011. Legislatures had initially authorized spending growth of 7.4 percent, so FY 2011 spending growth was close to expectations in most states (Figure 18).
- For FY 2012, legislatures authorized spending growth on average of 2.2 percent, one of the lowest rates on record. This reflects 11 states projecting actual declines in spending growth. Medicaid officials in over half of states reported that the chance they would experience a Medicaid budget shortfall in FY 2012 was at least 50 – 50; almost one-fourth indicated a Medicaid budget shortfall was almost certain.
- Followed by two years of declines, general fund spending on average increased in FY 2011 by 10.8 percent as the enhanced FMAP began to phase down over the final two quarters of the fiscal year. For FY 2012, the state general fund spending on Medicaid jumped dramatically, increasing on average by 28.7 percent as the enhanced FMAP ended and federal matching rates returned to statutory calculated levels.
- Enrollment growth averaged 5.5 percent in FY 2011, somewhat lower than the 6.1 percent growth projected at the start of FY 2011. Many states reported that enrollment growth began slowing during FY 2011. For FY 2012, states projected that enrollment growth rates would continue to taper, with an average growth projected of 4.1 percent (Figure 19)

FIGURE 18

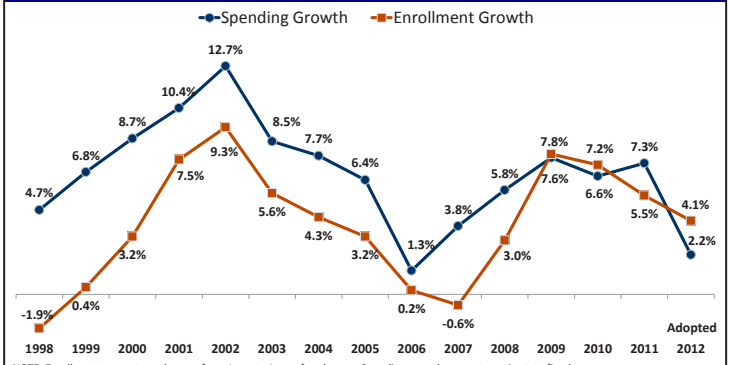
Projected and Actual Total Medicaid Spending and Enrollment Growth for FY 2011



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010 and September 2011.

FIGURE 19

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2012



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

SOURCE: *Medicaid Enrollment June 2010 Data Snapshot*, KCMU, February 2011. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

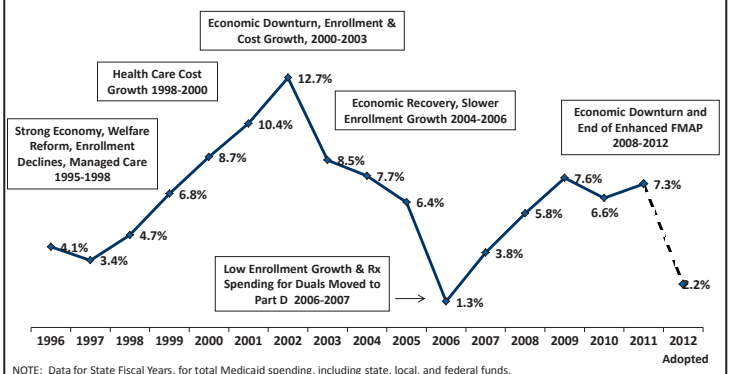
A. Total Medicaid Spending Growth

Total Medicaid spending includes all payments to Medicaid providers for Medicaid covered services provided to enrolled Medicaid beneficiaries. This definition includes "disproportionate share" (DSH) payments to hospitals that qualify for special payments to subsidize part of the costs of care for persons on Medicaid or that are uninsured. State obligations to finance a portion of the Medicare Part D prescription drug benefit for dual Medicare-Medicaid enrollees (the Clawback)[31] and Medicaid administrative costs are excluded from total Medicaid spending. Medicaid is financed with state funds, federal matching funds and in some states local funds.[32]

Total Medicaid Spending and Growth in Fiscal Year 2011. In state fiscal year 2011, total annual Medicaid spending increased on average by 7.3 percent.[33] By comparison, the original legislative appropriation for FY 2011 on average was 7.4 percent, nearly identical. The 7.3 percent growth in FY 2011 was highest rate of growth since 2004 during the last recession (Figure 20).

FIGURE 20

Total Medicaid Spending Growth, FY 1996 – FY 2011



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

SOURCE: Historic Medicaid Growth Rates from KCMU Analysis of CMS Form 64 Data, FY 2010, 2011 and 2012 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2011.

Medicaid spending growth is closely tied to changes in economic conditions that drive changes in Medicaid enrollment, as well as growth in health care costs in the overall health care market place. From its inception, Medicaid was designed to be counter-cyclical, so Medicaid spending increases more rapidly in an economic downturn. During such periods, people lose their jobs or their income drops, which makes it more likely that they will qualify for Medicaid for health coverage.

Looking back over the past decade, for example, Medicaid spending increased rapidly going into the last recession, including growth exceeding ten percent per year in 2001 and over 12 percent in 2002. Then, as the economy improved and enrollment growth slowed, spending growth declined to record low rates of 1.3 percent in FY 2006 and 3.8 percent in FY 2007. Slow growth in FY 2006 and FY 2007 was also impacted by the January 1, 2006 implementation of Medicare Part D, under which Medicare assumed what had been Medicaid's responsibility for prescription drugs for dual Medicaid – Medicare enrollees.[34] In 2008, the economy again began to slow, causing enrollment to grow and spending to increase. Annual average Medicaid spending growth rebounded to 5.8 percent in FY 2008, then peaked at 7.6 percent in FY 2009 before starting

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[31] States continue to pay the federal government part of the cost of prescription drugs for dual eligibles through a payment generally referred to as the "Clawback." However, the Clawback is classified as a source of financing for Medicare and is not counted as a Medicaid expenditure. In March 2010, CMS released guidance specifying that states could apply ARRA funds to help reduce state Clawback payments; however, they are still not counted as Medicaid spending. (http://www.cms.gov/smdl/downloads/SMD10004.pdf)

[32] 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 is determined by each state and is known to vary across states. In some states, for example, Medicaid-financed spending under the control of another agency such as a mental health or public health agency may be included, and not included in other states. The national rates of growth in Medicaid spending reported here are the weighted averages of growth rates reported by each state, with the weights based on actual expenditures for each state in FY 2010 as reflected in CMS Form 64 reports.

[33] FY 2011 spending levels were preliminary at the time of this survey, pending the official closing of the books for the fiscal year.

[34] States continue to pay the federal government part of the cost of prescription drugs for dual eligibles through a payment generally referred to as the "Clawback." However, the Clawback is classified as a source of financing for Medicare and is not counted as a Medicaid expenditure.

to slow in FY 2010 to 6.6 percent. High Medicaid spending and enrollment growth occurred just as state revenues plummeted throughout 2009, placing fiscal strain on states facing budget shortfalls. Without the ARRA enhanced FMAP, even more dramatic program cutbacks would have been necessary.

Total Medicaid Spending Growth for Fiscal Year 2012. Heading into FY 2012, most state economies were still depressed and states needed to budget for the end of the ARRA enhanced matching funds. On the positive side, many states were beginning to see signs that the economy was improving and state revenues were slowing increasing. It was in this context that the Medicaid budget and policy decisions were made during this period.

State legislatures appropriated growth in Medicaid spending for FY 2012 that averaged just 2.2 percent across all states, one of the lowest rates on record. A total of 11 states adopted initial appropriations assuming negative growth and another five states adopted appropriations with zero growth. Six states adopted Medicaid budgets with growth rates of ten percent or more.

Among the 16 states that assumed flat or negative growth in their FY 2012 appropriations, all except two projected positive enrollment growth, including six states projecting enrollment growth for 2012 that was at or above the national average of 4.1 percent. Arizona was the only state out of this group that estimated enrollment to decrease in 2012 (due to policy changes discussed in the eligibility section).

The annual spending and enrollment growth percentages are weighted averages, meaning the impact of spending and enrollment changes reported by larger states can have a larger impact. The numbers for 2012 are based on policy assumptions that states plan to implement during this upcoming fiscal year. Note that a state may not be able to implement a proposed policy without CMS approval. As past experience has shown, not all policies will be implemented as planned in the budget, which may result in different growth rates. In addition, some state legislatures passed budgets with appropriations set for Medicaid without enacting specific policies to achieve savings, instead leaving it up to the Medicaid agency to determine how to manage the budget. Since Medicaid is an entitlement and states are generally prohibited from restricting eligibility, it may be difficult for some state Medicaid programs to operate within the legislatively appropriated budget, which means that additional policy changes may occur in FY 2012 beyond those described in this survey, or supplemental appropriations may be needed later in the fiscal year. In fact, just over half of states indicated that the likelihood of a Medicaid budget shortfall in FY 2012 was at least 50 – 50; one-fourth said a Medicaid budget shortfall was virtually certain. This may result in actual annual Medicaid spending in FY 2012 that is higher than the initial appropriations.

In the 17 states that assumed flat or negative growth in their FY 2012 appropriations, almost all assumed some positive enrollment growth. In seven of these states enrollment growth for 2012 was at or above the national average of 4.1 percent. Arizona was the only state out of this group that estimated enrollment to decrease in 2012 (due to policy changes discussed in the eligibility section).

The spending and enrollment numbers are weighted averages, meaning the impact of spending and enrollment numbers reported by larger states can have a significant impact. The numbers for 2012 are based on policy assumptions that the state plans to implement during this upcoming fiscal year; however, in several cases a state may not be able to implement a certain policy without CMS approval. As past experience has shown, not all policies will be implemented as planned in the budget, which may result in different growth rates. In addition, some state legislatures passed budgets with appropriations set for Medicaid without enacting specific policies to achieve savings, instead leaving it up to the Medicaid agency to determine how to manage the budget. Since Medicaid is an entitlement and states are generally prohibited from restricting eligibility, it may be difficult for some state Medicaid programs to operate within the legislatively appropriated budget, and supplemental appropriations may be needed later in the fiscal year. In fact, just over half of states indicated that the likelihood of a Medicaid budget shortfall in FY 2012 was at least 50 – 50; one-fourth said a

Medicaid budget shortfall was virtually certain. This may result in actual annual Medicaid spending in FY 2012 that exceeds the initial appropriations.

B. State General Fund Spending Growth for Medicaid

Even though the growth in overall Medicaid spending authorizations for FY 2012 was at an historic low, states experienced large increases in their state general fund spending for Medicaid because the enhanced FMAP ended on June 30, 2011. States had to replace declines in federal support with increased state spending. On average, state general fund dollars appropriated for Medicaid increased by 28.7 percent in FY 2012 compared to the prior year, much larger than the 2.2 percent growth in total Medicaid spending. The increases in state spending occur as states continue to face budget shortfalls and depressed economic conditions.

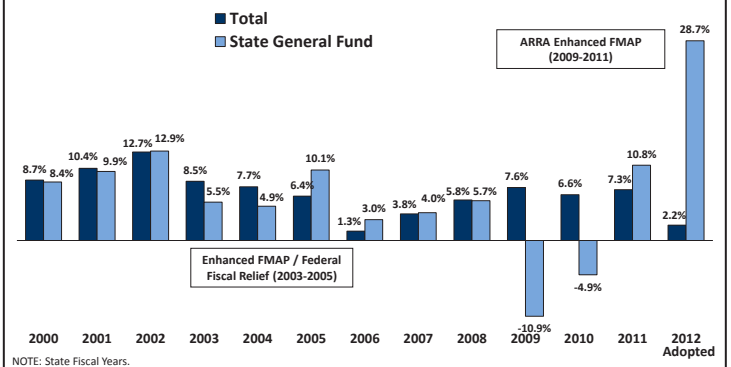
Both state and federal governments jointly pay for total Medicaid expenditures, but it is the cost to the state that is most relevant to state policy makers when making decisions about Medicaid payment rates, benefits or eligibility. The federal government provides matching funds to help pay for total Medicaid expenditures, but a state must be able to pay its share to obtain the federal matching funds.

Looking back historically, state and federal Medicaid spending typically grow at similar rates, but can grow at different rates from year to year due to a number of factors, such as changes in the FMAP, contributions from local governments, tobacco tax funding, special financing arrangements and provider taxes. During each of the past two recessions, Congress enacted temporary enhancements to the FMAP to provide fiscal relief to states that affected the state cost of Medicaid.

In 2003 and 2004, FMAPs were increased by 2.95 percentage points for five quarters, providing $10 billion in fiscal relief to states. In the more recent recession, the ARRA increased FMAPs by larger percentages than in 2003 and 2004, providing states with an additional $100 billion in federal funds over eleven quarters. Unlike in 2003 and 2004, the magnitude of the federal financing under ARRA resulted in a decline in the state share of Medicaid spending for the first time in the history of the Medicaid program. State general fund spending on Medicaid fell by 10.9 percent in FY 2009 and by 4.9 percent for FY 2010 while total spending increased. (Figure 21)

FIGURE 21

Total and State Funds Medicaid Spending Growth FY 2000 – FY 2012



NOTE: State Fiscal Years.

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

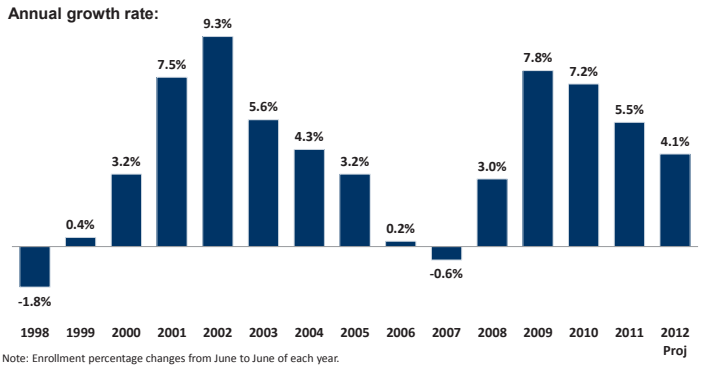
With the phase-down of the enhanced FMAP in FY 2011 and the expiration of ARRA funds in FY 2012, the federal share of federal Medicaid spending declined and state spending increased. This shift caused artificial jumps in state spending, beyond the effects of underlying program growth. In both these years, state general fund Medicaid spending growth was higher than total spending growth. For FY 2011, state Medicaid costs increased by 10.8 percent while total spending increased by 7.3 percent. For state FY 2012, legislatures appropriated increases in the state general fund cost of Medicaid that averaged 28.7 percent, the largest annual increase in the program's history. Attempts to mitigate the increase in general fund spending despite shifts in the share of financing from the federal government to the states contributed to lower overall increases in Medicaid spending than might otherwise have been expected.

C. Medicaid Enrollment Growth

The lingering economic downturn and high levels of unemployment continue to drive increases in Medicaid enrollment. In FY 2011, Medicaid enrollment increased on average by 5.5 percent (Figure 22). For the second consecutive year, the pace of enrollment growth moderated, down from 7.8 percent in FY 2009 and 7.2 percent in FY 2010. The actual growth of 5.5 percent was somewhat less than the 6.1 percent projected by states at the beginning of fiscal year 2011. While no state experienced a drop of enrollment in FY 2011, more than half of all states experienced actual growth below projections made at the time the budget was adopted.

FIGURE 22

Change in Medicaid Enrollment, FY 1998 – FY 2012



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

SOURCE: For 1998-2010: *Medicaid Enrollment June 2010 Data Snapshot*, KCMU, February 2011. FY 2011 and FY 2012 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2011.

For FY 2012, Medicaid enrollment is projected to increase on average by 4.1 percent. Compared to actual growth in FY 2011, 37 states projected enrollment growth that was either slower or the same. Only Minnesota projected enrollment growth in FY 2012 that was significantly higher than in FY 2011. This was largely attributable to increases in enrollment tied to the decision to take advantage of the early option in the ACA to cover childless adults. Only one state – Arizona – projected a net drop in enrollment for FY 2012. These changes were tied to specific policy changes that will be discussed in the eligibility section.

D. Factors Contributing to Medicaid Spending and Enrollment Growth

For the fiscal years 2011 and 2012, the leading factor driving spending growth reported by all but one state was the economy and increases in the number of persons enrolled in Medicaid due to continuing high rates of unemployment. Other factors included increases in utilization of services and health care inflation. States also listed factors that were acting to constrain the growth in Medicaid spending. Most frequently mentioned were rate freezes or reductions, along with other policy actions taken to slow or reduce spending growth, including utilization controls, benefit restrictions, payment reform, increased efforts in program integrity and recoveries, and greater use of managed care. Greater detail is provided in following sections of this report on FY 2011 and FY 2012 policy changes.

The primary drivers of Medicaid enrollment growth in both FY 2011 and 2012 were the economic downturn and continued high unemployment, which were factors in all states. Children and families - the eligibility groups most affected by the economic downturn - accounted for a significant share of growth in enrollment in FY 2011 and the growth expected in 2012. The five states that currently cover uninsured childless adults under a Medicaid waiver also cited growth in this group. A total of 16 states listed growth among persons with disabilities as increasing somewhat faster than expected or as a factor in overall enrollment growth, but for the most part growth among the elderly and disability groups has been steady and is related more to demographic trends than to changes in the economy. However, even slow growth in these populations is significant because the elderly and disabled have much higher per capita costs.

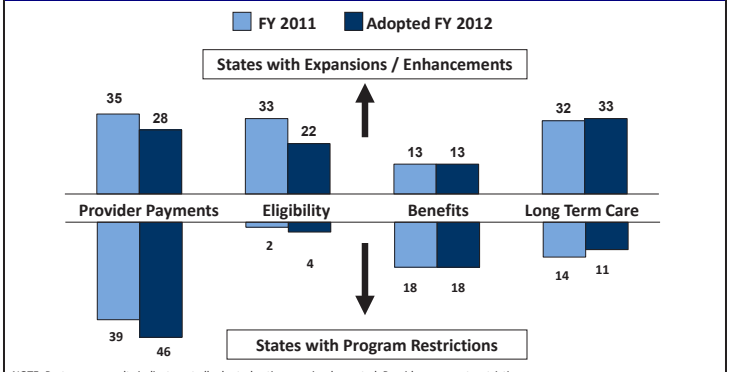
3. Medicaid Policy Initiatives for FY 2011 and FY 2012

Key Section Findings:

- In FY 2011, 47 states implemented at least one new policy to control Medicaid costs and 50 states planned to do so in FY 2012. Some states reported program reductions in multiple areas and also reported that mid-year budget reductions were possible.
- As in previous years, provider rate restrictions were the most commonly reported cost containment strategy. A total of 39 states restricted provider rates in FY 2011 and 46 states reported plans to do so in FY 2012. Some states increased or imposed new provider taxes that mitigated provider rate cuts in some cases.
- Restrictions to Medicaid eligibility or enrollment and reenrollment policies and procedures are generally prohibited under the MOE requirements in ARRA and the ACA. For FY 2011, 33 states made enhancements to eligibility standards or enrollment and renewal processes, and 22 states have plans to do so in FY 2012.
- Eighteen states reported eliminating, reducing or restricting benefits in both FY 2011 and FY 2012, down only slightly from the historic high of 20 states reporting benefit cuts for FY 2010. Seven states in FY 2011 and 19 in FY 2012 implemented or plan to implement cost containment actions focused on specialty drugs.
- There is a notable increase in the number of states raising or imposing new copayment requirements compared to previous surveys (five states in FY 2011 and 14 in FY 2012). A number of states had new or increased copayments for pharmacy or emergency room visits, and a few states were seeking broader authority to impose copayments above nominal levels to some previously exempt populations through waivers.
- A majority of states (32 states in FY 2011 and 33 in FY 2012) are continuing to increase HCBS service options, while a few states (14 in FY 2011 and 11 in FY 2012) have also implemented HCBS or institutional utilization controls and service limits.

FIGURE 23

State Policy Actions Implemented in FY 2011 and Adopted for FY 2012



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

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

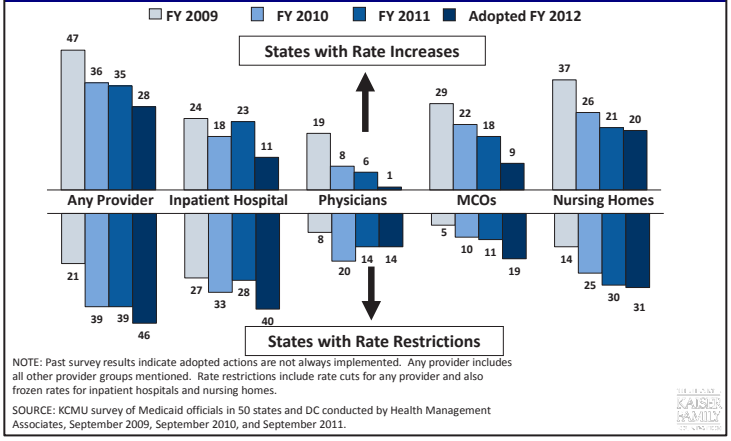
A. Changes in Provider Reimbursement

Rate Changes. State actions around provider rate changes are directly related to state fiscal conditions. Rate changes have an immediate impact on state budgets. During the economic downturn from 2001 to 2004, every state froze or cut provider payment rates to control costs, but starting in 2005, as the economy improved, states were less likely to cut and more likely to increase provider rates. During this recent recession, states again turned to provider rate cuts to control costs. Due to the maintenance of eligibility requirements in ARRA and then in the ACA, with only limited exceptions, states cannot restrict eligibility. This leaves states with few levers to control spending. Provider rates are an important determinant of provider participation and access to services for Medicaid beneficiaries, so cutting Medicaid rates (which are typically lower than Medicare or commercial insurance) can jeopardize provider participation in the program as well as access.

The ARRA enhanced FMAP mitigated some of the rate cuts that might have occurred; 35 states in FY 2010 and 34 states in FY 2011 reported that the ARRA funds helped to avoid or reduce provider rate cuts. However, even with enhanced ARRA funding, more states are restricting provider rates than increasing them. For FY 2011, 39 states reported rate restrictions for any provider type and 35 states reported rate increases for any provider. For FY 2012, when ARRA funds expired, 46 states planned provider rate restrictions compared to 28 states with planned rate increases as shown in Figure 24.

FIGURE 24

States with Provider Rate Changes FY 2009 – FY 2012



NOTE: Past survey results indicate adopted actions are not always implemented. Any provider includes all other provider groups mentioned. Rate restrictions include rate cuts for any provider and also frozen rates for inpatient hospitals and nursing homes.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, September 2010, and September 2011.

Institutional providers like hospitals and nursing homes are more likely than other providers to have inflation adjustments built into their rates, so historically they have been more likely than other groups to have rate increases and less likely than other provider groups to experience Medicaid rate cuts. States are also more likely to use provider tax arrangements to bolster Medicaid payment rates for these provider groups. Even accounting for inflation adjustments and new or increased provider taxes, more states restricted rates for these providers in FY 2011 and FY 2012 than increased rates. A total of 28 states restricted hospital payment rates in FY 2011 (16 states froze rates and 12 states reduced rates) and a total of 40 states planned rate restrictions for hospitals in FY 2012 (25 states plan to freeze rates and 15 states planned rate cuts). A total of 30 states restricted rates for nursing homes in FY 2011 (24 rate freezes and 6 cuts) and 31 states planned restrictions for FY 2012 (17 states plan to freeze rates and 14 states planned rate cuts).

Managed Care Organizations (MCOs) are generally protected from rate cuts by the federal requirement that states pay actuarially sound rates. However, MCO rates are often tied to fee-for-service rates, so when states cut fee-for-service provider rates, this may affect MCO rates too. In FY 2011, 18 states reported MCO rate increases and 11 states reported MCO rate cuts. For FY 2012, only nine states reported plans to increase MCO rates and 19 states reported plans to cut rates.

In prior recessions, physician rates have not been increased, but have seldom been cut by many states. In this survey, only 6 states in FY 2011 and one state in FY 2012 increased physician rates; in both FY 2011 and FY 2012, a total of 14 states implemented or adopted physician rates cuts. For this survey, states were asked to

report separately about rate changes for primary care physicians and specialists. In FY 2011, five states reported rate increases for primary care physicians and five states reported rate increases for specialists.[35] For FY 2012, one state (Alaska) reported rate increases for both primary care physicians and specialists. In both FY 2011 and FY 2012, primary care physicians were slightly less likely than specialists to see rate cuts. Prior to the recession, many states had implemented rate increases for dentists in an effort to promote participation of dentists in the program and expand access to dental care. However, fiscal pressures resulted in 11 states with cuts to dental rates in FY 2011 and 13 states that adopted cuts to dental rates in FY 2012. Only four states reported increases in dental rates for FY 2011 and three states planned increases for FY 2012 (Table 1).

Table 1: Number of States Changing Physician or Dental Payment Rates, FY 2011 and FY 2012

Certain Provider Rate Changes	*Fiscal Year 2011*		*Fiscal Year 2012*	
	Increase	Decrease	Increase	Decrease
Primary Care Physicians	5	11	1	9
Specialists	5	14	1	14
Dentists	4	11	3	13

The survey also provided states with an opportunity to provide information about rate changes to other categories of providers. Most states reported additional rate cuts. While the lists of providers with rate cuts were frequently long and varied significantly from state to state, the following were most often cited for rate cuts in either 2011 or 2012: medical equipment, medical supplies and related supports, ambulance, home health, various mental health providers, outpatient hospital, chiropractor, non-emergency medical transportation, HCBS providers, and podiatry. Some states reported rate increases, some of which occurred because the state sets Medicaid rates at a percentage of Medicare rates. A few states indicated rate increases for Federally Qualified Health Centers (FQHCs) or that certain providers were exempt from across -the-board rate cuts. Common exemptions from across-the-board rate cuts included FQHCs as well as HCBS and Hospice providers.

While the survey did not require that states indicate the magnitude of provider rate changes, several states provided a detailed response. The responses of several states are notable:

- **Arizona** cut most provider rates other than nursing home rates by five percent as of April 1, 2011. An additional across-the-board five percent cut was planned for October 1, 2011.
- **California** plans to implement up to a ten percent across-the-board payment reduction retroactive to June 1, 2011, pending federal approval. Nursing facilities were able to negotiate an actual rate increase that restores the prior cuts, in part through an increase in the nursing facility provider tax rate. Prior year rate reductions are the subject of litigation (see box later in this section).
- The **District of Columbia** reported a twenty percent across-the-board reduction for all physician rates and a ten percent cut for dental rates for FY 2011. (This reduction comes shortly after DC increased rates to Medicare levels).
- **New York** implemented a 1.1 percent across-the-board provider rate cut in FY 2011. For FY 2012, the state adopted a two percent across-the-board rate cut.[36] In addition, as part of the Medicaid Reform Team efforts, New York has implemented a Global Medicaid Cap, which limits state spending to a

[35] In 2011, four states reported increases for both primary care physicians and specialists. Washington reported an increase for primary care physicians but not specialists, while Louisiana reported an increase for specialists but not primary care providers.

[36] A 2% rate cut was passed as part of the original MRT recommendations. The state is working with providers in each sector to tailor cuts; this process is ongoing. "October 5 Status Update." Medicaid Redesign Team, accessed October 7, 2011. http://www.health.state.ny.us/health_care/medicaid/redesign/.

specified amount.[37] If spending is projected to exceed the cap, the Commissioner of the Department of Health has been given the authority to implement, without having to seek the approval of the legislature, Medicaid Savings Allocation Plans, which can include changing provider reimbursements (e.g., fees, premium levels, rates) as well as modifying program benefits.[38]

- **South Carolina** reduced all Medicaid provider rates by three percent as of April 2011. For FY 2012 all provider rates other than nursing facilities were cut further. The FY 2012 rate cuts vary, but most are three percent or greater.
- **Tennessee** implemented across-the-board rate cuts of 4.25 percent; however hospital rates were not cut due to an increase in hospital assessment fee.[39]

Four states (Alaska, North Dakota, West Virginia, and Wisconsin)[40] reported no rate restrictions in FY 2011 or FY 2012. There were 12 states that did not cut rates in 2011 and six states that did not cut rates in 2012; this includes Illinois where the legislature approved a Medicaid appropriation that was $1.4 billion lower than the previous fiscal year and prohibited any provider rate cuts to constrain Medicaid spending. North Dakota increased provider rates across the board by six percent for FY 2011. For FY 2012, providers other than physicians in North Dakota are receiving an additional three percent rate increase.[41]

[37] "Monthly Global Cap Updates." New York Department of Health. Accessed August 28, 2011. http://www.health.state.ny.us/health_care/medicaid/regulations/global_cap/

[38] Once developed, such plans will be posted to the DOH Web site and written copies will be provided to the Legislature at least 30 days prior to implementation.

[39] For other providers in the state, the originally proposed cuts of 8.5 percent were lowered to 4.25 percent based on the assumption the state is successful in its settlement with CMS over the Special Disability Workload dispute. If the state is unsuccessful, the originally planned rate cuts of 8.5 percent will be implemented on January 1, 2012. While other states have similar claims, the FY 2012 budget for Tennessee has actually included this funding as an assumed revenue source.

[40] Wisconsin was in the process of setting rates for their managed care organizations at the time of survey and therefore was counted as having no rate restrictions in either year.

[41] Physician rates are not being increased since the reimbursement was already approximately 140 percent of the Medicare fee schedule.

Recent Court Action and Regulations Related to Provider Rates

Supreme Court Case. In response to the significant budget crisis in California, the state passed a law to reduce reimbursement rates for a variety of Medicaid providers, including pharmacy, physician, dental, adult day health, clinic, and non-emergency transportation, by ten percent. A group of Medicaid providers and beneficiaries sued the state, asserting that the rate reductions would cause providers to stop participating in the Medicaid program and make it more difficult for beneficiaries to obtain necessary medical services. Due to injunctions issued as part of the lawsuits, California has been prohibited from implementing the rate cuts until the issue as to whether they violate the equal access provisions in Medicaid is decided.

The court that initially heard the case ruled that the plaintiffs had not established a cause of action and therefore that the court could not decide the case. The Ninth Circuit Court of Appeals reversed this decision. The lower court then determined that California's law conflicted with the federal Medicaid law's equal access provision because there was no evidence that the state legislature had considered how the reduced payment rates would affect factors such as efficiency, economy or quality of care. The Ninth Circuit affirmed that decision. Subsequently, the Supreme Court agreed to hear the case. In June, the US Solicitor General filed an amicus brief in support of the State's position that providers and beneficiaries had not established a cause of action to enforce the Medicaid statute.

On October 3, 2011, the Supreme Court heard oral arguments in a group of three cases, *Douglas v. Independent Living Center of Southern California, Douglas v. California Pharmacists Association,* and *Douglas v. Santa Rosa Memorial Hospital* (referred to collectively as "the *Douglas* case").[42] The Supreme Court will not consider whether California's rate reduction law actually violates the federal Medicaid Act. Instead, the Court will decide a preliminary issue: whether Medicaid providers and beneficiaries should be allowed to bring this lawsuit seeking to enforce the federal Medicaid Act. If providers and beneficiaries cannot establish a cause of action to take cases to court, enforcement of the Medicaid Act is up to CMS. However, the CMS administrative process to determine whether a state law is in violation of the Medicaid law does not provide for preliminary injunctive relief, in which courts can stop implementation of state laws that violate the Medicaid Act immediately, as in the Douglas case.[43]

Payment and Access Proposed Regulation. Related to this litigation, on May 6, 2011, CMS issued a proposed rule that would, for the first time, provide federal regulatory guidance regarding what states must do to demonstrate their compliance with the access requirement under federal Medicaid law.[44] Under the proposed rule, state Medicaid agencies would have to review access to a subset of Medicaid-covered services every year, and review access to every Medicaid-covered service at least once every five years. If a state identifies access issues through its reviews or monitoring, it would have to submit a corrective action plan to CMS within 90 days. The proposed rule also would significantly change the process for reducing Medicaid payments to fee-for-service providers. State Medicaid agencies that seek to reduce Medicaid payment rates would have to submit to CMS along with a state plan amendment an access review for the service in question that has been completed within the last 12 months and which demonstrates sufficient access to care. The state Medicaid agency also would have to submit an analysis reflecting its consideration of beneficiary and stakeholder input of the impact of the proposed rate change on access to the affected service.[45]

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[42] U.S. No. 09-958, U.S. No. 09-1158, and U.S. No. 10-283.

[43] *Explaining Douglas v. Independent Living Center: Questions about the Upcoming United States Supreme Court Case Regarding Medicaid Beneficiaries' and Providers' Ability to Enforce the Medicaid Act.* Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/medicaid/8240.cfm.

[44] Federal Register, May 6, 2011 (Vol. 76, No. 88), pp 26342 – 26362, at http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf.

[45] *Provider Payment And Access To Medicaid Services: A Summary of CMS' May 6 Proposed Rule*. Kaiser Commission on Medicaid and the Uninsured, July 2011. http://www.kff.org/medicaid/8207.cfm.

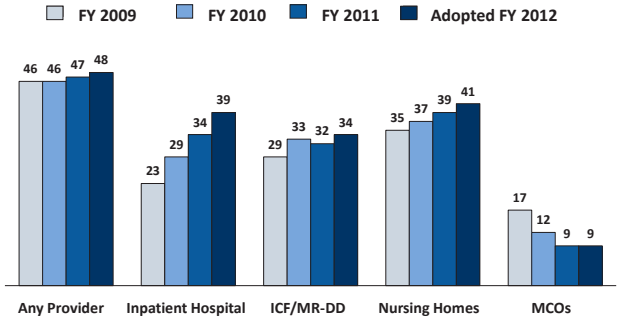
Provider Rates and Access to Care. States were asked to discuss issues for their state related to the proposed federal regulations requiring a study of the adequacy of access to care before provider rates can be cut. States commented that the proposed regulations would be an administrative burden and could delay rate cuts adopted by the legislature if the state is required to perform a study. States also had concerns about how adequate access would be defined, if a causal relationship between Medicaid rates and access could be demonstrated, and the prospect that the new rules would result in increased litigation risks. Some states indicated that if they were already prohibited from restricting eligibility and the proposed regulations would potentially limit the ability to impose rate cuts, then benefit adjustments and utilization management are the remaining tools to control Medicaid costs. Some states believe that these regulations could lead to substantial reductions in optional Medicaid benefits.[46]

Provider Taxes. States have increasingly relied on provider taxes to provide a portion of the non-federal share of the costs of Medicaid. At the beginning of FY 2003, a total of 21 states had at least one provider tax in place; the most common provider tax was a tax on nursing facilities (14 states.) For FY 2012 there are 48 states with one or more provider taxes in place (Figure 25). Only Alaska, Delaware[47] and Hawaii do not have any Medicaid provider taxes.[48]

During the recent economic downturn, states imposed new taxes and increased existing taxes to raise revenues. States often use additional revenue from provider taxes to support rate increases or to help mitigate rate reductions; although, some states use provider tax revenues more broadly (e.g. to fund a coverage expansion in Colorado). The most common Medicaid provider tax is still a tax on nursing facilities (41 states in FY 2012). Figure 25 shows changes in the number of provider taxes by major categories of providers. The most dramatic change from FY 2009 to FY 2012 is the increased use of hospital taxes. In a prior report we found that in FY 2003 there were ten states with Medicaid hospital taxes. That increased to 23 states in FY 2009 and is now 39 states in FY 2012. The number of states imposing Managed Care Organization (MCO) taxes has declined due to a change in federal law which required that MCO taxes be applied broadly to all providers (similar to the treatment of other provider taxes). A number of states that had applied taxes to a narrow set of MCOs, commonly Medicaid MCOs, subsequently dropped their taxes after the change in law. Some states already had broad based MCO taxes and others modified their MCO taxes to meet the new requirement. Other states, such as Michigan, replaced their MCO taxes with new taxes on all health care claims; however, this is not counted as a provider tax under federal regulations.

FIGURE 25

States With Medicaid Provider Taxes FY 2009 – FY 2012



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

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, September 2010, and September 2011.

Appendix Table A-3 provides a complete listing of Medicaid provider taxes in place for FYs 2011 and 2012.

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[46] NAMD Comments filed on CMS-2328-P, "Medicaid Program; Methods for Assuring Access to Covered Medicaid Services." July 5, 2011. http://www.namd-us.org/images/stories/accesspaymentregulation070511.pdf.

[47] Delaware Medicaid officials indicate that various provider taxes have been considered in recent years but none have been implemented.

[48] In some states the Medicaid program is also funded with other special taxes that are not categorized as Medicaid provider taxes. These include broad-based insurance taxes applied to all insurers, gross receipts taxes that are not a health care tax, or claims taxes that are applied to all health care claims. There are a handful of taxes of these types that are not included in the tables in this report.

Provider Taxes: Requirements and Proposed Changes[49]

Provider taxes are defined as any mandatory payment, including licensing fees or assessments, in which at least 85 percent of the burden falls on health care providers. Assessments or fees imposed on health insurance premiums paid by individuals or employers are not provider taxes. Federal regulations list 19 different classes of health care services on which provider taxes may be imposed including inpatient hospital services, nursing facility services, intermediate care facility services for individuals with intellectual disabilities, physician services, and services furnished through managed care organizations. States may not use the revenues from a provider tax as state share unless CMS determines that the tax meets three basic requirements: they must be broad-based, uniformly imposed, and must not hold providers harmless.

Taxes Must Be Broad-Based. In order to be considered broad-based, a provider tax must be imposed on all the health care items or services furnished by all the non-federal, non-public providers in the class in the state. For example, in the case of a tax on inpatient hospital services, a tax would not be broad-based if it exempted private nonprofit hospitals generally, or if it applied only to the hospitals in one region of the state. Public hospitals, however, could be exempt from the tax.

Taxes Must Be Uniformly Imposed. In general, a provider tax is uniformly imposed if it is the same amount or rate for each provider in the class. If a tax allows for credits or exclusions that result in the return to the provider of all or a portion of the tax paid, and if the net effect of the tax program is not "generally redistributive," then the tax would not be considered to be uniformly applied.

Taxes Cannot Hold Providers Harmless. A provider tax is considered to hold the provider harmless if the providers paying the tax receive, directly or indirectly, a non-Medicaid payment from the state or any offset or waiver that guarantees to hold the provider harmless for all or a portion of the tax. A provider tax is also considered to hold the provider harmless if the Medicaid payments to the provider vary based only on the amount of the taxes paid by the provider. Federal regulations create a safe harbor from this hold-harmless test for taxes that produce revenues at 5.5 percent or less of the revenues received by a provider; this threshold increased to six percent on October 1, 2011.

Secretary of HHS Can Waive Certain Provider Tax Requirements if Certain Conditions are Met. The Secretary is authorized to waive the broad-based and uniform tax requirements (but not the hold-harmless requirement). Thus, a tax might not apply to all providers in a class, or it might not be applied uniformly to the providers to which it does apply (rural and sole community providers are expressly cited as allowable exemptions). The Secretary may waive the broad-based and uniformity requirements, however, only if the net impact of the tax is "generally redistributive" (as determined by quantitative tests set forth in regulations) and not directly correlated with Medicaid payments to the providers subject to the tax.

Proposed Changes to Provider Taxes. Several proposals aimed at reducing the federal deficit have included proposals to limit states' ability to use provider tax revenue for Medicaid. Most recently, the President's Plan for Economic Growth and Deficit Reduction proposed to reduce the safe harbor threshold from 6 percent in 2014 to 4.5 percent in 2015, four percent in 2016 and 3.5 percent in 2017 and beyond. The Administration estimates that this proposal would yield $26.3 billion in federal savings over ten years.

During the period of enhanced FMAP through ARRA, a few states were able to temporarily reduce some provider taxes, commensurate with the reduced state share of Medicaid costs. In FY 2011, only two states reduced hospital taxes while just one reduced taxes on nursing facilities; all three were then increased in FY 2012. For FY 2012, only one hospital tax is scheduled for reduction. More states reported increases to existing provider taxes in FY 2011 and FY 2012. The original legislation establishing the parameters for allowable

[49] *Medicaid Financing Issues: Provider Taxes.* Kaiser Commission on Medicaid and the Uninsured, May 2011. http://www.kff.org/medicaid/8193.cfm

Medicaid provider taxes limited the amount of provider tax revenues eligible for federal matching dollars to an aggregate of 6 percent of the net patient revenues of the category of providers subject to the tax. That limit was temporarily reduced to 5.5 percent but returned to 6 percent on October 1, 2011. Many states report that taxes will increase when the limit is changed.

As part of the discussions around federal deficit reduction, the President has proposed a reduction in the amount of provider tax revenue eligible for federal matching dollars as a way to save federal funds. One limit that has been suggested is 3.5 percent. To assess the potential impact of such a policy change, states were asked whether any existing Medicaid provider taxes exceed the 3.5 percent of net patient revenues. States indicated that 29 nursing facility taxes, 28 ICF-ID taxes, ten hospital taxes, two MCO taxes and five taxes for other providers exceed the 3.5 percent level as of FY 2012. States noted that a reduction in the ceiling on Medicaid provider taxes would have a significant impact on state budgets, Medicaid provider payment rates or both. Some states indicated that state finances are too weak to replace the lost revenue. Additionally, some states noted that these provider taxes help fund the Medicaid program more broadly than just payments to the category of providers that pays the tax.

Table 2: Number of States with Changes in Provider Taxes, by Provider Type, FY 2011 and FY 2012

Provider Taxes	***Rate Decreases***		***Rate Increases***		***Total Taxes***	***Taxes Above 3.5% Net Patient Revenues***[50]
	FY 2011	**FY 2012**	**FY 2011**	**FY 2012**	**FY 2012**	**FY 2012**
Hospital	2	1	13	17	39	10
ICF-ID	0	0 (1 tax was eliminated)	3	12	34	28
Nursing Facility	1	0	11	21	41	29
MCO	0 (1 tax was eliminated)	0	1	1	9	2
Other Provider	0	0 (1 tax was eliminated)	2	1	18	5

[50] A small number of states reported that they were not sure if their some of their provider taxes were above 3.5 percent of net patient revenues.

B. Eligibility and Enrollment Process Changes

Medicaid eligibility standards determine who can qualify for the program. The enrollment and renewal procedures can impact the ease with which individuals that are eligible for assistance from Medicaid can actually access the program and its services. Under the ARRA and ACA MOE requirements, states have been and continue to be prohibited from restricting eligibility. These MOE provisions have helped to ensure coverage for millions of low-income individuals, particularly children, during the economic downturn.

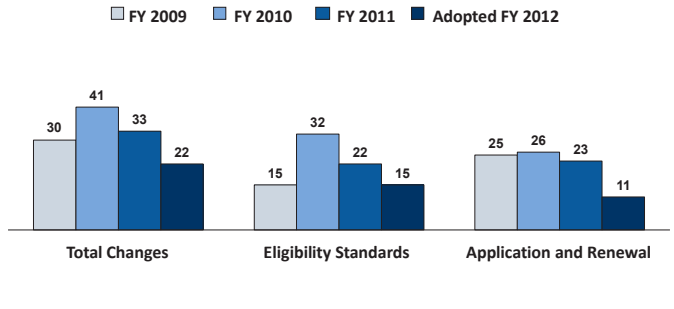
Maintenance of Eligibility (MOE) Requirements

As a condition of accepting additional federal fiscal relief through the ARRA, states were required to ensure that the eligibility standards, methodologies, or procedures under its Medicaid State Plan as well as under any waivers or demonstration programs were not more restrictive than those in effect on July 1, 2008. The ARRA enhanced funding and MOE requirements expired on June 30, 2011, but the ACA extended the ARRA MOE provisions. The ACA provides that states must maintain eligibility standards, methodologies and procedures that were in place on March 23, 2010, until Health Insurance Exchanges are operational. One exception to this requirement is for non-pregnant, non-disabled adults with incomes that exceed 133 percent of the federal poverty level in states certifying that they project a budget shortfall. Certain other exceptions apply to waiver coverage. For children, current eligibility levels and enrollment policies must be maintained through 2019.

During the last economic downturn in the early 2000s, federal fiscal relief enabled many states to avoid changes in eligibility standards; however, without prohibitions on restrictions to enrollment processes, many states made changes such as increasing the documentation requirements or increasing the frequency for eligibility determinations, which had immediate effects on slowing caseload growth. Many of these types of changes were reversed as states emerged from the last downturn. In FYs 2007 and 2008, several states implemented significant Medicaid coverage initiatives to help reduce the number of uninsured.

While states are now prohibited from restricting eligibility standards and enrollment procedures, Figure 26 shows that a number of states have taken actions between 2009 and 2012 to expand Medicaid eligibility or make the enrollment and renewal processes easier despite the recent recession. In FY 2010, 41 states made positive eligibility and enrollment changes, followed by 33 states in FY 2011. In FY 2012, 22 states plan positive changes. More detail about these changes related to eligibility standards and application processes is provided below. A complete listing of all changes by state and fiscal year is provided in Appendix A-4a and Appendix A-4b.

FIGURE 26
States With Eligibility Expansions / Enhancements FY 2009 – FY 2012



NOTE: Past survey results indicate adopted actions are not always implemented.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, September 2010, and September 2011.

Changes to Eligibility Standards. Eligibility standards are the rules related to age, family status, immigration and residency status, disability status, income and assets that determine whether an individual or family is eligible for healthcare services from the Medicaid program. As previously noted, due to the ARRA and ACA MOE requirements, states have been prohibited from implementing virtually all eligibility cuts. Despite challenging state fiscal conditions, a number of states have implemented eligibility expansions.

Table 3 lists a few of the more common eligibility changes that were implemented in FY 2011 or planned for FY 2012.

Table 3: Key Eligibility Changes

Eligibility Change	*States in FY 2011*	*States in FY 2012*
Adopted ICHIA Option	DE, IL, NE, NC, TX	VT
Expansion of Childless Adult Coverage	CA, DC, MN, NJ, WA	CO, MN
New or Expanded Buy-In or TWWIAA option	TX	CO, IL
Implement or Expand a Family Planning Coverage under a Waiver or a State Plan Amendment	GA, SC, WI	CT, IA, MD, NM, OH, VT, WA

There was a peak in the number of states implementing expansions of eligibility standards in FY 2010 as a number of states took advantage of new options made available under CHIPRA. For example, in FY 2010, 17 states implemented the CHIPRA option to cover children and/or pregnant women that are legal permanent residents with less than five years of US residency (ICHIA). In FY 2011 and FY 2012 an additional six states implemented the ICHIA option to cover legal immigrant children and/or pregnant women, bringing the total number of states up to 26 that have chosen this option for one or both of these groups (including 3 states that adopted this option in 2009.)

The ACA made it possible as of April 2010 for states to be "early adopters" of coverage of childless adults with incomes below 133 percent of the federal poverty level without a federal waiver. Funding of these initiatives is set at regular Medicaid matching rates through 2013, at which point the cost of coverage for this expansion population would change to 100 percent federal funding beginning on January 1, 2014. When adopting the early option, states may choose to expand coverage to a lower income threshold. Connecticut and the District of Columbia took advantage of this option in FY 2010. In both of these cases, the state was able to transition state-funded coverage programs to Medicaid and access federal matching dollars. In FY 2011, Minnesota also took advantage of the early coverage option and similarly converted a state-funded program into a Medicaid program accessing the federal matching dollars. In FY 2011 and FY 2012, six states are implementing new initiatives to cover childless adults in Medicaid through waiver initiatives. Under waivers, states obtained authority as part of their expansions to impose an enrollment cap, provide more limited benefits, and cover adults with incomes above 133 percent of poverty.[51]

Other positive eligibility changes in FYs 2011 and 2012 include: increases in income and asset limits or disregards (five states); new or expanded programs for disabled individuals to "buy-in" to Medicaid (the "Ticket to Work" or TWWIAA program) when they are over the financial qualifications (three states); increases in enrollment caps for waiver programs (three states), and new premium assistance programs (two states).

Ten states implemented or expanded coverage for family planning services under a waiver or through a state plan amendment (SPA) (a new option available under the ACA). In addition, a number of states reported plans to convert family planning waivers to a state-plan service. Family Planning waivers are required to meet "budget neutrality" standards that are not required under the state plan option. In some states, this could mean an increase in the number of individuals served; however, in most cases this conversion maintains but does not increase coverage. The states converting waivers to SPAs were noted in this survey, but were not counted as expanding eligibility unless there was an explicit increase in coverage groups.[52] These enrollees do not receive full scope Medicaid benefits; they only receive family planning services.

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[51] Additional states had childless adult waivers under Medicaid that pre-dated the ACA state plan option. See: *Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults.* Kaiser Commission on Medicaid and the Uninsured, February 2011. http://www.kff.org/medicaid/7993.cfm.

[52] California in 2011 and North Carolina and Virginia in 2012 reported conversions of family planning waivers to SPAs that did not include new eligibility groups. New Hampshire also reported potentially implementing a state plan amendment for family planning

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

- **California,** as part of its "Bridge to Reform" Section 1115 Medicaid waiver, expanded coverage to low-income adults through the Low-Income Health Program Coverage Expansion (LIHP) that builds upon coverage initiatives operating in ten counties. An estimated 455,000 low-income uninsured adults may gain coverage through LIHPs. LIHP coverage will be provided at the option of each county to: Medicaid Coverage Expansion (MCE) adults (non-pregnant adults between ages 19 and 64 who are not enrolled in Medicaid or CHIP and have family incomes at or below 133 percent of poverty) and Health Care Coverage Initiative (HCCI) adults (non-pregnant adults between ages 19 and 64 with family incomes between 133 percent and 200 percent of poverty, or a lower threshold set by the county).[53]
- **Colorado** plans to expand coverage to about 10,000 adults without dependent children through an 1115 waiver in early 2012. The expansion is funded by a hospital fee.
- **Illinois** implemented the ICHIA option to cover immigrant children in FY 2011. The implementation was retroactive to April 2009 since the state had been providing coverage for these children at state expense. Approximately 21,000 children were enrolled.
- **Minnesota** expanded coverage to childless adults with incomes up to 75 percent of poverty beginning March 1, 2011, under the ACA state plan option, providing Medicaid coverage for approximately 95,000 additional people.[54] On August 1, 2011, the state further expanded coverage for childless adults with incomes between 75 and 275 of poverty through an 1115 waiver, expected to total 35,000 adults.
- **New Jersey** implemented coverage for 59,000 childless adults with incomes below 24 percent of FPL on April 15, 2011, who were previously covered through a state funded program.
- **New York** anticipates implementing continuous coverage for adults during FY 2012 through a Section 1115 waiver.[55] The estimated number of individuals that would be affected is 61,000.
- **Ohio** plans to implement a new family planning waiver January 2012, adding about 54,000 people.
- **Oregon** has a reservation (waiting) list for the Oregon Health Plan (OHP) Standard program. In FY 2011 the number of randomized drawings from that list will be increased to reach an average monthly enrollment of 50,000 (which is 25,000 higher than the prior target). In FY 2012 the number will be further increased to reach an average monthly enrollment of 60,000.
- **Washington** implemented its "Transitional Bridges Demonstration" in January 2011, extending Medicaid coverage to 53,000 childless adults previously covered under the state's Basic Health program.

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rather than renewing their current waiver; however, as there was no definitive plan to implement the change this fiscal year at the time of the survey, this change was not counted as an expansion for purposes of this report.

[53] *California's "Bridge to Reform" Medicaid Demonstration Waiver.* Kaiser Commission on Medicaid and the Uninsured, June 2011. http://www.kff.org/medicaid/8197.cfm.

[54] The state estimated that 83,000 of these individuals were previously covered under the state-funded coverage in the GAMC and MinnesotaCare programs. "Minnesota Received Federal Approval for Medical Assistance Expansion." Press Release from Governor's Office, February 17, 2011. http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=9826.

[55] New York received approval from CMS of this amendment to their Federal-State Health Reform Partnership (F-SHRP) waiver in April 2011. The continuous eligibility policy for adults was retroactive to February 1, 2010. http://www.health.ny.gov/health_care/managed_care/appextension/health_reform_partnership/docs/extension_approve.pdf.

Exceptions to the MOE Requirements

Waiver Exceptions to the MOE. While states are generally prohibited from restricting eligibility, there are a few exceptions.[56] In February 2011, CMS issued guidance that specified that a state can modify or terminate a demonstration waiver that was in effect on March 23, 2010 at the end of the demonstration approval period since the MOE does not require a state to continue a waiver beyond the expiration date. Arizona operates its Medicaid program under a longstanding waiver that was set to expire on September 30, 2011. Under the waiver exceptions, the state has been able to make certain eligibility cuts as part of negotiations with CMS over its expiring waiver. Specifically, Arizona froze enrollment in the Medical Expense Deduction (spend-down) component of Medicaid on May 1, 2011, and ended the program on October 1, 2011, affecting 6,000 individuals. Arizona also froze enrollment in the childless adult Medicaid waiver as of July 8, 2011. The state estimates that by the end of the fiscal year, enrollment will decline from 230,000 to about 140,000 individuals. At the time of the survey, the state also has a number of other proposed changes in its waiver renewal request that are still pending with CMS, including a proposal to freeze enrollment for TANF-related parents with incomes between 75 and 100 percent of FPL.[57]

Certain Adults with Incomes Above 133 Percent FPL. The ACA provides an exception to the Medicaid MOE that allows states that cover non-disabled and non-pregnant adults with incomes above 133 percent of poverty (FPL) to scale back coverage for this population beginning in January 2011, if they are facing a documented budget deficit. Prior to July 1, 2011, a reduction would have resulted in a loss of the ARRA enhanced matching funds since the ARRA MOE does not include this exception. Twenty-two (22) states (AR, CA, CT, DC, HI, ID, IL, IN, IA, ME, MA, MN, NV, NJ, NM, NY, OK, OR, RI, UT, VT, WI) offer coverage to parents above 133 percent FPL. Fifteen (15) states (AR, CA, DC, HI, ID, IN, IA, MA, MN, NM, OK, OR, UT, VT, WI) currently offer coverage to childless adults above 133 percent FPL. States would not be permitted to restrict eligibility below the core federal minimum eligibility levels.[58]

This survey asked states whether they planned to reduce eligibility for adults with incomes over 133 percent of FPL under the ACA option for states that certify a budget deficit. On July 7, Hawaii submitted a modification of its 1115 waiver, under the ACA budget "stress" provisions, to decrease eligibility from 200 percent to 133 percent of FPL as of January 1, 2012. The number of individuals affected would be 4,500.[59] Wisconsin has recently announced plans to similarly reduce eligibility under this option if the state's waiver proposal is not approved by December 31, 2011.[60]

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[56] Connecticut reported reversing an expansion implemented last year to the amount of assets that can be retained for use of the community spouse of an individual receiving long term care services from Medicaid. Because the state is not reducing the amount of assets that can be retained by the community spouse beyond what was in place on March 23, 2010, this change is not in violation of the ACA MOE requirements. See the Department of Social Services section of the Connecticut State Budget for FY 2012 and 2013, published by the Office of Fiscal Analysis of the Connecticut General Assembly for details on the reversal of PA 10-73. http://www.cga.ct.gov/ofa/documents/year/BB/2012BB-20110916_FY%2012%20and%20FY%2013-Connecticut%20Budget-Part%20II.pdf. New Mexico plans in FY 2012 to expand the waiting list for State Coverage Insurance by preventing employer groups from adding new enrollees. New Mexico was allowed to take similar actions in FY 2009 and in FY 2010 within the ARRA MOE requirements.

[57] In a letter to the state, CMS outlined some outstanding issues with these proposed changes in its waiver renewal request and gave a preliminary no to the state on the proposal to freeze enrollment for TANF-related parents. Letter from CMS dated October 7, 2011.

[58] *Understanding the Medicaid and CHIP Maintenance of Eligibility Requirements*. Kaiser Commission on Medicaid and the Uninsured, June 2011. http://www.kff.org/medicaid/8204.cfm. [Updated for MN changes]

[59] 1115 Waiver amendment proposal published on Hawaii's Med-Quest website, accessed October 7, 2011. http://www.med-quest.us/PDFs/1115_Proposed_Amendments.pdf.

[60] A letter from Dennis Smith, Wisconsin Department of Health Services to the Wisconsin Joint Committee on Finance September 30, 2011, outlines the states plans for a Medicaid reform proposal which states "as outlined in the state budget, if the Department does not receive approval of the waiver request before December 31, 2011, the Department is required to reduce income eligibility for non-disabled, non-pregnant adults to 133% of the Federal Poverty Level (FPL), as allowed under federal law. Based on August 2011 caseloads, PPACA authorizes the state to dis-enroll 53,161 individuals (47,125 BadgerCare Plus parents and 6,036 BadgerCare Plus Core enrollees)."

Changes to Enrollment and Renewal Processes. About half of all states made positive application and renewal changes in FY 2009 through FY 2011. For FY 2012, the number of states making positive changes fell to 11. Streamlining and simplifying enrollment procedures makes it easier for beneficiaries to obtain and maintain coverage thus increasing Medicaid enrollment; these changes can also result in administrative cost savings. Still facing budget shortfalls, simplification of these procedures may not be a top priority for states in the short-term. However, looking forward to the implementation of the ACA, states will be required to adopt new coordinated, simplified and streamlined enrollment procedures across Medicaid, CHIP and the new Health Insurance Exchanges. Many states made or are making multiple modifications to their enrollment and/or reenrollment processes in FY 2011 and FY 2012. Among the changes states reported that make the enrollment or reenrollment process easier for applicants/enrollees were the following:

- Expansion or implementation of the ability to submit applications or renew Medicaid eligibility on-line (15 states)
- Implementation or expansion of Express Lane Eligibility (ELE) or similar approaches (eight states). Under ELE or similar approaches, states may use information and eligibility findings from other public benefit programs, such as food stamps, child care or school meals programs – and from state tax forms – to facilitate an eligibility determination for children's health coverage
- Administrative renewals using data from other state agencies (seven states)
- Passive Renewals (three states)

States continue efforts to streamline enrollment that could help them qualify for performance bonus payments that were enacted as part of CHIPRA. To qualify for a CHIPRA bonus, states must meet specified enrollment targets and implement five out of eight enrollment and renewal procedures in Medicaid and CHIP (12-month continuous eligibility, no asset test or administrative verification of assets, no in-person interview, use of common forms and uniform procedures, administrative renewal, express lane eligibility (ELE), presumptive eligibility and premium assistance in CHIP). Three states in FY 2011 and nine states in FY 2012 reported that they were moving forward with new initiatives that count toward a CHIPRA bonus.

Two states report restrictions in their enrollment and renewal processes. Illinois is modifying its administrative (automatic) renewal process; rather than just keeping the case open, Illinois wants to amend the policy to require a response from the family. This change is pending approval from CMS.[61] Pennsylvania indicated that they are not changing any eligibility or redetermination policies, but will more rigorously apply current policies, which could mean closing cases for failure to submit documentation.[62]

[61] IL also sought two other enrollment changes passed by their legislature – requiring proof of Illinois residency and proof of one month's income - but these were deemed as violations of the ACA MOE requirements. The agency is working with CMS to pursue potential data matches with other agencies to verify this information electronically instead, though there were no definitive plans to implement at the time of this survey. HFS Outreach E-News, June 2011. http://hfs.illinois.gov/enews/june2011.html.

[62] As no policy was changed, this change was not counted as an eligibility restriction in this report.

C. Premium Changes and Buy-in Programs

While the ability of states to impose enrollment premiums or enrollment fees for Medicaid participation is extremely limited, states are allowed to use premiums to make Medicaid assistance available to certain individuals that would not otherwise qualify for Medicaid. The most common premiums allow disabled individuals receiving Medicaid to remain on the program by paying premiums as they begin to earn income and accumulate assets that would otherwise make them ineligible for Medicaid. The Family Opportunity Act (FOA) similarly made it possible for families with uninsured disabled children to pay a premium for Medicaid for these children. A few states have received federal waivers to allow individuals with incomes that exceed Medicaid thresholds to purchase coverage through Medicaid.

Forty states reported a total of 60 different premium or buy-in programs. The most common is a buy-in program for the working disabled (33 programs). Six states reported buy-in programs for disabled children (FOA or Katie Beckett). Fifteen states have buy-in programs that are only possible under a waiver (mostly for higher income populations) and six states have other buy-in programs.

In this 2011 survey, states reported four new premium programs. FOA programs for disabled children were added by Texas in FY 2011 and Colorado in FY 2012. Colorado also added a buy-in program for disabled adult workers in FY 2012. Florida is seeking a waiver that would allow individuals in the medically needy program who meet the share of cost for one month to remain eligible for up to six months by paying a monthly premium not to exceed the share of costs.

A total of five states reported some premium increase in FY 2011 and FY 2012, two states reported premium decreases and two states eliminated premiums (Iowa eliminated premiums in their 1115 waiver for those between 100 and 150 percent FPL and Minnesota plans to eliminate premiums this year for children below 200 percent FPL).

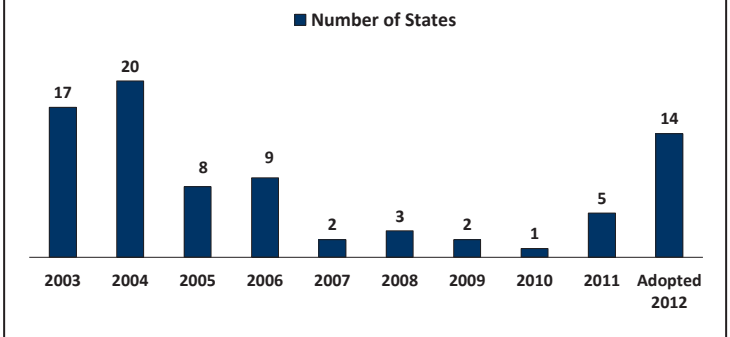
A complete listing of all changes by state and fiscal year is provided in Appendix A-5a and Appendix A-5b.

D. Copayment Requirements

Copayment requirements are used to varying degrees by most state Medicaid programs: a total of 45 states (including DC) have copayment requirements, including five states (Delaware, Louisiana, Maryland, New Hampshire and West Virginia) that impose copayments only on drugs. Only six states (Connecticut, Hawaii, Nevada, New Jersey, Rhode Island and Texas) reported having no copayment requirements at all. One state (Washington) implemented copayment requirements for the first time for its Basic Health Plan group when that program was converted from a state-funded program to Medicaid in January 2011 (using 1115 Waiver authority).[63]

FIGURE 27

States Imposing New or Higher Copayments FY 2003 – FY 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004, 2005, 2006, and 2007 and September 2008, 2009, 2010 and 2011.

[63] For purposes of this report, this change is not counted as an increase or decrease but instead as having a neutral affect. The copayments were unchanged from the state-funded program and were only applied to the expansion group that transitioned from the state-funded program to Medicaid.

In this year's survey, there is a notable increase in the number of states raising or imposing new copayment requirements compared to previous surveys. Five states in FY 2011 and 14 states in FY 2012 increased copayment amounts or imposed new copayments (compared to only one state in FY 2010) (Figure 27). Many of these states have implemented or plan to implement multiple new copayment requirements. Some state changes in copayments for FY 2011 and FY 2012 are highlighted below:

- ***Pharmacy.*** New or increased pharmacy copayments were the most frequently cited. Three states (Arizona, Massachusetts, and Oregon) increased pharmacy copayments in FY 2011. Six states (California, Illinois, Maine, Massachusetts, Minnesota, and Nebraska) planned to increase pharmacy copayments in FY 2012.

- ***Emergency Room.*** Two states (Arizona and Oregon) imposed copayments on emergency room services in FY 2011. Five states (California, Florida, Illinois, Iowa, and North Carolina)[64] planned to implement copayments for non-emergency use of the emergency room in FY 2012.

- ***Waivers.*** Some states are seeking waivers to impose copayments (on exempt populations or at higher amounts) that would otherwise not be allowable under current law.
    - Arizona implemented mandatory copayments for prescriptions, doctor visits and non-emergency use of the emergency room in FY 2011. In FY 2012, Arizona proposes to expand mandatory copayments for adults and children (subject to federal approval).[65]
    - In FY 2012, California is seeking waiver authority to impose the following new mandatory enforceable copayments: a $50 copayment for all services received in an emergency room; a $100 per day copayment for inpatient hospital services, with a maximum copayment of $200 per admission; a $3 copayment for each preferred drug prescription or refill; a $5 copayment for each non-preferred drug prescription or refill; and a $5 copayment for each physician, FQHC, RHC, and clinic visit and for other outpatient services including dental.[66]
    - In FY 2012, Florida has submitted a waiver amendment that proposes to require a $100 copayment for non-emergent services provided in the emergency department.

Other common copayment changes included inflationary increases in four states (Georgia, Pennsylvania, Oregon and South Carolina). Only three states reported reducing or eliminating copayments in FY 2011: Minnesota and North Dakota both reduced their emergency room copayment amounts, and Delaware eliminated its copayment for non-emergency transportation.

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[64] Both California and Florida are seeking waivers or waiver amendments to implement their copay changes since they are above nominal levels. California 1115 Waiver – Copayment Amendment. California Department of Health Care Services, submitted June 6, 2011. http://www.dhcs.ca.gov/Pages/CopaymentAmendment.aspx. Florida Waiver Amendment #3 Submission. Florida Agency for Health Care Administration, submitted August 1, 2011. http://ahca.myflorida.com/Medicaid/statewide_mc/fsdocs/Amendment_3_1115_Medicaid_Reform_Waiver_08012011.pdf.

[65] In a letter to the state, CMS outlined some outstanding issues with these proposed changes in its waiver renewal request and gave a preliminary no to the state on some of these copayment changes while approving others. Letter from CMS dated October 7, 2011.

[66] *Health and Human Services Chapter of the Enacted Budget Summary*. Department of Finance, June 30, 2011. http://www.ebudget.ca.gov/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

Court Ruling on Arizona Cost Sharing

On August 24, 2011, the Ninth Circuit Court of Appeals ruled in *Newton-Nations et al. v. Betlach and Sebelius*, a case that involves the authority to impose heightened, mandatory copayments on waiver expansion populations including childless adults with incomes up to 100 percent of poverty and certain persons with high medical expenses whose income, after deducting those expenses, would fall below 40 percent of the 2000 federal poverty level. The Secretary approved the copayments under section 1115 of the Social Security Act which allows the Secretary to approve "experimental, pilot, or demonstration" projects that are "likely to assist in promoting the objectives of the Medicaid Act." The decision reversed the Secretary's approval.

The Court ruled that the Secretary's review did not satisfy the obligation under the Social Security Act to determine whether the proposal was likely to further the goals of the Medicaid Act and that the review did not adequately "consider the impact of the project on the" persons the Medicaid Act "was enacted to protect." The Court remanded the case to the district court, ordering it to vacate the Secretary's decision and remand to the Secretary for further consideration consistent with the dictates of its opinion.

In the ruling, the Court questioned whether the project could have an experimental, pilot or demonstration value, expressing doubt that the copayments could "demonstrate something different than the last 35 years' worth of health policy research" (which consistently concludes that copayments cause low-income people to forego even medically necessary care). The Court further held that the Secretary must determine whether the project has value as a demonstration, experimental or pilot project, and that a project undertaken to cut benefits, that might save money, will not satisfy this requirement.

This decision raises important questions about how the Secretary approves state requests for 1115 waiver demonstration authority to impose copayment requirements. While this ruling applies only to states within the jurisdiction of the Ninth Circuit, it does call into question how the Administration will decide pending waiver requests related to cost sharing.

Prior to the Deficit Reduction Act in 2005, federal law limited Medicaid copayments to nominal amounts, generally defined as $3 or less per service, and also prohibited states from applying copayments to certain services (e.g., emergency services) 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 for certain eligibility groups and most services and also permits states to vary the cost-sharing requirements by eligibility group. 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.

In this year's survey, only one state (Pennsylvania) reported using DRA authority to impose greater than nominal copayment requirements or to vary copayment obligations by eligibility group. Pennsylvania plans to implement DRA alternative cost-sharing (20 percent coinsurance on non-exempt services) for certain disabled children under age 18, who have household incomes above 200 percent of poverty. Four states (Arizona, New Hampshire, Utah and Wisconsin) reported that copayment requirements were enforceable in FY 2011 for at least one eligibility group as allowed by the DRA. Another four states (California, Idaho, Illinois and Maine) reported plans to take advantage of the DRA authority to make copayments enforceable in FY 2012.

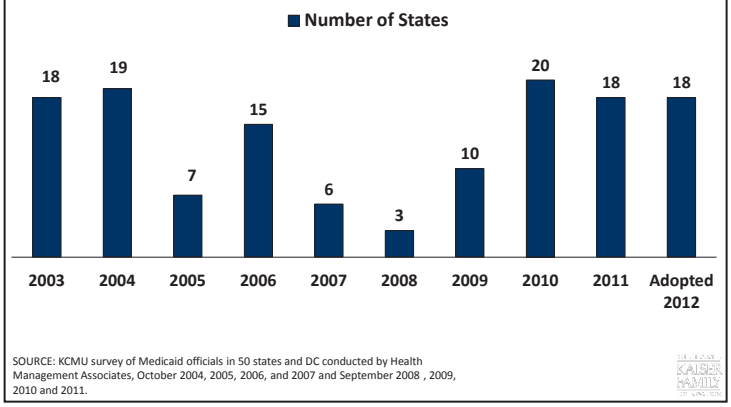
Additional information on FY 2011 or FY 2012 changes to copayments is reported in Appendices A-5a and A-5b.

E. Benefits Changes

With eligibility restrictions off the table due to the ARRA maintenance of effort requirements, many states turned to benefit cuts and limitations to reduce Medicaid spending in FY 2011 and FY 2012. Eighteen states reported eliminating, reducing or restricting benefits in both FY 2011 and FY 2012, down only slightly from the historic high of 20 states reporting benefit cuts for FY 2010 (Figure 28). A few states also mentioned the potential for additional mid-year reductions.

FIGURE 28

States Cutting or Restricting Benefits FY 2003 – FY 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004, 2005, 2006, and 2007 and September 2008 , 2009, 2010 and 2011.

Benefit restrictions reflect the elimination of a covered benefit or the application of utilization controls for existing benefits. Of the 18 states reporting cuts or eliminations in FY 2011 and FY 2012, six states in FY 2011 and seven in FY 2012 reported one or more benefit eliminations as described in the Table 4. Each of the eighteen states in FY 2011 and all but one of the 18 states in FY 2012 applied more narrowly targeted limits or utilization controls to existing benefits as described in Table 5.

In addition to states reducing benefits, 13 states in both FY 2011 and FY 2012 also reported expanding benefits – slightly lower than the number reporting expansions in the FYs 2008 through 2010. These totals include two states in both FY 2011 and FY 2012 adding substance abuse services, and one state in FY 2011 and four states in FY 2012 that expanded coverage for smoking cessation services,[67] and four states in FY 2011 and two states in FY 2012 that are restoring or expanding dental benefits.

Additional information on FY 2011 or FY 2012 changes to benefits is reported in Appendices A-6a and A-6b.

[67] Other states also reported adding coverage of smoking cessation services to pregnant women. As this was required under the ACA, these were not counted as benefit expansions for the purposes of this report.

Table 4: Benefit Eliminations by State

State	FY 2011
Arizona*	• Most dental care, podiatry services, percussive vests, hearing aids, cochlear implants, well exams, certain microprocessor-controlled prosthetics, and all orthotics. The state also eliminated coverage for certain transplants on October 1, 2010, but restored coverage on April 1, 2011.
Idaho*	• Collateral contact and DD supportive counseling.
Kansas*	• Attendant care provided in the local education agency setting.
Massachusetts*	• Restorative dental services and dentures.
North Carolina*	• Obesity surgery, panniculectomy procedures, and maternal outreach worker program services.
South Carolina	• Podiatry, vision and dental services.
State	*FY 2012*
California*	• Adult Day Health.
Colorado*	• Circumcision and oral hygiene instruction.
Idaho*	• Eyeglasses and audiology.
Indiana	• Targeted case management.
North Carolina*	• Eye exams and optical supplies.
Oregon*	• 13 lines on the OHP Prioritized List of Health Services.[68]
Washington*	• Eyeglasses and hearing aids and devices.

*These states also implemented or plan additional benefit limits or tighter utilization controls

Table 5: Benefit Limitations by Service Category and State

Benefits Limited	*2011*	*2012*
Chiropractic services	Minnesota	Idaho
Dental or denture services	Arizona, Indiana, Massachusetts, New Jersey, New Mexico, South Carolina, Washington	Colorado, Connecticut, Idaho, Iowa, North Carolina, Pennsylvania, Washington
Home health services	South Carolina	Colorado, North Carolina
Hospice	Kansas	–
Imaging services	Vermont	Colorado, Oregon
Inpatient hospital stays	Indiana, Massachusetts	Arizona, Hawaii, Oregon
Outpatient hospital/ER	–	Arizona, Colorado, New Hampshire, Oregon, Washington
Medical supplies or DME	Colorado, Nebraska, New Mexico, Virginia	California, North Carolina, Oregon, Texas
Mental health services	Idaho, Indiana	Hawaii, Idaho
Occupational, physical or speech therapy	Arizona, Indiana, Vermont, Virginia	Colorado, Idaho, New York, North Carolina, Oregon, Washington
Personal care services	District of Columbia, New Mexico, North Carolina, Washington	District of Columbia, Hawaii, Michigan, New Mexico, New York, North Carolina
Physician visits	Arizona[69]	California, Hawaii
Podiatry	New Hampshire	Idaho, Washington
Screening Services	New Mexico	–
Vision services	Connecticut, Idaho, Indiana	Connecticut, Idaho

[68] The list of 13 lines Oregon is eliminating coverage for beginning January 1, 2012, can be found at: http://www.oregon.gov/OHA/healthplan/meetings/hs-prioritized-list.pdf?ga=t.

[69] Arizona eliminated physician well visits for adults, a limit to the physician benefit.

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 allowed states to replace the traditional Medicaid benefits package with "benchmark" plans that offer coverage equivalent to one of the following options: (1) the Blue Cross/Blue Shield standard plan option under the Federal Employees Health Benefits Program (FEHBP), (2) the coverage generally available to state employees, (3) the coverage offered by the largest commercial HMO in the state, or (4) Secretary-approved coverage. The DRA also provided new flexibility for states to vary benefits across beneficiary groups and across areas in the state, but maintained Early Periodic Screening Diagnosis and Treatment (EPSDT) services as a wrap around for children.

Previous reports have described the DRA benchmark plans implemented by eight states[70] in FY 2007 and FY 2008. No states, however, reported adopting a DRA benchmark plan in FY 2011 or planning to do so in FY 2012. Wisconsin, however, reported amending its DRA Benchmark Plan in FY 2011 to expand EPSDT coverage and add non-emergency transportation coverage to comply with recent federal regulations (see discussion below).[71]

New Benefit Requirements

ACA Required Benefits. The ACA added the following additional Medicaid benefit mandates:

Coverage for Freestanding Birth Center Services (effective March 23, 2010): Requires Medicaid coverage of care provided in freestanding birthing centers. States are required to separately pay providers administering prenatal, labor and delivery, or postpartum care in such centers. (P.L. 111-148: §2301)

Scope of Coverage for Children Receiving Hospice Care (effective March 23, 2010): Certain children who receive hospice services under Medicaid and CHIP are not required to forgo coverage of services related to the treatment of the child's terminal illness. (P.L. 111-148: §2302)

Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid (effective October 1, 2010): States are required to offer counseling and pharmacotherapy to promote cessation of tobacco use by pregnant women. Cost-sharing for such services is prohibited. (P.L. 111-148: §4107)

Benchmark Plan Requirements. CMS regulations promulgated in 2010[72] now require states to ensure medically necessary transportation to and from providers when transportation is not a covered benefit under a benchmark or benchmark-equivalent plans. Further, the ACA made additional changes. Effective upon passage, Medicaid benchmark and benchmark-equivalent plans were required to provide family planning services and supplies and by 2014, they must also provide at least "essential benefits" defined as (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services including oral and vision care.

[70] Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia, and Wisconsin.
[71] Wisconsin also added hearing instruments and certain asthma supplies to their benchmark plans, which were not required by these recent regulations.
[72] Federal Register, April 30, 2010 (Vol. 75, No. 83), pp 23068 – 23104, at http://www.gpo.gov/fdsys/pkg/FR-2010-04-30/pdf/2010-9734.pdf.

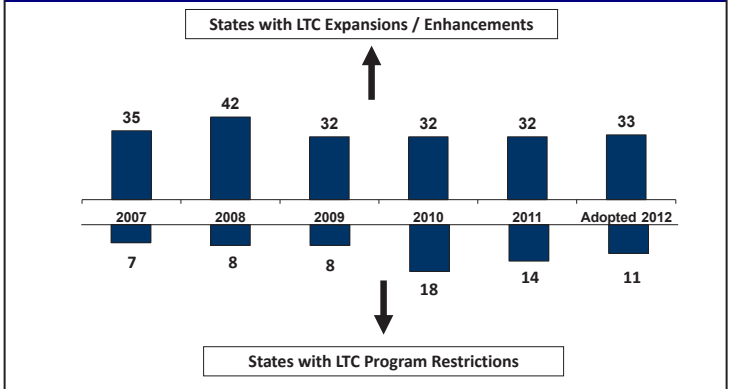
F. Long-Term Care and Home and Community–Based Services

Medicaid is the nation's primary payer for long-term care services and supports (LTC) covering a continuum of services ranging from home and community-based services (HCBS), that allow persons to live independently in their own homes or in the community, to institutional care provided in nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs-ID). LTC also accounts for approximately one-third of total Medicaid spending and has therefore not been immune from the Medicaid cost containment plans that states have been forced to develop and implement during the current economic downturn. Nevertheless, this year's survey shows that the majority of states are continuing to increase HCBS service options, a trend that has continued for more than two decades.

In FY 2011 and FY 2012, 32 and 33 states, respectively, took actions that expanded LTC services (primarily expanding HCBS programs), comparable to the number of states making expansions in FY 2009 and FY 2010 (32 in both years) but less than the high of 42 states taking actions to expand LTC services in FY 2008. Conversely, a total of 14 states in FY 2011 and 11 states in FY 2012 took action to constrain LTC services (compared to the low of seven states in FY 2007) (Figure 29). In total for both years, 11 different states reported institutional reductions and 12 different states reported HCBS reductions.

FIGURE 29

Long Term Care Policy Actions FY 2007 – FY 2012



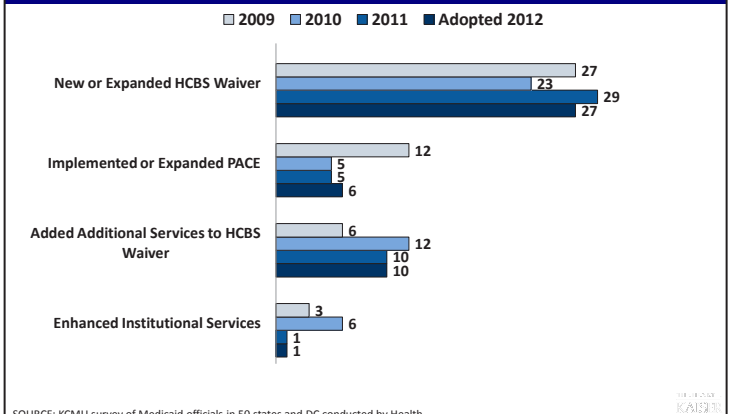
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, 2010 and 2011.

The following section details state actions taken to both expand and control LTC services in both institutional and community-based settings. This section also includes results from survey questions about certain DRA-related LTC state options and new options under the ACA.

HCBS Programs. This year's survey found that states are continuing to work on reorienting their Medicaid LTC delivery systems towards more community-based services. States' efforts to expand HCBS options for LTC 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 LTC costs which represent a third of total Medicaid spending.

FIGURE 30

Medicaid Long-Term Care Expansions, Implemented in FY 2009 – FY 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, 2010 and 2011.

As in past years, the most commonly reported LTC expansion change in FY 2011 and FY 2012 was adopting new HCBS waivers or expanding existing waivers (including home and community-based services delivered through Section 1115 Research and Demonstration waivers or through the Section 1915(i) HCBS State Plan option). The number of states reporting

this type of expansion was 29 in FY 2011 and 27 in FY 2012, slightly higher than the number of states reporting these changes in FY 2010 (23) and FY 2009 (27 states), but fewer than in FY 2008 (38 states). Other examples of LTC expansions include adding services to an existing HCBS waiver and expanding PACE programs (Figure 30).[73]

While most states already have limits in place for their community-based services such as coverage limits, enrollment caps, and waiting lists for services, this year's survey found that seven states in both FY 2011 and FY 2012 imposed additional restrictions directed at HCBS programs and services (compared to nine states in FY 2010 and only two states in FY 2009). These reductions and restrictions are described in Table 6. Also, four states in FY 2011 and six states in FY 2012 are making reductions to personal care services (which are included and counted under section "E. Benefit Changes" in Table 5).

Table 6: HCBS Reductions and Restrictions

State	FY 2011 Reductions and Restrictions
Idaho	• Eliminated coverage for service coordination and added prior authorization for supervisory RN visits for personal care services and for the Aged and Disabled Waiver. Also, eliminated coverage for home health skilled nursing in the Aged and Disabled Waiver.
New Hampshire	• Established limits for certain HCBS-In Home Supports service categories (e.g. technology and modifications).
North Carolina	• Replaced state plan PCS with state plan in-home care programs and applied utilization controls to community support services.
Oregon	• Reduced in-home community services for aged and physically disabled.
Rhode Island	• Changed methodology for determining budgets in self-directed option.
South Carolina	• Established an HIV/AIDS Waiver Waiting List Cap and eliminated HCBS chore/appliance services and adult day health nursing services.
West Virginia	• Eliminated Medical Adult Day Care in the Aged and Disabled Waiver program.
	FY 2012 Reductions and Restrictions
Arizona	• Limiting respite care services in ALTCs and the Behavioral Health program.
Montana	• Eliminating PACE program.
Minnesota	• Planning to tighten the nursing facility level of care criteria, subject to federal approval (see discussion of the ACA maintenance of effort requirement below).
Rhode Island	• Making changes to contracts with Home Health Agencies regarding authorizations for hours of care and certification of agencies.[74]
South Carolina	• Eliminating home social work visits and reducing pest control benefit slightly. Also capping PACE enrollment.
Virginia	• Implementing a 56 hour per week cap on HCBS personal care services (with exception criteria) excluding DD and ID waivers. Also, reducing allowable hours for respite care from 720 per year to 480 per year.
Wisconsin	• Caps placed on Family Care, Partnership, IRIS and PACE programs.

[73] 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.

[74] This change is also counted as an institutional reduction for FY 2012.

MOE Requirements and Long-Term Care

States' ability to impose certain HCBS restrictions in FY 2011 and FY 2012 was limited by the ARRA and ACA maintenance of eligibility (MOE) requirements.

ARRA MOE Requirements for Long-Term Care. Because of the link between eligibility for Medicaid LTC services and Medicaid eligibility generally, CMS determined that the following actions would be considered violations of the MOE requirements:[75] Increasing stringency in institutional level of care (LOC) determination processes that results in individuals losing actual or potential eligibility for Medicaid pursuant to institutional eligibility rules or in the special eligibility group for HCBS waiver participants under 42 CFR 435.217; adjusting cost neutrality calculations for section 1915(c) waivers from the aggregate to the individual, resulting in individuals being dropped from waiver coverage or hindered from moving out of an institutional setting; reducing occupied waiver capacity for section 1915(c) HCBS waivers, or reducing or eliminating section 1915(c) waiver slots that were funded by the legislature but unoccupied as of July 1, 2008.

ACA MOE Requirements for Long-Term Care. The ACA also contains an eligibility MOE provision that requires states to maintain eligibility for adults until January 1, 2014, and for children in Medicaid and CHIP until October 1, 2019, using the same language as ARRA. CMS has therefore decided to apply the same MOE criteria to HCBS actions (described above), but also notified states that it would be possible to increase institutional LOC criteria without violating the MOE if an alternative eligibility pathway to Medicaid HCBS services was created for all individuals that would have previously been able to gain eligibility under the original LOC.[76] CMS offered the following examples of how this could be done: utilize the Section 1915(i) HCBS State Plan Option (described below) to extend HCBS benefits to individuals who would have been eligible under former LOC levels; or, use Section 1115 demonstration waiver authority to offer different levels of care for receipt of HCBS and institutional services, ensuring that the available capacity for Medicaid eligibility remains unchanged.

CMS also noted that HCBS waivers are time limited and that the ACA MOE requirement does not require a state to renew a waiver that is expiring. Thus, a state may discontinue an HCBS waiver when it expires or may request a renewal at the end of the approved waiver period, with modifications, without creating an MOE issue.

Institutions. There were no states that reported expansions for institutional services in FY 2011 and only one state that reported plans to remove restrictions or enhance institutional services in FY 2012 (compared to six states in FY 2010). New York will add a requirement for hospitals, nursing homes and home health care providers to provide patient centered palliative care in FY 2012.

Seven states in both FY 2011[77] and FY 2012[78] implemented or planned to implement cost controls related to institutional placements (compared to 13 in FY 2010).

Examples include:

- Efforts to reduce the size of or close state-owned mental health institutions or Intermediate Care Facilities for Persons with Intellectual Disabilities (Delaware, Massachusetts and Texas);
- Reductions in payments for bed-holds (Indiana, Nebraska, New Jersey, Ohio, and South Carolina);

[75] State Medicaid Director Letter, SMD#09-005, ARRA#5. CMS, August 19, 2009. http://www.cms.gov/SMDL/downloads/SMD081909.pdf.
[76] State Medicaid Director Letter, SMDL#11-009, ACA#19. CMS, August 5, 2011. http://www.cms.gov/smdl/downloads/SMD11-009.pdf.
[77] Delaware, Indiana, Massachusetts, Maine, Nebraska, Texas, and Wisconsin.
[78] Massachusetts, Minnesota, Nebraska, New Jersey, Ohio, South Carolina, and Wisconsin.

- Reductions in Medicare cross-over claims payments (Nebraska);
- New limits on private non-medical institutional care (Maine);
- An institutional relocation program for nursing facilities and ICFs-ID (Wisconsin); and
- Subject to federal approval, plan to tighten the nursing facility level of care criteria (Minnesota).[79]

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 institutional quality enhancement reviews and other increased HCBS oversight and monitoring efforts; the reconfiguration (e.g., "unbundling") of waiver benefits and reimbursement; efforts to increase the utilization of participant directed and managed services; development of rules to more effectively manage funds for beneficiaries receiving consumer directed waiver services; changes in provider qualification requirements, and efforts to focus on the provision of supported employment and competitive employment services for persons with intellectual disabilities. Finally, several states reported efforts to implement or expand managed LTC programs including New York, Tennessee, Texas, and California. Florida reported on plans to expand LTC managed care beginning in FY 2013.

Long-Term Care Partnership Programs. LTC Partnership Programs established by the Deficit Reduction Act (DRA) are designed to increase the role of private LTC insurance in financing LTC services by allowing persons who purchase qualified LTC insurance policies to shelter some or all of their assets when they apply for Medicaid after exhausting their policy benefits. Thirty states reported having in place a LTC Partnership Program before FY 2011; two states (Washington and West Virginia) reported implementing a program in FY 2011[80]; three states (Delaware, Illinois, and Michigan) indicated that they were planning to implement a program in FY 2012 (which would bring the total number of implementing states to about two-thirds of all states); nine states reported no plans to implement and seven states responded "don't know".

LTC Options in the ACA. The ACA included a number of new LTC options described in the box below. These options are in effect now (while the coverage expansions in the ACA do not go into effect until 2014).

[79] Also counted as a community restriction for FY 2012.

[80] Four of the 30 states that reported having plans in place before FY 2010 (California, Connecticut, Indiana and New York) have had demonstration model programs underway since 1992 and did not utilize DRA authority.

Key ACA Provisions Affecting Long-Term Care in Effect Now

HCBS State Plan Option. The DRA gave states a new option to offer home and community-based services through a Medicaid state plan amendment rather than through a 1915(c) waiver. Responding to low state take-up, effective October 1, 2010, the ACA built on the DRA authority by expanding eligibility under this option to individuals with incomes up to 300 percent of the maximum SSI payment and by making a number of other changes to address state concerns. However, the ACA also eliminated the states' ability to cap enrollment, maintain a waiting list or waive the requirement for the benefit to be offered statewide. Only five states (Colorado, Iowa, Nevada, Washington and Wisconsin) reported having the HCBS state plan option in place prior to FY 2011.

State Balancing Incentive Payments Program. Beginning in October 2011, the program makes additional Medicaid matching funds available to states that meet certain requirements for expanding the percentage of LTC spending for HCBS (and reducing the percentage of LTC spending for institutional services). To qualify, states must: develop a no wrong door/single entry point system to access all long-term care services and supports (LTCSS), create conflict-free case management services, and develop core standardized assessment instruments to determine eligibility for non-institutionally based LTC.

Community First Choice (CFC) Option. Beginning in October 2011, states electing this state plan option to provide Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

Money Follows the Person (MFP) Rebalancing Demonstration. The ACA continues the existing MFP grant funding[81] for states for another five years and also reduces the length of time a person is required to reside in an institutional setting before they are eligible to participate in this program (previously at least six months, but now at least 90 consecutive days).

The survey asked states about implementation of the HCBS state plan option and also whether they were interested in taking advantage of the new LTC options in the ACA when they became available. One state (California) reported implementing the HCBS state plan option in FY 2011, and nine states reported plans to implement in FY 2012, often focusing on behavioral health-related services. Since the ACA eliminates the ability of states to impose an enrollment cap on the HCBS state plan option, one of the five states that had previously implemented this option (Washington) reported plans to eliminate it in FY 2012 and transition enrollees into comparable HCBS waiver services.

Many states (34) did not know if they would apply for the State Balancing Incentive Payment Program or the CFC option, suggesting that the option was still under consideration or being evaluated. However, four states reported plans to implement the State Balancing Incentive Payments Program in FY 2012 (Connecticut, Missouri, New Jersey and Rhode Island) and three states (Alaska, Rhode Island and Washington) reported plans to implement the CFC Option. The remainder reported no plans to implement these options.

Thirty states reported that the Money Follows the Person Rebalancing Demonstration was already in place prior to FY 2011. Five states reported implementing this program in FY 2011 (Minnesota, Mississippi, Nevada, Rhode Island, and Tennessee), eight states reported plans to implement in FY 2012 (Colorado, Idaho, Massachusetts, Maine, New Mexico, South Carolina, Vermont and West Virginia). The remainder had no plans to implement or did not know.[82]

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[81] A total of 30 states and DC 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 percent) for an individual's costs for 12 months from the date of institutional discharge.

[82] Wyoming did not respond to this question.

G. Prescription Drug Utilization and Cost Control Initiatives

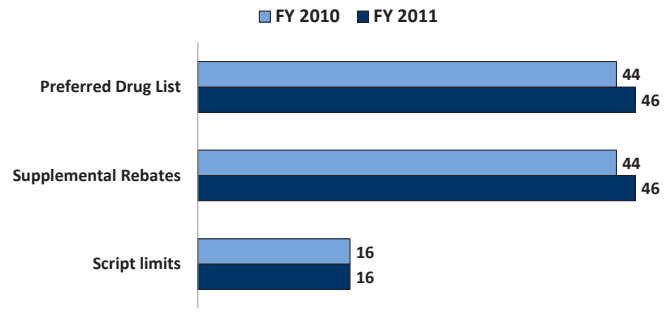
Over the past decade, almost all state Medicaid programs have adopted significant changes to their pharmacy programs by employing a variety of sophisticated pharmacy management tools, including preferred drug lists (PDLs), supplemental rebate programs, prior authorization programs, other utilization management efforts, state maximum allowable cost ("state MAC") programs, generic incentives and other cost containment measures. While the pace of change in this area has slowed from the 2001 to 2005 period when reform efforts peaked, state officials reported that their pharmacy management programs continue to reap significant cost containment benefits for their states. At the same time, many states continue to find new ways to refine their pharmacy programs to achieve greater quality improvements and savings.

Pharmacy Management Policies in Place. In FY 2011, a total of 46 states indicated that they had adopted a Preferred Drug List (PDL) and obtained supplemental rebates. This was an increase of two states (Nebraska and North Carolina) from the number in FY 2011. The number of states with limits on the number of prescriptions that Medicaid would pay for each month remained at 16 states in FY 2011 (Figure 31).

Summary of FY 2011 and FY 2012 Pharmacy Policy Changes and Cost Containment Efforts. Thirty-one states in FY 2011 and 38 in FY 2011 implemented cost-containment initiatives in the area of prescription drugs, comparable to the numbers of states taking such actions in FY 2009 (35 states) and 2010 (38 states). Compared to previous years, however, fewer states reported expansions or enhancements to their PDL and supplemental rebate programs, likely reflecting the fact that these programs have become fully "mature" in most states with routine updates performed in the normal course of business (Figure 32). However, the number of states reporting plans to reduce ingredient cost reimbursement (14 states) or dispensing fees (nine states) in FY 2012 increased compared to the last few years. Five states reported changes in a state limit on the number of prescriptions in FY 2011 and two states did so in FY 2012.

FIGURE 31

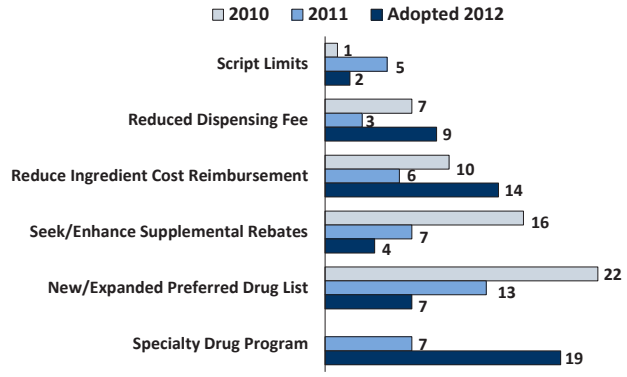
Medicaid Pharmacy Policy Measures in Place at the beginning of FYs 2010 and 2011



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.

FIGURE 32

Medicaid Prescription Drug Policy Changes FY 2010 – FY 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, 2010 and 2011.

AWP Ingredient Cost Pricing. State Medicaid programs reimburse pharmacies for the "ingredient cost" of each prescription, plus a dispensing fee.[83] A majority of states currently use the "Average Wholesaler Price" (AWP) benchmark in their pharmacy reimbursement policies for ingredient costs. However, in recent years the validity of an AWP-based methodology has been challenged in the courts and as a result, one major AWP publishing firm used by many states (First DataBank) announced that it will no longer publish AWPs after September 2011. This forced many states to seek an alternative AWP source or adopt a different pricing benchmark.[84]

One alternative benchmark is the "Average Acquisition Cost" (AAC). Currently, two states (Alabama and Oregon) have developed AAC methodologies that rely on periodic random sampling of enrolled pharmacies to collect actual pricing information. CMS is also developing a database of National Average Drug Acquisition Costs (NADACs) and is encouraging states to adopt an AAC methodology using this resource when it is available. CMS plans to distribute NADACs data at the end of CY 2011 based on a CMS survey of retail pharmacies. Careful modeling will be needed for states to assess the fiscal impact to both the state and pharmacy providers of moving to an AAC reimbursement methodology model, or some other benchmark, compared to the methodologies currently used.[85]

In this year's survey, states using AWP were asked if they planned to adopt an alternative AWP source or methodology. Thirty-three states responded "yes" and reported the following plans:

- Sixteen states indicated that they would rely on the Wholesale Acquisition Cost (WAC) benchmark;
- Five states reported plans to move to the Average Acquisition Cost (AAC) benchmark;[86]
- Five states intend to rely on a different AWP publisher;
- One state reported plans to rely on the Suggested Wholesale Price (SWP) benchmark, and
- Seven states indicated that a decision had not yet been made.

Other states indicated that they would reevaluate their ingredient cost reimbursement methodologies when the CMS NADACs became available.

Specialty Drugs. Overall drug spending across all health care sectors (including Medicaid) grew by 3.6 percent in 2010. Specialty drugs, however, grew at a considerably higher rate of 19.6 percent.[87] By 2014, industry analysts predict that specialty drugs will comprise 40 percent of United States drug spending, causing many health care payers to consider options for better managing this benefit. This year's survey asked states about specific cost containment efforts focused on specialty drugs. A total of seven states in FY 2011 and 19 states in FY 2012 reported implementing or planning to implement a cost containment action focused on specialty drugs in FY 2011 or FY 2012. (Table 7)

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[83] In accordance with federal and state law, states pay the lower of (a) the ingredient cost rate plus a dispensing fee; (b) the Federal Upper Limit (FUL) or State Maximum Allowable Cost rate, if applicable, plus a dispensing fee; or (c) the pharmacy's Usual and Customary Charge.

[84] Medi-Span, Gold Standard, and Micromedex, unlike First DataBank, will continue to publish AWP.

[85] *Managing Medicaid Pharmacy Benefits: Current Issues and Options.* Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/medicaid/8234.cfm.

[86] One state indicated that it would move to a combination of AAC and WAC.

[87] *Express Scripts 2010 Drug Trend Report, a Market and Behavioral Analysis*, April 2011, available at http://www.express-scripts.com/research/studies/drugtrendreport/2010/dtrFinal.pdf

Table 7: Specialty Drug Cost Containment Approaches by Type and State

Cost Containment Approach	*2011*	*2012*
Selective contracting with specialty drug providers	Oregon, Tennessee	California, Colorado, Delaware, Illinois, Nevada, North Carolina, Wyoming
Revisions to the reimbursement methodology for specialty drugs	South Carolina, South Dakota, Wyoming	Colorado, Georgia, Illinois, Mississippi, New Hampshire, South Carolina, South Dakota, Tennessee, Vermont, Virginia, West Virginia, Wyoming
Implementation of specialty drug case management efforts	South Carolina, Washington	Arkansas, Illinois, South Carolina, Tennessee, Utah
Other	Pennsylvania	South Carolina, Wisconsin

"Other" actions reported included adding drug classes to an existing specialty drug program (Pennsylvania), expanding utilization management efforts (South Carolina) and creating a "best practices" certification process for specialty pharmacies to manage costs (Wisconsin). Also, three states (Indiana, Michigan, and Nevada) reported that future specialty drug initiatives were possible or under consideration.

Managed Care Carve-outs. Prior to the passage of the ACA, states were unable to collect rebates on prescriptions purchased for Medicaid recipients by managed care organizations (MCOs) operating under capitated arrangements. As a result, states sometimes "carved-out" the pharmacy benefit from MCO contracts to maximize state rebate collections. In last year's survey, a total of 15 states reported having a managed care carve-out (partial or full). This year's survey shows 13 states with full carve-outs and 8 with partial carve-outs (21 in total) in place before FY 2011. The ACA now allows states to collect rebates on prescription drug expenditures by MCOs and several states reported plans to "carve-in" the pharmacy benefit into MCO contracts as a result:

- For FY 2012, New York, Ohio and Texas reported plans to carve-in prescription drugs and New Jersey reported plans to carve-in the previously carved-out pharmacy benefit for the aged and disabled population.
- Illinois elected to carve-in the pharmacy benefit to the Integrated Care managed care program serving aged, blind and disabled beneficiaries that was implemented in FY 2011 (but has continued to carve pharmacy out of its managed care program for low-income families and children).

Conversely, Louisiana reported that pharmacy is not included in the core benefits and services that will be provided by MCOs in the Coordinated Care Network Program when it is implemented in FY 2012.

Other Pharmacy Policy Changes. Twenty states in FY 2011 and 27 in FY 2012 reported on a wide range of other pharmacy cost containment measures including:

- Increasing prior authorization requirements (Alaska, Illinois, Indiana, Kansas, Maryland, Mississippi, Oregon, Pennsylvania, Washington, Wisconsin, Wyoming);
- Initiatives focused on better controlling behavioral health drug utilization (Alabama, Illinois, Indiana, Maryland, Massachusetts, North Carolina, Pennsylvania and Washington);
- Enhancing or improving State Maximum Allowable Cost (SMAC) programs (Colorado, New Jersey, New Mexico, Rhode Island, South Carolina, and Utah);
- Limiting optional and over the counter (OTC) drugs (California, Illinois, Iowa, Kentucky, Tennessee, Texas, and Vermont);

- Seeking supplemental rebates for diabetic supplies (District of Columbia, New Hampshire, South Carolina, and West Virginia);
- Imposing additional dosage or quantity limits (Illinois, Indiana, Iowa, Kentucky, New York, Oregon, Tennessee, Washington and Wisconsin), and
- Implementing a medical pharmacy management, medication therapy management, or disease management program (Connecticut, Maine, Michigan, Minnesota, Utah, and Wisconsin);

In addition, three states (Arizona, California, Vermont) were implementing a 340B initiative; two states (North Carolina, Wisconsin) were making changes to a pharmacy lock-in program; New Hampshire reported harmonizing prescriptions so all maintenance medications have the same fill date to reduce transportation costs; Wyoming was implementing a pharmacy integrity effort and financial recoupment program; and Kentucky reported imposing prior authorization when a prescriber is not enrolled as a Medicaid provider.

Finally, a few states reported pharmacy-related expansions or reversals of previous pharmacy cost containment actions including two states increasing dispensing fees in FY 2011 (Alabama and Connecticut) and five states increasing dispensing fees in FY 2012 (Alaska, Hawaii, Iowa, Mississippi, and Vermont), one state increasing ingredient cost reimbursement for rural pharmacies in FY 2012 (Minnesota) and one state (West Virginia) that removed a prescription limit on children enrolled its benchmark plan in FY 2011.

See Appendices A-7a and A-7b for more detail on pharmacy cost containment actions.

4. Delivery System and Quality Initiatives, Program Integrity, Health Information Technology and Waivers

Key Section Findings:

- Seventeen states in FY 2011 and nearly half (24) states in FY 2012 reported that they were expanding their managed care programs primarily by expanding the areas and populations covered.
- New initiatives relating to the development of systems of integrated, coordinated care to serve dual eligibles were a top priority in FY 2011 and FY 2012. In April 2011, CMS awarded $1 million planning contracts to 15 states for the development of systems to serve duals. In July 2011, CMS released guidance that it would assist additional states in developing payment and delivery systems that would facilitate the coordination and integration of care for the duals. Many states indicated that they had planned to submit proposals. Since the time of the survey, CMS has announced that 37 states have submitted letters of intent related to the opportunities announced by CMS in July 2011.[88] Tied to grants, guidance, and other state efforts, several states reported efforts to implement or expand managed long-term care programs, including New York, Tennessee, Texas, and California.
- States are using managed care as a vehicle to implement quality and performance strategies such as tying payment or default enrollment to performance and adding quality measures for reporting.
- Over the next few years, states will be required to implement significant changes in health information technology. Four major HIT initiatives are common across most states, with timelines for implementation that are driven by national deadlines: Medicaid Electronic Health Record (EHR) certification and incentive programs; major upgrades to claims payment systems; updates to the coding system for medical claims; and implementation of health reform in 2014, which will require major Medicaid IT development, particularly for Medicaid eligibility systems, and integration with new systems developed for state Health Insurance Exchanges. In addition, states are also using data systems to monitor for fraud and abuse to assure the highest level of fiscal and program integrity.
- A number of states are pursuing Section 1115 Medicaid waivers to make program changes not otherwise allowable under Medicaid law. Many states are still developing these proposals and have not submitted formal applications to CMS, while other states have applications pending or have approval for program changes. The majority of states with waiver plans reported delivery system and/or provider payment reforms for broad or targeted populations, including duals or individuals with disabilities and special health care needs.

[88] For more information, including a list of states that submitted letters of intent, see: http://www.cms.gov/medicare-medicaid-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf.

A. Delivery System Changes

States have adopted managed care in Medicaid because the organization and structure of managed care help Medicaid achieve some of its most important objectives. In a 2011 survey of Medicaid directors, state officials indicated that they see significant benefits from their experience with managed care such as: greater ability to assure access to care and to measure and improve quality, a structured means of promoting population health objectives (e.g. improved birth outcomes), promotion of appropriate utilization of emergency rooms, and obtaining greater value for the cost of Medicaid, including the potential for savings.[89]

Types of Medicaid Managed Care Arrangements

Capitated MCOs. The most prevalent form of Medicaid managed care involves state contracts with prepaid, capitated at-risk MCOs. To participate in Medicaid, risk-based managed care organizations (MCOs) must meet stringent state and federal regulations, including requirements to have a geographically adequate and accessible network of high-quality, credentialed providers. Medicaid MCOs must demonstrate quality of care, and also quality improvement. It is a federal requirement that an independent external quality review organization audit health plan records to ensure that the data and the care meet quality benchmarks. Federal rules require that Medicaid capitation payment rates be "actuarially sound."[90]

Primary Care Case Management (PCCM). PCCM is a system of care that is organized and administered by the Medicaid agency itself or a contractor. In PCCM programs each Medicaid beneficiary is enrolled with a primary care provider (PCP) who agrees to serve as the patient's medical home, to provide primary and preventive services and to coordinate specialty care. Generally, reimbursement is on a fee-for-service basis for services actually delivered, and in addition, the PCP is usually paid a small per member, per month case management fee. Some states use a partial capitation to the PCP that bundles a defined set of primary care services within a single rate. Some states pay the PCP on a capitated basis for a defined bundle of primary care services. Some states have "Enhanced PCCM" models that incorporate the types of care coordination, care management, medical home and quality improvement features characteristic of capitated MCOs.

Prepaid Health Plans (PHPs). Non-comprehensive PHPs are pre-paid health plans paid on a risk basis to provide a limited set of Medicaid services. Under federal regulations Prepaid Inpatient Health Plans (PIHPs) provide a subset of services that includes any inpatient hospital service, and Prepaid Ambulatory Health Plans (PAHPs) provide a subset of services that does not include inpatient hospital services. Many states use these non-comprehensive PHPs to provide services that are "carved-out" of MCOs. States often contract with PHPs to provide behavioral health, substance abuse services, non-emergency medical transportation, long-term care, and dental care. States may also enroll beneficiaries in FFS into PHPs for some services.

States continue to increase their reliance on managed care in Medicaid. In 2011, all states except Alaska, New Hampshire and Wyoming operated managed care programs. The total number included 36 states with risk-based contracts with managed care organizations (MCOs) providing comprehensive benefits, and 31 states that operated a Primary Care Case Management (PCCM) programs. These totals include 17 states that used only MCOs, 19 states that had both MCOs and PCCM programs, and 12 states that used only a PCCM program.[91] A total of 35 million Medicaid enrollees received care through either an MCO or a PCCM program as of October 2010, including over 26 million receiving care through an MCO and almost 9 million through a

[89] Kathleen Gifford, Vernon Smith, Dyke Snipes and Julia Paradise, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/medicaid/8220.cfm.

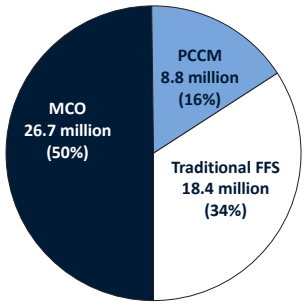
[90] Federal requirements for Medicaid managed care, including payment rates, quality assessment and performance improvement, external quality review, protections for persons enrolled in managed care, state contracts with managed care organizations, and other requirements, are found at 42 CFR 438.

[91] Louisiana reported that they are contracting with an MCO in FY 2012 to pair with their PCCM program.

PCCM program. A total of 66 percent of all 54 million Medicaid beneficiaries in October 2010 were enrolled in one of these two managed care arrangements.[92] (Figure 33)

FIGURE 33

Medicaid Enrollment in Comprehensive Managed Care, October 2010



Total = 53.9 million Medicaid beneficiaries

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

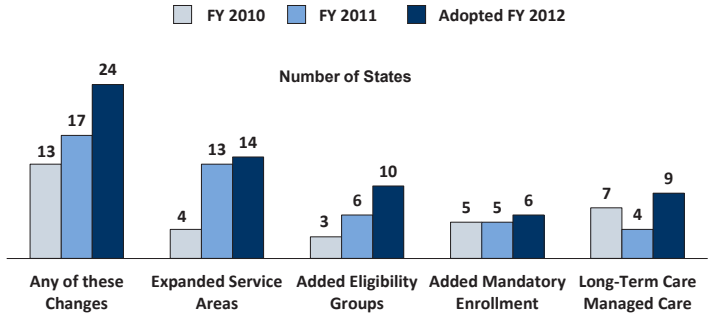
Looking back over the past decade, the share of Medicaid beneficiaries enrolled in either MCOs or PCCM programs increased substantially from 51 percent of enrollees in 2000 to 66 percent in 2010.[93] Over the same time period, MCO enrollment increased from 12.4 million to 26 million (110 percent) and PCCM enrollment increased from 4.6 million to almost 9 million (91 percent). The growth in Medicaid managed care is particularly noteworthy given the downward trend in HMO enrollment among U.S. workers with employer-sponsored insurance. Over the same ten years, the share of the national commercial market accounted for by HMOs dropped by one-third, from 29 percent of all workers with employer-sponsored insurance in 2000 to 19 percent in 2010.[94]

This survey focuses on changes in delivery systems and quality initiatives in FY 2011 and 2012 which are reported in appendix A-8.

Delivery System Changes in Managed Care. In FY 2011, Medicaid programs continued to develop, expand and improve their managed care programs. A total of 17 states expanded service areas, added eligibility groups to managed care, required enrollment into managed care or implemented new managed long-term care programs. For FY 2012, a total of 24 states (including 12 states in the FY 2011 group) adopted such policies (Figure 34). In FY 2011, the most common managed care policy changes involved adding counties to existing managed care service areas and adding persons with disabilities into managed care. For FY 2012, the most common changes related to inclusion of persons with disabilities and dual eligibles, along with new initiatives for managed long-term care. Connecticut reported that it will make a shift from PCCM and MCOs to an Administrative Service Organization (ASO) model in 2012.

FIGURE 34

Medicaid Managed Care Changes FY 2010 – FY 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2010 and 2011.

The value of managed care lies in its potential to deliver better care at a lower cost. State officials were asked if their budget for FY 2012 included savings from the implementation of Medicaid managed care. A total of 16 states indicated that their Medicaid budget for FY 2012 counted savings from managed care. A number of

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[92] Kathleen Gifford, Vernon Smith, Dyke Snipes and Julia Paradise, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/medicaid/8220.cfm.

[93] *2000 Medicaid Managed Care Enrollment Report*. CMS, 2001.

[94] *Employer Health Benefits 2010 Annual Survey.* Kaiser Family Foundation, 2010. http://ehbs.kff.org/.

other states indicated that they believed managed care had accrued savings, but that an amount was not specifically accounted for in the budget or had been counted in previous years.

Managed Care Expansion in New York

As part of the state's Medicaid Reform Team recommendations, over the course of three years, all New York Medicaid members will be enrolled in some form of care management, including an expansion of mandatory managed care to beneficiaries previously excluded and an expansion of managed long term care (MLTC). In April 2011, the state submitted an amendment to its current 1115 waiver program to expand mandatory managed care to new geographic areas, include additional benefits, and enroll populations previously excluded.[95] New York has proposed the following timeline to phase-in these expansions:

2011: Personal Care Services would be added to managed care (except consumer directed personal care) and pharmacy services would be carved-in. Several groups of previously exempted individuals would be required to enroll in managed care, including individuals living with HIV (upstate) [96], non-SSI adults and children with severe and persistent mental illness and serious emotional disturbance, and pregnant women with a prenatal provider that is not participating in any managed care plans.[97]

2012: Additional groups previously excluded from managed care would be required to enroll, including individuals with (ESRD), homeless individuals, individuals receiving services through the Chronic Illness Demonstration Program, and individuals enrolled in the Long Term Home Health Care Program where capacity exists.[98] Skilled Nursing Facility services would be added to managed care plans and residents of nursing homes would be required to enroll.

April 2013: Remaining populations would be required to enroll in managed care including residents of ICFs-ID, those receiving services through the Nursing Home Diversion and transition waiver, children in the foster care waiver program, Medicaid Home and Community-Based Services Waiver recipients,[99] and residents of state-operated psychiatric centers.

New York has had MLTC plans operating in the state for a number of years, though enrollment has always been voluntary. New York is proposing to require dual eligibiles over the age of 21 and in need of community-based long term care services for more than 120 days to enroll in MLTC. If this waiver amendment is approved, enrollment in MLTC plans will be required for Medicaid enrollees living in New York City beginning April 2012. Mandatory enrollment would expand throughout the state as MLTC plans become available.[100]

Delivery System Changes in PCCM. A few states indicated that they were expanding current PCCM programs and adding new initiatives. In FY 2011, one state, Nebraska, ended its PCCM program. In FY 2012, three states will end PCCM programs. Kentucky will replace the PCCM program with the use of MCOs statewide. In Connecticut, Medicaid is replacing both MCO and PCCM programs with a managed ASO model. In Texas, the PCCM program is being phased out as capitated managed care is expanded statewide.

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[95] Waiver Amendments submitted to CMS, April 13, 2011. http://www.health.state.ny.us/health_care/managed_care/appextension/index.htm.

[96] The state began requiring individuals living with HIV in New York City in beginning September 1, 2010. http://www.health.ny.gov/health_care/managed_care/living_with_hiv/questions_and_answers.htm.

[97] The state has received approval for most of these changes. Letter of Approval for F-SHRP demonstration changes, July 15, 2011. http://www.health.state.ny.us/health_care/managed_care/appextension/health_reform_partnership/docs/extension_terms_and_conditions.pdf.

[98] These individuals will have the option of enrolling in Managed Long Term Care instead.

[99] These individuals will be required to enroll in managed care but may also stay in the waiver program.

[100] Individuals served by the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver, and those served through the Office of People with Developmental Disabilities would be exempted until appropriate program features were available under these plans. Amendments submitted to CMS for current 1115 waiver on April 13, 2011. http://www.health.ny.gov/health_care/managed_care/appextension/index.htm#mrt_waiver_materials.

Patient-Centered Medical Home (PCMH) Initiatives. A growing number of states are building on PCCM models to better coordinate and manage care for beneficiaries. These strategies are often referred to as medical home or patient-centered medical home (PCMH) models. The National Academy for State Health Policy has identified PCMH activity in 41 states for Medicaid and CHIP enrollees.[101] Definitions for medical homes vary, but, in broad terms, PCMH has been characterized as a clinic or practice, led by a primary care physician or other medical professional (such as a specialist or an advanced practice nurse), that provides care that is "accessible, continuous, coordinated and delivered in the context of family and community."[102] Medical home models can operate in Medicaid or across all payers and can be implemented broadly or for specific populations.

For FY 2011 and FY 2012, a number of states were expanding or implementing new PCMH initiatives. Some states were implementing targeted programs, such as Arkansas, which is piloting an enhanced PCCM program for the state's aging population, and Nebraska, which implemented pilot PCMH programs in two counties. Other states were implementing broader initiatives. For example, Idaho will be part of a multi-payer collaborative PCMH initiative in FY 2012; Maryland is implementing an all-payer PCMH initiative scheduled to begin August 1, 2011; Michigan is implementing a multi-payer PCMH demonstration which includes Medicaid; Massachusetts implemented a targeted all-payer (except Medicare) medical home initiative for a limited set of providers with the goal of including all providers by 2015; New York is expanding its PCMH initiative statewide and to additional payers with the goal of enrolling one million Medicaid patients into medical homes[103]; Ohio has a PCMH initiative planned for implementation at the end of FY 2012 to be administered through the health department and in which Medicaid will participate; and Vermont is expanding its PCMH initiative and plans for it to be statewide.

B. Delivery System Changes for Special Populations

Initiatives for Dual Eligibles. Few initiatives are commanding higher priority for Medicaid in FY 2011 and 2012 than those relating to the development of new systems of integrated, coordinated care to serve dual eligibles (individuals enrolled in both Medicaid and Medicare). The ACA included a provision establishing a new Medicare Medicaid Coordination Office to address care for the dual eligibles, and also a new Center on Medicare and Medicaid Innovation. Together, these new offices are working with states to facilitate new approaches to improve the care for this population. The nine million dual eligibles account for 15 percent of all Medicaid beneficiaries, but 39 percent of all Medicaid expenditures.

Two CMS actions have been particularly important to states. First, in December 2010, the new CMS Medicare Medicaid Coordination Office requested proposals from states seeking to establish innovative approaches to integrate and coordinate care for duals. In April 2011, CMS awarded $1 million planning contracts to 15 states for the design of such systems. The 15 States were California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.[104]

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[101] "Medical Home Map." NASHP, accessed October 2011. http://www.nashp.org/med-home-map.

[102] Kelly Devers, Robert Berenson, Terri Coughlin, and Juliana Marci. *Innovative Medicaid Initiatives to Improve Service Delivery and Quality of Care: A Look at Five State Initiatives.* Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/medicaid/8224.cfm.

[103] "Phase I Project Management Work Plan (as of 7/12/2011)." Accessed September 1, 2011. http://www.health.ny.gov/health_care/medicaid/redesign/.

[104] For a summary description of proposed approaches in all 15 awardee states, see: *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS.* Kaiser Commission on Medicaid and the Uninsured, August 2011. http://www.kff.org/medicaid/8215.cfm.

Then, in July 2011, CMS announced that it would assist additional states in developing payment and delivery systems that would facilitate the coordination and integration of care for duals. The guidance to states described two models, a capitated approach and a managed fee-for-service (FFS) approach, to integrate care for dual Medicare-Medicaid enrollees. CMS indicated that all 50 states were eligible for funding under this initiative. Many states, including several of the 15 states who received design contracts in April 2011, indicated they plan to submit proposals due in October 2011.

At the time of this survey, 29 states (including the 15 states receiving design contracts in April 2011) indicated that they were actively developing policy in this area and had decided to move forward with an initiative to integrate and coordinate care for their dual populations in FY 2012. Since the time of the survey, CMS has announced that 37 states have submitted letters of intent related to the opportunities announced by CMS in July 2011 described above.[105] Although it was not a question on the survey, other states conveyed that they also were looking at this area and that an initiative could follow in 2013.

Managed Long-Term Care. Responding to the opportunity to apply for design grants from CMS to develop integrated and coordinated systems of care for dual eligibles, many states have turned to developing new approaches to managed LTC for dual eligibles and other Medicaid beneficiaries. In many states, these strategies include approaches to integrate acute and long-term care within a managed care delivery system. Several states are looking at ways to integrate those in need of long-term care services (including dual eligibles) into existing managed care systems, while others are examining approaches designed specifically for this population group. Examples include:

- California is planning to integrate long-term care services in the County Organized Health Systems in FY 2012.
- In the Illinois "Integrated Care Delivery System," individuals in long-term care will receive their medical and behavioral health care services through the MCO, which is also responsible for the first 90 days of a nursing home stay.
- Tennessee is integrating both home and community-based services and nursing home services into the MCO benefit package as part of its Community Choices program.
- In Texas, the Star-Plus program, which manages both long-term and acute care, is being expanded to include additional counties.

Other states are planning to implement specific MLTC programs or dual eligible programs under the auspices of a planning grant from CMS. Altogether, four states in FY 2011 and eight states in FY 2012 listed specific initiatives related to managing care for those in need of long-term care services and supports.

Disease Management, Care Management, Care Management for Complex Cases: Medicaid programs have found value in special programs designed to coordinate and manage the care of individuals with specific conditions and complex health needs. In part, the value of these initiatives is in the improved quality of care that can occur when individuals have assistance and guidance to help them navigate the health care system and to obtain the right care at the right time and place. There is also added value for Medicaid given that such programs can prevent unnecessary, fragmented or duplicative utilization of services, which can easily occur in a complicated health care system. In Medicaid, as in the health care system as a whole, a very small share of individuals account for a large share of expenditures. Analysis has shown that just five percent of beneficiaries account for more than half of all Medicaid spending.[106] The disease and care management initiatives focus

[105] For more information, including a list of states that submitted letters of intent, see: http://www.cms.gov/medicare-medicaid-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf.
[106] KCMU and Urban Institute estimates based on 2007 MSIS and CMS 64 data.

their attention on these individuals with the most complex medical situations where coordination efforts can have the greatest payoff for the patients in terms of improved quality of care and for state Medicaid programs in terms of potential to avoid unnecessary costs.

In FY 2011, Medicaid programs in 15 states reported expanded efforts to coordinate care for individuals with high-cost, chronic and complex medical conditions. In FY 2012, a total of 20 states began or expanded initiatives. In some cases, these efforts were carried out in conjunction with public health efforts focusing on conditions such as diabetes and asthma. In other cases, the initiative was tied to new requirements for managed care, or augmented coordination already occurring in MCOs or PCCM arrangements. For example, Missouri began a new care management program for people with severe mental illness in the spring of 2011; Oklahoma will begin an initiative in ten rural counties with the highest fetal mortality rates to improve prenatal care for pregnant women through their pregnancy; Rhode Island and South Dakota are moving forward with case management programs for high-cost, complex cases; and Texas implemented the Medicaid Wellness program in FY 2011 for persons with chronic and complex conditions in both fee-for-service and its PCCM programs, in which program nurses will work with caregivers to manage health between visits, to educate patients about medications and their condition, and to find the best medical care for their situation.

Health Home for Persons with Chronic Conditions: Section 2703 of the ACA creates a new option for states to establish "Health Homes" for persons on Medicaid who have two or more chronic conditions, including mental health diagnoses. In its guidance to states in November 2010, CMS described this as an "…opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness."[107] With an approved plan, a state can earn an enhanced 90 percent federal matching rate on specified expenditures related directly to care provided through the health home for the first eight quarters of implementation.

During FY 2011, no state had a health home program operating under the authority of this section. However, the prospect of the 90 percent federal matching rate has proved to be a strong incentive and a large number of states are evaluating the opportunity and planning for adoption of this health home option in FY 2012 or FY 2013. In this survey, a total of 21 states indicated that they planned to adopt or implement this option during FY 2012.

New York submitted a Health Home state plan amendment to CMS for approval with the goal of January 1, 2012 implementation and enrollment of 200,000 Medicaid recipients in a health home by the end of fiscal year. DOH will prioritize patient assignment to health homes with comprehensive service delivery and care management capability, including both medical and behavioral health capacity.[108]

[107] SMDL #10-024, Health Homes for Enrollees with Chronic Conditions. CMS, November 10, 2010. http://www.cms.gov/smdl/downloads/SMD10024.pdf.
[108] "State Health Department Accepting Applications for Medicaid Health Homes." Press Release from MRT, August 4, 2011.

C. Quality Initiatives

MCO Quality Initiatives. A total of 35 states with risk-based MCOs listed new or enhanced quality strategies for FY 2011 or FY 2012. Note that states were not asked to list all strategies in place, just those newly implemented in 2011 or planned for 2012. These strategies vary widely in focus and scope across the states. Other states implemented these or similar strategies in earlier years and are not included in this listing unless the state enhanced the strategy in 2011 or 2012. Examples of new initiatives include:

- Increasing the extent to which capitation payments are at risk based on performance on specific quality measures (California, District of Columbia, Illinois, Louisiana, Maryland, Massachusetts, Texas)
- Implementing quality-based incentives or algorithms for auto-enrollment that favor higher performing health plans (Florida, Illinois, Minnesota, New York, Washington)
- Requiring MCOs to have NCQA accreditation (Missouri, South Carolina and Tennessee)
- Implementing emergency room diversion programs (California, Colorado, Delaware, Florida, Georgia, Ohio, Nevada, New Jersey, Rhode Island)
- Adding quality measures to MCO contracts (California, Florida, Georgia, Illinois, Kentucky and Louisiana, Nebraska, Washington, West Virginia, Wisconsin)

California is implementing a broad array of quality strategies in managed care, including 1) implementation on January 1, 2012, of a 5 percent Quality Factor in capitation payments, 2) use of new 2012 HEDIS measures, 3) use of HEDIS measures so more default enrollments go to higher performing plans, 4) finalizing a statewide collaborative on reducing avoidable ER visits, 5) new statewide collaborative on reducing hospital readmissions, 6) individual plan Quality Improvement Projects based on HEDIS scores, 7) new reporting and quality measures for seniors and persons with disabilities [SPDs], 8) new plan requirements for risk stratification and assessments for SPDs, 9) requiring plans to report on SPD-related quality activities, 10) new measures for monitoring PCMHs, 11) new contract requirements to improve quality including case management/care coordination, health risk assessments, medical home, discharge planning, and others.

A number of states are implementing an array of additional MCO quality initiatives targeted to specific populations or service areas. Some examples include the following: Colorado is working with behavioral health organizations to develop performance incentives related to psychotropic medications; Mississippi implemented a new managed care program (MississipiCAN) to coordinate care for high-cost patient populations including SSI, Disabled Child Living at Home, Working Disabled, Foster Care Children and Breast/Cervical Cancer Group; and New Jersey implemented a preventive Oral Health Initiative that will encourage oral health risk assessment, fluoride varnish and referral to a dentist by age one.

PCCM Quality Initiatives. For PCCM programs, a total of 19 states listed new or enhanced quality improvement strategies or initiatives. These initiatives tended to be more focused on quality measurement and less likely to include reimbursement incentives compared to those for MCOs. Selected examples include:

- Alabama developed a system for monitoring and reporting quality metrics for networks using standardized data collection methods, and administered Clinician and Group Primary Care adult and child CAHPS© surveys.
- Louisiana will require PCCM entities to report 37 HEDIS©, AHRQ, CHIPRA and other quality measures (same as for MCOs). Louisiana also reduced the base monthly PCCM fee from $3 to $1.50 and added a pay for performance (P4P) component that includes added per member per month (PMPM) fees of $.50 for extended office hours, $.75 to pursue NCQA PCMH recognition, $.25 if they perform EPSDT

screening themselves, and $.75, $.50 or $.25 depending on quartile for ER visits for members in their practice.

- Vermont will provide an additional fee for providers participating in care management.

Additional Quality Initiatives. A total of 15 states listed new or enhanced quality strategies for long-term care that rely on home and community-based waivers, pay-for-performance for nursing homes and increased use of quality measures and reporting for managed long-term care. A number of states also listed new or enhanced quality improvement strategies in their fee-for service programs including development or use of HEDIS© measures; use of performance measures in a report card or introduction of reimbursement incentives. For example, a number of states had instituted incentives to lower the frequency of Caesarean deliveries and improve birth outcomes (Nevada, Ohio, South Dakota and Washington), to prevent unnecessary hospital readmissions (Colorado, New York and Pennsylvania), and to reduce non-emergency ER use (Colorado, Delaware, New Jersey and Rhode Island).

D. Program Integrity

Numerous state and federal initiatives focus on assuring fiscal and program integrity of the Medicaid program. It is essential that systems are in place to assure that when payments are made, they are accurate and appropriate, and are only made to qualified providers for covered services that were appropriately delivered to eligible clients. It is equally important that the taxpaying public knows this is the case. Since the inception of the Medicaid program, numerous measures have been put in place to assure program integrity, including: quality control initiatives to assure that Medicaid enrollees are eligible for the services they receive; Third Party Liability (TPL) units to avoid paying for services that are the responsibility of private insurers and other responsible parties; Surveillance and Utilization Review Systems (SURS) to review Medicaid claims to identify and address inappropriate patterns of service delivery or utilization and identify potential fraud; and dedicated Medicaid fraud control units administered by each state attorney general or another state office with statewide prosecutorial authority.[109] In addition, Medicaid programs perform on-site audits of provider records to assure that services billed to the program were actually provided and were appropriate.

In recent years the number and scope of Medicaid audit and program integrity functions have escalated. For example, in 2003 the Medicare Modernization Act (MMA) added a requirement for annual independent audits of Medicaid Disproportionate Share Hospital (DSH) payments. The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP). Within the MIP framework, the federal government both provides assistance to states in their program integrity efforts and also hires Audit Medicaid Integrity Contractors (Audit MICs) to conduct provider audits. The ACA extended the Medicare Recovery Audit Contractor (RAC) initiative to Medicaid[110] and added numerous additional Medicaid program integrity provisions, including a national registry of providers terminated by any state Medicaid program, expanded data elements in Medicaid Management Information Systems (MMIS) to detect fraud and abuse, and mandatory use of the National Correct Coding Initiative (NCCI).

In this survey Medicaid officials were asked if they were making any significant new investments or changes to their Medicaid programs to enhance program integrity in either FY 2011 or FY 2012. Of the fifty states and the

[109] Under section 1902(a)(61) of the Medicaid statute, all states must operate "separate and distinct" Medicaid Fraud Control Unit, unless they demonstrate to the Secretary that they can operate without such a unit. All states operate a MFCU except North Dakota which received an exception from HHS in 1994.

[110] Section 6411 of the ACA requires that each Medicaid program must have a contract with a Medicaid Recovery Audit Contractor (RAC). The role of the RAC contractor is to identify and recover Medicaid overpayments and also to identify Medicaid underpayments. At the time the Medicaid directors were interviewed the final rules for the RAC initiative had not been issued, however the ACA required that states submit plans for RAC audits by December 2010.

District of Columbia that responded to this question, forty-six indicated that they were investing in these initiatives or making changes to address program integrity. States are investing in additional staff, in contracted auditors and analysts, in information technology supports and in creation of special units to focus on Medicaid program integrity.

Some current enhancements to provider integrity respond to ACA requirements, while others are state initiated or expand beyond the ACA requirements. In response to an open-ended question, many states specifically mentioned investment in RAC audits and three states mentioned new implementation of NCCI. In addition at least nine states are making modifications to provider enrollment or re-enrollment processes to comply with the ACA. Sixteen states mentioned enhancements to data systems (SURs, MMIS, and Medicaid Information Technology Systems (MITS)) to increase the analytic capabilities. In particular states are implementing new data mining tools to perform more sophisticated analyses of Medicaid claims to detect potential fraud or program abuse. Several states are making improvements to their Payment Error Rate Measurement (PERM) audits.[111] Six states mentioned the creation of new specialized units to focus on Medicaid program integrity. Some of these new units are within the Medicaid agency and some are in other units of state government. Two states created interagency task forces on Medicaid fraud or program integrity.

E. Health Information Technology

Medicaid programs are making unprecedented investments in information technologies designed to improve the efficiency and effectiveness of the health care system. In the past, such investments focused on developing or updating Medicaid Management and Information Systems (MMIS) and Medicaid eligibility systems or implementing changes to these systems to enable new programs or policies. These IT projects tended to occur over time depending on state priorities and budgets. In 2011 and 2012, however, all Medicaid programs are involved simultaneously with several significant system changes.

Four major HIT initiatives are common across most states, with timelines for implementation that are driven by national deadlines.

First, in 2011, states are working on Medicaid Electronic Health Record (EHR) certification and incentive programs. Second, states are focusing their HIT resources on a major upgrade to existing claims payment systems, with an initiative known as HIPAA 5010, which is to be implemented by Medicaid and all other payers, insurers and providers on January 1, 2012. Third, the coding system for billing and identifying diagnoses and diseases that is used on all medical claims is being updated nationally for the first time since 1999; coding system updates, known as ICD–10–CM, must be implemented by October 1, 2013. Fourth, states have begun to work toward implementation of health reform in 2014, which will require major Medicaid IT development, particularly for Medicaid eligibility systems, and integration with new systems developed for state Health Insurance Exchanges.

Medicaid Electronic Health Record Incentive Programs. Of immediate importance in 2011 has been preparation for the implementation of the Medicaid EHR Incentive Program. Pursuant to funding in ARRA, every state has been preparing to assist medical providers in the adoption of EHRs. The law provided substantial incentive payments, to be paid by the Medicaid agency but which are 100 percent federally funded, to hospitals and individual providers who adopt and use EHRs in a meaningful way. Medicaid agencies have been working with providers and developing state systems to ensure that qualifying providers receive the incentive payments. In general, providers qualify if they meet specified Medicaid patient volume standards

[111] PERM requires states on a rolling cycle to contract with outside auditors to measure and report payment error rates by testing a sample of Medicaid payments for the eligibility of the client and the accuracy and appropriateness of the provider payment.

and meet federal standards for "meaningful use" of certified EHR technology. Beginning in 2011, Medicaid is able to pay incentives of up to $63,750 over a six year period to individual providers who qualify, while hospitals can receive incentive payments based on a hospital-specific calculation. Nationally, it is expected that Medicaid programs will award a total of $21.6 billion over the period beginning in 2011 through 2021.

The EHR Incentive Payment program begins with the preparation and CMS approval of a State Medicaid HIT Plan (SMHP.) In an open-ended question, states commonly indicated their SMHP was approved in 2011, and that the business processes in the plan would be used to administer the incentive payments as well as integrate this effort with other efforts. In some states, the EHR initiative is tied to a broader Health Information Exchange or to an e-prescribing initiative.

A total of 14 states indicated in this survey that they had already begun making incentive payments as of July 2011. For example, through June 2011, Iowa indicated that they had paid qualifying hospitals and other providers a total of $5.5 million, and Louisiana had paid $31.7 million. Most other states indicated they would begin making payments by the end of 2011; only seven states indicated they would begin payments after December 2011.

HIPAA 5010 and ICD-10-CM. All state Medicaid programs – along with every other payer and every medical provider – are making complex system upgrades to ensure consistency, privacy and security in healthcare transactions, as required by HIPAA 5010. The HIPAA 5010 system changes must be operational by January 1, 2012 for claims to be filed or paid by any provider, payer or insurer. A similar situation applies to the latest upgrade to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), which must be operational on October 1, 2013, replacing the ICD-9-CM that has been in use since 1999. ICD–10–CM includes improvements in the classification of ambulatory and managed care encounters, expanded codes for injuries, and new combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition. Both HIPAA 5010 and ICD-10-CM require major system changes by state Medicaid programs, and both are required for the ongoing operation of the program.

In response to a survey question, a total of 45 states indicated that they believed they would be in at least partial compliance with the requirements of 5010 by January 2012, and 45 states also indicated that they were on track for implementation of ICD-10-CM by October 2013. Five states indicated they were working toward implementation but did not know or did not think they would be able to meet the deadline; one state did not respond to this question. However, even among states that indicated they would be able to meet the deadlines, several mentioned that these deadlines were a significant challenge and were stretching their resources.

Medicaid Eligibility Systems. Under health reform, states are expected to develop coordinated and integrated eligibility systems for Medicaid and the Health Insurance Exchange. The vision under health reform is a process that would simultaneously, through a simple and largely real-time process, determine eligibility for Medicaid, CHIP or the amount of a subsidy for health insurance through the Exchange. To achieve this more streamlined and simplified eligibility system, the law requires all states to use a common definition of income based on Modified Adjusted Gross Income (MAGI). The conversion to the MAGI standard and other reform-related changes will require substantial changes in current Medicaid eligibility systems. Several states are planning to replace outdated Medicaid eligibility systems while taking advantage of favorable federal Medicaid matching funds now available for this purpose. With implementation set for January 2014, almost all states indicated they were awaiting needed technical guidance from CMS to begin development of these systems as soon as possible. In addition, some states indicated they were participating in larger statewide efforts relating to Health Information Exchanges.

F. State Waivers

Section 1115 Waivers. Under Section 1115 of the Social Security Act, states may carry out experimental, pilot, or demonstration projects that promote the objectives of the Medicaid statute, subject to approval by the Secretary of Health and Human Services which is discretionary. Under this authority, states have expanded eligibility, changed delivery systems, altered benefits and cost sharing, and modified provider payments in ways not otherwise allowed under federal rules. Under approved Section 1115 waivers, states have also obtained federal Medicaid matching funds for services and expenditures that do not otherwise qualify for federal funding. As of June 2011, 30 states and the District of Columbia operated one or more comprehensive Section 1115 Medicaid waivers.[112] Longstanding administrative policy has required that Section 1115 waivers be "budget neutral" for the federal government, meaning that federal costs under a waiver may not exceed what federal costs would have been without the waiver. Waivers are typically approved for a period of five years, after which states may renew or amend the waiver to continue operations.

State Medicaid officials were asked if they were planning to implement a new Section 1115 waiver or waiver amendment in FY 2012.[113] A total of 17 states indicated plans to do so. The approval process for waivers can be lengthy and involves negotiations between the state and CMS. States usually develop a plan, then submit a concept paper to CMS prior to a formal application. Ideas in the concept paper may not be included in a final waiver approval. At the time of the survey, these waivers were in various stages, but the majority of states with waiver plans were still in development or in the concept paper phase.

States are pursuing a number of different types of program changes through waivers, with some states proposing to make multiple types of broad program changes. In this survey:

- The majority of states with waiver plans reported significant delivery system and/or provider payment reforms for broad or targeted populations, including duals or individuals with disabilities and special health care needs (Arizona, Arkansas, Delaware, Florida, Iowa, New Jersey, New York, Oregon, Texas and Washington).
- A number of states reported waivers or waiver amendments to implement cost containment measures including increased cost sharing (Arizona, California and Florida); benefit changes (Arizona, Oklahoma and Oregon), and enrollment caps or eligibility cuts (Arizona and Hawaii). New Jersey reported that they were looking broadly at measures to control costs through a waiver.
- Two states (Colorado and Minnesota[114]) reported plans to use 1115 waiver authority to expand eligibility to childless adults.

State Projects with the CMS Innovations Center. States were asked whether they were working with the CMS Innovations Center on any projects (other than those related to dual eligibles). Nine states responded "yes" and cited projects relating to Express Lane Eligibility; payment reform (including shared savings arrangements, bundled and global payments); state health information exchanges; multi-payer initiatives; alignment of measure sets (and EHR standards for coding) of key clinical quality and outcome measures across federal reform initiatives, Meaningful Use, and CMS provider reporting requirements; and health homes.

Federal Technical Assistance to States. States were asked if they were working with the Medicaid State Technical Assistance Teams (MSTAT) offered by HHS. Of the forty-seven states that responded to this question, eighteen indicated that they had worked with MSTAT. Since MSTAT teams are available on a wide variety of

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[112] *Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers.* Kaiser Commission on Medicaid and the Uninsured, June 2011. http://www.kff.org/medicaid/8196.cfm

[113] 1115 Waivers to cover childless adults that were approved for FY 2011 for California, District of Columbia, New Jersey and Washington were included and discussed in the eligibility section of this paper.

[114] Minnesota did receive approval for this waiver to expand coverage to childless adults with incomes up to 275% FPL.

subjects, there was not a common theme of what areas states had worked on with them. Among the programs mentioned by states were dual eligibles initiatives (four states), development of health homes (two states), and Money Follows the Person initiatives (two states). Connecticut reported working with the MSTAT teams to implement payment reform and develop a contracted Administrative Service Organization (ASO) model to replace current managed care models.

5. Key Issues in Implementing Health Reform

One year after the passage of the ACA, almost all states were heavily engaged in the task of preparing for, or at least analyzing the potential impact of, health reform implementation including the expansion of Medicaid eligibility in 2014, the implementation of a new eligibility methodology and redesigning eligibility systems to interface with new Health Insurance Exchanges. This year's survey asked for state responses to several open-end questions related to the process of planning for health care reform implementation and various impacts, implications and challenges. State responses are summarized below.

Role of Medicaid Agency in Implementing the ACA. Most states indicated that the Medicaid agency was heavily involved in some type of interagency planning effort that also included the state insurance department. A few states mentioned working with a formal health care reform coordinating body or office charged with overseeing state health care reform planning efforts including the:

- California Health Benefit Exchange Board;
- Illinois Health Care Reform Implementation Council;
- Maryland Health Reform Coordinating Council;
- New Mexico Office of Health Care Reform;
- Health Care Reform Unit housed within the Nevada Division of Health Care Financing and Policy, and
- Virginia Health Reform Office.

In a number of cases (e.g., Colorado, Delaware, Minnesota, Nevada, Tennessee, Texas, and Vermont), survey respondents indicated that the Medicaid agency (or the umbrella agency that Medicaid resides in) is playing the lead role in health care reform planning. Three states (Alabama, Nebraska and North Carolina) indicated that the Department of Insurance had the lead role. Almost all states indicated the Medicaid agency was working with the state insurance commissioner on implementation issues.

Almost all states reported that planning efforts were underway; however, planning efforts were limited to only mandatory requirements in a small number of states where there was a lack of political support for the ACA. Two states, Louisiana and Montana, reported that their states had decided not to run their own health insurance exchange (electing to defer exchange development and administration to the federal government) and Arizona, Indiana and Oklahoma officials indicated that it was currently uncertain whether or not their states would run their own exchanges. Florida reported that no ACA implementation activities were underway as the State of Florida had filed a lawsuit challenging the ACA resulting in the Eleventh Circuit Federal Court of Appeals ruling that parts of the ACA were unconstitutional and striking down the entire law. Other states among those party to a lawsuit challenging the ACA indicated that they were looking for those ACA provisions that might be advantageous to the state, or that the politics of the issue made implementation uncertain.

Key Challenges and Information Needs in Implementing the ACA. States were asked to identify the biggest challenges for Medicaid in implementing health reform. Most states identified multiple health care reform implementation challenges. The most commonly listed challenges included: the fiscal impact of health care

reform implementation, the tight implementation timelines, lack of clear federal guidance, limited staff and administrative resources to accomplish all of the required health care reform planning and implementation tasks such as streamlining eligibility processes, building an exchange and integrating Medicaid eligibility and enrollment processes with the exchange, as well as various systems and IT issues, and provider access issues. A few states also mentioned political challenges relating to ACA opposition in their states.

States were asked what information they needed from CMS to enable them to move forward with health care reform implementation. The most common response (20 states) was regulations and guidance on the new "Modified Adjusted Gross Income" (or "MAGI") eligibility standard and eligibility simplification.[115] Seventeen states referred generally to the need for clear, timely regulations, interpretations and guidance on all aspects of the ACA. Nine states cited the need for the definition of "essential benefits" and seven states referred to the need for additional guidance and information concerning exchanges. Information needs cited by two states included eligibility system-related information, information concerning the ACA mandated rate increases for primary care providers, and information on the Basic Health Plan Option. Other issues mentioned by states were questions about the health status and needs of the newly eligible Medicaid population entering the program in 2014, the definitions and duties of health insurance exchange navigators, regional exchanges, and the federal processes, deliverables and shared services that will be provided as part of the Exchange (e.g., identity management).

Transitioning to MAGI Eligibility Standard. The ACA will require states to use a new income eligibility methodology known as "Modified Adjusted Gross Income," or "MAGI" in 2014. While the goal of MAGI is to simplify eligibility and help coordinate eligibility determinations across various types of health coverage, planning for the transition to MAGI as well as developing the eligibility systems to accommodate both the Medicaid expansion and the new income methodology were highlighted as a key challenges for many states in preparing to implement health reform. This survey asked states to comment on the implications of moving to MAGI, including whether they were developing a new eligibility system.

Nearly half of all states (24) indicated that they were either developing new eligibility systems or rules engines or planning to adapt their current systems. States were also waiting for federal regulations to complete their analysis of the impact of MAGI (which were released on August 4, 2011 after interviews with most states had been completed). Two states mentioned changes already made that would likely make the MAGI transition easier: Oklahoma's online enrollment process and Utah's adoption of an Adjusted Gross Income (AGI) standard for CHIP renewals in 2011 (to be extended to Medicaid and CHIP applications in 2012).

Eligibility Systems and 90/10 Enhanced Medicaid Administrative Match. Responding to the concerns in most states about the cost of upgrading Medicaid eligibility systems to implement health care reform, in November 2010 CMS announced the availability of enhanced federal funding for new or upgraded systems. For qualified states, the federal government will pick up 90 percent of the development cost through December 2015 (referred to as the "90/10" rule). Under the final rule adopted in April 2011,[116] states may also receive a 75 percent federal matching rate for maintenance and operations. This represents a significant increase above the 50 percent match rate previously available for these systems. To qualify for the enhanced match, states must meet a set of performance standards and conditions, including seamless coordination with the exchanges. Thirty-eight states indicated that they were planning to take advantage of the 90/10 enhanced Medicaid FMAP.

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[115] This survey was completed prior to the release of proposed regulations on Eligibility Changes under the Affordable Care Act of 2010 released on August 4, 2011.

[116] Federal Register, April 19, 2011 (Vol. 76, No. 75), pp 21950 - 21975, at http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf.

Potential role of the Medicaid agency in determining the eligibility for subsidies in the Exchange. Under the ACA, states are required to coordinate eligibility for Medicaid with that for premium subsidies available through the new exchanges with a single application form, on-line applications, and integrated screening and enrollment requirements. To help achieve this coordination, the law allows exchanges to contract with Medicaid agencies to perform the eligibility and subsidy determinations for those purchasing coverage in the Exchange. In this survey, states were asked what role, if any, the Medicaid agency was expected to play in determining eligibility for exchange subsidies. Reflecting the fact that states have much work yet to do and many important decisions are still months away, almost half the states (23) indicated that Medicaid's role in determining eligibility for Exchange subsidies was not yet known.

Despite uncertainty, a number of states indicated that they expected the Exchange would likely use the Medicaid eligibility system or the same "rules based engine" as Medicaid for subsidy determinations or that the Medicaid agency would play a lead role in subsidy determinations. Again, responses reflected the early stages of state policy development in this important area. Only a few states responded that Medicaid would not have a role in subsidy eligibility determinations and two states described the Medicaid role as only assisting with the development or building of the exchange.

Medicaid Demonstration Opportunities in the ACA. The ACA contains a number of demonstration opportunities available to state Medicaid programs to test new delivery system and payment reforms intended to promote more cost effective, high quality care. This year's survey asked whether states were planning to apply for one or more of the five Medicaid demonstration opportunities described below. An invitation for applications had been released for each of the following two programs:

- *Medicaid Incentives for Prevention of Chronic Diseases Program.* This program provides state grants to test approaches that encourage behavior modification for healthy lifestyles. CMS issued an invitation to States to apply for grants in February 2011 with applications due by May 2, 2011. Twenty-one states reported applying for this grant program.[117]
- *Medicaid Emergency Psychiatric Demonstration Project:* [118] This program provides up to $75 million in funding to states on a competitive basis over three years to help care for Medicaid patients with psychiatric emergencies in private inpatient psychiatric facilities with 17 or more beds, also known as institutions for mental diseases (IMDs). On August 9, 2011, CMS announced that it was accepting applications and set the deadline for submission as October 14, 2011. Ten states reported plans to apply for this demonstration grant opportunity; 14 indicated that they did not plan to apply, 27 states responded "don't know."

The majority of states indicated that they did not know if they would apply for the following grants (for which invitations for application had not been issued at the time of this report):

- *Medicaid Integrated Care Hospitalization Demonstration Program.* Up to eight states will be selected to use bundled payments to promote integration of care around hospitalization.
- *Medicaid Global Payment System Demonstration*. Up to five states will be selected to test paying a safety net hospital system or network using a global capitated payment model.

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[117] *Initial Announcement for Medicaid Incentives for Prevention of Chronic Disease.* Center for Medicare and Medicaid, February 2011. https://www.cms.gov/MIPCD/downloads/HHS_ACA_S4108_Solicitation.pdf. Closing date for applications was May 2, 2011. The number of grant programs approved by CMS depends on the scope (e.g., proposed enrollment and scope of services) and quality of the proposed programs; however, CMS anticipates the funding level to be sufficient to support approximately 10 States with between $5 million and $10 million each over the life of the program. Awards have been made to 10 states on September 13, 2011. HHS TAGGS database. Accessed October 12, 2011. http://taggs.hhs.gov/index.cfm.

[118] *Letter to State Medicaid Directors.* CMS, August 9, 2011. https://www.cms.gov/DemonstrProjectsEvalRepts/downloads/MEPD_State_Medicaid_Director.pdf

- *Pediatric Accountable Care Organization Demonstration Project.* This project will allow pediatric providers to organize as accountable care organizations (ACOs) and share in federal and state Medicaid cost savings.

Several states commented on the lack of available state administrative resources to pursue demonstration opportunities. One state commented that these focused and limited demonstrations may not fit with the state's larger goals (e.g., managed care) and another state observed that it was not interested in population-limited, time-limited opportunities and was instead seeking ACO-type flexibility through a Section 1115 waiver. However, one state indicated an intention to apply for all of the demonstration opportunities noting that the state would try to "leverage the ACA to drive reform."

6. Looking Ahead: Perspectives of Medicaid Directors

At the outset of state fiscal year 2012, Medicaid directors were asked to identify the most significant issues, challenges and opportunities for their Medicaid programs over the next year or two. The responses across all states described difficult challenges and demands, as well as an unprecedented array of opportunities. Dominating state Medicaid concerns were the ongoing effects of the economic downturn and revenue shortfalls on state budgets and on Medicaid spending, and the unrelenting fiscal pressure to craft program changes that would bring spending under control even when faced with increasing enrollment. Since the most recent economic downturn began in 2008, Medicaid and state budget shortfalls have been the rule across almost all states, forcing states to continuously examine all possible options for cost containment. Pressure to control costs was identified as the most significant Medicaid issue by program officials for 2012.

The challenge of funding the Medicaid program has focused state efforts to develop strategies for a sustainable and more effective program. Across states, the fiscal pressure has accelerated a trend toward the use of managed care and care management, particularly for duals and for beneficiaries with disabilities or with high-cost, complex health needs. While these models are promising options to both reduce costs and better coordinate care, it is difficult to implement major new policy directions in a time of severely constrained administrative resources.

After fiscal concerns, issues related to health reform were listed as a priority by almost all states. State Medicaid programs have significant responsibilities for implementation of health reform. The expansion of Medicaid eligibility for adults in 2014, the opportunity for a simplified eligibility system coordinated with the Health Benefit Exchange, initiatives to strengthen primary care, efforts to integrate care for dual eligibles, and demonstration opportunities for balancing in long term care all represent new opportunities for states. However, Medicaid officials are concerned about the short timelines, the lack of detailed guidance regarding state requirements, the availability of state resources to carry out the policy changes, work force issues and provider capacity, and the underlying political uncertainty around federal health reform.

The third issue listed by Medicaid officials relates to imminent deadlines for major systems changes, including HIPAA 5010 on January 1, 2012, and ICD-10-CM in October 2013, and in several states, upgrades to Medicaid eligibility systems or Medicaid management information systems in preparation for health reform. The confluence of these major system changes is taxing state resources and the availability of HIT vendors who assist states. One state expressed that they are "so busy dealing with cost containment implementation, 5010 and ICD-10 (that are major efforts)" that they have not yet had time to prepare for changes in the ACA.

In addition to these three top issues, which were mentioned by a majority of states, a number of additional issues were listed as key concerns for the next year related to state-specific priorities. These included significant managed care expansions and initiatives for dual eligibles, patient-centered medical homes,

behavioral health and physical health initiatives, overall quality improvement, and "right-sizing" long term care.

Adding uncertainty to the outlook for state Medicaid programs are the discussions at the federal level on deficit reduction. Medicare and Medicaid are a primary target for federal savings, since these health programs continue to grow as a share of the federal budget and as a share of GDP. State officials expressed concern about the potential that federal policy makers might undertake policies to save federal dollars that would shift costs to states, such as proposals for a blended FMAP or for limits on provider taxes.

Conclusion

For Medicaid programs, extraordinary challenges have become the norm. FY 2011 and FY 2012 continued a string of consecutive years characterized by state budget shortfalls, strong demands on the program and unrelenting pressure to control the pace of spending. Now, Medicaid officials face additional pressure from major system changes associated with HIPAA 5010 and ICD-10-CM, followed closely by major changes required by federal health reform.

Last year, Medicaid experienced increases in total spending that averaged 7.3 percent. More significant for states, the state general fund cost of Medicaid grew by 10.8 percent, adding to state fiscal stress as enhanced ARRA federal Medicaid matching rates began to phase down and state revenues recovered slowly but remained well below actual levels of three years earlier. For FY 2012, legislatures made optimistic assumptions about program growth and adopted a range of changes to help control spending. With these changes, FY 2012 appropriations for total Medicaid spending averaged just 2.2 percent above FY 2011 levels, well below projected increases in enrollment growth that averaged 4.1 percent. However, the end of enhanced federal funding meant that states faced unprecedented increases in the state general fund cost of Medicaid, which averaged 28.7 percent for FY 2012 as states had to replace lost federal financing.

The intensity of fiscal pressure on Medicaid is evident in the actions being taken to control costs. A total of 46 states reported plans to restrict or cut provider payment rates in FY 2012, and 18 states planned to restrict or cut benefits. Several states are planning to significantly increase the role of managed care in Medicaid, including plans to use managed care delivery systems for persons with disabilities. States also continue a focus on home and community based services as a way to improve care and reduce spending on more expensive institutional long-term care. Medicaid directors were focused on quality, quality improvement, high performance and obtaining greater value for the tax dollars that support the program. Facilitated by new information technology and managed care, states now almost universally use quality measures in reimbursement methodologies that reward high performance and penalize poor performance. States are also using data systems to monitor for fraud and abuse to assure the highest level of fiscal and program integrity.

When asked about what they were most proud of in their programs, Medicaid directors cited a wide range of program improvements and strategies now underway to make their programs better. A common theme was that states were proud of how Medicaid has been able to make improvements in delivery and payment systems even during this time of extreme fiscal strain, along with policies that have achieved savings and increased the value of program expenditures.

Medicaid officials indicated that the major concerns for the future relate to the ability of states to afford the program over the long run and preparation for the expansion of Medicaid under health reform in 2014, particularly in the face of limits on administrative capacity across all state programs and the need to implement other major system changes. State concerns are exacerbated by federal discussions about debt and deficit reduction because some proposals would achieve federal savings by shifting Medicaid costs to states, compromising their ability to move forward with new initiatives and changes required by health reform. In many ways, Medicaid programs have proven to be a resilient part of the nation's health care system, innovating and adapting to new opportunities afforded by an evolving health care system and implementing new provisions of federal law. The current challenges may appear daunting, but Medicaid directors communicated that they and their programs are poised for a greater role in health care delivery, and are committed to assuring access to high-quality care delivered in the most effective manner possible.

Appendix A: State Survey Responses

Appendix A-1
Positive Policy Actions Taken in the 50 States and the District of Columbia
FY 2011-2012

States	Provider Payment Increases		Benefit Expansions		Eligibility Expansions		Simplification to Application/ Renewal		Decreased or Eliminated Copayments		Long Term Care Expansions	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
Alabama											x	x
Alaska	x	x	x		x						x	x
Arizona	x	x										
Arkansas							x	x			x	x
California	x	x	x		x	x	x				x	x
Colorado		x	x	x		x	x	x				x
Connecticut				x		x					x	x
Delaware	x	x			x				x		x	x
District of Columbia	x			x	x						x	
Florida	x	x			x		x				x	x
Georgia	x	x	x		x		x				x	x
Hawaii	x			x								
Idaho	x											x
Illinois	x				x	x					x	x
Indiana	x	x					x	x			x	
Iowa					x	x	x				x	x
Kansas	x	x					x					x
Kentucky	x	x									x	x
Louisiana	x	x	x	x	x	x	x	x			x	x
Maine	x	x										
Maryland						x						x
Massachusetts	x	x					x	x			x	x
Michigan	x	x	x			x						x
Minnesota	x	x			x	x			x		x	x
Mississippi					x						x	
Missouri	x	x									x	x
Montana	x	x			x		x				x	x
Nebraska	x		x		x		x				x	x
Nevada	x											
New Hampshire	x	x	x	x								
New Jersey					x			x				
New Mexico	x	x				x						
New York				x		x	x	x				x
North Carolina				x	x			x			x	x
North Dakota							x		x		x	
Ohio	x	x		x		x	x				x	x
Oklahoma	x	x	x				x				x	
Oregon				x	x	x	x	x				
Pennsylvania	x	x					x				x	
Rhode Island	x	x	x	x								
South Carolina					x		x				x	x
South Dakota												
Tennessee				x							x	x
Texas			x		x		x				x	x
Utah	x						x	x			x	
Vermont	x	x			x	x	x					x
Virginia	x	x			x						x	x
Washington	x		x	x	x	x					x	x
West Virginia	x	x						x				x
Wisconsin	x	x	x		x		x				x	x
Wyoming	x	x										
Total	**35**	**28**	**13**	**13**	**22**	**15**	**23**	**11**	**3**	**0**	**32**	**33**

Appendix A-2
Cost Containment Actions Taken in the 50 States and the District of Columbia
FY 2011-2012

States	Provider Payments		Pharmacy Controls		Benefit Reductions		Eligibility Cuts		Changes to Application		New or Increased Copay Requirements		LTC	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
Alabama	x	x		x										
Alaska			x	x										
Arizona	x	x		x	x	x	x	x			x	x		x
Arkansas		x		x										
California	x	x	x	x		x						x		
Colorado	x	x	x	x	x	x								
Connecticut	x	x		x	x	x		x						
Delaware	x	x		x									x	
District of Columbia	x	x	x		x	x								
Florida		x										x		
Georgia	x	x	x	x								x		
Hawaii		x		x		x		x						
Idaho	x	x		x	x	x						x	x	
Illinois	x	x	x	x						x		x		
Indiana	x	x		x	x	x							x	
Iowa	x		x	x		x						x		
Kansas		x	x	x	x									
Kentucky		x	x											
Louisiana	x	x	x											
Maine	x	x		x								x	x	
Maryland	x	x		x										
Massachusetts	x	x	x		x						x	x	x	x
Michigan	x	x	x	x		x								
Minnesota	x	x		x	x							x		x
Mississippi	x	x	x	x										
Missouri	x	x												
Montana	x	x		x										x
Nebraska		x			x							x	x	x
Nevada	x	x		x										
New Hampshire	x	x	x	x	x	x							x	
New Jersey	x	x	x		x									x
New Mexico	x	x	x		x	x	x							
New York	x	x	x	x		x								
North Carolina	x	x	x	x	x	x						x	x	
North Dakota														
Ohio	x	x												x
Oklahoma	x	x	x											
Oregon		x	x	x		x					x		x	
Pennsylvania		x	x	x		x						x		
Rhode Island	x	x	x										x	x
South Carolina	x	x	x	x	x						x	x	x	x
South Dakota	x	x	x	x										
Tennessee	x	x	x	x										
Texas	x	x	x	x		x							x	
Utah	x	x	x	x										
Vermont		x	x	x	x						x			
Virginia	x	x		x	x									x
Washington	x	x	x	x	x	x								
West Virginia				x									x	
Wisconsin	x		x	x									x	x
Wyoming	x	x	x	x										
Total	**39**	**46**	**31**	**38**	**18**	**18**	**2**	**3**	**0**	**1**	**5**	**14**	**14**	**11**

Appendix A-3
Provider Taxes in Place in the 50 States and the District of Columbia
FY 2011-2012

States	Hospitals		ICF-ID		Nursing Facilities		Managed Care Organizations		Other***		Any Provider Tax	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
Alabama	x	x			x	x			x	x	x	x
Alaska												
Arizona							x	x			x	x
Arkansas	x	x	x	x*	x	x					x	x
California	x	x	x	x*	x	x					x	x
Colorado	x	x	x		x	x					x	x
Connecticut		x*		x*	x	x					x	x
Delaware												
District of Columbia		x	x	x*	x	x	x	x			x	x
Florida	x	x	x	x*	x	x					x	x
Georgia	x	x			x	x					x	x
Hawaii												
Idaho	x	x		x	x	x*					x	x
Illinois	x	x	x	x*	x	x					x	x
Indiana		x	x	x*	x	x*					x	x
Iowa	x	x	x	x*	x	x					x	x
Kansas	x	x			x	x					x	x
Kentucky	x	x	x	x	x	x			x	x*	x	x
Louisiana			x	x**	x	x			x	x	x	x
Maine	x	x*	x	x*	x	x*			x	x	x	x
Maryland	x	x	x	x*	x	x*	x	x			x	x
Massachusetts	x	x*			x	x*					x	x
Michigan	x	x			x	x*					x	x
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	x
Nevada					x	x*					x	x
New Hampshire	x	x*			x	x*					x	x
New Jersey	x	x	x	x*	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	x	x
North Dakota			x	x*							x	x
Ohio	x	x	x	x*	x	x*					x	x
Oklahoma		x			x	x					x	x
Oregon	x	x*			x	x*					x	x
Pennsylvania	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*			x	x
Texas			x	x*			x	x			x	x
Utah	x	x	x	x*	x	x*					x	x
Vermont	x	x*	x	x*	x	x*			x	x*	x	x
Virginia				x*								x
Washington	x	x	x	x*		x*					x	x
West Virginia	x	x	x	x*	x	x*			x	x*	x	x
Wisconsin	x	x	x	x**	x	x			x	x*	x	x
Wyoming	x	x			x	x					x	x
Total	**34**	**39**	**32**	**34**	**39**	**41**	**9**	**9**	**11**	**12**	**47**	**48**

*States reported that these taxes would be impacted were the safe harbor threshold to be dropped to 3.5%.
**States reported that they did not know at the time of the survey if these taxes would be impacted were the safe harbor threshold to be dropped to 3.5%.
***States reporting multiple "other" provider taxes were Kentucky, Minnesota, New York, and Vermont in both 2011 and 2012 and Missouri and North Carolina in 2012. West Virginia had multiple "other" taxes in FY 2010 but eliminated one in FY 2011.

Appendix A-4a:
Eligibility and Application Renewal Process Related Actions Taken in the 50 States and the District of Columbia
FY 2011[119]

State	Eligibility and Application Changes 2011
Alabama	
Alaska	**Aged & Disabled (+):** Alaska updated its special long-term income standard to 300 percent of current SSI income standard. The income standard had previously been frozen at 2003 levels of $1656 per month. The state does not expect an increase in enrollment as the policy change will eliminate the need to use a trust. (affects 200; 1/1/2011)
Arizona	**Spend-Down (-):** Medical Expense Deduction (MED) Spend Down Program enrollment frozen. (5/1/11)
Arkansas	**Application & Renewal (+):** Added an online application for the Medicare Savings Program and family Medicaid (Section 1931).
California	**Childless Adults (+):** Early adoption of 133 percent under new childless adult waiver. Expansion is available in all 58 counties at the option of counties. (Unknown, 6/1/2011) **Adults (nc):** Family Planning converted from waiver to State Plan Amendment. (7/1/10) **Application & Renewal (+):** Implemented online application capability (known as Public Access) for the general public to be screened for Medi-Cal for low-income children and pregnant women; the original application is known as Health-e-App which can be mailed in or submitted electronically by certified application assistors.
Colorado	**Application & Renewal (+):** Fully implemented the Program Eligibility and Application Kit (PEAK), an online service for Coloradans to screen themselves and apply for medical, food, and cash assistance programs.
Connecticut	
Delaware	**Children & Pregnant (+):** Implemented CHIPRA Section 214 (ICHIA) coverage of legally residing immigrant children and pregnant women. (Previously covered under a State-only program.) (500; 7/1/2010)
District of Columbia	**Childless Adults (+):** Expanded coverage from 133 to 200% FPL through a waiver, transferring individuals from their state-funded Alliance program. (2,700; 10/1/2010)
Florida	**Aged & Disabled (+):** Change from age 75 to 60 for individuals covered by the comprehensive adult day health care home and community based services Medicaid waiver (Unknown, 11/1/2010) **All (+):** Exclusion of federal tax refunds and credits as income or assets for all eligibility groups. (Unknown, 2/21/11) **All (+):** Exclusion of Energy Employees Occupational Illness Compensation Program payments as income or assets. **Application & Renewal (+):** Supplemental Security Income termination review process. **Application & Renewal (nc):** Vital Statistics Death Matches and Department of Corrections Prison incarceration information **Application & Renewal (+):** Processing emergency Medicaid for aliens requests for individuals in open cases **Application & Renewal (+):** Systemic Alien Verification for Entitlements (SAVE) verification not required after application unless change to alien status.
Georgia	**Adults (+):** New family Planning waiver implemented. (2,500, 1/1/2011) **Application & Renewal (+):** Automatic WIC referral implemented.
Hawaii	
Idaho	
Illinois	**Children (+):** CHIPRA option (ICHIA) to cover legally residing immigrant children. (21,000, implemented in FY 2011, retroactive CMS approval to 4/1/2009)
Indiana	**Application & Renewal (+):** Implemented simplified process for annual redeterminations by moving to a mail-in form and eliminating face-to-face requirements. **Application & Renewal (+):** Continued roll-out of technology to allow online applications.
Iowa	**Children (+):** Presumptive Eligibility **Application & Renewal (+):** Express Lane Eligibility
Kansas	**Application & Renewal (+):** Implement Express Lane eligibility for children. **Application & Renewal (+):** Passive Renewal for children. **Application & Renewal (+):** Extend self-declaration of income to all forms of income on reviews and changes of income. **Application & Renewal (+):** Modified and pre-populated renewal form.

[119] Positive changes counted in this report are denoted with (+). Negative changes counted in this report are denoted with (-). Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (nc).

State	Eligibility and Application Changes 2011
Kentucky	
Louisiana	**Aged & Disabled (+):** The State took advantage of a new CMS interpretation permitting Home and Community-Based Services waiver consumers to spend-down to special income standard (300 percent of SSI). (50, 12/1/2010) **Application & Renewal (+):** Implement Express Lane Eligibility renewals. (07/01/2010) **Application & Renewal (+):** Revised Child-related application to incorporate focus group recommendations, to create a more user friendly application for applicants and for improved data entry process for eligibility staff.)
Maine	
Maryland	
Massachusetts	**Application & Renewal (+):** Enhanced the eligibility system to electronic interface with SVES for electronic citizenship and identify verification. **Application & Renewal (+):** Eliminated the obligation of members to verify new hire data received via electronic interface with the Division of Revenue (DOR). The decision to eliminate this administratively burdensome process was made after statistical data revealed a re-enrollment rate in excess of 95 percent of terminated members. **Application & Renewal (+):** Implemented an Electronic Document Management (EDM) process to the intake and annual review for all households residing in a community setting. Systems enhancement included a safeguard preventing administrative closing when required documents had been submitted by a member but not yet processed by operations. **Application & Renewal (nc):** Added a question to the application to capture information relative to an applicants' visitor status. **Application & Renewal (nc):** Absent parent application supplement was updated to allow applicant to declare a deceased, or unknown absent parent or single parent circumstance. **Application & Renewal (nc):** If an absent parent circumstance exists in the household and questions are left blank on the application a verification letter is mailed with a blank supplement form with deadline by which to complete and return. NOTE: Pregnant Women and children are held harmless from denial/termination of benefits in this circumstance if they fail to respond to the verification request.
Michigan	
Minnesota	**Childless Adults (+):** Adopted new option under ACA to expand coverage to childless adults up to 75% FPL under State Plan Amendment.
Mississippi	**Disabled (+):** increased enrollment cap - Healthier MS 1115 waiver. (500, 11/1/2010)
Missouri	
Montana	**Disabled (+):** 1115 Basic Medicaid waiver mental health population.(350; 12/1/2010) **Application & Renewal (+):** Created online application, a common application for children's Medicaid and CHIP.
Nebraska	**Children & Pregnant Women (+):** Implemented ICHIA option of coverage for legally residing immigrant children and pregnant women. (504 children, 226 pregnant women, 7/1/2010) **Application & Renewal (+):** Further development of online application process. **Application & Renewal (+):** Implementation of Call Center.
Nevada	
New Hampshire	
New Jersey	**Childless Adults (+):** Implemented a waiver to cover General Assistance adults to 24 percent of FPL. (59,000, 4/15/2011)
New Mexico	**Adults (-):** Plan to expand waiting list for State Coverage Insurance (SCI) by preventing employer groups enlisting new enrollees. (6,062; Unknown)
New York	**Application & Renewal (+):** Implement a statewide enrollment center to take telephone renewals for certain community Medicaid recipients. **Application & Renewal (+):** Expand attestation of income, resources and residence at renewal for aged, blind and disabled recipients receiving community-based long term care services and attestation of interest income for Family Health Plus and certain Medicaid applicants. **Application & Renewal (nc):** Automate enrollment in Medicare Savings Program under MIPPA.
North Carolina	**Children & Pregnant Women (+):** Implemented ICHIA option to cover legally residing immigrant pregnant women and children. (1,228, 7/1/10)
North Dakota	**Application & Renewal (+):** Online enrollment system. **Application & Renewal (+):** Eased redetermination requirements to expand exparte reviews.
Ohio	**Application & Renewal (+):** Implement real-time online application. (10/1/2010) **Application & Renewal (nc):** Collabor-8 Pilot Project (multi-county resource sharing arrangement for eligibility determination]

State	Eligibility and Application Changes 2011
Oklahoma	**Application & Renewal (+):** Online Enrollment. **Application & Renewal (+):** Rolling renewal date when demographic data changes
Oregon	**Adults (+):** OHP Standard randomized drawings from reservation list will be increased to reach an average monthly enrollment of 50,000. (Was previously 25,000.) **Application & Renewal (+):** Implemented Express Lane Eligibility using information already gathered for SNAP, WIC, and the free or reduced school lunch programs. **Application & Renewal (+):** Form no longer requests proof of citizenship or identify; exparte sources are used. **Application & Renewal (+):** The renewal process has been modified so that most clients who are at the end of their certification period are sent a pre-filled notice. **Application & Renewal (+):** Application form was adjusted to allow clients to provide an e-mail address and indicate their preferred method of contact.
Pennsylvania	**Children (nc):** Newborn policies modified to meet CHIPRA requirements which include deemed eligibility and elimination of citizen documentation requirements. (5/1/2011) **Application & Renewal (+):** Redesign of Medicare Savings Program application and renewal forms using easy to understand text and simplifies form layouts.
Rhode Island	
South Carolina	**Adults (+):** Converted Family Planning waiver to new state plan option and extended coverage of family planning services to males. (1/1/2011) **Families (nc):** Eliminate Gross Income Test for Low Income Families. (Still have net income test for eligibility.) **Application and Renewal (+):** Express Lane Renewal process for Partners for Healthy Children's program for annual reviews. (Includes Medicaid and CHIP)
South Dakota	
Tennessee	
Texas	**Pregnant Women & Children (+):** Implemented ICHIA option for legally residing immigrant children and pregnant women. **Disabled Children (+):** Implemented a Medicaid Buy-in for Children Program for children with a disability under age 19. (148, 1/1/2011) **Application & Renewal (+):** Enhanced online application and client self-service features, effective 1/2011. **Application & Renewal (+):** Revised application forms effective 8/2011
Utah	**Application & Renewal (+):** Developed an online Medicaid eligibility renewal tool.
Vermont	**Premium Assistance Program (+):** expansion of Premium Assistance Program to Medicaid on voluntary basis. (35; 7/1/2010) **Application & Renewal (+):** Online submittal of application.
Virginia	**Children (+):** New premium assistance program – HIPP for Kids. (600, 10/1/2010)
Washington	**Adults (+):** Washington's Transitional Bridge is a statewide section 1115 Demonstration to sustain coverage for early expansion-eligible individuals (Transition Eligibles) with countable household incomes up to and including 133 percent of the FPL who are enrolled in the State-only Basic Health, Disability Lifeline, or Alcohol and Drug Addiction Treatment and Support Act programs. (53,000, 1/1/2011)
West Virginia	
Wisconsin	**Adults (+):** Converted Family Planning waiver to State Plan Option, increased income level and extended coverage to males. (11/1/2010) **Adults (+):** Certain Basic Plan (non-Medicaid) members are allowed to enroll into the Core Plan (Medicaid waiver for childless adults) based on medical reasons (12/1/10) **Application & Renewal (+):** Administrative renewals for certain cases. **Application & Renewal (+):** Verification notice redesign.
Wyoming	

Appendix A-4b:
Eligibility and Application Renewal Process Related Actions Taken in the 50 States and the District of Columbia
FY 2012[120]

State	Eligibility and Application Changes in FY 2012
Alabama	
Alaska	**Aged & Disabled (nc):** Increased Personal Needs Allowance for Nursing Home residents from $75 to $200/month. The state does not except an increase in enrollment from this policy change. (affects 260, 7/1/2011)
Arizona	**Spend-Down (-):** Medical Expense Deduction (MED) Spend Down Program to end. (Approximately 6,000, 9/30/2011) **Childless Adults (-):** AHCCCS Care for Childless Adults Frozen. (First year estimate is 90,000 out of 230,000; 7/8/2011) **Parents (-):** Enrollment for TANF-related (parents) over 75 percent of FPL frozen. (First year estimate is 22,500 out of 70,000; 10/1/2011, CMS issued a preliminary no to this change on October 7, 2011.)
Arkansas	**Application & Renewal (+):** Plan to implement streamlined annual renewals for the children's groups including telephone and ex parte renewals.
California	**Disabled (+):** Working Disabled Program (WDP) that covers up to 250% FPL will be modified with the following changes: continuous eligibility; exemption of Social Security disability income that converts to Social Security retirement income at age 5, and two expansion of assets that are exempt. (5,860, 8-1-11) **Application & Renewal (nc):** As a result of litigation and compliance with a court order, CA is refining the Health-e-App for purposes of screening children who submit an application through the Single Point of Entry that processes Healthy Families Program applications and screens children to Medi-Cal. The application changes will include questions to screen for the 1931(b) program in addition to the current poverty level programs for children.
Colorado	**Childless Adults (+):** Colorado plans submit a waiver to expand Medicaid coverage to adults without dependent children with incomes below 10% FPL. Program will initially be capped at 10,000 with a waiting list. (10,000, March 2012 pending approval) **Disabled Adults (+):** Implement Disabled Buy-in program for working adults (TWWIIA). (1,200, early 2012) **Disabled children (+):** Implement Disabled Buy-in program for children (Family Opportunities Act). (mid-2012) **Application & Renewal (+):** Implement interfaces to eliminate paper for citizenship, identity and income. **Application & Renewal (+):** Implement Express Lane Eligibility using criteria from other agencies. **Application & Renewal (+):** Changed rules to permit passive and telephone redeterminations.
Connecticut	**Adults (+):** Tuberculosis waiver. (11/2011) **Aged & Disabled (+):** Increasing the amount of income disregards for the Medicare Savings Program. (7/2011) **Aged & Disabled (-):** Decreasing the amount of spousal assets retained for long term care population. (7/2011) **Adults (+):** Implemented new family planning state plan. (11/2011)
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	**Adults (-):** Hawaii is requesting an 1115 waiver modification to decrease eligibility from 200 percent to 133 percent of FPL. (4,500, 1/1/2012 if CMS approves)
Idaho	
Illinois	**Disabled (+):** Expanded Ticket to Work (TWWIIA) Medically Improved under 1902(a)(10)(A)(ii)(XVI). (10; 10/1/2011) **Application & Renewal (-):** Modification of the administrative renewal process; adds electronic support, but requires an active response from family. (pending CMS approval)
Indiana	**Application & Renewal (+):** Continued roll-out of technology to allow online applications.
Iowa	**Adults (+):** Expand eligibility for Family Planning Waiver. (13,214, 9/1/2011) **Adults (nc):** Suspend Medicaid eligibility for inmates. (Unknown, 1/1/12)

[120] Positive changes counted in this report are denoted with (+). Negative changes counted in this report are denoted with (-). Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (nc).

State	Eligibility and Application Changes in FY 2012
Kansas	
Kentucky	
Louisiana	**Disabled (+):** LA Behavioral Health Partnership (CSOC) 1915c HCBS waiver for Mentally Ill and Seriously Emotionally Disturbed Youth. (600, 3/1/2012) **Application & Renewal (+):** Add option to online application system for adding household members or to report pregnancy (rather than require a whole new application)
Maine	
Maryland	**Adults (+):** Family Planning Waiver expansion. (33,191, 1/1/2012) **Application & Renewal (nc):** New LTC application and redetermination forms 7/1/2011
Massachusetts	**Application & Renewal (+):** Plans to implement an electronic signature component to our electronic application. **Application & Renewal (+):** Express Lane Eligibility scheduled for implementation in FY 12 with SNAP caseload as basis for family renewal of MassHealth Insurance benefits. **Application & Renewal (+):** Administrative Renewal Process will be expanded to include additional populations, community residents who receive social security as their sole source of income. **Application & Renewal (nc):** October 2011 plan to expand data collection under Native American Indian section of the application to identify all Native American/Alaskan Native (adults and children) who are exempt from cost sharing. **Application & Renewal (+):** A limited Telephonic Renewal Pilot will be launched in one of four enrollment Centers in FY 12 to explore the viability of a potential statewide rollout. **Application & Renewal (nc):** Plans are underway to revamp 'visitor' question noted above in FY 11 section (letter B above). Goal is to redirect emphasis on Massachusetts residency status rather than 'visitor' status.
Michigan	**All (+):** Converting Plan First! Family planning waiver into SPA which include adding coverage for men and eliminating any age restrictions.
Minnesota	**Childless Adults (+):** Childless adults with incomes from 75 percent to 275 percent FPL moved to Medicaid (35,000, 8/1/11)
Mississippi	
Missouri	
Montana	
Nebraska	
Nevada	
New Hampshire	**Adults (nc):** Potential for Family Planning state plan option. (Unknown)
New Jersey	**Application & Renewal (+):** Expand Express Lane Application State-wide - National School Lunch Program (NSLP)
New Mexico	**Adults (+):** Remove age and Third Party Liability restrictions from family planning. (560, 7/1/2011)
New York	**Disabled (+):** Increase resource levels for MBI-WPD (Medicaid buy-in for working persons with disabilities) and disregard of retirement accounts. (100, 10/1/2011) **Adults (+):** Implement 12 months continuous coverage for adults. (61,000, FY 2012 anticipated) **Application & Renewal (+):** Automate renewals for aged, blind and disabled recipients with fixed incomes.
North Carolina	**Adults (nc):** Move Family Planning from waiver to state plan option. (Unknown) **Application & Renewal (+):** Medicaid for Infants & Children and SCHIP reenrollment process change to an exparte process.
North Dakota	**Aged & Disabled (nc):** Expand personal needs allowance for persons in Long Term Care to allow payment of taxes from rental property (<100, 8/1/2011)
Ohio	**Adults (+):** Implement Family Planning waiver. (54,000, 1/1/2012) **Pregnant Women (+):** Presumptive Eligibility for pregnant women. (Unknown) **Children (+):** Added 19 and 20 year old “Ribicoff Kids”. (5,500, 10/1/2011)
Oklahoma	
Oregon	**Adults (+):** OHP Standard randomized drawings from reservation list will be increased to reach an average monthly enrollment of 60,000. **Application & Renewal (+):** Medicaid will be suspended rather than terminated for clients who are incarcerated as long as their stay is expected to be a year or less (in a county jail vs. prison); medical assistance will be restored upon their release from custody. **Application & Renewal (+):** A household may be eligible for MAA benefits based on un- or underemployment (deprivation) of the primary wage earner (PWE) in a two-parent household. Policy is being revised to look back only 60 days rather than 12 months **Application & Renewal (+):** OR is working with an IT vendor to develop an integrated approach to policy automation, while improving access to clients through an automated “No Wrong Door” customer service delivery system.

State	Eligibility and Application Changes in FY 2012
Pennsylvania	**Application & Renewal (nc):** More rigorous application of existing eligibility policies.
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Texas	
Utah	**Application & Renewal (+):** Use of ex-parte data in renewals. **Application & Renewal (+):** Receive notices electronically. Members can sign up for paperless system - done through a secure portal where they can retrieve their message after receiving a notice that they have a message from Medicaid.
Vermont	**Adults (+):** Plan to adopt new adopt the family planning state plan option (4/1/12) **Children & Pregnant Women (+):** CHIPRA ICHIA option to allow Medicaid eligibility for legally residing pregnant women and children (20, 7/1/2011) **Children (+):** Adopted a premium grace period for children (240, 7/1/2012)
Virginia	**Adults (nc):** Family planning waiver converted to a state plan option. (10/1/2011)
Washington	**Adults (+):** Family Planning Waiver - Increase income limit from 200 percent to 250 percent FPL. (12,000, FY 2012)
West Virginia	**Application & Renewal (+):** An application change that will be taking place in 11/11 will be that a face to face interview will not be required for any type of Medicaid. The option of e-signature will also be given to these groups. **Application & Renewal (+):** In April 2011, added children's Medicaid groups to list for passive renewals reviews on an every other year basis. Beginning in September 2011 passive renewals will be possible every year for children's Medicaid groups. Enables state to qualify for CHIPRA Bonus. **Application & Renewal (+):** An application change that will be taking place in 11/11 will be that a face to face interview will not be required for any type of Medicaid. The option of e-signature will also be given to these groups.
Wisconsin	**Application & Renewal (nc):** Childless adult cases will be administered by counties instead of the Enrollment Services Center.
Wyoming	

Appendix A-5a:
Premium and Copayment Related Actions Taken in the 50 States and the District of Columbia FY 2011[121]

State	Premium and Copayment Changes FY 2011
Alabama	
Alaska	
Arizona	**Copayments (NEW):** New mandatory copayments for prescriptions, doctor visits and non-emergency use of the emergency room for childless adults under 100% FPL (11/1/10), Medical Expense Deduction program (11/1/10), and Transitional Medical Assistance (10/1/10).
Arkansas	
California	
Colorado	
Connecticut	
Delaware	**Copayments (Eliminated):** Eliminated copayment for non-emergency transportation. (July 1, 2010)
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	
Illinois	
Indiana	
Iowa	**Premiums (Increase):** Medicaid for Employed People with Disabilities. **Premiums (Decrease):**1115 Waiver (Iowa Care). As part of the 1115 renewal, CMS required reduction in the premiums for those above 150 percent of FPL. **Premiums (Eliminated):**1115 Waiver (Iowa Care). Premiums were eliminated for those between 100 percent and 150 percent FPL.
Kansas	
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	**Copayments (Increased):** Increased generic and over-the-counter drug copayments from $2.00 to $3.00 (with some exceptions) in FY 2011.
Michigan	
Minnesota	**Copayments (Decreased):** Reduced ER copayment from $6 to $3.50. (Jan 1, 2011)
Mississippi	
Missouri	**Premiums (Increase):** Ticket to Work
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	

[121] New premiums or copayments as well as new requirements such as making copayments enforceable are denoted as (NEW). Increases in existing premiums or copayments are denoted as (Increased), while decreases are denoted as (Decreased) and eliminations are denoted as (Eliminated). Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (Neutral). States denoted as (Neutral)* were already counted as expansions in the eligibility section but also reported here.

State	Premium and Copayment Changes FY 2011
North Carolina	
North Dakota	**Copayments (Decreased):** Reduced ER copayment from $6 to $3. (July 1, 2010) **Copayments (Neutral):** Eliminated copayments for hospice residents, as required under the ACA. (July 1, 2010)
Ohio	
Oklahoma	
Oregon	**Copayments (NEW):** Implemented nominal copayments for clients enrolled in managed care for the following services: some prescription drugs, office visits, home visits, hospital emergency room services when there is not an emergency, outpatient hospital services, outpatient surgery, outpatient treatment for chemical dependency, outpatient treatment for mental health, occupational therapy, physical therapy, speech therapy, restorative dental work, and vision exams. (Jan. 1, 2011)
Pennsylvania	
Rhode Island	
South Carolina	**Copayments (Increased):** Increased all copayment amounts to maximum allowed with CPI adjustment. (April 1, 2011)
South Dakota	
Tennessee	
Texas	**Premiums (NEW):** Children with a Disability under age 19 (Family Opportunity Act).
Utah	
Vermont	**Premium Assistance Program (Neutral)*:** Expansion of Premium Assistance Program to Medicaid on voluntary basis. (35; 7/1/2010) **Deductible (Increased):** Increased deductible requirement in Catamount Health program. (October 1, 2010)
Virginia	**Premium Assistance (Neutral)*:** New premium assistance program – HIPP for Kids. (600, 10/1/2010)
Washington	**Copayments (Neutral):** In implementing the new 1115 waiver, the state implemented the same cost-sharing for this expansion population that had been in place under the state-funded Basic Health program that they had been transferred from. These copayments include: an annual deductible of no more than $250 per individual per calendar year; out of pocket maximum of no more than $1500 per individual per year; copayments on benefits and services including office visits, pharmacy benefits, ER visits, out of area emergency services, organ transplants consistent with those in place in the Basic Health program as of January 1, 2010.
West Virginia	
Wisconsin	**Premiums (Increased):** Parents and caretakers with income above 150 percent FPL.
Wyoming	

Appendix A-5b:
Premium and Copayment Related Actions Taken in the 50 States and the District of Columbia FY 2012[122]

State	Premium and Copayment Changes in FY 2012
Alabama	
Alaska	
Arizona	**Copayments (NEW):** Propose to expand mandatory copayments for all Title XIX adults and children, with some limitations for children. (October 1, 2010 subject to federal approval; CMS issued a preliminary no to this change on October 7, 2011.)
Arkansas	**Premiums (Increased):** ARHealthNet Works for the non-subsidized population from $255 to $275. **Premiums (Decreased):** TEFRA (Katie Beckett) decreased for those with incomes at or below 150% FPL.
California	**Copayments (NEW):** Propose to implement new mandatory copayments on the following services: all nonemergency services received in an emergency room; emergency services received in an emergency room; each hospital inpatient day, with a maximum per admission; preferred drugs prescription or refill; non preferred drugs prescription or refill; each visit for services including dental services received on an outpatient basis; each physician/FQHC/RHC and/or clinic visit.
Colorado	**Premiums (NEW):** Medicaid Buy-in Program for Working Adults with Disabilities (TWWIIA) **Premiums (NEW):** Medicaid Buy-in Program for Children with Disabilities (FOA)
Connecticut	
Delaware	
District of Columbia	
Florida	**Premiums (NEW):** Florida is seeking amendment to 1115 MEDS AD Waiver to Implement newly passed legislation to revise Florida's Medically needy program to allow qualifying individuals who meet the share of cost for 1 month to remain eligible for up to 6 months by paying a monthly premium not to exceed the share of costs. **Copayments (NEW):** Plan to require a $ 100 copayment for non-ER services provided in the ER department in FY 2012.
Georgia	**Copayments (Increased):** Plan to increase all current copayment requirements to the federal definition of 'nominal' in FY 2012.
Hawaii	
Idaho	**Copayments (NEW):** New copayment requirements are planned for FY 2012. (Final list not yet determined.) Some of the services that might be considered for co-pays are: Physician Visits, Chiropractic Visits, Optometrist Visits, Podiatrist Visits, Non-Hospital Physical & Occupational, Therapy Non-Hospital Speech Therapy, and Outpatient Hospital Services. The state is also planning to make copayments enforceable for those over 100 percent FPL for non-exempt populations.
Illinois	**Copayments (NEW):** Plan to implement new copayment for non-emergency ER visits for adults. State also plans to begin enforcing prescription drug copayments.
Indiana	
Iowa	**Premiums (Increase):** Medicaid for Employed People with Disabilities. **Premiums (Increase):**1115 Waiver (Iowa Care). **Copayments (NEW):** Imposing a $3 copayment for non-emergency use of the ER (FY 2012).
Kansas	
Kentucky	
Louisiana	
Maine	**Copayments (NEW):** Plan to make pharmacy copayments enforceable for those above 100 percent FPL.
Maryland	
Massachusetts	**Copayments (Increased):** An increase for generic and over-the-counter drug copayments from $3.00 to $3.65 (with some exceptions) is planned for FY 2012.
Michigan	

[122]New premiums or copayments as well as new requirements such as making copayments enforceable are denoted as (NEW). Increases in existing premiums or copayments are denoted as (Increased), while decreases are denoted as (Decreased) and eliminations are denoted as (Eliminated). Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (Neutral). States denoted as (Neutral)* were already counted as expansions in the eligibility section but also reported here.

State	Premium and Copayment Changes in FY 2012
Minnesota	**Premiums (Eliminated):** Eliminated premiums for children below 200 percent FPL. (unknown date and number) **Copayments (Increased):** Increasing the monthly maximum pharmacy copayment amount from $7 to $12. **Copayments (New):** Imposing a $3 copayment on all non-preventive office visits effective October 1, 2011.
Mississippi	
Missouri	
Montana	
Nebraska	**Copayments (NEW):** New copayment requirements planned for FY 2012 including: Inpatient hospital stays ($15); mental health and substance abuse visits ($2); and DME over $50 ($2). (October 1, 2011) **Copayments (Increased):** Increasing brand name pharmacy copayment from $2 to $3 and increased copayments for chiropractic visits, non-hospital based occupational and physical therapy in FY 2012.
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	**Copayments (NEW):** New copayments for emergency room use in FY 2012.
North Dakota	
Ohio	
Oklahoma	
Oregon	
Pennsylvania	**Copayments (Increased):** Planning to increase sliding scale copayment amounts to reflect changes in the medical care component of the consumer price index. **Copayments (NEW):** Plan to implement DRA alternative cost-sharing (20 percent coinsurance on non-exempt services) for certain disabled children under age 18, who have household incomes above 200 percent FPL.
Rhode Island	**Premium (Increased):** Families and Children >150 percent FPL.
South Carolina	**Copayments (Increased):** Increased office visit copayments by $1. (July 1, 2011)
South Dakota	
Tennessee	
Texas	
Utah	
Vermont	**Premium (Neutral)*:** Adopted a premium grace period for children (240, 7/1/2012)
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

Appendix A-6a:
Benefit Related Actions Taken in the 50 States and the District of Columbia
FY 2011[123]

State	Benefit Changes in FY 2011
Alabama	
Alaska	**All Adults (+):** Expanded dollar cap for adult dentures.
Arizona	**All Adults (-):** Eliminated certain transplants on October 1, 2010, but coverage reinstated April 1, 2011. **All Adults (-):** Eliminated podiatry services. (Oct. 1, 2010) **All Adults (-):** Eliminated well exams. (Oct. 1, 2010) **All Adults (-):** Outpatient physical therapy limited to 15 visits per contract year. (Oct. 1, 2010) **All Adults (-):** Eliminated microprocessor-controlled lower limbs and joints. (Oct. 1, 2010) **All Adults (-):** Eliminated percussive vests, hearing aids, cochlear implants, and all orthotics. (Oct. 1, 2010) **All Adults (-):** Eliminated most dental services. (Oct. 1, 2010)
Arkansas	
California	**Non-institutionalized, Non-Pregnant Adults (+):** Restored optometry benefit. (by court order, July 27, 2010)
Colorado	**All (+):** Increased number of procedures allowed by unsupervised dental hygienists (July 2010). **All (-):** Placed limits on incontinence supplies. **Adults (+):** Added SBIRT services (screening, brief intervention and referral to treatment) for substance abuse. (August 2010)
Connecticut	**Adults (-):** Limited vision coverage. **Pregnant women (nc):** Added coverage for smoking cessation services.
Delaware	
District of Columbia	**All (-):** Added utilization controls to state personal care benefit.
Florida	
Georgia	**Children (+):** Allowed pediatricians to apply fluoride varnishes.
Hawaii	
Idaho	**Adults (-):** Limited coverage for mental health and DD testing, assessment, diagnostic and treatmentplanning services. Also limited coverage for psychosocial rehabilitation services hours to 5 per week. (January 1, 2011) **Adults (-):** Eliminated coverage for collateral contact and DD supportive counseling. (January 1, 2011) **Adults (-):** Limited coverage of contact lenses.(January 1, 2011)
Illinois	
Indiana	**All Adults (-):** Previously excepted dental services (not including emergency services) counted toward the annual cap. (January 1, 2011) **All Non-Duals (-):** Prior authorization applied on all non-emergency hospital inpatient admissions (except for routine vaginal and C-section deliveries). (January 1, 2011) **All (-):** Added utilization controls on Medicaid mental health rehabilitation option services. (July 2010) **All Adults (-):** A limit of 25 visits per year applied to each type of therapy (speech, OT and PT) on January 1, 2011. Visit limits removed effective June 30, 2011 but prior authorization requirements applied. **All Adults (-):** Eyeglass coverage revised from one pair every 2 years to one pair every 5 years. (Jan. 1, 2011)
Iowa	
Kansas	**All (-):** Hospice services limited to 210 days. (October 1, 2010) **Children (-):** Eliminated coverage for attendant care services in schools under the Medicaid School Based Services Program. (July 1, 2010) **Children (nc):** Added concurrent care for children receiving hospice services (an ACA requirement).
Kentucky	
Louisiana	**All (+):** Added coverage for diabetes self-management training services. (February 1, 2011) **Pregnant Women (+):** Added coverage for progesterone treatments for high risk pregnancies. (April 2011) **Pregnant Women (nc):** Added coverage for smoking cessation services (an ACA requirement). (April 2011)
Maine	
Maryland	
Massachusetts	**Adults (-):** Eliminated a number of dental benefits including restorative services (filings), crowns, endodontic services (root canals), periodontic services (deep scalings, gingivectomy), dentures (full, partial or repair) and house call/home visit. (July 1, 2010) **Adults (-):** Limited coverage for most acute hospitals stays to only the first 20 days. (October 1, 2010)
Michigan	**All (+):** Added coverage of ambulatory surgical centers. (January 1, 2011)

[123] Positive changes counted in this report are denoted with (+). Negative changes counted in this report are denoted with (-). Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (nc).

State	Benefit Changes in FY 2011
Minnesota	**All Adults (-):** Limited number of chiropractic visits per year to 12. (July 1, 2010) **Pregnant women (nc):** Adding coverage for birthing centers. (January 2011)
Mississippi	
Missouri	
Montana	
Nebraska	**All (-):** Placed limits on Durable Medical Equipment: incontinence products and breast pumps. (Oct. 2010) **Children (+):** Added coverage for Pediatric Feeding Clinics. (July 1, 2010)
Nevada	
New Hampshire	**All (+):** Hospice benefit implemented. (November 1, 2010) **All (-):** Podiatry service limit reduced from 12 visits per year to 4. (July 1, 2010).
New Jersey	**All (-):** Orthodontic services limited to persons with severe medical needs. (July 1, 2010)
New Mexico	**All Adults (-):** Reduced frequency of panoramic and full mouth oral x-rays from once every 4 years to once every 5 years for adults. (August 1, 2010) **All Adults (-):** Reduced frequency and amounts allowed for disposable medical supplies. (August 1, 2010) **All Adults (-):** Reduced the number of hours allowed during the temporary authorization period for new Personal Care Option (PCO) users from 20 to 10 hours per week. (December 1, 2010) **All (-):** Reduced coverage of Pap smears for women under age 21 and reduced coverage of prostate screenings for men under age 40 (but still covered for high risk diagnoses). (March 1, 2011)
New York	
North Carolina	**All (-):** Applied additional PCS utilization controls - increased medical necessity standard. (January 1, 2011) **All Adults (-):** Eliminated coverage for surgery for clinically severe obesity and panniculectomy procedures. (October 1, 2010) **All Adults (-):** Imposed new coverage limitations on breast surgery. (October 1, 2010) **All Adults (-):** Eliminated Maternal Outreach Worker program. (September 1, 2010)
North Dakota	
Ohio	
Oklahoma	**Children (+):** Allowed pediatricians to apply fluoride varnishes. (June 25, 2011)
Oregon	
Pennsylvania	
Rhode Island	**Aged and Disabled (+):** Added coverage for smoking cessation services. (September 1, 2010)
South Carolina	**Adults (-):** Eliminated dental services for adults. (February 1, 2011) **Adults (-):** Reduced the limit on home health visits from 75 to 50 per year. (February 1, 2011) **Adults (-):** Eliminated podiatry services for adults. (February 1, 2011) **Adults (-):** Eliminated vision services for adults. (February 1, 2011) **All (nc):** Restructured rehabilitative behavioral health services benefit as required by CMS. (July 1, 2010)
South Dakota	
Tennessee	
Texas	**All (+):** Expanded coverage for total parenteral nutrition services and parenteral nutrition infusion pumps. (October 1, 2010) **All (+):** Added coverage for insulin pumps and hearing tests. (July 1, 2011) **Adults, Children and Pregnant Women (+):** Added a comprehensive substance abuse benefit for children and adults. (September 1, 2010) **Children (+):** Added specific vitamin and mineral coverage and expanded coverage for telemedicine services for pediatric specialty and subspecialty care in metropolitan areas. (August 1, 2011)
Utah	
Vermont	**All (-):** Added prior authorization requirements for radiology services. (July 1, 2010) **Adults (-):** Limited number of physical therapy, occupational therapy, and speech therapy visits to 30 per calendar year. (July 1, 2010) **Adults (-):** Reduced number of covered urine drug tests. (July 1, 2010)
Virginia	**Adults (-):** Revised the annual limit and prior authorization requirements on physical therapy, occupational therapy, and speech therapy. (August 1, 2010) **All (-):** Modified current limit for incontinence supplies. (July 1, 2010)
Washington	**All Adults (+):** Partially restored in-home personal care hours reduced on July 1, 2009. (July 1, 2010) **All Adults (-):** In-home personal care hours reduced for clients aged 21 and older. (March 1, 2010) **All Adults (-):** Reduced dental benefits and limited denture benefit to 2 per lifetime. (July 1, 2010)
West Virginia	

State	Benefit Changes in FY 2011
Wisconsin	**Adults and Children (+):** Coverage added for hearing instruments to the Benchmark plan. (August 1, 2010) **Adults, Children and Expansion Adults (+):** Coverage added for certain asthma supplies to the Benchmark and Core plans. (August 1, 2010) **Adults and Children (nc):** Added coverage for non-emergency medical transportation (July 1, 2010) and EPSDT-related services (August 15, 2010) to the BadgerCare Plus Benchmark plan as required by federal regulations.
Wyoming	

Appendix A-6b:
Benefit Related Actions Taken in the 50 States and the District of Columbia
FY 2012[124]

State	Benefit Changes in FY 2012
Alabama	
Alaska	
Arizona	**All Adults (-):** Limiting emergency room visits to 12 per year (subject to CMS approval). (October 1, 2011) **All Adults (-):** Limiting inpatient hospital stays to 25 days per year (subject to CMS approval). (October 1, 2011)
Arkansas	
California	**Non-institutionalized Adults (-):** Will cap hearing aid benefits at $1,510 per year including repairs, ear molds and hearing aids. (November 1, 2011) **Adults (-):** Will limit physician and clinic visits to 7 (using a soft cap). Additional visits will require a physician certification. (November 1, 2011) **Adults (-):** Eliminated Adult Day Health benefit. **Adults (-):** Will limit enteral nutrition. (September 1, 2011)
Colorado	**Pregnant Women (+):** Will increase access to smoking cessation counseling. **All (-):** Limited coverage for fluoride application and dental prophylaxis. (July 2011) **Adults (-):** Will enforce limitations on acute home health services. **Adults (-):** Will prior authorize certain radiology services. **Adults (-):** Will prior authorize certain outpatient hospital services. **Adults (-):** Limited number of physical therapy and occupational therapy units. (July 2011) **All (-):** Eliminated coverage of circumcisions and oral hygiene instruction. **Adults (-):** Limited oral nutrition benefit. (July 2011)
Connecticut	**Adults (+):** Expanded podiatry services. **Adults (-):** Limited coverage of dental services. **Adults (-):** Limited coverage of eyeglasses.
Delaware	
District of Columbia	**Adults (+):** Adding coverage for substance abuse and rehabilitative services. **Children (+):** Adding hospice benefit for children. **All (-):** Further reforms of state personal care benefit planned.
Florida	
Georgia	
Hawaii	**Expansion Adults (+):** Will expand benefits of QUEST-ACE and QUEST-Net to equal those for adults in QUEST. **All Adults (-):** Limiting inpatient coverage to 10 days per year. (Jan 2012) **Aged and Disabled Adults (-):** Decreasing outpatient rehabilitation benefit to Medicare level. (Jan 2012) **Aged and Disabled Adults (-):** Reducing coverage for chore services from 20 to 10 hours per week. (Jan 2012) **All Adults (-):** Limiting outpatient visits to 20 per year. (Jan 2012)
Idaho	**Adults (-):** Chiropractic coverage reduced from 24 visits per year to 6. **Non-pregnant Adults (-):** Dental benefits for non-pregnant adults aged 21 and over limited to emergency dental care only. Emergency dental treatment may include medically necessary oral surgery, extractions, exams, anesthesia, and x-rays to support those services. Some palliative care will also be covered. **Adults (-):** Psycho Social Rehabilitation (PSR) coverage for adults reduced from 5 to 4 hours/week for those over 21 years old. **Adults (-):** Medicaid therapy coverage policy will be aligned with Medicare by capping physical and speech therapy for adults at $1,870 per year. Occupational therapy for adults will have a separate cap of the same amount. **Adults (-):** Podiatry coverage limited for adults based on chronic care criteria. **Adults (-):** Coverage for eyeglasses eliminated. **Adults (-):** Vision coverage limited for adults based on chronic care criteria. **Adults (-):** Coverage for audiology services eliminated.
Illinois	
Indiana	**All (-):** Targeted Case Management Services eliminated. (July 1, 2011)
Iowa	**All (-):** Increased prior authorization requirements for orthodontia related to certain medical conditions. (July 1, 2011) **Aged and Disabled (nc):** Transitioned remedial services to managed care. (July 1, 2011)
Kansas	

[124] Positive changes counted in this report are denoted with (+). Negative changes counted in this report are denoted with (-). Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (nc).

State	Benefit Changes in FY 2012
Kentucky	
Louisiana	**Children (+):** Allowing pediatricians to apply fluoride varnishes. (October 1, 2011)
Maine	
Maryland	
Massachusetts	
Michigan	**All (-):** Reduction in Home Help Program, which provides personal care services.
Minnesota	
Mississippi	
Missouri	
Montana	
Nebraska	**Adults (nc):** Added coverage for Free-standing Birthing Centers (an ACA requirement). (July 1, 2011)
Nevada	
New Hampshire	**All (-):** Will limit non-emergency visits to hospital emergency room to 4 per year. (January 1, 2012) **All (+):** Will remove 12 visit limit on physician services. (October 1, 2011)
New Jersey	**All (nc):** Several services carved in to managed care arrangements including home health, medical day care, prescription Rx, rehabilitation services and personal care assistant. (July 1, 2011)
New Mexico	**Adults (-):** Capping the Personal Care Option (PCO) benefit at 30 hours per week (using a "soft" cap). (September 1, 2011)
New York	**All (+):** Adding coverage of substance abuse screening (SBIRT) provided by office-based primary care practitioners. (Coverage previously limited to hospital outpatient departments, free-standing clinics, and emergency room settings). (September 1, 2011) **All (+):** Expanded coverage of smoking cessation counseling for all recipients. (Coverage was previously limited to pregnant women and persons under age 21.) (April 11, 2011) **All (+):** Require hospitals, nursing homes and home health care providers to provide patient centered palliative care. (9/27/2011). **Adults (-):** Will limit physical, occupational and speech therapy to 20 visits (each) per 12-month period. (Persons with developmental disabilities or traumatic brain injuries will not be subject to the limits.) (October 1, 2011) **All (-):** Limit the number of hours of Level 1, personal care services to 8 hours per week
North Carolina	**Children and Adults (-):** Applying new limits to denture coverage and coverage for dental scaling and root planning (deep cleaning). **Children (-):** Applying new utilization controls on orthodontic services. **Adults (-):** Reducing covered home health visits. **Adults (-):** Applying utilization controls to incontinence supplies. **Adults (-):** Limiting occupational therapy, physical therapy and speech therapy to 3 visits per year. **All Adults (+):** Restored coverage for obesity surgery with new standards and limits. (July 1, 2011) **All (-):** Changing PCS functional eligibility requirements from 2 ADLs to 3. **Adults (-):** Eliminating coverage of eye exams and optical supplies. (October 2011)
North Dakota	
Ohio	**Pregnant women and children (+):** Expanding coverage for smoking cessation services (ACA required for pregnant women). (Jan. 1, 2012) **Pregnant women (nc):** Adding coverage for Free-standing birth clinics (an ACA requirement) (Jan. 1, 2012) **All (+):** Adding coverage for obesity screening. (Jan. 1, 2012) **Pregnant women (+):** Adding medical nutritional therapy. (Jan. 1, 2012)
Oklahoma	
Oregon	**Expansion Adults (+):** Increase OHP Standard hospital benefit. (January 1, 2012) **All (-):** Will add more prior authorization and other utilization controls on radiology, OP and IP hospital services, DME, and therapies. **All (-):** Will eliminate coverage of 13 lines on the OHP Prioritized List of Health Services. For details see: http://www.oregon.gov/OHA/healthplan/meetings/hs-prioritized-list.pdf?ga=t. (January 1, 2012)
Pennsylvania	**Adults (-):** Reducing dental services by eliminating endodontic services and limiting dentures to 1 per lifetime and cleanings to 2 per year. (September 30, 2011)
Rhode Island	**All (+):** Adding a pain management benefit for targeted beneficiaries. (April 1, 2012).
South Carolina	
South Dakota	
Tennessee	**Non-pregnant Adults (+):** Coverage added for medically necessary smoking cessation products (previously available only to pregnant women and enrollees under the age of 21). (July 1, 2011)
Texas	**All (-):** Added requirement for a Qualified Rehabilitation Professional assessment to be conducted for fitting and receipt of wheeled mobility devices. (September 1, 2011)
Utah	

State	Benefit Changes in FY 2012
Vermont	
Virginia	
Washington	**Pregnant women and LTC beneficiaries (+):** Restoring comprehensive dental care for pregnant women, clients living in institutions and HCBS waiver enrollees. **Adults (-):** Limited dental coverage to emergency dental only. (July 1, 2011) **All (-):** Imposing a 3 visit per year limit on non-emergent use of the hospital emergency room. (July 1, 2011) **Adults (-):** Eliminating coverage hearing aids and devices. **Adults (-):** Imposing a 12 visit per year limit on occupational therapy, physical therapy, and speech therapy. (July 1, 2011) **Adults (-):** Applied limits podiatry services. (July 1, 2011) **Adults (-):** Eliminating coverage for eyeglasses.
West Virginia	
Wisconsin	
Wyoming	

Appendix A-7a
Pharmacy Cost Containment Actions in Place in the 50 States and the District of Columbia
FY 2011

States	Preferred Drug List	Supplemental Rebates	Script Limits	Full MC Carve-out	Partial MC Carve-out
Alabama	x	x	x		
Alaska	x	x			
Arizona					
Arkansas	x	x	x		
California	x	x	x		x
Colorado	x	x			
Connecticut	x	x		x	
Delaware	x	x		x	
District of Columbia	x	x			
Florida	x	x			x
Georgia	x	x			
Hawaii					
Idaho	x	x			
Illinois	x	x	x	x	
Indiana	x	x		x	
Iowa	x	x			
Kansas	x	x	x		x
Kentucky	x	x	x		
Louisiana	x	x	x		
Maine	x	x	x		
Maryland	x	x			x
Masschusetts	x	x			
Michigan	x	x			x
Minnesota	x	x			
Mississippi	x	x	x		
Missouri	x	x		x	
Montana	x	x			
Nebraska	x	x		x	
Nevada	x	x			
New Hampshire	x	x			
New Jersey					x
New Mexico	x	x			
New York	x	x		x	
North Carolina	x	x	x		
North Dakota					
Ohio	x	x		x	
Oklahoma	x	x	x		
Oregon	x	x			x
Pennsylvania	x	x			
Rhode Island	x	x			
South Carolina	x	x	x		
South Dakota					
Tennesee	x	x	x	x	
Texas	x	x	x	x	
Utah	x	x	x	x	
Vermont	x	x			
Virginia	x	x			
Washington	x	x			x
West Virginia	x	x	x	x	
Wisconsin	x	x		x	
Wyoming	x	x			
Total	**46**	**46**	**16**	**13**	**8**

Appendix A-7b
Pharmacy Cost Containment Actions Taken in the 50 States and the District of Columbia
FY 2011-2012

States	Impose Script Limits		Reduce Disp Fee		Reduce Ingredient Cost		Preferred Drug List		Suplemental Rebates		Specialty Drug		Other Actions	
	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012
Alabama		x												x
Alaska						x							x	x
Arizona														x
Arkansas												x		
California						x						x	x	
Colorado							x	x				x	x	x
Connecticut				x		x								x
Delaware												x		
District of Columbia													x	
Florida														
Georgia												x	x	
Hawaii						x								
Idaho				x		x								
Illinois					x	x	x					x	x	x
Indiana				x										x
Iowa							x							x
Kansas	x						x	x					x	
Kentucky									x				x	
Louisiana	x													
Maine														x
Maryland				x										x
Massachusetts													x	
Michigan							x	x	x	x				x
Minnesota						x								x
Mississippi						x						x	x	
Missouri														
Montana				x										
Nebraska														
Nevada												x		
New Hampshire							x		x			x	x	x
New Jersey													x	
New Mexico			x		x								x	
New York				x		x	x	x	x	x				x
North Carolina						x						x	x	x
North Dakota														
Ohio														
Oklahoma							x						x	
Oregon			x		x				x		x			x
Pennsylvania	x										x			x
Rhode Island													x	
South Carolina	x			x	x	x	x	x	x	x	x	x	x	x
South Dakota				x	x	x					x	x		
Tennessee											x	x		x
Texas		x	x	x			x	x					x	x
Utah					x	x						x		x
Vermont							x					x		x
Virginia						x						x		x
Washington							x	x	x	x	x			x
West Virginia												x		x
Wisconsin	x						x				x	x	x	x
Wyoming												x	x	x
Total	**5**	**2**	**3**	**9**	**6**	**14**	**13**	**7**	**7**	**4**	**7**	**19**	**20**	**27**

Appendix A-8:
Delivery System, Care Management and Quality Initiative Changes In the 50 States and the District of Columbia, by Delivery System, FY 2011 and 2012

State	System*	Description of Delivery System, Care Management or Quality Initiative
Alabama	PCMH	Implemented 'Patient-centered medical home' initiative referred to as Patient Care Networks of Alabama (PCNA) by establishing 3 regional patient care networks as part of the PCCM program. In FY 2012, will expand regional care networks into additional counties. Clinician and Group Primary Care CAHPS Adult and Child Surveys will be conducted in 12 counties for PCNA group.
	DM	Expanded existing care management program with state health departments to coordinate referrals and care for high cost/complex/chronic patients identified in Regional Care Networks (the PCCM program). Chronic care management will focus on diabetes and asthma. This care management program will expand with the PCCM program to new geographic regions.
	FFS	Implemented an enhanced maternity care program in FY 2011 that included physician performance incentive measures and healthcare professional report cards. Implemented a self-reporting mechanism for hospitals in FY 2011 to reduce payments for preventable events by reporting 'never events/serious preventable events.' Replaced local technical specifications for data collection with HEDIS measures.
Alaska	PCMH	Started the Tri-state Child Health Improvement Consortium pilot (CHIPRA Quality Demonstration Project in collaboration with Oregon and West Virginia). Medical home initiative under this pilot will identify and evaluate methods for expanding access to EPSDT services for children and adolescents. Pilot will develop and implement quality measurement tools (compliant with the 24 recommended Children's Health Care Quality Measures being tested under the demo), develop or improve HIT, EHR, participation in HIE, and medical home approaches for children. This pilot will expand to 2 or more additional sites in FY 2012.
	LTC	Implemented enhanced quality improvement and assurance strategies in HCBS waivers, FY 2011.
	FFS	Increased number of HEDIS pediatric quality measures reported to CMS to 14 of the 24.
Arizona	MCO	Implemented flexible payment options to encourage the development and implementation of health homes, ACOs, or other programs to reward quality care and efficiencies in care delivery.
	LTC	May implement Community First Choice.
Arkansas	PCCM	Implementing several condition specific education projects. Targeted public education materials, using Geo-Mapping. Focusing on preventive services, well check-up.
	PCMH	Piloting an enhanced PCCM program for aging population. Reviewing PCCM program for enhancements.
	DM	Streamlined referral process for children meeting the definition for intense services to be provided by state children's hospital medical home clinic
	LTC	Implemented the Arkansas Innovative Performance Program for nursing homes and assisted living centers.
	FFS	Implemented Inpatient Quality Incentive Program in which hospitals meeting criteria receive bonus payments.
California	MCO	Mandatorily enrolling Seniors and Person with Disabilities (SPDs), except duals, into health plans. Developing stratified reporting and SPD specific quality measures. Plans will conduct risk assessments and report on SPD related quality activities. State will include new contract requirements to improve quality (such as PCMS, case management/care coordination, health risk assessments, medical home, discharge planning group needs assessment). Reimbursement will include a 5% quality factor withhold from the capitation rate beginning January 2012. Will implement new 2012 HEDIS Performance Measures. State will use of certain HEDIS Measures to give more default enrollments to higher performing plans. The state will also use HEDIS measures to implement individual plan Quality Improvement Projects based on HEDIS scores.
	PCMH	Included as part of the waiver that required enrollment of SPDs into managed care. Developing measures for monitoring Patient Centered Medical Homes.
	DM	Phasing-in disease management as part of MCO expansion in FY 2012.
	LTC	Will carve LTC services into its County Organized Health Systems (COHS) in FY 2012. P4P being integrated into payment, using MDS, staffing, patient satisfaction, with implementation in 2013.
	Duals	Developing pilot programs under the Duals contract for late 2012 to integrate the full range of Medicare and Medicaid benefits for dual beneficiaries. In these pilot programs, Medi-Cal will ensure that systems of care align for both populations and include mandatory medical homes, care management, better connection to specialty providers, incentives to reward providers and individuals for achieving desired clinical, utilization, and cost-specific outcomes.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Colorado	MCO	Working with Behavioral Health Organizations to develop performance incentives around managing psychotropic medications, prevention and early intervention services.
	PCCM	Providing efficient and effective health care through the Regional Accountable Care Organizations (ACOs) that assure care coordination, provider support, and other services under Accountable Care Collaborative. ACC expanded to 14 counties in FY 2011, expanding in FY 2012.
	PCMH	Required medical homes for all members under the ACC program.
	DM	In ACC program, regional ACOs are responsible for enhanced medical management, including care coordination and integrated disease management. Eliminated separate contract in FY 2011.
	Duals	Overlaying a structure of regional care coordination and support within Medicaid FFS (which includes Duals) provided by Regional Care Collaborative Organizations (RCCOs) and medical home care provided by PCPs. Using a statewide data and analytics vendor to process Medicaid, and eventually Medicare, data to analyze care delivery among regions and providers; will use this data to incentivize improved health outcomes for clients and reduced care costs.
	FFS	Finalizing the Statewide Collaborative on Reducing Avoidable ER visits and implementing the new Statewide Collaborative on Reducing Hospital Readmissions in FY 2012. Planning to implement initiatives around reducing unintended pregnancies.
Connecticut	MCO/PCCM	Ending HMO and PCCM programs on 12/31/11. The new ASO contract includes care management features that are more robust than current HMO contracts. There will be analytics to profile provider performance. The ASO will be dedicated to this type of oversight.
	PCMH	Planning to implement PCMH in FY 2012. The ASO will support emergence of PCMH network.
	DM	Implementing an intensive case management program in FY 2012.
	LTC	Moving LTC population under the management of the new ASO in FY 2012. HEDIS and CAHPS quality measures will be used.
	Duals	Will managed Duals under new ASO.
Delaware	Overall	Created a hospital emergency room diversion task force in FY 2011.
	LTC	Planning to implement managed LTC in April 2012. 1115 waiver will combine institutional LTC and HCBS waiver services to offer incentives to keep clients in community as long as possible.
	Duals	Developing a PACE program for April 2012 implementation.
District of Columbia	MCO	Focusing in the Health Care Collaborative on Perinatal and Chronic care in FYs 2011 & 2012. P4P incentives: FY 2011- 1% withhold, FY 2012 - 2% withhold, based on ER related HEDIS measures.
Florida	MCO	Phasing in managed care over the period Jul. 2012 to Oct. 204 under 2011 legislation. Developing a P4P program that will award enhanced assignments to higher performing health plans, using HEDIS and other quality metrics to identify higher performing plans. The External Quality Review vendor will facilitate an emergency department diversion project in select counties using a modification of the Institute for Healthcare Improvement model.
	PCCM	Applying utilization review information to Risk and Efficiency Modeling of providers. Proportion of high to low risk patients is used to evaluate provider efficiency. Implementing enhanced 'Child Health Check-Up' quality activities (under CHIPRA grant.)
	DM	Extended care management as part of changes to the state's Medically Needy program.
	LTC	Expanded Nursing Home Diversion to N. Florida counties in FYs 2011 and 2012. National Quality Enterprise (NQE) is providing technical assistance to Project AIDS Care and DD HCBS waivers. Human Services Research Institute and NQE working on interagency agreements for DD waivers.
	Duals	Establishing statewide, integrated managed care program for Medicaid under Legislation - agency to apply for and implement waivers and provide plan requirements in Medicaid managed care.
	FFS	Implementing utilization management for diagnostic imaging. Expanded Quality Improvement Organization activities will now include therapy services.
Georgia	MCO	Including new family planning waiver group in managed care plan. The option for 2 plans will expand statewide in January 2012. Thirty-two HEDIS/NCQA metrics including hybrid measures are being used to measure quality. Plan performance is posted.
	DM	Terminated CM contracts in Fall 2011 for failure to meet performance requirements.
	LTC	Implemented LTC quality incentive fee.
	FFS	Applying the same metrics as in MCO contracts (32 HEDIS/NCQA metrics) to FFS.
Hawaii	MCO	Implemented P4P, HEDIS & CAHPS, public report cards; financial incentives for performance Phasing in value-based contracting for non-ABD MCO procurement.
	DM	Adding care management for high cost cases - the top 1% of spenders in FY 2012.
	LTC	Requiring ABD MCOs to have SNP contracts beginning January 2012. CMS quality framework for 1915(c) waivers will be added to Hawaii MCO contracts.
Idaho	PCCM	Implemented tiered PCCM fee based on Basic/Enhanced/Extended Hours.
	PCMH	Included as part of a multiplayer collaborative.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Illinois	MCO	Implemented the "Integrated Care Program" April 2011 to improve health care quality and outcomes for approximately 40,000 beneficiaries. The program to be phased in with 3 service packages. Service Package 1 includes all standard Medicaid medical services. Service Package 2 includes LTC services and HCBS waiver services. Service Package 2 adds the DD waiver services. MCOs are required to establish an integrated care delivery system connected with EMRs where care is organized around the needs of patients to achieve efficient and effective assessment of need, treatment planning, treatment implementation and outcome evaluation. Systems will use nationally recognized P4P measures that reward providers with incentives based on select measures. Under these value-based contracts, the MCOs have P4P measures and withholds that create incentives for care that provides better health and quality of life, while reducing the cost of service over time. Withholds are 1% in year 1; 1.5% in year 2; 2% in year 3, to be paid only if benchmarks are met. The contracts contain 30 performance measures, of which 13 are P4P. MCOs can earn up to 5% of capitation payments in incentives through withholds and bonuses.
	LTC	Included in ICP are Medicaid eligible clients, residing in a designated county in a long-term care facility or covered under a HCBS waiver. During the first year of the ICP, these participants will receive all of their medical and behavioral health services (Service Package I) through their MCO. In addition, the MCOs are also responsible for the first 90 days of a nursing home stay.
Indiana	LTC	Implementing Quality Enhancement Restructures of waiver services to 1915c ICF/MR waiver to provide a new way of reviewing plans of care.
	Duals	Pursuing better care coordination for duals and other medically needy members.
Iowa	PCCM	Added population age 65+ to the Iowa Plan for mental health and substance abuse, with voluntary enrollment. Behavioral health intervention services will be added to this plan FY 2012. New medical HMO activity to be effective Jan. 2012.
	PCMH	Included in both 1115 waiver and the behavioral health plan are medical home pilots. (Each as 4 sites) SPA with a broader scope is in development for FY 2012 implementation.
	DM	Contracting with new vendor for disease management with new disease categories; now cover asthma, coronary artery disease, congestive heart failure, COPD, diabetes for adults, pulmonary/lung disease. Also offering case management program geared to pregnant women.
Kentucky	MCO	Expanding managed care program statewide in FY 2012 and will include Duals, foster kids, and SSI kids. Enrollment in an MCO will be mandatory with a few exceptions. The PCCM program will be phased out. With expanding managed care, will expand use of member satisfaction surveys (CAHPS), HEDIS data collection, Performance Improvement Projects (PIP).
	DM	Including as part of new MCO contracts in 2012.
Louisiana	MCO	Transitioning almost 900,000 enrollees the MCO or PCCM model in FY 2012, with auto-assignment to the capitated model. Mandatory population includes ABD as well as AFDC or TANF related and Poverty Level Pregnant Women. SSI and foster children are voluntary. Plans will be required to report on 37 HEDIS, AHRQ Preventive Quality Indicator, CHIPRA, and other quality measures. For HMOs, up to 2.5% of the capitation payment is at risk for failure to meet the benchmarks (0.5% for each of 5 selected measures).
	PCCM	Mandating enrollment in PCCM or MCO in FY 2012 for most populations. The PCCM (CommunityCARE) monthly case management fee was reduced effective 1/1/11 from $3 to a $1.50 PMPM base amount with an added P4P component. PCPs can qualify for $0.50 PMPM if they have extended office hours, $0.75 if they are pursuing NCQA PCMH recognition by 10/1/11, $0.25 if they perform EPSDT screening themselves rather than sub-contract, and $0.75, $0.50 (or $0.25 for first six months) depending on quartile they fall within for low level ER visits for those linked to their practice. P4P payments are made quarterly. For providers under the PCCM model, 100% of savings that may be shared is at risk (20% for each of 5 selected measures, which are the same 5 measures as MCO model). Also implemented of a web-based tool that PCPs can use to determine how their HEDIS measures compare to peers in the Region and the state average.
	PCMH	Implemented through Coordinated Care Networks (CCN)
	DM	Implemented through Coordinated Care Networks (CCN)
Maine	PCCM	Expanding PCP responsibilities in PCCM program in FY 2012. State will restructure P4P program and quality report cards to provide more incentives. Care management will expand statewide.
	PCMH	Will expand the PCMH program implemented in 2010, possibly including dual eligibles.
	DM	Expanded care management services for high-use individuals in FY 2011 and will expand care management statewide in FY 2012.
	Duals	Adding Duals to PCMH pilot.
Maryland	MCO	Increasing the amount at risk (from 0.5% to 1%) in value-based purchasing initiative.
	PCMH	Implementing an all-payer PCMH initiative, scheduled to begin August 2011.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Massachusetts	MCO	Implemented an enhanced P4P. Effective with the 07/01/2010 contracts, MCOs became a statewide option. CommonHealth members, Home and Community Based Services waiver members (Medicaid only, under 65), Kaileigh Mulligan children and Title IV-E children became eligible for MCO enrollment in FY 2011. CommonHealth members moved from voluntary to mandatory managed care in FY 2011.
	PCCM	Procuring enhanced administrative and quality management support for the PCC Plan. Re-procurement of behavioral health contractor, who will target populations for new care management program.
	PCMH	Implemented medical home initiative both the PCC and MCOs. The initiative is an all-payer model (except Medicare). The state has goal of including all providers in PCMH by 2015.
	LTC	Planning a nursing facility P4P for FY 2012. One Senior Care Organization will expand its service area in 2012, increasing the population that will have access to coordinated care in SCOs.
	Duals	Developing a demonstration to integrate Medicare and Medicaid care and financing for individuals who are eligible for both programs.
	DM	Included significant enhanced care / case management requirements in newly procured contracts in FY 2011, which includes a requirement that all contracted MCOs implement a complex care management program capable of serving all members with complex and special health care needs (including members formerly served under the AIDS/HIV and severely disabled programs). Identified DM programs include: Asthma, Diabetes, Depression, Substance Abuse.
	FFS	Implemented an Asthma Bundled Payment in FY 2011. Implementing a Hospital P4P in FY 2012.
Michigan	MCO	Implemented e-prescribing, PCP expanded access, and patient registries in MCO contracts in FY 2011. In FY 2012, Dual eligibles will be able to enroll in Managed Care on voluntary basis and children with special health care needs (CSHCN) will be required to enroll.
	PCMH	Implementing a Multi-payer PCMH demo which includes Medicaid in FY 2012.
	Duals	Developing integrated, coordinated care system that will integrate Medicare and Medicaid funds to deliver all covered services for Duals in FY 2012. Duals would be enrolled, with the ability to opt out of the plan. A robust care coordination program is the hub of the delivery model, with each enrollee having a health home focused on person-centered care. Reimbursement would be an acuity-based capitation arrangement, with shared risk. Input being received and incorporated from the full range of stakeholders.
Minnesota	MCO	In the FY 2012 MCO competitive bidding process, half of the points awarded were based on cost; half were based on quality initiatives or quality measures. Also implementing in January 2012 a health care system demo for the children and family population that will provide the opportunity for gain-sharing based on cost and quality measures, with the goal of leading to higher quality. A provider peer group project is under development that will collect data on cost and quality to populate a profile of providers. This profile will be made available to enrollees to incentivize enrollees to seek care with lower-cost, higher quality providers. Also expanding Medication Therapy Management to new groups in FY 2012.
	PCMH	Expect implementation of Medicare gain-sharing initiative during FY 2012.
	LTC	Beginning in Jan. 2012, state will phase in auto-enrollment in managed care for all but LTC services for non-elderly disabled, unless they return an opt-out form. They will have option to opt out later.
	Duals	Have one of the 15 Duals contracts. Focusing on data streams to get real-time combined data on duals, better risk adjustment methodology, how to undertake Medicare gain-sharing opportunity for the disabled duals and how to coordinate care for non-elderly disabled.
	FFS	Pursuing a Virtual ACO initiative that will incorporate a significant amount of care coordination.
Mississippi	MCO	Implemented a new managed care program for a select group of Medicaid enrollees, including SSI recipients, working disabled, disabled children living at home, foster care children in state custody, and women in the breast/cervical cancer program. Inpatient hospital, non-emergency transportation and LTC services were carved out in FY 2011.
Missouri	MCO	Required NCQA accreditation for health plans, effective in October 2011.
	DM	Implementing new care management program for SMI began in the Spring of 2011 – limited to 3,700 people.
Montana	PCCM	Contracting with FQHCs, CHCs to better manage disease states using predictive modeling tool.
	PCMH	Working with other payers on statewide definition; no plans for implementation yet in FY 2012.
Nebraska	MCO	Discontinued PCCM program and added an additional MCO contract in FY 2011. In FY 2012, expanding MCO program statewide. Will use CAHPS and HEDIS in FY 2012 (used CAHPS before).
	PCMH	Implemented medical home pilot program in 2 counties in FY 2011, measuring access, health outcomes, costs, patient and provider satisfaction.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Nevada	Overall	Changed maternity payment in both FFS and managed care to incent to reduce Caesarean deliveries.
	MCO	Began an improvement project to reduce emergency room utilization in MCOs in FY 2011.
	PCMH	Planning to implement PCMH in FY 2012.
	DM	Implementing new disease management program by June 30, 2012.
	LTC	Planning to make supplemental payments through P4P based on Minimum Data Set quality measures.
New Hampshire	Overall	Publishing first clinical report cards in FY 2012.
	MCO/PCCM	While no managed care for FY 2011, newly enacted legislation requires Medicaid to begin the managed care implementation process in FY2012 with a target data for initial enrollment of 7/1/2012 and all members enrolled within one year. At this time, the type of managed care program is unknown.
New Jersey	Overall	Concluded the Emergency Room Diversion pilot program on-site activities in November 2010, with a final report expected September 2011. NJ Healthy Living Disease Management Program concluded activities in December 2010. Also, planning to implement a Pilot ACO.
	MCO	Expanded HealthFirst statewide in FY 2011. The new waiver populations (adults up to 24% FPL) will enroll in MCOs in FY 2012. Also, in FY 2012 plans are to require ABD enrollees (Duals and non-Duals) to enroll (those in nursing homes and part of new waiver expansion are excluded). A Care Management Transformation Initiative set program redesign goals including: 1) improving how health plans identify beneficiaries with care management needs; 2) updating care and case management definitions, and 3) updating the performance measurement approach. Health plans will identify those in need based on data such as risk scores, utilization patterns, pharmacy, medical history and analysis of care needs.
	PCMH	MCOs began to implement PCMHs in FY 2011 and will expand further in FY 2012.
	Duals	Implementing Special Needs Program in Jan 2012. Duals will be required to enroll in managed care in FY 2012 (planned for Oct 2011.)
	Dental	Developed in collaboration with stakeholders and the American Academy of Pediatrics a Preventive Oral Health Initiative is to encourage medical providers to provide oral health risk assessment, fluoride varnish and referral to a dentist by the age of one. Two HMOs have Fluoride Pilot Programs with non-dental health providers doing risk assessments, placing fluoride varnish and referral to the dentist.
New Mexico	PCMH	Planning to implement patient centered medical home in FY 2012.
New York	MCO	Mandating populations previously exempt or excluded from Medicaid managed care to enroll over the next three years. In FY 2011, the state began implementation of mandatory enrollment for HIV+ persons in NYC (geographic roll-out to specific boroughs and zip codes) with intense outreach, as well as for non-SSI SPMI adults and SED children, and pregnant women with a prenatal provider not in managed care. For populations included in the state's 1115 waiver, additional counties will be added to the mandatory program (4 counties in FY 2011 and 6 counties in FY 2012.) Risk-Adjusted Capitation reimbursement methodology includes Quality Incentive Program. Also, personal care and pharmacy carved-in as MCO services.
	PCMH	Expanding PCMH program implemented April 2010 statewide and will add additional payers with the goal of enrolling 1 million Medicaid patients into medical homes.
	LTC	Upon 1115 approval, begin mandatory enrollment of those who need community based services, including duals, into MLTC. Expect to certify additional PACE and MLTC plans. MLTC will include quality measurement and reporting, with reimbursement based on risk adjusted capitation.
	Duals	Received planning contract to develop demonstration model(s) for dual eligible individuals. If demonstration approved by CMS, begin implementation dual eligible initiative(s).
	FFS	Reform includes reimbursement incentives to reduce preventable hospital readmissions. Chronic Illness Demonstration Project provides coordinated care for high-need Medicaid beneficiaries with multiple chronic conditions.
North Carolina	PCCM	Implementing new initiative focused on ER utilization and an Oncology home for cancer patients during cancer treatment in FY 2012. Also expanding capitated PIHP for Mental Health, Developmental Disability, and Substance Abuse services statewide.
	DM	Implemented a Pregnancy Medical Home in March 2011.
North Dakota	PCMH	Submitted a renewal waiver to continue the health management program in FY 2012. Will be looking for opportunities to incorporate medical home components within this program.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Ohio	Overall	The Ohio Perinatal Quality Collaborative is focusing on scheduled deliveries before the 39th week and human milk for premature infants. Also developing an ACO model for ABD children.
	MCO	Considering a withhold or bonus methodology for their P4P program for MCOs, which currently places 1% of capitation rate at risk and the plan has to refund that 1% if it didn't meet the quality standard. Developing a new P4P methodology using all nationally recognized quality measures. In FY 2011, began the "Implement Medicaid Programs for the Reduction of Avoidable ED Visits" (IMPROVE) Collaborative, a partnership between Medicaid and Medicaid managed care plans in 5 regions to identify priority populations and develop quality improvement interventions. IMPROVE adopted the rapid-cycle quality improvement approach developed by the Institute for Healthcare Improvement. EPSDT collaborative is focused on upper respiratory and dental.
	DM	Requiring MCOs to use case management for high cost cases (new in FY 2012.)
	LTC	Developing P4P using more objective measures; working toward 2013 implementation.
Oklahoma	PCMH	Health Access Network works with participating PCPs and assists them in becoming an advanced (tier 2) medical home provider. The HAN measures performance on clinical quality and patient experiences develops strategies and initiatives for identified problem areas, and tracks performance on quality standards set forth in CMS Quality Measures Compendium.
	DM	Implementing several new disease management programs in FY 2012: 1) Care management for persons with bleeding disorders. 2) Care management initiative targeting pregnant women in the 10 rural counties with the highest fetal mortality rates. The program will identify pregnant women in these areas and a care manager will follow them through pregnancy. 3) Frequent ER program targets those with 3 or more visits in a quarter. A letter will be sent with call back information to direct them to other providers.
Oregon	MCO	Participating in the ABCD3 developmental screening performance improvement project, aimed at designing, evaluating and learning about different approaches to improve care coordination among child health providers and parents. EQROs will implement series of Performance Improvement Projects that will be conducted by volunteer MCOs.
	PCMH	Implemented a Patient-centered medical home in FFS in FY 2011.
Pennsylvania	MCO	Announced plans to expand mandatory MCO program statewide. MCOs will operate side-by-side with the existing Enhanced PPCM program (Access+). Contracts to be awarded in FY 2012, with implementation of new contracts in FY 2013.
	PCCM	Implemented and expanded two quality initiatives in FY 2011: 1) Transition of Care - places nurses in hospitals to provide care management after a patient is discharged from the hospital with the intention of reducing readmissions. Program is expanding to 20 hospitals. 2) Poly-pharmacy initiatives - cases with members that have outlying pharmacy claims are reviewed and members are provided case management to ensure compliance with clinical guidelines. In FY 2012, began collecting CHIPRA measures and included chronic care questions for child CAHPS.
	PCMH	Enhanced Medical Home - in FY 2012 plan to implement an Enhanced Medical Home initiative involving nurse care managers embedded in high volume practices and selected hospitals, focusing on chronic conditions and transition of care. The state is also participating in the Multi-payer Advanced Primary Care Practice Demonstration.
	DM	Expanded the number of disease states covered in Enhanced PCCM from 6 to 21 in FY 2011.
	LTC	As mandated by state law (P.A. 96-1501) evidence-based nursing facility reimbursement rate methodology will be developed for implementation by July 1, 2012.
Rhode Island	MCO/PCCM	Implemented the Communities of Care (COC) Initiative in FY 2011, a comprehensive program to reduce non-emergent and avoidable Emergency Department (ED) use and its associated costs. COC targets high ED users, defined as Medicaid recipients (RIte Care children, CSHCNs, RIte Care Adults, and ABD adults) who have utilized the ED 4+ times in a 12 month period. Key components include dedicated provider networks, care management, peer navigators, and an incentive and reward program. This program was implemented across all delivery systems.
	PCMH	Expanding Chronic Care Sustainability initiative to include Duals in FY 2012.
	DM	Implemented a high cost case review (HCCR) process for their FFS program in FY 2011. This process will be expanded to managed care in FY 2012.
South Carolina	MCO	Expanded the managed care program October 1, 2010, to mandatory managed care and moved managed care eligibles into either an existing managed care organization or a medical homes network. Also added acute behavioral health admission coverage to MCO contracts in FY 2011. Contracts were approved with two new medical homes network providers in early 2011. The state will begin requiring NCQA accreditation for MCOs in January 2012.
South Dakota	PCCM	Added more HEDIS quality measures for both PCCM and FFS in FY 2012.
	DM	Adding care management program aimed at high cost complex cases in FY 2012.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Tennessee	MCO	Continuing NCQA certification of health plans.
	LTC	Implemented new Community Choices Act, which integrates HCBS and Nursing Home services for the elderly and disabled into an MCO. The state included enhanced care coordination in MLTC contract requirements and will monitor the plans for these requirements through complete integration.
	Duals	Received a demonstration grant to determine the efficacy of providing services for duals in a managed care organization model.
Texas	MCO	Planning to expand capitated managed care statewide and add dental managed care in FY 2012. Also will end the PCCM program (planned for March 2012). Reimbursement is on a Performance-Based Capitation Rate, in which Medicaid/CHIP MCOs are at-risk for a percentage of their capitation rate(s). If the MCO does not meet targets, HHSC (Medicaid) adjusts future monthly capitation payments by an appropriate portion of the at-risk amount. HHSC's objective is for all MCOs to achieve performance levels that enable them to receive the full at-risk amount. For FY 2011, the at-risk percentage was 1%; for FY 2012, the at-risk percentage will be increased to 5%. Quality Challenge Award: If one or more MCOs do not receive the full amount of the at-risk portion of the capitation rate, HHSC reallocates the funds. HHSC uses these funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction. HHSC determines the number of MCOs that receive Quality Challenge Award funds annually based on the amount to be reallocated.
	DM	Implemented the Texas Medicaid Wellness Program for clients in fee-for-service and PCCM. It is a special health program for people have chronic or complex health conditions. Program nurses provide care to clients and help clients and caregivers work with doctors to manage care needs. Includes: managing health between doctor visits, learning more about clients' health condition(s), educating clients on medications and how to take them, and picking the best medical care for client. In FY 2102, the Texas Medicaid Wellness Program will be expanded to include health home services.
	LTC	Expanding STAR+PLUS to additional counties and to Lubbock, El Paso, and South Texas areas in FY 2012. In new STAR+PLUS counties, ABD enrollees will be required to enroll in managed care where as previously, they had the option to voluntarily enroll in the Star program.
	Duals	Planning a new managed care program for duals that would share risk with Medicare.
Utah	DM	Implementing a new Diabetes Management program in FY 2012.
Vermont	MCO/PCCM	The Medicaid agency is the managed care entity. Implemented an additional fee for providers participating in care management. Implemented Performance Improvement Projects, including CHF. The state is planning to include 2 new populations in its managed care program - ICHIA and its limited-benefit family planning ACA initiative.
	PCMH	Expanding the PCMH initiative statewide by the end of 2011.
	DM	Expanded its care coordination program, fully-integrating it into the Blueprint for Health program in FY 2011. In FY 2012, state is moving away from telephone support.
	Duals	Vermont was one of 15 states to be awarded a $1 million dollar planning contract for a State Demonstration to Integrate Care for Dual Eligible individuals. Vermont's project proposal is to have the state be a Medicare Managed Care entity for all 21,000 dual eligibles statewide. Vermont proposal is to rely upon its current two Medicaid 1115 waiver demonstrations for Medicaid authority and work with CMS on securing Medicare authority. This effort will be in coordination with Vermont's Multi payer demonstration known as the Blueprint for Health.
	FFS	Planning to implement in FY 2012 a GME quality initiative which will tie GME payments to quality initiatives to be negotiated with the state.
Virginia	MCO	Published a new version of the State Managed Care Quality Strategy for Medicaid / CHIP for 2011 – 2015. In FY 2011, one county was changed from PCCM/MCO area to MCO only area. In FY 2012, the state is expanding MCOs into 24 new localities effective January 2012 and expanding MCOs in 16 localities effective June 2012. The state also plans to implement a foster care managed care pilot program in Richmond in December 2011. The EQRO is conducting a new focused study on behavioral health in FY 2011 and FY 2012.
	PCMH	Planning to work towards a medical home/ACO with an FQHC in Southwest VA.
	DM	Adding care coordination for individuals in the Elderly/Disabled Waiver in FY 2012.
	Duals	Exploring dual eligible strategies.
	FFS	The EQRO administered the CAHPS survey for FFS.

State	System*	Description of Delivery System, Care Management or Quality Initiative
Washington	MCO	Adding the following populations to their managed care program in FY 2012: Medically Needy Blind/Disabled, Categorically Needy Blind/Disabled, Categorically Needy Healthcare for Workers with Disabilities, and Foster Care/Adoption Support with the option to opt in. In FY 2011, state implemented P4P program for MCOs focused on immunizations and well-child care. Top four plans received a bonus payment for year-over-year improvement and improvement compared to peers. MCOs must conduct PIPs if they do not meet standard for immunizations for children.
	PCMH	Planning to implement a PCMH initiative in FY 2012.
	FFS	Implemented report cards for pregnancy care providers, with regard to C-section rates, low birth weight and early delivery rates.
West Virginia	MCO	Added quarterly standards to its MCO program. Also added requirement for medical assistance with smoking cessation to contracts.
	PCCM	Implementing a program to ensure the use of appropriate medication for people with asthma in its PCCM program.
	LTC	Implementing the Quality Improvement (QI) System for the "Take Me Home" program, modeled after the existing QI systems already in place in the MR/DD Waiver and ADW. Quality oversight will focus on required elements of level of care determinations, service plan development, provision of services by qualified HCBS providers, overall health and welfare, administrative authority, and financial accountability. Specific data sources include provider monitoring, claims data, incident management reports, contract oversight meetings and reports, and other stakeholder feedback and input.
Wisconsin	MCO	Expanded the MCO program to additional counties in FY 2011. The state expanded and revised its pay for performance (P4P) program from BadgerCare Plus to also include SSI. In FY 2012, the P4P scope and measures will expand further.
	PCMH	Planning to implement a health home for the chronically ill in FY 2012.
	DM	Implemented a care management initiative for pregnant women in FY 2011.
	FFS	Planning to implement a Hospital P4P initiative in the FFS program.

*Overall – initiatives that crossed more than one delivery system
MCO – Managed Care Organizations
PCCM – Primary Care Case Management
PCMH – Patient Centered Medical Home
DM – Disease Management
LTC – Long Term Care
Duals – initiatives targeted toward those dually eligible for Medicare and Medicaid.
FFS – Fee-For-Service

Appendix B: Profiles of Selected States:

- **Minnesota**
- **New York**
- **Tennessee**

Minnesota Case Study

Minnesota had the distinction of being the site of the longest state government shutdown in recent history due to a stalemate between the Republican-controlled legislature and newly-elected Democratic Governor Mark Dayton.[125] After failing to pass a budget by June 30, Minnesota's government shut down for three weeks in July before a compromise was reached. At issue was a $5 billion budget deficit. The Governor proposed to raise taxes on the wealthiest Minnesotans while the Republican budget proposed cuts to higher education, aid to local governments and human services programs, which alone faced a $1.6 billion reduction.[126]

Due to a constitutional provision that prohibits spending except under an appropriation, and the fact that only one appropriations bill dealing with agriculture was passed, the Governor developed a shutdown plan that closed 49 agencies entirely, kept open 29 with minimal staffing and laid off 22,000 state employees.[127] Those critical core functions that continued, including benefit payments and medical services to individuals, were approved and overseen by the Ramsey County District Court.[128]

The compromise did not include the Governor's proposed tax increase and Republican's agreed to withdraw certain social policy legislation Democrats found objectionable.[129] The compromise reached also had significant impacts on the health and human services budget, including the following:

- Requirement to competitively bid managed care contracts with rates that will build in payment reductions and limit future rate increases intended to bring down future costs.
- Reduced payments for many services and providers, including inpatient hospital services, non-emergency transportation, physician and professional services, dental services, and basic care services.
- Repeal of nursing facility and hospital rebasing that will save money in future years.
- Suspension of incentive payments to managed care plans for expanding preventative services.[130]

Home and community-based services for persons with disabilities and the elderly were also affected:

- Rates for most long-term care providers were reduced by 1.5 percent for the 2012-13 biennium. This reduction will change to 1 percent in the 2014-15 biennium.
- Rates for lower needs individuals on certain waivers were reduced by 10 percent.
- Payments to personal care assistants who provide care to a relative were reduced 20 percent.
- The State plans to seek a waiver to implement new nursing facility level of care criteria that would direct people with lower care needs to other supports and ensure nursing home care is limited to people with the greatest need. If not granted, LTC providers will be subject to an additional cut.[131]

The budget impasse had other repercussions including a noticeable impact on the national hiring outlook as well as on Minnesota's credit-worthiness. The monthly report by the U.S. Department of Labor for July showed that employers added about 117,000 jobs. Private business added 154,000, but 37,000 government

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[125] James Hohman,"Deal Reached to End Minnesota Shutdown," POLITICO, July 14, 2011, accessed at http://www.politico.com/news/stories/0711/58985.html

[126] Justin Horwath, "Ten Days and Counting: Why Minnesota's Government Could Shut Down July 1," TIME, June 21, 2011, accessed at http://www.time.com/time/nation/article/0,8599,2079026,00.html

[127] Ibid.

[128] Catherine Richert, FAQ on Minnesota's State Government Shutdown, Minnesota Public Radio, July 12, 2011, accessed at http://minnesota.publicradio.org/display/web/2011/06/13/minnesota-government-shutdown-faq/

[129] Gov. Mark Dayton, "Ending the Shutdown Through Compromise," Press Release, July 24, 2011, Office of Governor Mark Dayton, accessed at http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=102-14649

[130] Fast Facts: 2011 Legislative Session, "Overview of Changes Affecting Human Services," "Changes for State Health Care Programs," and Changes for Continuing Care Programs," Minnesota Department of Human Services, accessed at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6415-ENG, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6416-ENG and https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6417-ENG

[131] Ibid.

jobs were lost with the Minnesota layoff responsible for over half of the losses.[132] Moody's changed its outlook for Minnesota from stable to negative due to the size of the state's reserves and the short-term budget fixes that were part of the budget deal. While this action did not change the state's bond rating from Moody's (AA1) or its borrowing costs, it may indicate a change in the future. However, Fitch Ratings did downgrade Minnesota in July (from AAA to AA+). The state retains a AAA rating only from Standard &Poor's.[133]

Expansion of Coverage to Childless Adults

After much debate and an impasse in the during the 2010 regular session, legislation was passed in the October 2010 special session to expand coverage to childless adults under 75 percent of poverty through the new Affordable Care Act (ACA) state plan option if directed by the Governor before January 15, 2011.[134] Among the first actions taken by Governor Dayton after he took office was to issue an Executive Order authorizing the early Medicaid expansion.[135] This allowed approximately 83,000 individuals previously enrolled in the state's General Assistance Medical Care (GAMC) and MinnesotaCare programs to enroll in Medicaid, providing federal funds to cover this population that was previously covered by state funds only. An estimated 12,000 additional individuals who were previously uninsured also received coverage.[136]

The FY 2012 budget compromise maintained the Medicaid expansion and expanded coverage further to childless adults with incomes up to 275 percent of poverty previously enrolled in the state-funded MinnesotaCare program. However, as part of the budget compromise, the Healthy Minnesota Contribution Program was created to provide childless adults with incomes above 200 percent of poverty with a monthly contribution from the state to purchase private health insurance.[137]

Status of Health Care Reform

Shortly after taking office, Governor Dayton rescinded outgoing Governor Tim Pawlenty's Executive Order prohibiting executive branch agencies and departments from applying for any discretionary grants under the ACA.[138] With this barrier removed, Minnesota applied for and received a $1 million Exchange Planning Grant.[139] Under this grant, Minnesota has completed an Exchange IT RFP and an IT Gap Analysis. The state issued a Request for Proposals (RFP) in June 2011 for a two-staged, proof of concept approach to evaluate IT infrastructure options and costs for an Exchange. During stage one, RFP respondents will propose prototypes and in stage two, successful respondents will be awarded funds to develop detailed cost estimates, work plans and timelines for implementation of the prototype. Due to the government shutdown, these activities have been delayed.[140] Two Exchange establishment bills were introduced during the session, but neither passed.[141]

Minnesota reported the following Medicaid policy changes for FYs 2011 and 2012 described in the table below.

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[132] Patrick Condon, "Minnesota Shutdown Added to Government Job Loss," Associated Press, August 5, 2011, accessed at http://hosted2.ap.org/MSJBJ/0db96b6363bf4fe8a81d630820d8eb8c/Article_2011-08-05-Economy-Minnesota/id-1cb0b753085f4202b0ad40edb795ceb8

[133] Annie Baxter, "State's Rating from Moody's Goes from Stable to Negative," Minnesota Public Radio, August 1, 2011, accessed at http://minnesota.publicradio.org/display/web/2011/08/01/states-rating-moodys-stable-to-negative/

[134] http://www.house.leg.state.mn.us/hinfo/NewLaws/2010SSNewLaw.htm.

[135] Executive Order 11-01, January 5, 2011.

[136] "Minnesota Received Federal Approval for Medical Assistance Expansion." Press Release from Governor's Office, February 17, 2011. http://mn.gov/governor/newsroom/pressreleasedetail.jsp?id=9826.

[137] Lorna Benson, "Health Care Providers Weigh Changes with New HHS Budget," Minnesota Public Radio, July 29, 2011, accessed at http://minnesota.publicradio.org/display/web/2011/07/29/health-care-copes-hhs-bill/

[138] Executive Order 11-02, January 5, 2011.

[139] Minnesota Department of Health and Department of Commerce Press Release, January 20, 2011, accessed at: http://www.health.state.mn.us/news/pressrel/2011/exchange012011.html

[140] Minnesota Quarterly Project Report, State Planning and Establishment Grants, July 29, 2011, accessed at: http://www.state.mn.us/mn/externalDocs/Commerce/Exchange_Planning_Grant_Quarterly_Report_2_081611093201_2011-Q2-HealthProjectReportJuly2011.pdf

[141] Ibid.

Eligibility Changes

- Effective March 1, 2011, Minnesota expanded eligibility for childless adults up to 75% of the FPL under the ACA state plan option, affecting approximately 95,000 individuals.
- In FY 2012, MinnesotaCare premiums will be eliminated for children in families with incomes below 200% of the federal poverty level (FPL).
- Effective August 1, 2011, Medicaid eligibility was extended to approximately 35,000 childless adults between 75% and 275% of the FPL.

Provider Rates

- In FY 2011, reimbursement rates were reduced for inpatient hospital services, specialty physicians, dentists and managed care organizations (MCOs).
- In FY 2012:
  - Outpatient hospital, chiropractor and podiatry rates will be reduced.
  - MCO rates will be reduced by nearly 10%.
  - Inpatient hospital will also be reduced by 10%; however, hospitals will be allowed to "buy back" these cuts through reductions in ER admissions and readmissions.
  - Rates for most LTC providers (except nursing facilities) reduced by 1.5%.

Benefit Changes

- In FY 2011, limited number of chiropractic visits per year to 12 for adults. (July 1, 2010)

Cost Sharing Changes

- In FY 2011, reduce ER copayment from $6 to $3.50.
- Effective October 1, 2011, increased monthly maximum pharmacy copayment from $7 to $12 and imposed a new $3 copayment on non-preventive services.

Long Term Care

- In FY 2011:
  - HCBS waiver enrollment growth continues although caps applied to Elderly waiver and CADI waiver to provide for growth at a slower rate.
  - Services added to the Community Alternatives for Disabled Individuals (CADI) waiver.
- In FY 2012:
  - HCBS waiver enrollment growth continues within caps applied to Elderly waiver and CADI waiver to provide for growth at a slower rate.
  - Subject to federal approval, will tighten the nursing home level of care criteria.

Pharmacy Changes

- In FY 2012:
  - Will decrease overall ingredient cost reimbursement in the process of converting from an AWP-based methodology to a WAC-based methodology. However, a small increase will be provided to rural pharmacies.
  - Will expand Medication Therapy Management program to additional persons.

Managed Care Changes

- Beginning in January 2012, will phase in auto-enrollment into managed care of non-elderly, non-LTC disabled members with an opt-out option.
- In FY 2012, implementing a Medicare patient centered medical home initiative and a virtual ACO initiative that includes care coordination.
- Received a CMS Dual Eligible Demonstration grant that will be used to focus on obtaining real time data streams for duals that combine Medicaid and Medicare to support a better risk adjustment methodology. Will also explore how to undertake the Medicare gain-sharing opportunity for the disabled duals and also how to coordinate care for non-elderly disabled.

New York Case Study

Overall Budget Picture

Despite a projected $10 billion state budget shortfall,[142] the New York State Legislature succeeded in passing an on-time budget for FY 2012 for the first time in five years.[143] The 2012 budget proposed by Governor Cuomo and eventually passed by the legislature reduced overall spending by two percent compared to the prior year with projections of out-year spending gaps reduced by 85 percent without raising taxes or relying on new borrowing. To reduce spending, the budget included state agency consolidations, the closure of some state facilities, $450 million in state workforce reductions and two-year appropriations and caps on state spending for education and Medicaid.[144] The budget also implemented a majority of the recommendations made by the Medicaid Redesign Team (MRT) convened by the Governor less than three months earlier to develop alternatives for fundamentally restructuring and reforming New York's extensive Medicaid program.

Medicaid Redesign Team

The Governor's January 5, 2011 Executive Order establishing the Medicaid Redesign Team (MRT) appointed 27 voting members including health care industry leaders, business and consumer leaders, State officers, and State legislative members. The MRT was tasked with developing a plan to reform the state's Medicaid program with a focus on cost-savings as well as quality.

The MRT began work immediately on its first charge – developing Medicaid cost containment recommendations for the FY 2012 budget.[145] After an unprecedented public input process involving six public meetings across the state and the collection of over 4,000 suggestions from online submissions by a wide array of stakeholders, the public, and policy makers, the MRT submitted its first report with 79 reform recommendations to the Governor on February 24, 2011. The Governor accepted the recommendations, and sent them to the New York State Legislature in his revised budget bill. The final budget included 74 of the recommendations which were projected to reduce Medicaid state spending by $2.2 billion in FY 2012 and $3.3 billion in FY 2013 through a series of both short term cost controls and longer-term reforms including a global Medicaid spending cap and moving the Medicaid program out of fee-for-service and into various forms of care management.[146]

Phase 2 of the MRT's work will focus on comprehensive reform and the development of a multi-year quality improvement/care management plan. Ten MRT work groups will also engage a broader set of stakeholders and focus on complex issues that were not addressed in Phase 1, such as behavioral health reform, managed long term care implementation, changing scope of practice, affordable housing, among others, with the goal of submitting recommendations to Governor Cuomo by December 2011. The MRT will submit a final report to the Governor in December 2011.

Global Medicaid Spending Cap

The state budget caps state Medicaid spending at $15.3 billion for FY 2012 and $15.9 billion for FY 2013, and also imposes a four-year state cap linked to growth in the CPI-Medical.[147] If spending is projected to exceed the

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[142] "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, June 17, 2011. http://www.cbpp.org/files/9-8-08sfp.pdf.

[143] Gramlich, John. "New York lawmakers OK first on-time budget in five years." *Stateline*, March 31, 2011. http://www.stateline.org/live/details/story?contentId=563754.

[144] "Governor Cuomo Announces On-Time Passage of Historic, Transformational 2011-12 New York State Budget." Press Release from Governor Cuomo's Office, March 31, 2011. http://www.governor.ny.gov/print/460.

[145] "Department of Health." *2011-2012 Executive Budget Agency Presentations*. Governor Andrew Cuomo, February 1, 2011. http://publications.budget.ny.gov/eBudget1112/agencyPresentations/pdf/AgencyPresentations.pdf.

[146] July 2011 Monthly Progress Report, Department of Health. http://www.health.state.ny.us/health_care/medicaid/redesign/docs/july_2011_progress_report.pdf.

[147] Defined as no greater than the ten-year average rate for the long-term medical component of the CPI, which is about 4 percent. "Monthly Global Cap Updates." Accessed August 2011. http://www.health.state.ny.us/health_care/medicaid/regulations/global_cap/

cap, the Commissioner of the Department of Health (DOH) is authorized to implement Medicaid Savings Allocation Plans, without seeking legislative approval, which can include provider reimbursement changes as well as benefit changes.[148] DOH is closely monitoring Medicaid expenditures and as of August 2011, the state has stayed below the spending cap by about 2.5 percent.[149]

Care Management

A second major Medicaid reform initiative recommended by the MRT and included in the state budget is to move the New York Medicaid program out of fee-for-service. Over the course of three years, all New York Medicaid members will be enrolled in some form of care management, including an expansion of mandatory managed care to beneficiaries previously excluded, an expansion of managed long term care, increased enrollment in the state's PCMH initiative and the new ACA state plan option for health homes.

Mandatory Managed Care. In April 2011, the state submitted an amendment to its current 1115 waiver program, F-SHRP, to expand mandatory managed care to new geographic areas, include additional benefits, and enroll populations previously excluded.[150] The state has proposed phasing in these expansions along the following timeline:

- 2011: Personal Care Services would be added to managed care (except consumer directed personal care) and pharmacy services would be carved-in. Several groups of previously exempted individuals would be required to enroll in managed care, including individuals living with HIV (upstate), non-SSI adults and children with severe and persistent mental illness and serious emotional disturbance, and pregnant women with a prenatal provider that is not participating in any managed care plans.

- 2012: Additional groups that were previously excluded from managed care would be required to enroll, including individuals with (ESRD), homeless individuals, individuals receiving services through the Chronic Illness Demonstration Program, and individuals enrolled in the Long Term Home Health Care Program where capacity exists.[151] Skilled Nursing Facility services would be added to managed care plans and residents of nursing homes would be required to enroll.

- April 2013: Remaining populations would be required to enroll in managed care including residents of ICFs-ID, those receiving services through the Nursing Home Diversion and transition waiver, children in the foster care waiver program, Medicaid Home and Community-Based Services Waiver recipients,[152] and residents of state-operated psychiatric centers.[153]

The state has received approval to require pregnant women, children under the age of 20, parents or caretaker relatives, adults and children receiving SSI payments or otherwise disabled, adults over the age of 65, individuals living with HIV[154], and those enrolled in the Recipient Restriction program. The state has also received approval to add personal care and pharmacy services to managed care plans.[155]

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[148] Once developed, such plans will be posted to the DOH Web site and written copies will be provided to the Legislature at least 30 days prior to implementation.

[149] August 2011 Monthly Progress Report, Department of Health. http://nyhealth.gov/health_care/medicaid/regulations/global_cap/docs/august_2011_report.pdf.

[150] Waiver Amendments submitted to CMS, April 13, 2011. http://www.health.state.ny.us/health_care/managed_care/appextension/index.htm.

[151] These individuals will have the option of enrolling in Managed Long Term Care instead.

[152] These individuals will be required to enroll in managed care but may also stay in the waiver program.

[153] Amendments submitted to CMS for current 1115 waiver on April 13, 2011. Accessed October 3, 2011 http://www.health.ny.gov/health_care/managed_care/appextension/index.htm#mrt_waiver_materials.

[154] The state began requiring individuals living with HIV in New York City in beginning September 1, 2010. http://www.health.ny.gov/health_care/managed_care/living_with_hiv/questions_and_answers.htm

[155] Letter of Approval for F-SHRP demonstration changes, July 15, 2011. http://www.health.state.ny.us/health_care/managed_care/appextension/health_reform_partnership/docs/extension_terms_and_conditions.pdf

Managed Long Term Care. New York has had managed long term care plans operating in the state for a number of years, though enrollment has always been voluntary. The state is moving to require those in need of community-based long term care services, including Duals, to enroll into managed long term care. As part of the earlier referenced waiver amendment, New York is also proposing to require those dually-eligible for Medicare and Medicaid over the age of 21 and in need of community-based long term care services for more than 120 days to enroll in managed long term care. If this waiver amendment is approved, enrollment in MLTC plans will be required for Medicaid enrollees living in New York City currently being served in personal care, Long Term Home Health Care, Certified Home Health Agencies, as well as people who are new to long term care if they need such care for more than 120 days beginning in April 2012. Mandatory enrollment would expand throughout the rest of the state as MLTC plans become available.[156]

Creation and expansion of health homes and patient-centered medical homes. New York submitted a Health Home state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for approval with the goal of January 1, 2012 implementation and enrollment of 200,000 Medicaid recipients in a health home by the end of fiscal year. DOH will prioritize patient assignment to health homes with comprehensive service delivery and care management capability, including both medical and behavioral health capacity.[157] The state is also working to expand their patient-centered medical home program, which began April 2010 and has expanded statewide, to more payers, with the goal of enrolling one million Medicaid patients into medical homes.[158]

Other MRT Recommendations

Other MRT reform recommendations adopted include contracting with Behavioral Health Organizations and reforming home health fee-for-service rates to encourage more appropriate utilization and begin transitioning to episodic pricing. The state also created a Medical Indemnity Fund to fund the medical costs not covered by insurance for children with a neurological impairment related to a birth injury as a result of medical malpractice (or alleged) for which the child has either settled or been awarded a jury award. This initiative is estimated to lower hospital insurance premiums by 20 percent ($320 million).[159]

Integrate Medicare and Medicaid Benefits for Duals

New York was also one of the 15 states to be awarded a contract to develop service delivery and payment models that integrate care for dual eligibles by the Center for Medicare and Medicaid Innovation (CMMI). Their proposal included several options, including: the state would assume full risk – state would integrate delivery, management, and administration of all Medicare benefits with Medicaid; and (2) the state would promote existing managed LTC initiatives (3) the state would provide care coordination for nursing home residents by enrolling in Medicare SNPs; and (4) the state would expand the PACE program by allowing for duals to maintain existing provider relationships in community, and/or allowing duals under 55 to participate in a PACE model designed for their needs (PACE without walls); The state proposed an implementation date of October 2012.[160] The state is coordinating the work under this proposal with other efforts being undertaken.[161]

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[156] Individuals served by the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver, and those served through the Office of People with Developmental Disabilities would be exempted until appropriate program features were available under these plans. Amendments submitted to CMS for current 1115 waiver on April 13, 2011. http://www.health.ny.gov/health_care/managed_care/appextension/index.htm#mrt_waiver_materials.

[157] "State Health Department Accepting Applications for Medicaid Health Homes." Press Release from MRT, August 4, 2011.

[158] "State Health Commissioner, Local Officials Promote Use of Patient-Centered Medical Homes During Visit to Bronx Health Center." DOH Press Release, April 6, 2011. http://www.health.ny.gov/press/releases/2011/2011-04-06_medical_home.htm

[159] Proposals are outlined in the summary of the Phase I initiatives being implemented at http://www.health.state.ny.us/health_care/medicaid/redesign/docs/redesign_proposals.pdf.

[160] *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS*. Kaiser Commission on Medicaid and the Uninsured, August 2011. http://www.kff.org/medicaid/upload/8215.pdf.

Health Reform

On June 13, 2011, Governor Cuomo released draft legislation to establish a state-run health insurance exchange in New York. Later that month, the State Assembly passed a similar bill which would have established the exchange as a public benefit corporation (A 8514/S 5849). The next day, the legislative session ended and the bill failed in the Senate without a vote. While it has been suggested the legislature will readdress the bill during a special session this fall, one has yet to be scheduled. The next regular session begins in January 2012. In the absence of legislation, the New York Insurance Department and the State Department of Health partnered to lead exchange planning in the state. The state received a federal Exchange Planning grant of $1 million in 2010 and a Level One Establishment Grant in August 2011. The state also received an Early Innovator grant of $27.4 million to develop an exchange information technology infrastructure that could be replicated by other states.[162]

New York reported the following Medicaid policy changes in FYs 2011 and FY 2012 in the table below.

Eligibility and Enrollment Changes
• In FY 2011 – Automated enrollment in Medicare Savings Program under MIPPA. – Began statewide enrollment center for telephone renewals of certain community Medicaid recipients. – Expanded attestation of income, resources and residence at renewal for ABD recipients receiving community LTC and attestation of interest income for Family Health Plus and certain Medicaid enrollees. • In FY 2012 – Increase resource levels for MBI – WPD and disregard for retirement accounts. – Plan to implement 12 month continuous coverage for adults. – Plan to automate renewals for aged, blind, and disabled recipients with fixed incomes.
Provider Rates
• In FY 2011, 1.1% provider rate cuts were instituted across-the-board in response to the stepped-down extension of the ARRA-enhanced FMAP from September 16, 2010 through the end of the fiscal year.[163] • Provider rate cuts were implemented for all providers asked about in the survey except for physicians for FY 2012. Inpatient hospital rate cuts were lessened by an increase in their assessment.
Benefit Changes
• In FY 2011 – Added coverage of smoking cessation for pregnant women and those under 21. – Added coverage of substance abuse screening in emergency rooms. • In FY 2012 – Expanded coverage of smoking cessation to all recipients. – Require hospitals, nursing homes and home health care providers to provide patient centered palliative care. – Plan to expand coverage of substance abuse screening (SBIRT) to office-based primary care practitioners (previously limited to hospital outpatient department, free-standing clinics, and emergency rooms). – Plan to limit physical, occupational, and speech therapy to 20 visits for each service in 12 month period. – Limited the number of hour for Level 1 to 8 hours per week.

[161] Proposals are outlined in the summary of the Phase I initiatives being implemented at http://www.health.state.ny.us/health_care/medicaid/redesign/docs/redesign_proposals.pdf. The contract awarded by CMMI was one of 15 and is awarded for planning purposes only. For more information on the contracts, see *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS*. Kaiser Commission on Medicaid and the Uninsured, August 2011. http://www.kff.org/medicaid/upload/8215.pdf.

[162] *Implementing Health Insurance Exchanges: New York.* Kaiser Family Foundation, September 15, 2011. http://www.kff.org/healthreform/upload/8223-NY.pdf.

[163] New York State Medicaid Update - February 2011. Volume 27, No. 3. http://www.health.state.ny.us/health_care/medicaid/program/update/2011/2011-02.htm.

Long-Term Care
• In FY 2011 – Lengthened the timeframe between required reassessments for LTHHCP waiver participants from 120 days to 180 days to recognize participant length of stay and reduce Medicaid reimbursement costs. – Added 2 PACE sites. – Radiology Management program was implemented for all Medicaid FFS recipients.[164] – Limited Reserved Bed Day reimbursement to 14 days per year for temporary hospitalizations and to 10 days per year for non-hospital/therapeutic leaves of absence for residents over 21. – Increased availability of Medicaid assisted living by adding 6,000 nursing home beds over 5 years. • In FY 2012 – Implement new LTHHCP waiver requirements and enhancements to waiver (added Assistive Technology, Community Transitional Services, and Home and Community Support Services).[165] – Require hospitals, nursing homes, and home health providers to provide patient-centered palliative care.
Managed Care
• In FY 2011 – Began mandatory enrollment into managed care for persons with HIV to specific boroughs and zip codes. – Transitioned 4 additional counties from voluntary to mandatory enrollment into managed care. – Certified additional PACE and MLTC plans. • In FY 2012 – For populations under the state's existed 1115 waiver, 6 additional counties will be moved from voluntary enrollment to mandatory enrollment in FY 2012. – Over the next 3 years, populations previously exempted or excluded from Medicaid managed care will be mandated to enroll in areas with a mandatory program.
Other
• Carving in pharmacy benefits effective October 1, 2011. • Plan to move to AAC for pharmacy ingredient cost reimbursement. • Limit opioid prescriptions to 4 per 30-day period planned for of Oct. 1, 2011. • Begin mandatory enrollment into MLTC for those in need of community-based LTC services April 1, 2012. Contingent upon waiver approval, this initiative will also include Duals.

[164] New York State Medicaid Update - February 2011. Volume 27, No. 3. http://www.health.state.ny.us/health_care/medicaid/program/update/2011/2011-02.htm.
[165] New York State Medicaid Update - July 2011. Volume 27, No. 10. http://www.health.state.ny.us/health_care/medicaid/program/update/2011/2011-07.htm#topdec.

Tennessee Case Study

TennCare History

The TennCare program was designed to cover not only traditional Medicaid populations, but also other low-income uninsured or uninsurable individuals in Tennessee. Over time the number of non-traditional enrollees grew to about 40% of total TennCare enrollment. Total TennCare enrollment peaked in late 2001 with about 1.5 million enrollees of whom more than 600,000 were not part of a traditional Medicaid group. As Tennessee struggled to support a program of this magnitude, in several stages over ensuing years, enrollment in the non-traditional component of the program was scaled back. Today the non-traditional TennCare enrollees are almost exclusively children covered in a TennCare waiver category which is primarily funded by the Children's Health Insurance Program. At the same time traditional Medicaid enrollment has grown so that total TennCare enrollment is about 1.2 million.

Tennessee Budget

The Republican-controlled Tennessee legislature unanimously passed newly elected Republican Governor Bill Haslam's $30 billion budget for FY 2012, allowing the earliest end to the legislative session since 1998.[166] Because state revenue collections were projected to exceed earlier expectations, the Governor amended his budget to eliminate more than $48 million in previously planned cuts to TennCare, mental health clinics and programs for the intellectually disabled.[167] The budget also added $70 million to the state's Rainy Day fund, and allocated $70 million to disaster relief. [168] Tennessee is still recovering from devastating floods in May 2010 that included the highest crest level ever recorded on the Cumberland River in Nashville.[169] The budget included a 1.6 percent pay raise for state employees, the first such increase in four years[170], while eliminating over 1,100 state jobs (of which about half are currently filled). Higher education received a two percent cut, opening the door to tuition increases of between eight and eleven percent at the state's six universities, 13 community colleges and 27 technology centers,[171] while spending on K-12 education was increased.[172]

Despite optimistic revenue projections, in August the Tennessee Finance Commissioner directed all State agency heads to draw up plans to include both a 15 percent and 30 percent cut that might be necessary due to federal deficit reduction activities.[173] Tennessee's budget is made up of 40 percent federal funding and these proposals are the State's effort to demonstrate to credit rating agencies that it will be able to absorb any federal cuts that may be forthcoming.[174] While none of the credit agencies has downgraded Tennessee's AAA rating yet, Moody's has placed the state on "negative" watch because of uncertainty in Washington and the State's heavy reliance on federal funding.[175]

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[166] Tennessee State Budget, Sunshine Review, accessed at http://sunshinereview.org/index.php/Tennessee_state_budget
[167] Tom Humphrey, "Some State Budget Cuts Avoided," Knoxville News Sentinel, May 4, 2011, accessed at http://www.knoxnews.com/news/2011/may/04/some-budget-cuts-avoided/
[168] See Sunshine Review.
[169] "Record or Near-Record Flood Levels Across Middle Tennessee," National Weather Service, May 4, 2010, accessed at http://www.srh.noaa.gov/news/display_cmsstory.php?wfo=ohx&storyid=51780&source=0
[170] Tennessee State Employees Association Blog, "TSEA's Efforts Pay Off! State Employees Receive First Raise in 4 Years!," accessed at http://tseaonline.wordpress.com/2011/07/01/tsea%e2%80%99s-efforts-pay-off-state-employees-receive-first-raise-in-4-years/
[171] "Regents Approve More College Tuitions Hikes," WSMV-TV Nashville, June 24, 2011, accessed at http://www.wsmv.com/story/14969190/regents-to-vote-on-tuition-hike.
[172] See Sunshine Review.
[173] "Tenn. Agencies Looking at 30 Percent Spending Cuts," WSMV-TV, August 19, 2011, accessed at http://www.wsmv.com/story/15297224/tenn-agencies-looking-at-30-percent-spending-cuts.
[174] Ibid.
[175] Andy Sher, "State Preparing for Less Federal Money," Chattanooga Time Free Press, August 19, 2011, accessed at http://www.msnbc.msn.com/id/44211409.

TennCare Budget

As noted above, the increased revenue assumptions in the final FY 2012 budget allowed the State to reduce cuts to TennCare providers. The original budget proposed 8.5% rate cuts for certain TennCare providers including nursing homes, MCO administrative rates, transportation providers, lab and x-ray services, dental, PACE program, and home health providers. The final budget reduced these to 4.25% cuts in part through the increased revenue projections and also by including contingency appropriations. The contingency appropriation assumes that Tennessee will recover approximately $82 million from the federal government through successful resolution of a credit owed to the states related to an error in the Social Security Administration's system that prevented some disabled individuals from being enrolled in Medicare and instead enrolled them in Medicaid.[176] If these funds are not recovered from the federal government, there is the potential of further cuts as of January 1, 2012 for managed care organizations, nursing homes, transportation providers, laboratory and x-ray services, dental services and home health care.[177] Hospitals were able to avoid any rate cut due to an increase in the hospital provider tax.

Long Term Care and Dual Eligibles

In August 2010, the TennCare managed care program for long-term care services, CHOICES, was launched statewide. Under the program, managed care organizations are responsible for providing the full continuum of care for elderly and disabled members, including home and community-based services (HCBS), nursing facility care, behavioral health services, as well as acute and primary care services.[178] Early indications are that more than 30 percent of new members are choosing HCBS over institutional care, permitting the State to make substantial progress in rebalancing its long-term care expenditures towards community settings. [179]

In early 2011 the federal government announced that Tennessee was one of 13 states awarded a Money Follows the Person (MFP) grant to provide individuals living in nursing homes with new opportunities to live in the community. (These 13 states join 30 states that already have MFP programs). Tennessee was awarded up to $2.4 million for the first year and a total of up to $119.6 million is committed for Tennessee through 2016.

Tennessee is one of fifteen states to receive funding for a design contract for integrating care for dually eligible Medicare and Medicaid beneficiaries from CMS through its Center for Medicare and Medicaid Innovation in cooperation with the Medicare-Medicaid Coordination Office. The State's proposal will build on its experience with TennCare CHOICES. The State plans to create TennCare PLUS under which the State would contract with MCOs to integrate Medicare and Medicaid benefits and coordinate care for the 137,000 duals in Tennessee.[180] Because there is no fee-for-service Medicaid program in Tennessee, dual eligibles already receive their Medicaid services, including behavioral health care, from an HMO. In addition, as previously noted, Tennessee has already integrated long term care Medicaid services with Medicaid acute care services.

Status of Health Care Reform

No action has taken place regarding Exchange legislation. The Administration is working through its Division of Health Care Finance and Administration and in collaboration with other stakeholders and state agencies, including Commerce and Insurance on Exchange planning.[181] In consultation with Technical Assistance Groups it has established, the State is considering whether to operate a state-level Exchange, and if it decides to do so,

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[176] There is a dispute between multiple states and the federal government about the failure of the federal government to resolve these cases through the Special Disability Workload project.

[177] HMA interview with state official.

[178] TennCare CHOICES website, accessed at http://www.tn.gov/tenncare/CHOICES/

[179] HMA interview with state official.

[180] MaryBeth Musumeci, John Connolly, Jhamirah Howard, and Gretchen Jacobson, "Proposed Models to Integrate Medicare and Medicaid Benefits for Duals Eligibles: A Look at the 15 State Design Contracts Funded by CMS," Kaiser Commission on Medicaid and the Uninsured, August 2011, accessed at http://www.kff.org/medicaid/upload/8215.pdf

[181] HMA interview with state official.

how it would be structured and governed.[182] During the 2011 legislative session, the Tennessee Health Care Freedom Act was passed which would allow citizens to "choose or to decline to choose any mode of securing health care services without penalty or threat of penalty." [183] This legislation is designed to exempt Tennesseans from any health care mandate. Another bill establishing an interstate "Health Care Compact" is pending for next year.[184]

Other actions related to Medicaid taken by the state in FY 2011 or planned for FY 2012 are described below:

Provider Rates
• In FY 2011: No Medicaid provider rate changes occurred in FY 2011. • In FY 2012: – Provider rates were cut by 4.25% for dentists, MCOs, nursing homes, transportation, lab and x-ray, home health and PACE providers. – ER doctors are limited to a triage fee for non-emergency cases. – Physician rates for deliveries will be based on a blend of the current rates for C-section deliveries and vaginal births. – Additional rate cuts are possible later in the fiscal year if contingency revenue funds do not materialize.
Eligibility, Application and Renewal Changes
• Tennessee reported no changes to eligibility, application and renewal policies or procedures for either FY 2011 or FY 2012.
Benefit/Service Changes
In FY 2012: – Coverage added for medically necessary smoking cessation products. (July 1, 2011) – Eliminated coverage for acne and rosacea medications. (July 1, 2011)
Long-Term Care
• In FY 2011: – Implementation of Community Choices Act has integrated LTC services for the elderly and disabled into managed care organizations. (8/1/10) – Money Follows the Person Demonstration Grant awarded. (4/1/11) – PACE additional site planning grant. (6/1/11) – Awarded a contract for Medicare/Medicaid Integration planning (4/1/11) • In FY 2012: – Implementation of Medicare/Medicaid Integration.
Prescription Drug Controls and Limits:
• In FY 2011: Tennessee limited purchase of hemophilia factor to a designated specialty pharmacy provider. • In FY 2012: – Imposed a dosage limit on opioid detoxification drugs (weaning process in terms of milligrams per day) and a quantity limit (14 per month) on sedative hypnotics for adults. (July 1, 2011) – The reimbursement methodology for specialty drugs is being modified for FY 2012 and a specialty drug case management effort is being implemented.
Other Actions
• In FY 2011 and FY 2012 the TennCare MCOs are implementing a "patient centered medical home" initiative

[182] Health Insurance Exchange, TN.gov, accessed at http://www.tn.gov/nationalhealthreform/exchange.html#1
[183] TN H 115, summary accessed at www.ncsl.org
[184] TN H 369, summary accessed at www.ncsl.org. Once an interstate compact is approved by Congress, legislatures of member states have primary responsibility to regulate health care in their respective states. Four states have passed Interstate Health Care Freedom Compacts.

Appendix C: Survey Instrument

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2011 AND 2012

This survey is being conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. If you have any questions, please call Vern Smith at (517) 318-4819.

Return Completed Survey to: Vsmith@healthmanagement.com

State _____ **Name** _____

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

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

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

_____

b. Is your state projecting an overall state budget shortfall for FY 2012? *(Select one)* _____

c. How did your state use the ARRA enhanced Medicaid FMAP? *(Check all that apply.)*

i. ☐ Closed/reduced a Medicaid budget shortfall	v. ☐ Helped fund Medicaid caseload increases
ii. ☐ Avoided/reduced Medicaid provider rate cuts	vi. ☐ Closed/reduced a non-Medicaid budget shortfall
iii. ☐ Avoided Medicaid benefit cuts	vii. ☐ Other: _____
iv. ☐ Avoided/restored Medicaid eligibility cuts	

Additional comments: _____

d. Has your legislature enacted the Medicaid budget for FY 2012? ☐ Yes ☐ No

e. Looking now at the FY 2012 Medicaid appropriation (or the expected appropriation), how likely is a Medicaid budget shortfall in your opinion? *(Check one)*

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

2. Medicaid Expenditure Growth: State Fiscal Years 2010, 2011 and 2012

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

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 2010 (FY 2010) i. Percentage change: FY 2010 over FY 2009	%	%	%	%
FY ending in 2011 (FY 2011) ii. Est. Percentage Change: FY 2011 over FY 2010	%	%	%	%
FY ending in 2012 (FY 2012) iii. Est. Percentage Change: FY 2012 over FY 2011	%	%	%	%

Comments: _____

b. Does your state require *mandatory* local or county contributions to fund the non-federal share of the state's Medicaid expenditures (excluding DSH payments)? ☐ Yes ☐ No

3. Factors Driving Expenditure Changes

What would you consider the most significant factors contributing to increases or decreases in your total Medicaid spending in FY 2011 and FY 2012 (e.g., enrollment, healthcare inflation, rate changes, utilization, specific policy changes, etc.)? Note that it is possible to have offsetting upward and downward pressures.

		FY 2011	FY 2012
a. ***Upward*** Pressure	i. Most significant factor?		
	ii. Other significant factors?		
b. ***Downward*** Pressure	i. Most significant factor?		
	ii. Other significant factors?		

4. Medicaid Enrollment

	2011 over 2010	2012 over 2011 (proj.)
a. Overall % enrollment growth/decline (+/–):	i. %	ii. %

b. Are specific eligibility groups contributing to overall enrollment growth or decline? _____

c. Please describe what you believe are the *key factors or pressures* that contributed to increases or decreases in enrollment in FY 2011, and will do so in FY 2012.

In FY 2011:	
In FY 2012	

Comments : _____

5. Provider Payment Rates

a. Compared to the prior year, please indicate by provider type any rate increases or decreases implemented in FY 2011 or to be implemented in FY 2012. Include COLA or inflationary changes as increases. Use "+" for an increase, " – " for a decrease and "0" for no change. Optional: if available, please indicate actual percentage change as well.

Provider Type	FY 2011	FY 2012
i. Inpatient hospital		
ii. Doctors – primary care physicians		
iii. Doctors – specialists		
iv. Dentists		
v. Managed care organizations		
vi. Nursing homes		

b. Please list any other provider rates subject to reimbursement increases or reductions:
   i. for FY 2011. _____
   ii. for FY 2012. _____

Comments (e.g., if rate changes were court-ordered or limited by legal action, etc.): _____

c. With respect to the new proposed federal regulations requiring a study of the adequacy of access to care before provider rates can be cut, what are the biggest opportunities, challenges or issues for your state?

_____

6. Provider Taxes/Assessments

Please use the drop down boxes provided in the table below to indicate any provider taxes in place in FY 2010, and any new taxes and or changes for FY 2011 and FY 2012. In the last column (far right), please indicate whether a proposed federal provider tax cap of 3.5% of net patient revenues would require the state to decrease its established rate(s).

Provider Group Subject to Tax	In place in FY 2010 (Yes, No)	Provider Tax Changes (New, Increased, Decreased, Eliminated, No Change or N/A) in:		FY 2012 increase due to federal cap increase? (Yes, No, N/A)	Does this tax exceed 3.5% of Net Patient Revenues and therefore is affected by federal proposals to limit taxes to that level?
		FY 2011	FY 2012		
a. Hospitals					
b. ICF/MR-DD					
c. Nursing Facilities					
d. MCOs					
e. Other: _____					
f. Other: _____					

Comments (e.g., regarding replacement of MCO tax, impact of a potential limit on provider taxes at 3.5%, other federal impacts, etc.): _____

7. Medicaid Eligibility Standards

a. Describe changes in Medicaid eligibility standards* implemented in FY 2011 or planned for FY 2012. Under "Nature of Impact," use the drop down boxes to indicate if the change is an "Expansion," a "Restriction," or a change with a "Neutral" affect. If there are no eligibility changes to report, please check the box on line "iii." (Please exclude changes in CHIP-funded programs.)

Year	Nature of Eligibility Change and Affected Eligibility Groups	Effective Date	Est. Number of People Affected	Nature of Impact	By Waiver Authority
i. FY 2011	A.				☐
	B.				☐
ii. FY 2012	A.				☐
	B.				☐
iii. ☐ **No changes in either FY 2011 or FY 2012**					

* "Eligibility standards" include income standards, asset tests, retroactivity, continuous eligibility, treatment of asset transfer or income, enrollment caps or buy-in options (including Ticket to Work and Work Incentive Improvement Act or the DRA Family Opportunity Act). If applicable, include adoption of the new Family Planning State Plan Option, the CHIPRA "ICHIA" option (cover lawfully residing immigrant children and pregnant women without 5 year waiting period), or election of the early expansion state plan option to cover childless adults.

b. **Adults Above 133% FPL**. Does your state plan to reduce eligibility for adults with incomes over 133% FPL under the ACA option for states that certify a budget deficit? *(Select one)* _____

Comments: _____

8. Application/ Renewal Process

Describe any changes to the application or renewal process.* Under "Nature of Impact," use the drop down boxes to indicate whether the change is a " liberalization, a "restriction" or a change with a neutral effect. Note if the change is designed to qualify for a CHIPRA Bonus. If there are no changes to report, please check the box on line "c".

Year	Application or Renewal Process Change	Nature of Impact:	CHIPRA Bonus Related?
a. FY 2011	A.		☐
	B.		☐
b. FY 2012	A.		☐
	B.		☐
c. ☐ No changes in either FY 2011 or FY 2012			

*Application changes include changes in forms, verification or face to face interview requirements, frequency of redeterminations or renewals, new on-line enrollment systems, etc.).

Comments : _____

9. Premiums

Please list any Medicaid eligibility group subject to a premium requirement (including a Ticket to Work, Family Opportunity Act or other buy-in program) and use the drop down boxes to indicate the nature of any changes made in FY 2011 or planned for FY 2012. (Do not include premiums for CHIP-funded programs.)

Eligibility Group Subject to a Premium Requirement	In Place in FY 2010?	Changes (New, Increased, Decreased, Eliminated or No Change) in:		By Waiver Authority?
		FY '11?	FY '12?	
a.	☐			☐
b.	☐			☐
c.	☐			☐

Comments : _____

10. Benefits

Describe below any change in benefits *implemented* during FY 2011 or planned for FY 2012. Under Column 5 "Nature of Impact," use the drop down boxes to indicate whether the change is an "Expansion," a new or increased benefit "Limitation," a benefit "Elimination" or a benefit change with an overall "Neutral Affect." If there are no benefit changes to report for either year, please check the box on line "c".

Year	Benefit Change	Effective Date	Eligibility Groups Affected	Nature of Impact	By DRA Authority	By Waiver Authority
a. FY 2011	i.				☐	☐
	ii.				☐	☐
	iii.				☐	☐
	iv.				☐	☐
b. FY 2012	i.				☐	☐
	ii.				☐	☐
	iii.				☐	☐
	iv.				☐	☐
c. ☐ No changes in either FY 2011 or FY 2012						

Comments : _____

11. Long Term Care Policy

a. Briefly identify LTC actions[1] taken during FY 2011 or planned for FY 2012. Under "Community or Institutional Action," use the drop down boxes to indicate if the action impacts "Community"-based services, "Institutional" services or "Both." Under "Nature of Impact," use the drop down boxes to indicate whether the action is an "Expansion," a new or increased LTC service "Limitation," a service "Elimination" or a service change with an overall "Neutral Affect." If there are no actions to report for either year, please check the box on line "iii." (Exclude rate, tax or benefit changes already reported in questions 5, 6 or 10).

Year	Long Term Care Policy Action	Community or Institutional Action?	Effective Date	Nature of Impact
i. FY 2011	A.			
	B.			
	C.			
	D.			
ii. FY 2012	A.			
	B.			
	C.			
	D.			
iii. ☐ **No changes in either FY 2011 or FY 2012**				

b. LTC State Options. Using the check boxes in the table below, indicate whether your state has or will exercise the following DRA and ACA LTC options.

LTC Option	In Place in 2010	New in FY 2011	Discon-tinued in 2011	Plan to Implement in 2012	Discon-tinued in 2012	No Plans to Imple-ment	Don't Know
i. HCBS **State Plan** Option (**not HCBS waiver**)	☐	☐	☐	☐	☐	☐	☐
ii. Long Term Care Partnership Program	☐	☐	☐	☐	☐	☐	☐
iii. Money Follows the Person Rebalancing Demonstration	☐	☐	☐	☐	☐	☐	☐
iv. State Balancing Incentive Payment Program				☐	☐	☐	☐
v. Community First Choice Option				☐	☐	☐	☐

c. Is there additional information you need or are awaiting from CMS before implementing one or more of these options? _____

Comments : _____

12. Cost Sharing

a. Does your state require copays (S*elect one*)? _____
b. Are copayments enforceable[2] in your state for any eligibility group (*Select one*)? _____
c. If yes, for what group(s) are copayments enforceable? _____

[1] LTC actions include, but not limited to, changes to waiver slots or services, state plan personal care services, PACE sites, nursing home diversion/transition programs, or level of care requirements. LTC actions also includes policies impacting institutional care such as bed-hold policies, Medicare cross-over payment policies, bed moratoriums, level of care requirements, or quality enhancement initiatives.

[2] "Enforceable" means state policy allows Medicaid providers to deny care to beneficiaries who do not pay a copay (pursuant to the Deficit Reduction Act of 2005.)

d. Please describe any beneficiary cost sharing actions taken in FY 2011 or planned for FY 2012. Under "Nature of Impact," use the drop down boxes below to indicate if the action was a "New" requirement, an "Increase" to an existing requirement, a "Decrease" to an existing requirement, an "Elimination" of an existing requirement or an action with an overall "Neutral Affect." If there are no cost sharing changes to report for either year, please check the box on line "iii."

Year	Cost Sharing Action	Effective Date	Eligibility Groups Affected	Nature of Impact	By Waiver Authority ?
i. FY 2011	A.				☐
	B.				☐
	C.				☐
ii. FY 2012	A.				☐
	B.				☐
	C.				☐
iii. ☐ No changes in either FY 2011 or FY 2012					

Comments : _____

13. Prescription Drug Policy

a. **Specialty Drug Cost Containment.** Using the check boxes in the table below, please indicate if any specialty drug cost containment actions were implemented in FY 2011 or are planned for FY 2012. If there are no changes to report for either year, please check the box on line "v."

Specialty Drug Cost Containment Action	FY 2011	FY 2012
i. Implement selective contracting with specialty drug providers	☐	☐
ii. Revise the reimbursement methodology for specialty drugs	☐	☐
iii. Implement a specialty drug case management effort	☐	☐
iv. Other action: _____	☐	☐
v. ☐ **No changes in either FY 2011 or FY 2012**		

b. **Ingredient Cost Reimbursement Methodology.**

i. If your state used an AWP-based system in **F**Y 2011, do you plan to adopt an alternative methodology in anticipation of First DataBank discontinuing its publication of AWPs after September 2011 (e.g., AAC, WAC mark-up, discounted AWP from another source, discounted SWP)?

☐ Yes ☐ No ☐ N/A (Not using AWP-based system in FY 2011)

A. If "yes" please briefly indicate new methodology: _____

ii. Other than specialty drug actions reported under (a) above, did/will ingredient cost reimbursement increase, decrease or stay about the same,

A. In FY 2011? _____ B. In FY 2012? _____

C. Briefly describe any change: _____

c. **Dispensing Fees.** Did/will dispensing fees increase, decrease or stay the same,

i. In FY 2011? _____ ii. In FY 2012? _____

iii. Briefly describe any change: _____

d. **Selected Pharmacy Management Tools**. For the pharmacy program management tools listed in the table below, please indicate changes implemented in FY 2011 or planned for FY 2012. Under "Fiscal Impact," please use the drop down boxes to indicate if the change will have generate savings, increase costs, or be fiscally neutral. Check the box on line "vi" if there are no changes to report for either year.

Program Tool/Policy		In place at end of FY 2010?	Fiscal Year	Program Change in Fiscal Year	Fiscal Impact
i.	Preferred Drug List (PDL)	☐	2011		
			2012		
ii.	Supplemental rebates	☐	2011		
			2012		
iii.	Prescription cap[3]	☐	2011		
			2012		
iv.	Managed Care Rx Full Carve-out	☐	2011		
			2012		
v.	Managed Care Rx Partial Carve-out	☐	2011		
			2012		
vi	☐ **No changes in these pharmacy management tools either FY 2011 or FY 2012**				

e. **Other Pharmacy Program Changes.** In the table below, please indicate any other pharmacy program changes implemented in FY 2011 or planned for FY 2012. Under "Fiscal Impact," please indicate if the change will have a "Positive" impact (i.e., state savings), a "Negative" impact, or be fiscally "Neutral." Use the check box on line "iv" if there are no changes to report for either year.

Pharmacy Program Changes	Fiscal Impact	FY 2011 or FY 2012?
i.		
ii.		
iii.		
iv. ☐ **No changes in either FY 2010 or FY 2011**		

Other comments on pharmacy policy changes: _____

14. Medicaid Care Management, Quality and Access

a. What managed care programs are used by Medicaid in FY 2012: (*Check all that apply):*

☐ Capitated comprehensive health plans
☐ PCCM
☐ Non-comprehensive plans (e.g., for behavioral health)
☐ Other _____
☐ None

[3] "Prescription cap" refers to a limit on the number of prescriptions allowed for a beneficiary (in month, year or other time period.)

b. What managed care program or policy actions were *implemented* during FY 2011, or will be implemented in FY 2012? Please briefly describe those that apply.

Managed Care Program or Policy Actions	Actions Implemented FY 2011	Actions To Be Implemented FY 2012
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		

c. Does your Medicaid budget for FY 2012 assume any savings due to expansion of Medicaid managed care? ☐ Yes ☐ No

Comments: _____

d. Please identify/describe new Medicaid care coordination initiatives implemented or planned to be implemented in FY 2011 or 2012 in your state:

Care Coordination Initiatives	Actions Implemented FY 2011	Actions To Be Implemented FY 2012
i. Implement or expand disease management, care management for high cost/complex cases, or a chronic care management program (if applicable, specify disease state)		
ii. Implement a "patient-centered medical home" initiative		
iii. Implement new ACA State plan option to establish Health Homes for persons with chronic conditions		
iv. Other actions (including initiatives with the Center for Medicare and Medicaid Innovations) _____		

Comments: _____

e. Is your state developing new payment or delivery system programs for dual eligibles? ☐ Yes ☐ No
If "yes," please briefly describe: _____and:
   i. Are you working with the Innovation Center on your dual eligibles project? ☐ Yes ☐ No
   ii. Are you working with the new Duals office? ☐ Yes ☐ No

f. State Medicaid programs have pursued multiple quality strategies in recent years to improve the efficiency and effectiveness of health care delivery while reducing costs. Please identify / describe new Medicaid quality initiatives implemented or planned to be implemented in FY 2011 or 2012 for each delivery system category used in your state*:

Delivery System	Year	Description of New or Enhanced Quality Strategy
i. Capitated Managed Care		A.
		B.
ii. PCCM		A.
		B.
iii. Fee For Service		A.
		B.
iv. Long Term Care		A.
		B.

* Examples of new initiatives might include use of HEDIS and CAHPS data, health plan quality report cards, P4P and other payment incentives or penalties, value- and quality- based purchasing, prevention and wellness programs, etc.

15. Medicaid Health Information Technology (HIT) Initiatives

a. Please briefly describe Medicaid-related HIT initiatives (eRx, EHRs, etc.) undertaken in FY 2011 and planned in FY 2012. Indicate if related to Medicaid Transformation Grants, ARRA or other funding.

In FY 2011	
In FY 2012	

b. Has your state applied for enhanced federal matching funds for state planning activities necessary to implement the ARRA electronic health record (EHR) incentive program? *(Select one)* _____

c. When did / will your state begin making EHR incentive payments to providers? (Month/Year) _____

d. Is your agency on track to meet the following compliance deadlines:
   i. Implementation of HIPAA 5010 by January 1, 2012? (*Select one*) _____
   ii. Implementation of ICD-10-CM by October 1, 2013? (*Select one*) _____

Comments: _____

16. Section 1115 Waivers

a. Is your state currently planning to implement a Section 1115 Medicaid waiver or waiver amendment in FY 2012? ☐ Yes ☐ No
   i. If yes, what is the status of the waiver? (*Select one*) _____
   ii. Please indicate key areas to be affected by the waiver and briefly describe each: (*Check all that apply):*
      A. ☐ Global cap on federal spending _____
      B. ☐ State limit on Medicaid spending _____
      C. ☐ Eligibility _____
      D. ☐ Benefits _____
      E. ☐ Cost sharing _____
      F. ☐ Delivery system _____
      G. ☐ Provider payment _____
      H. ☐ Dual eligibles _____
      I. ☐ Incentives/fees to encourage healthy behavior _____
      J. ☐ Changes for persons with disabilities _____
      K. ☐ Other _____

b. Does your state have any current 1115 waivers that will expire in FY 2012? ☐ Yes ☐ No
   i. If yes, will you pursue waiver renewal or let the waiver expire? (*Select one*) _____
   ii. If you are seeking waiver modifications, please describe those modifications. _____
   iii. Please briefly describe any pending issues in your state relating to an upcoming renewal of a Section 1115 Medicaid reform waiver: _____

Comments: _____

17. Federal Health Reform: Medicaid Demonstration Opportunities

Use the drop down boxes below to indicate whether your state is currently planning to apply for the listed Affordable Care Act Medicaid demonstrations / initiatives:

a. _____ Medicaid Integrated Care Hospitalization Program (Sec. 2704: Up to 8 states, CY 12 – CY 16)
b. _____ Medicaid Global Payment System Demonstration (Sec. 2705: Up to 5 states, FY 10 – FY 12)
c. _____ Pediatric Accountable Care Organization Demonstration (Sec 2706: CY 12 – CY 16)
d. _____ Medicaid Emergency Psychiatric Demonstration (Sec. 2707: up to 3 years, funded to 12/31/15)
e. _____ Medicaid Chronic Disease Incentive Payment Program (Sec 4108: 1/1/11 or when criteria developed by HHS Secretary)

18. Looking Forward (Federal Health Reform and Other Initiatives):

a. Overall

i. Please briefly describe the Medicaid agency role in your state in preparing for federal health care reform. _____

ii. Is (and how is) Medicaid working with the state insurance department? _____

iii. What are the biggest challenges you see in implementing health reform? _____

iv. What Information do states need from CMS to move forward with implementing reform?

_____

v. Is you agency working with the Innovation center on any projects other than those related to dual eligibles? ☐ Yes ☐ No. If yes, please describe the initiative. _____

b. Eligibility and Enrollment

i. How would you describe the implications of the new Modified Adjusted Gross Income ("MAGI") eligibility standard (including whether you will develop a new eligibility system):

_____

ii. If you will be developing a new eligibility and enrollment system, will your state seek to obtain the 90/10 enhanced Medicaid administrative FMAP? *(Select one)* _____

iii. What role (if any) do you expect the Medicaid agency to play in determining eligibility for exchange subsidies? _____

19. Medicaid Administration

a. Has your agency experienced reductions or increases in administrative capacity for FY 2011 or FY 2012?

☐ Reductions ☐ Increases ☐ No change

i. If yes, please describe the nature of the reductions or increases. _____

ii. Do you believe your state Medicaid program has or will have the administrative capacity to carry out the policies and policy changes anticipated through 2014? What are your biggest areas of challenge?_____

b. Are you making any significant new investments or changes to your program to enhance program integrity in FY 2011 or FY 2012? ☐ Yes ☐ No.

i. If yes, please describe the initiative(s) and indicate which year(s) apply. _____

c. Is your agency working with the HHS strategic teams? ☐ Yes ☐ No.

i. If yes, please describe the initiative. _____

Comments: _____

20. Outlook for Medicaid in the Future?

a. What do you see as the most significant issues, challenges or opportunities Medicaid will face over the next year or two?_____

_____

This completes the survey. Thank you very much.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.

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