THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

October 2013

Medicaid in a Historic Time of Transformation:

Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014

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

ACKNOWLEDGEMENTS

We thank the Medicaid directors and Medicaid staff in all 50 states and the District of Columbia who completed the survey on which this study is based. Especially in this time of limited resources and challenging workloads, we truly appreciate the time and effort provided by these public servants to complete the survey, to participate in structured interviews and to respond to our follow-up questions. It is their work that made this report possible.

We offer special thanks to two of our colleagues at Health Management Associates. Dennis Roberts developed and managed the database, and his work is invaluable to us. Jenna Walls assisted with writing the case studies and we thank her for her excellent work.

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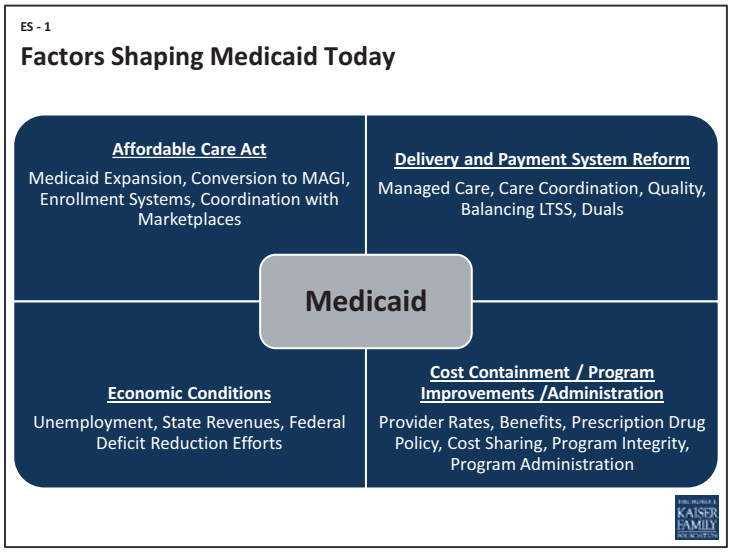
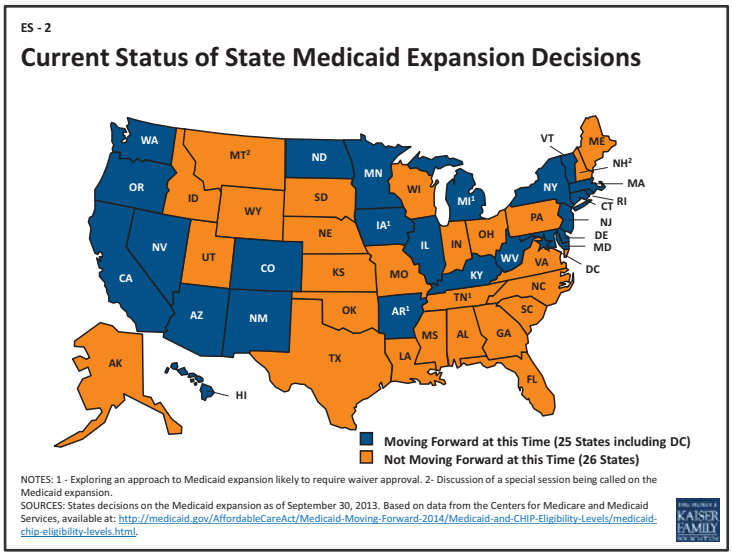
EXECUTIVE SUMMARY

The dominant forces shaping Medicaid during FY 2013 and heading into FY 2014 were the implementation of the Affordable Care Act (ACA) and the development and implementation of an array of delivery and payment system reforms. These changes represent some of the most significant changes to Medicaid since its enactment in 1965, and taken together, are transforming the role of Medicaid in the health care system in each state. At this time, the intensity of fiscal pressures and the focus on cost Medicaid containment were somewhat lessened as the economy slowly recovers; however, controlling costs and improving program administration are still important priorities for Medicaid program. (ES-1)



Today, Medicaid provides health and long-term care coverage to more than 66 million low-income Americans. Medicaid accounts for one in six dollars of all health care spending in the US but is the primary payer for long-term care services and supports (LTSS) and a major source of revenue for safety-net providers. Medicaid provides assistance for over 9.5 million low-income Medicare beneficiaries. The program continues to evolve as states implement programs to improve care, manage costs and improve quality using managed care as well as other care coordination initiatives.

As enacted in the ACA, Medicaid's role was broadened to become the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) ($15,856 per year for an individual in 2013). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. Twenty-five states (including the District of Columbia) have announced plans to move forward with the expansion; the remaining 26 states are not moving forward with the Medicaid expansion at this time. (ES-2) State decisions about implementing the Medicaid expansion have important coverage and fiscal consequences for states. In states that do not expand Medicaid, adults may face large gaps in coverage.



The findings in this report are drawn from the 13th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates (HMA). The report highlights trends in Medicaid spending, enrollment and policy initiatives for FY 2013 and FY 2014 with an intense focus on eligibility and enrollment changes tied to the implementation of the ACA as well as payment and delivery system changes. The report provides detailed appendices with state-by-state information and a more in-depth look at four case study states: Arizona, Florida, Kentucky and Washington.

Key findings from the survey include the following:

- Improvements in the economy resulted in modest growth in Medicaid spending and enrollment in FY 2013. In FY 2014, national enrollment and spending growth are expected to rise. States moving forward with the Medicaid expansion are expected to see higher enrollment and total spending growth driven by increases in coverage and federal funds.
- The implementation of the ACA will result in major changes to Medicaid eligibility and enrollment for all states whether they are implementing the ACA Medicaid expansion or not.
- Nearly all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings.
- Improvements in the economy have enabled states to implement more program restorations or improvements in provider rates and benefits compared to restrictions, but states also adopted policies to control costs and enhance program integrity.
- Looking ahead, FY 2014 will be a transformative year for Medicaid.

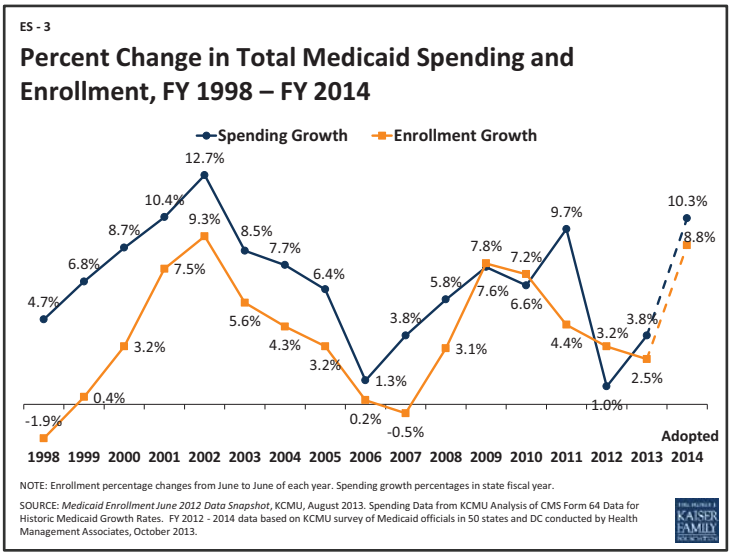
Methods

The KCMU/HMA Medicaid survey on which this report is based was conducted from June through August 2013. The survey instrument was designed to document policy actions states implemented in state FY 2013 and adopted for FY 2014 (which began for most states on July 1, 2013.) The Medicaid budget for FY 2014 had been adopted by all states at the time each survey was completed. Medicaid directors and 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 2013. All 50 states and DC completed surveys and participated in telephone interview discussions in July and August 2013. The telephone discussions are an integral part of the survey to ensure complete and accurate responses and to record the complexities of state actions. For most states, the interview included the Medicaid director as well as Medicaid policy or budget staff.

The focus of the annual survey is on Medicaid policy changes and new initiatives that are implemented, or are adopted and planned for implementation. This survey asked state officials to describe policy changes that occurred in FY 2013 and those adopted for implementation for FY 2014. The survey does not attempt to catalog all Medicaid policies.

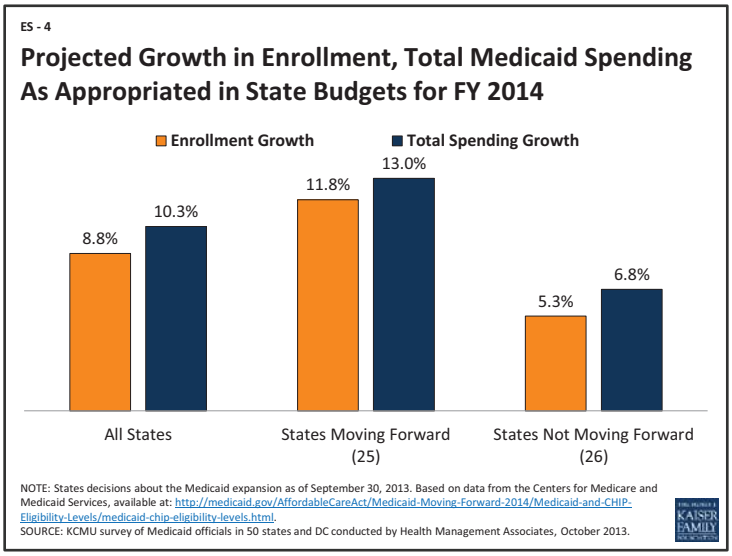
1. **Improvements in the economy resulted in modest growth in Medicaid spending and enrollment in FY 2013. In FY 2014, national enrollment and spending growth are expected to rise. States moving forward with the Medicaid expansion are expected to see higher enrollment and total spending growth driven by increases in coverage and federal funds.**

Headed into state fiscal year (FY) 2014, states are still recovering from the Great Recession as state revenues grow and national unemployment continues to fall slowly. As economic conditions have continued to improve, pressure on Medicaid enrollment and state budgets has lessened. In FY 2013, Medicaid enrollment growth slowed to 2.5 percent, the lowest rate of growth in six years, since the beginning of the Great Recession, and very close to original projections of 2.7 percent. Total Medicaid spending increased at an annual rate that averaged 3.8 percent across all states, relatively modest compared to historical growth rates and on target with original legislative appropriations. (ES-3) The state share of Medicaid spending increased by 3.1 percent in FY 2013.



For FY 2014, enrollment growth was projected to average 8.8 percent across all states. Part of the increase in expected enrollment is because all states (even those not implementing the Medicaid expansion) anticipate increases in Medicaid coverage due to additional participation among those currently eligible. These increases are tied to changes in enrollment processes that are required in all states.

State decisions about the Medicaid expansion had implications for anticipated spending and enrollment growth in FY 2014. The states that are planning to adopt the Medicaid expansion are expecting to see higher enrollment and total spending growth compared to the states not expanding Medicaid. These states are likely to see larger increases in coverage. The large difference in total Medicaid spending growth across these groups primarily reflects the cost of covering newly eligible enrollees which qualify for the 100 percent federal funding. A number of states moving forward expect to see net fiscal benefits from the ACA Medicaid expansion. (ES-4)

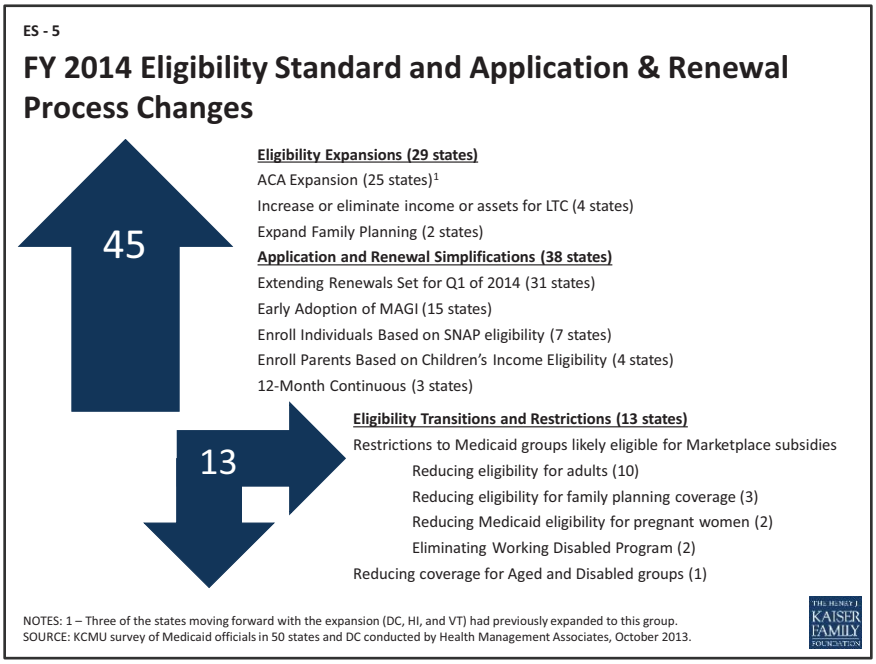


2. The implementation of the ACA will result in major changes to Medicaid eligibility and enrollment for all states whether they are implementing the ACA Medicaid expansion or not.

Leading up to 2014, states were generally limited from making eligibility cuts or restrictions due to the Maintenance of Eligibility (MOE) provisions in the ACA, which helped to maintain coverage during the economic downturn. A total of 18 states made positive eligibility or enrollment changes during FY 2013. Five states with a documented budget deficit restricted eligibility in FY 2013 for adults with incomes above 133 percent FPL, restrictions which were exempt from the MOE requirements.

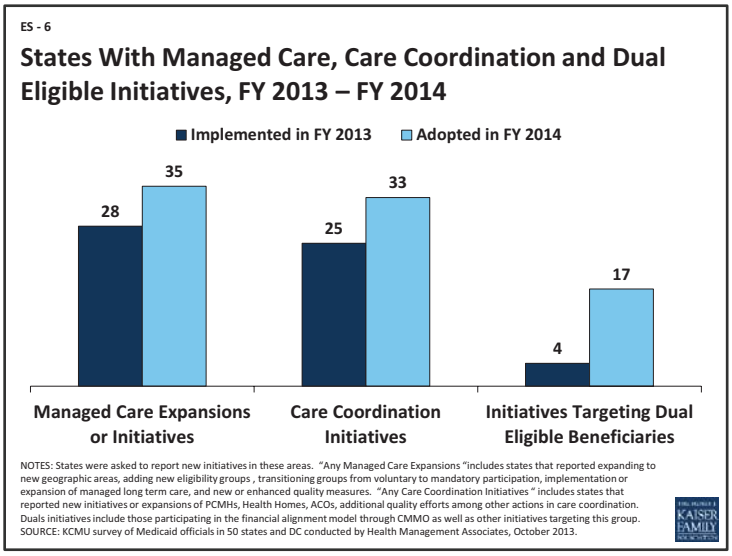
In FY 2014, states will implement some of the most significant modifications to eligibility and enrollment standards in the history of the Medicaid program. All states are required to transition to a uniform income eligibility standard using Modified Adjusted Gross Income (MAGI), transition children with income above 100 and up to 138 percent FPL from CHIP to Medicaid and implement new streamlined application, enrollment and renewal processes. In addition to these changes, Medicaid agencies will be required to coordinate with new Health Insurance Marketplaces. Working with the new Marketplaces, states will provide outreach to educate people about new health care options and assist consumers in navigating the enrollment process.

Beyond these requirements, nearly all states (45) reported eligibility and enrollment expansions and enhancements for FY 2014. Adopting the Medicaid expansion for nearly all low-income Americans with incomes up to 138 percent FPL (25 states) was the most significant eligibility change for FY 2014. Eight states reported plans to implement eligibility expansions aside from the ACA Medicaid expansion. Thirty-eight states reported changes to enrollment processes beyond the ACA required changes. The large majority of these changes were tied to states adopting new options to streamline enrollment that were authorized under CMS guidance released May 17, 2013. Thirteen states are implementing Medicaid eligibility restrictions in FY 2014. However, these cuts are targeted to non-disabled adults; most of those that will lose Medicaid eligibility in these states will be able to obtain subsidies to purchase coverage in the new Marketplaces.



3. Nearly all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings.

In FY 2013 and FY 2014, state Medicaid programs focused attention on delivery system and payment reforms designed to improve quality and minimize unnecessary costs. A total of 39 states (28 in FY 2013 and 25 in FY 2014) reported a policy change or initiative to expand managed care, or to improve care through a managed care focused quality initiative. States continue to expand managed care into new geographic areas and add eligibility groups (including those made newly eligible for coverage under the ACA), and expand managed long term care. In addition, states are developing more sophisticated quality metrics and performance measures within managed care programs. Such initiatives were implemented in 21 states in FY 2013 and 22 states adopted initiatives for FY 2014. Outside of managed care, new or expanded care coordination efforts were underway in 40 states (25 states in FY 2013 and 33 states in FY 2014.) These initiatives include health homes, patient-centered medical homes, and Accountable Care Organizations as well as other quality related initiatives. (ES-6)

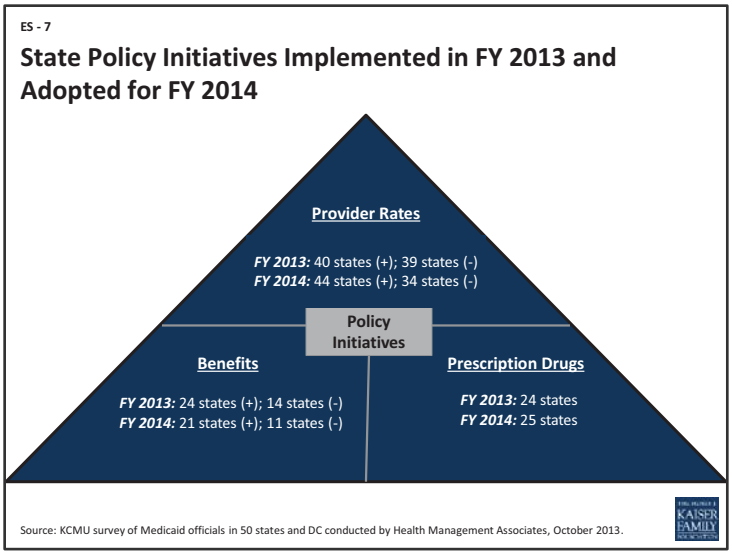


Many states reported initiatives designed to target specific populations or services such as coordinating across physical and behavioral health and across long-term care and acute care services. For example, states are using multiple strategies to better integrate physical and behavioral health such as health homes or carving this service into managed care contracts, or implementing a new behavioral health organizations. Developing integrated, coordinated systems of care to serve dual eligible beneficiaries continues to be an area of focus for states. In FY 2014, a total of 14 states reported plans to implement a formal demonstration project pending final approval under the CMS financial alignment demonstration; three other states plan to implement their own initiatives to serve this group. Others are working toward implementation in FY 2015.

Efforts to better balance the delivery of institutional and community based long-term services and supports are on-going. States continue to expand the use of community based long-term care through traditional 1915(c) waivers and expansions of PACE programs. States are also taking advantage of new options in the ACA. Specifically, the number of states taking advantage or planning to adopt the time-limited Balancing Incentive Program (BIP) jumped to 19 in FY 2014, and the use of the 1915(i) HCBS State Plan option is also becoming more widespread, growing from 10 states in FY 2012 to an expected 16 by the end of FY 2014. However, state adoption of the Community First Choice (CFC) option has been limited, in part due to the lack of final federal regulations until May 2012. To date, only California and New York have implemented the option; however, seven states (Arkansas, Maryland, Minnesota, Montana, Oregon, Texas, and Wisconsin) reported plans to implement the CFC option in FY 2014. Under the CFC option, states providing Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

4. Improvements in the economy have enabled states to implement more program restorations or improvements in provider rates and benefits compared to restrictions, but states also adopted policies to control costs and enhance program integrity.

Largely due to improvements in the economy, more states adopted increases or enhancements to provider rates or benefits than restrictions in FY 2013 and FY 2014. A total of 40 states in FY 2013 and 44 states in FY 2014 adopted provider rate increases compared to 39 states in FY 2013 and 34 states in FY 2014 reporting restrictions. This trend was true across all major provider groups (physicians, managed care organizations and nursing homes) except hospitals. While implementation has been challenging, states reported that the federally funded increased payments to primary care providers required by the ACA have begun. For benefits, a number of states were able to expand or restore cuts to home and community-based services, dental care and behavior health; however, a smaller set of states made targeted restrictions largely in these same areas. As in previous years, efforts to manage prescription drug costs are on-going. About half the states continue to take steps to refine their pharmacy programs. Frequently cited focus areas include refinements to PDL and supplemental rebate programs, utilization or reimbursement initiatives relating to specialty and physician administered drugs, managed care-related changes including efforts to "carve-in" the pharmacy benefit into capitated manage care arrangements as well as continued state interest in adopting the "Actual Acquisition Cost" reimbursement methodology for ingredient costs. (ES-7) States also reported on an array of new program integrity initiatives including the use of advanced data analytics and predictive modeling, enhanced provider screening and data sharing initiatives.



5. Looking ahead, FY 2014 will be a transformative year for Medicaid.

At the start of FY 2014, Medicaid directors were relieved to have weathered the storm of the economic downturn while striving to minimize adverse impacts on the beneficiary population and, in some cases, restoring earlier program cuts. State Medicaid programs are dynamic and evolving, but never more so than looking ahead to 2014 and beyond. The scope and volume of change related to the implementation of the ACA, payment and delivery system reforms as well as controlling costs create enormous opportunities and challenges. These changes have placed intense pressure on Medicaid agencies that have already been operating with limited resources due to the effects of the recent recession. States face additional challenges and uncertainty as the federal budget and debt ceiling debate go unresolved and federal deficit reduction efforts loom. Notwithstanding intense challenges, Medicaid faces new opportunities to make improvements in program administration that underpin improvements in delivery systems, quality, outcomes and coverage.

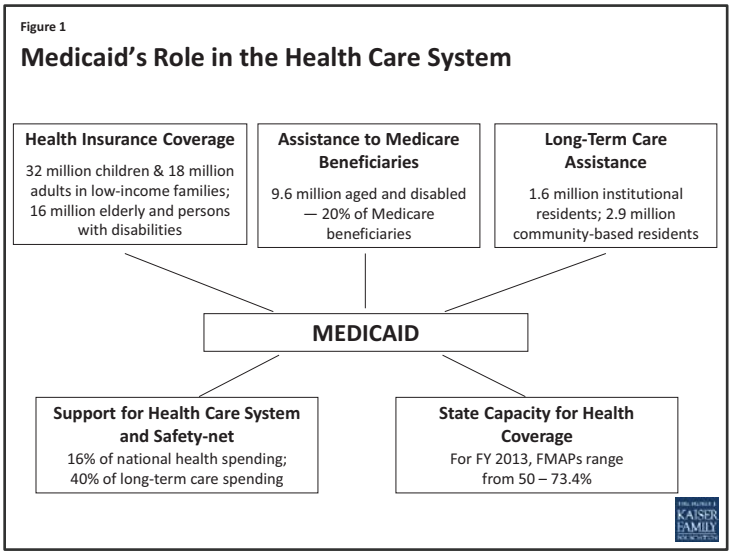
BACKGROUND

1. Medicaid Today

Medicaid serves multiple roles in the health care system. Medicaid provides health and long-term care coverage to more than 66 million low-income Americans including 32 million low-income children, nearly 18 million adults and 16 million elderly and people with disabilities.[1] The program also provides assistance for over 9.5 million low-income Medicare beneficiaries (dual eligible beneficiaries or "duals") who rely on Medicaid to pay Medicare premiums and cost-sharing and to cover benefits Medicare does not cover, especially long-term care. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all U.S. health care spending, 40 percent of long-term care expenditures, and critical funding for a range of safety-net providers. Medicaid also supports state capacity to finance health coverage. (Figure 1)

Figure 1

Medicaid's Role in the Health Care System

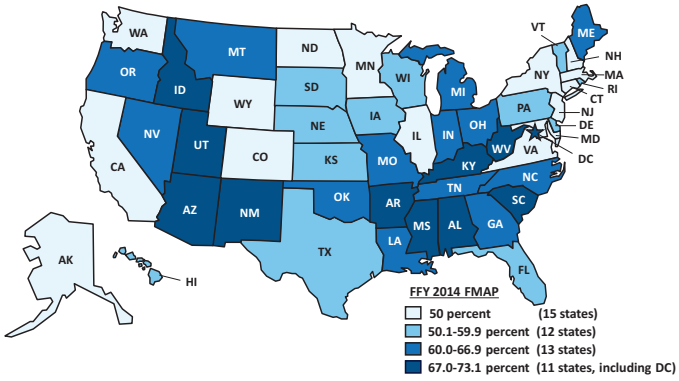


States administer Medicaid within broad federal guidelines. Within federal guidelines, states have flexibility to decide who qualifies for coverage, what benefits to cover, how much to pay Medicaid providers, and how to deliver care (through managed care or another delivery system model).[2]

Medicaid is financed by states and the federal government. The Medicaid program is jointly funded by states and the federal government. In federal fiscal year (FFY) 2011, total Medicaid expenditures totaled to nearly $414 billion. The federal government guarantees matching funds (FMAP) to states for qualifying Medicaid expenditures (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 which is based on a state's average personal income relative to the national average. States with lower average personal incomes have higher FMAPs. Personal income data are lagged, so data used for FY 2014 FMAPs are from the three years of 2009 to 2011. According to the statutory formula, for FFY 2014, the FMAP varies across states from a floor of 50 percent to a high of 73.05 percent. (Figure 2)

Figure 2

Federal Medicaid Matching Rates, FFY 2014

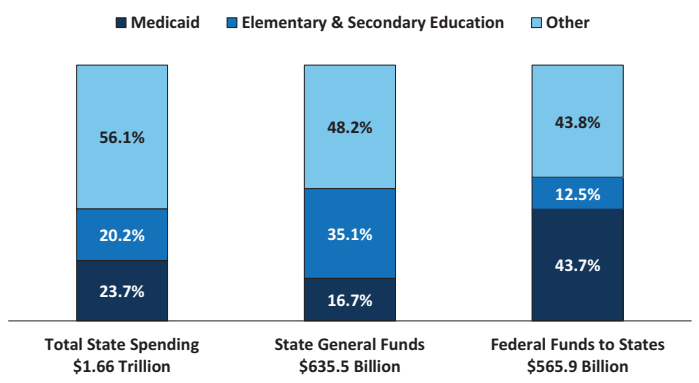


NOTE: FMAP percentages are rounded to the nearest tenth of a percentage point. These rates are in effect Oct. 1, 2013-Sept. 30, 2014.
SOURCE: Federal Register, November 30, 2012 (Vol. 77, No. 231), pp 71420-71423, at http://www.gpo.gov/fdsys/pkg/FR-2012-11-30/html/2012-29035.htm.

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, incomes and economic activity. The economic impact of Medicaid in each state 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; conversely, to save $1 in state funds a state must cut at least $2 in program spending. Federal Medicaid dollars represent the single largest source of federal grant support to states, accounting for an estimated 44 percent of all federal grants to states in FY 2011. On average, states spent almost 17 percent of their own funds on Medicaid, making it the second largest program in most states' general fund budgets following spending for elementary and secondary education, which represented 35 percent of state spending in FY 2011. (Figure 3)

Figure 3

Share of Medicaid Spending by Funding Source, FY 2011

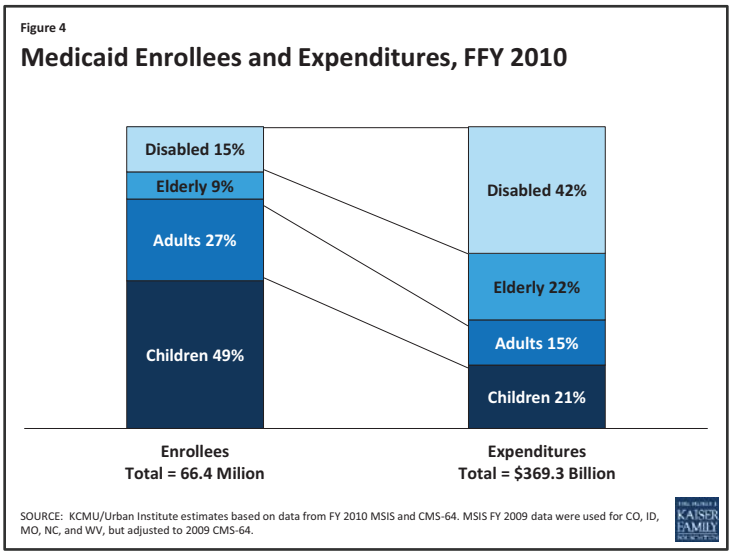


SOURCE: Actual FY 2011 data reported in: State Expenditure Report. NASBO, December 2012.

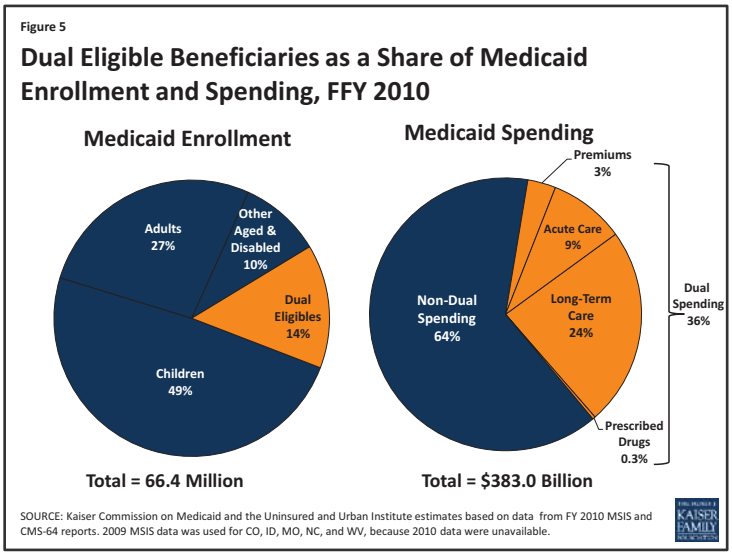
Medicaid is a counter-cyclical program so when there is an economic downturn, Medicaid enrollment and spending rise. During an economic downturn individuals lose jobs, incomes decline, and more people qualify and enroll in Medicaid which increases program spending. At the same time, increases in unemployment have a negative impact on state tax revenues, making it even more difficult for states to pay their share of Medicaid spending increases. As economic conditions improve, pressure on Medicaid enrollment and state budgets has lessened.

In an effort to boost an ailing economy, Congress enacted and President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The single most significant source of fiscal relief to states in the ARRA was a temporary increase in the federal share of Medicaid costs. 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. To be eligible for the ARRA funds, states could not restrict eligibility or tighten enrollment procedures to make it more difficult to obtain and retain coverage. The ARRA-enhanced matching rates provided states with over $100 billion in total funds over 11 quarters, ending in June 2012. The increased federal funds allowed state spending of their own funds on the program to fall, the only declines in state spending on Medicaid in the program's history. When the matching rate enhancements expired in June 2012, states had to replace the lost federal support with increased state spending.

Half of Medicaid enrollees are children, but most Medicaid spending is for the elderly and people with disabilities. Over three-quarters of Medicaid beneficiaries are children and non-disabled adults, mostly parents. The elderly and people with disabilities represent just one-quarter of enrollees, but account for almost two-thirds of program spending because these groups tend to have higher utilization of acute care services 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 (54 percent) of program spending.



Dual eligible beneficiaries account for 14 percent of Medicaid enrollees, but account for 36 percent of costs. Over 9.5 million elderly and persons with disabilities rely on both the Medicare and Medicaid programs to obtain needed health and long-term care services and supports. These dual eligible beneficiaries accounted for only 14 percent of Medicaid enrollment, but 36 percent of Medicaid spending in FFY 2010. (Figure 5) These same people accounted for 20 percent of Medicare enrollment and 33 percent of Medicare spending in 2009.[3] This population relies on Medicaid to pay Medicare premiums and cost-sharing, and to cover benefits not covered by Medicare, such as LTSS. In 2006, prescription drug coverage for dual eligible beneficiaries was transitioned from Medicaid to Medicare Part D, but states still finance part of this coverage through a payment often called the "Clawback." Many states are focused on efforts to improve coordination between Medicare and Medicaid and across acute and long-term care to achieve savings and better quality of care for this group.



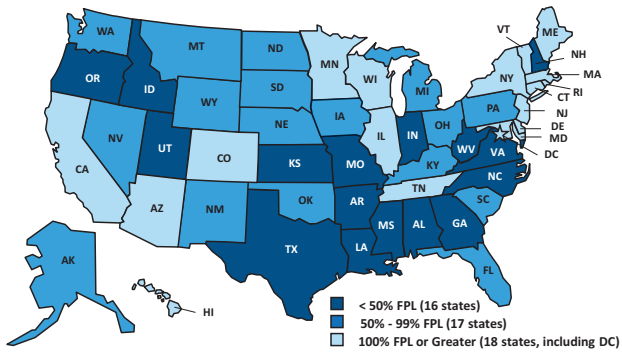
Today, eligibility levels vary significantly across states, especially for adults. To be eligible for Medicaid today, ahead of the coming ACA eligibility changes, individuals must meet income and resource requirements and must also fall into one of the categories of eligible populations. The federal government sets minimum eligibility levels for coverage, and then states have the option to expand eligibility to higher incomes. As of January 2013, all but four states (Alaska, Idaho, North Dakota and Oklahoma) set Medicaid/CHIP income levels for children at or above 200 percent FPL. Meanwhile, median coverage for the elderly and those with disabilities is about 75 percent FPL (tied to the levels for Supplemental Security Income).

Medicaid coverage for non-disabled adults ahead of the ACA Medicaid expansion varies significantly. As of January 2013, 33 states set parent eligibility levels below the poverty level, with 16 states limiting eligibility for parents to less than half the poverty level. (Figure 6)

Medicaid coverage for adults without dependent children is even more limited than for parents. Prior to the passage of the ACA, states could not receive federal Medicaid matching funds to cover non-disabled adults without dependent children; states could only cover these adults if they obtained a waiver or through a fully state-funded program. Effective April 2010, the ACA gave state flexibility to expand Medicaid to adults to get an early start on the 2014 Medicaid expansion. As of January 2013, only nine states, including DC, provide full Medicaid coverage to adults without dependent children, and enrollment is closed in two of these states. Sixteen states provide more limited coverage to adults without dependent children with enrollment closed in seven of these states.

Figure 6

Medicaid Eligibility for Working Parents by Income, January 2013

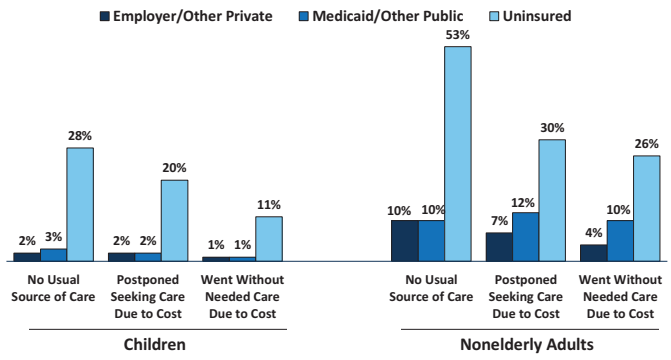


NOTE: The federal poverty line (FPL) for a family of three in 2013 is $19,530 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013, updated to reflect eligibility restrictions in Maine as of March 2013.

Medicaid provides affordable and comprehensive benefits reflecting the health and long-term care needs of the population it serves. Medicaid provides a comprehensive benefit 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 such as transportation, durable medical equipment, case management, and habilitation services, that are often not covered by private insurance today.[4] Medicaid also provides protections against high out-of-pocket expenses by prohibiting or limiting premiums and cost-sharing requirements. On important measures of access to primary care, Medicaid enrollees fare as well as those with private health insurance, even though they are sicker and more disabled. (Figure 7) Accounting for the health care needs of its beneficiaries, Medicaid is a low-cost program with lower per capita spending than private insurance.

Figure 8

Access to Care by Health Insurance Status, 2011

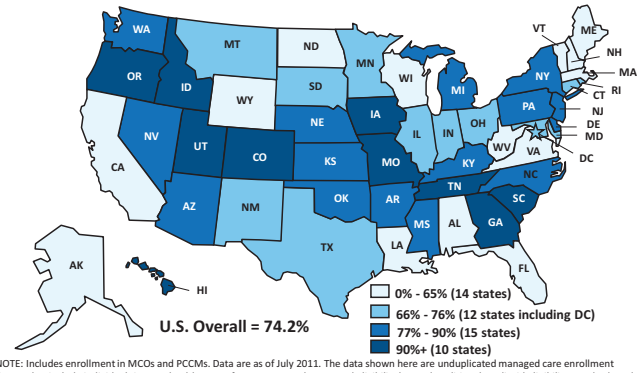


NOTES: In past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).
SOURCE: KCMU analysis of 2011 NHIS data.

Most Medicaid enrollees receive care through managed care arrangements. Nearly three-fourths of Medicaid enrollees receive care through managed care arrangements. (Figure 8) A large majority of states contract with managed care organizations to provide comprehensive services and a provider network for many of their beneficiaries. States have used managed care – including risk-based, capitated models as well as primary care case management (managed fee-for-service models) – to improve access to primary care, restrain costs and implement an array of quality improvement initiatives for Medicaid.

Figure 7

Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, July 2011

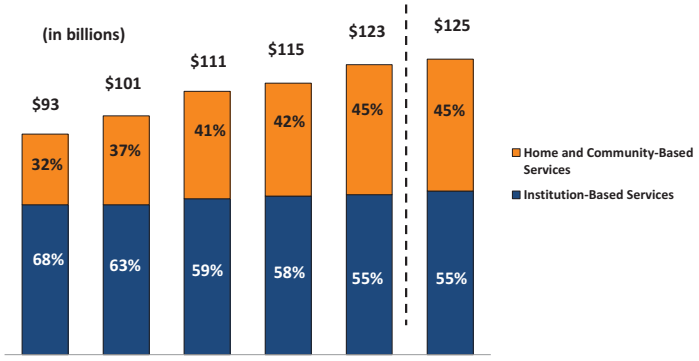


NOTE: Includes enrollment in MCOs and PCCMs. Data are as of July 2011. The data shown here are unduplicated managed care enrollment figures that include individuals in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards and enrollees receiving comprehensive and limited benefits.
SOURCE: Medicaid Managed Care Enrollment Report, CMS, November 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

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 services and supports (LTSS) 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 LTSS represents just under a third of total Medicaid spending. Medicaid has evolved to become the primary payer for LTSS and supports to low-income individuals. Over the past two decades, spending on Medicaid home and community-based services (HCBS) has been growing as more states attempt to reorient their long-term care programs by increasing access to HCBS options. In FY 2011, spending on HCBS accounted for 45 percent of total Medicaid long-term care spending, up from 32 percent in FFY 2002. (Figure 9)

Figure 9

Growth in Medicaid Long-Term Services and Supports Expenditures, 2002 - 2011



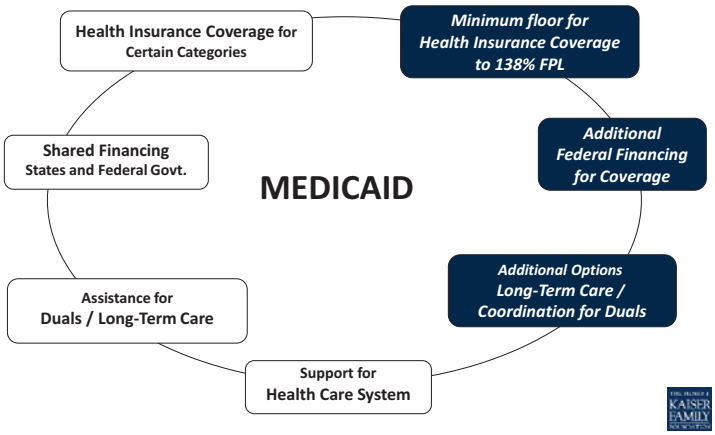
NOTE: Home and community-based care includes state plan home health, state plan personal care services and § 1915(c) HCBS waivers. Institutional care includes intermediate care facilities for individuals with intellectual/developmental disabilities, nursing facilities, and mental health facilities.
SOURCE: KCMU and Urban Institute analysis of CMS-64 data.

2. The Affordable Care Act and Medicaid

On March 23, 2010, President Obama signed into law comprehensive health reform, the Patient Protection and Affordable Care Act (ACA; Public Law 111-148.) The law expands options for affordable health insurance coverage through a Medicaid eligibility expansion and the creation of new Health Insurance Marketplaces (also referred to as Exchanges) that will offer subsidies to moderate-income individuals who do not have access to affordable employer-sponsored insurance to purchase coverage. Under the law, employer sponsored coverage will remain the dominant source of coverage for most Americans. The ACA bolsters coverage by requiring individuals to have health insurance and by making changes to the health insurance markets designed to protect consumers. The ACA 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 of dual eligible beneficiaries (Figure 10).

Figure 10

Medicaid Before and After Implementation of the ACA

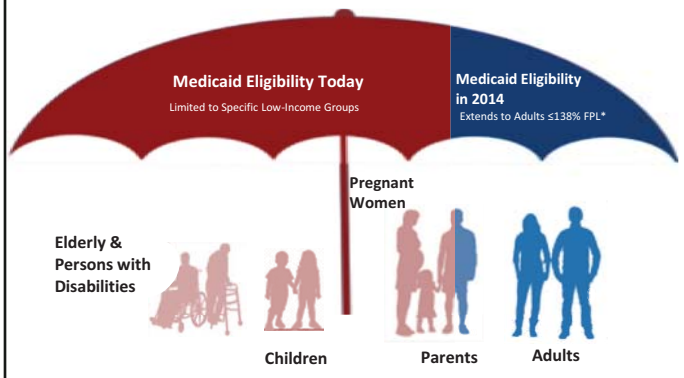


The Medicaid Expansion and the Supreme Court Decision. As enacted in the ACA, Medicaid eligibility would expand to nearly all low-income people under age 65 with incomes up to 138 percent of the federal poverty level ($15,856 for an individual or about $26,951 for a family of three in 2013) as of January 1, 2014. This expansion would make millions of parents and adults without dependent children newly eligible for the program. (Figure 11) For most Medicaid enrollees, income will be based on the Modified Adjusted Gross Income (MAGI) financial methodology without an asset or resource test.

On June 28, 2012, the United States Supreme Court issued its decision about the constitutionality of the ACA Medicaid expansion in National Federation of *Independent Business (NFIB) v. Sebelius*. The Supreme Court ruling maintains the Medicaid expansion but limits the Secretary's authority to enforce it. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. This decision in effect makes the Medicaid expansion optional for states. The Court's decision focuses only on the ACA's Medicaid expansion, defined as coverage of adults under age 65 with incomes up to 138 percent FPL; other provisions of the law are not affected.

Figure 11

Medicaid Eligibility Before and After Implementation of the ACA Medicaid Expansion



NOTE: The June 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius maintained the Medicaid expansion, but limited the Secretary's authority to enforce it, effectively making the expansion optional for states. 138% FPL = $15,856 for an individual and $26,951 for a family of three in 2013.

Along with changes in eligibility, the ACA requires simplified and coordinated processes to enroll in health coverage for both Medicaid and the Marketplace. Regardless of whether a state chooses to implement the Medicaid expansion, it must meet new requirements for web-based, paperless, real-time Medicaid eligibility and enrollment processes that take effect January 1, 2014. States also will need to shift to a uniform income eligibility standard (MAGI) for most coverage groups and coordinate closely with the new Marketplaces to

establish a "no wrong door" enrollment approach, so that, regardless of a person's point of entry (i.e., a Marketplace or state Medicaid agency), eligibility is determined for all insurance affordability programs. For states, these changes will represent a huge transformation of their current systems. Due to changes in enrollment processes, increased outreach and program awareness, the ACA is expected to result in more people who are already eligible for Medicaid under current rules learning about and signing up for coverage.

Financing. The ACA 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 federal matching rate for individuals already eligible for Medicaid prior to the ACA. States that already expanded coverage to adults to at least 100 percent FPL prior to the ACA (referred to as expansion states), receive an "expansion" or "transition" matching rate that provides a phased-in increase in their federal match rate for adults without dependent children so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults in other states.

The fiscal impact of the Medicaid expansion decision varies across states. A report prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured estimates that if all states expanded Medicaid, the total cost of the expansion would be about $1 trillion over the 2013-2022 period, with the federal government paying $952 billion (93 percent) and the states paying up to $76 billion. State costs are related to increased participation among those currently eligible for coverage (reimbursed at the traditional Medicaid match rate) and a small share for those newly eligible (up to 10 percent by 2020). Increased participation in Medicaid is likely to occur even if a state chooses not to implement the ACA Medicaid expansion due to national outreach and enrollment activities as well as requirements to simplify and streamline the enrollment process and to coordinate enrollment for the Marketplace, Medicaid and CHIP.

States are also likely to see net savings or offsets to costs from the Medicaid coverage expansion from: reduced state spending for uncompensated care; the transition of current Medicaid coverage for specific groups to the "newly eligible" category at the higher match rates; individuals previously eligible for Medicaid with incomes above 138 percent FPL moving to coverage in the Marketplace; or reduced spending for programs that serve indigent populations (such as state-funded mental health or substance abuse programs.) States could also see increased revenue from broader economic effects such as increased jobs, income and state tax revenues in the healthcare sector and beyond.

Benefits and Access. The ACA provides all newly-eligible adults with a benchmark benefit plan or benchmark-equivalent plan that meets the minimum essential health benefits (EHBs) available in the Health Insurance Marketplaces. The ACA makes other important changes to Medicaid benefits and access such as: increasing Medicaid payments for primary care to 100 percent of the Medicare rates for 2013 and 2014 with 100 percent federal financing for the increase; 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 pilots for health homes and other delivery system reforms.

Long-Term Care. The ACA also includes new options to provide long-term care services and supports including the Community First Choice (CFC) Option, the Balancing Incentive Program (BIP), and the HCBS State Plan Option. The CFC allows states to provide community-based attendant supports and services to individuals with incomes up to 150 percent FPL who require an institutional level of care through a state plan amendment and provides states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. The BIP makes enhanced Medicaid matching funds available to states that meet certain requirements for expanding the percentage of LTSS spending for HCBS (and reducing the percentage of LTSS spending for institutional services).[5] Funding is available through September 2015. The ACA expands the authority for states to offer HCBS through a state plan under the 1915(i) option. In addition, the ACA extends funding for Medicaid Money Follows the Person Rebalancing Demonstration Program through 2016. The law requires the Secretary to improve coordination of care for dual eligible beneficiaries through a new office within the Centers for Medicare and Medicaid Services.

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 and track trends in Medicaid spending, enrollment and policy making. This is the thirteenth annual report based on these surveys, conducted at the beginning of each state fiscal year from FY 2002 through FY 2014. In addition, eight mid-year surveys have been conducted during state fiscal years 2002-2004 and 2009-2013, when many states faced budget shortfalls and were forced to consider mid-year Medicaid policy changes.[6] Findings from previous surveys are referenced in this report when they help to highlight trends.

The KCMU/HMA Medicaid survey on which this report is based was conducted from June through August 2013. The survey instrument (in Appendix C) was designed to document policy actions states implemented in state FY 2013 and adopted for FY 2014 (which began for most states on July 1, 2013.[7]) The Medicaid budget for FY 2014 had been adopted by all states at the time each survey was completed. Each survey is designed to capture information consistent with previous surveys, particularly for spending trends, enrollment, eligibility, provider payment rates, benefits, long-term care and managed care. As with prior years, questions were added to address specific current issues, such as state actions to implement health reform in 2013 and 2014.

Medicaid directors and 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 2013. All 50 states and DC completed surveys and participated in telephone interview discussions in July and August 2013. The telephone discussions are an integral part of the survey to ensure complete and accurate responses and to record the complexities of state actions. For most states, the interview included the Medicaid director as well as Medicaid policy or budget staff.

The focus of the annual survey is on Medicaid policy changes and new initiatives that are implemented, or are adopted and planned for implementation. This survey asked state officials to describe policy changes that occurred in FY 2013 and those adopted for implementation for FY 2014.The survey does not attempt to catalog all Medicaid policies. Experience has shown that adopted policies are sometimes delayed or not implemented, for reasons related to legal, fiscal, administrative, systems or political considerations, or due to delays in approval from CMS. Policy changes under consideration are not included in the survey.

Annual rates of growth for Medicaid spending and enrollment are calculated as weighted averages across all states. For FYs 2012 through 2014, average annual Medicaid spending growth was calculated using weights based on the most recent state Medicaid expenditure data for fiscal year 2011, based on estimates prepared for KCMU by the Urban Institute using CMS Form 64 reports, adjusted for state fiscal years. These data were also used for historic Medicaid spending. Medicaid enrollment annual average growth rates were calculated using weights based on state enrollment data for June 2012.[8]

This report includes four state Medicaid case studies (in Appendix B), for Arizona, Florida, Kentucky and Washington. These profiles illustrate state Medicaid policy changes and new initiatives as well as the fiscal and political context in these specific states in FY 2013 and FY 2014.

SURVEY RESULTS FOR FISCAL YEARS 2013 AND 2014

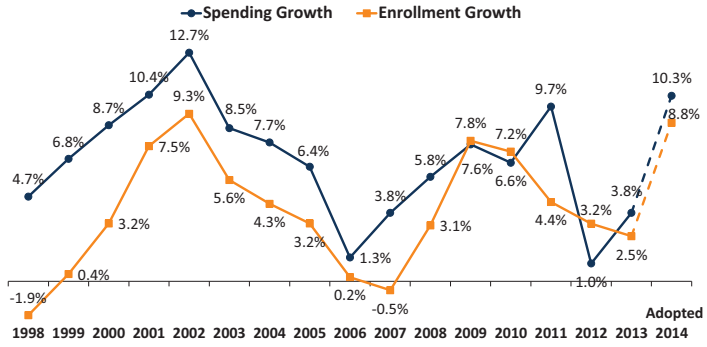
1. Medicaid Spending and Enrollment Growth Rates

Key Section Findings:

- Headed into state fiscal year 2014, economic conditions were improving as states continue to recover from the Great Recession. States have seen 14 consecutive quarters of year over year tax revenue growth; however, economists caution that recent growth may be artificially high.[9] At the same time, the national unemployment rate continues to decline slowly. Despite 42 months of private-sector job growth, there were still 1.9 million fewer jobs in August 2013 than when the recession began and an estimated 11.3 million people were unemployed. As economic conditions have started to improve, pressure on Medicaid enrollment and state budgets has lessened. However, states are concerned about the slow pace of recovery as well as potential deficit reduction actions at the federal level.
- FY 2013 total Medicaid spending increased at an annual rate that averaged 3.8 percent across all states, a relatively modest increase compared to historical growth rates. Actual spending growth of 3.8 percent matched the original legislative appropriations for FY 2013. The state share of Medicaid spending increased by 3.1 percent in FY 2013.
- For FY 2014, legislatures authorized total spending growth that averaged 10.3 percent across all states. Among the 25 states that were moving forward with the Medicaid expansion at this time, the average annual growth in total Medicaid spending averaged 13.0 percent compared to 6.8 percent in states not moving forward. The large difference in total Medicaid spending growth across these groups reflects newly eligible enrollees, for which the costs are covered by the 100 percent federal funding.
- For FY 2014, the state share of Medicaid spending is expected to increase by 5.1 percent across all states. State spending growth was slightly lower for the 25 states that are moving forward with the Medicaid expansion (4.4 percent) compared to the remaining states (6.1 percent). Increases in state spending reflect costs related to increased participation among individuals currently eligible for Medicaid reimbursed at a state's regular Medicaid match rate. This will occur in all states, even those not moving forward with the expansion at this time, due to simplified, streamlined and coordinated enrollment processes as well as outreach efforts. The lower growth in the FY 2014 state cost among the 25 states that are moving forward with the expansion may be in part because most of the 25 states moving forward with the expansion indicated that the state would achieve net state savings from the expansion.
- Medicaid enrollment growth slowed in FY 2013 to 2.5 percent on average, the lowest rate of growth in six years since the since the start of the Recession and very close to original projections of 2.7 percent. For FY 2014, enrollment growth was projected to average 8.8 percent across all states. Among the 25 states that had opted to expand Medicaid at the time of the survey, enrollment growth was projected to average 11.8 percent tied to the expansion in coverage. For states that are not moving forward with the Medicaid expansion at this time, enrollment growth was projected to increase on average by 5.3 percent.

Figure 12

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2014



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

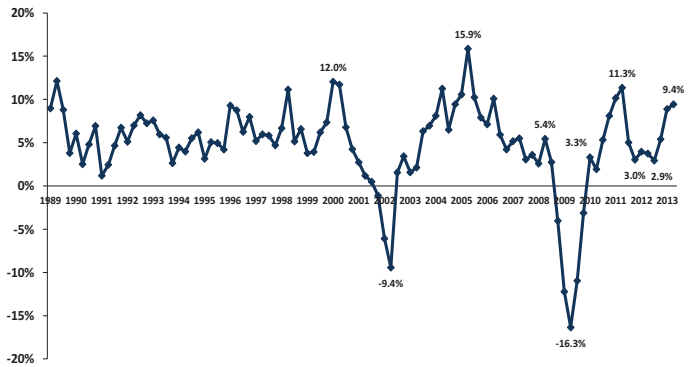
SOURCE: *Medicaid Enrollment June 2012 Data Snapshot*, KCMU, August 2013. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 - 2014 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

A. Current Fiscal Conditions

Headed into state fiscal year 2014, economic conditions have continued to improve but states are still recovering from the Great Recession. After experiencing the largest collapse in state tax revenues on record during the recessionary period, preliminary data from the US Census Bureau indicate total state tax collections grew by 9.4 percent in the second quarter of 2013 compared to the same period one year earlier, driven by the strongest quarter of growth in personal income tax revenue since the start of the Recession. While this marks the 14th consecutive quarter of year over year growth reflecting improvements in the economy, economists caution that growth for this quarter as well as the previous two may be artificially high due to actions taken at the end of the calendar year in response to the federal tax increases as well as a recent large tax increase in California.[10] (Figure 13)

Figure 13

State Tax Revenue, 1989 – 2013

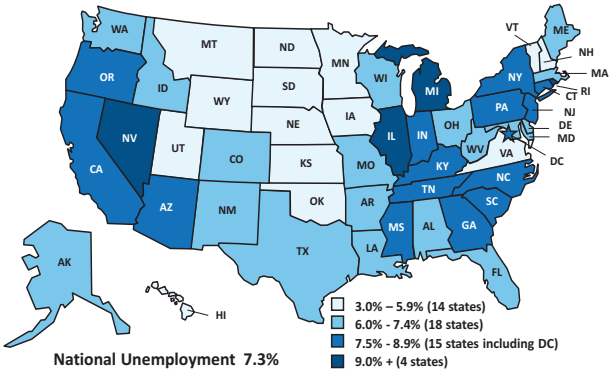


SOURCE: Percent change in quarterly state tax revenue, US Census Bureau. Updated September 30, 2013.

At the same time, the national unemployment rate fell to 7.3 percent in August 2013, having slowly but steadily declined from the national peak of 10.0 percent in October 2009, and is the lowest level since December 2008. However, despite 42 months of private-sector job growth, there were still 1.9 million fewer jobs in August 2013 than when the Great Recession began. An estimated 11.3 million people are unemployed, two-thirds of whom are long-term unemployed (those who have been actively looking for work for 27 weeks or longer.[11]) While unemployment has fallen in a number of states, four states had unemployment rates at or above nine percent in August 2013. (Figure 14) As economic conditions have started to improve, pressure on Medicaid enrollment and state budgets has lessened.

Figure 14

Unemployment Rates by State, August 2013



SOURCE: State figures from the Table 3, *Regional and State Employment and Unemployment: August 2013,* Bureau of Labor Statistics. (Figures are preliminary).

However, states are concerned about the slow pace of recovery as well as potential deficit reduction actions at the federal level. An automatic reduction (or sequester) in federal spending of $1.2 trillion went into effect in March 2013. Medicaid is exempt from the sequester cuts; however, cuts could be part of a future alternative deficit reduction package. Deficit reduction discussions are likely to resume this fall as Congress deals with authorizing funds to fund government operations post October 1, 2013, the extension of the debt limit and a budget for the federal fiscal year 2015. Federal changes to Medicaid could shift costs to states, beneficiaries or providers.

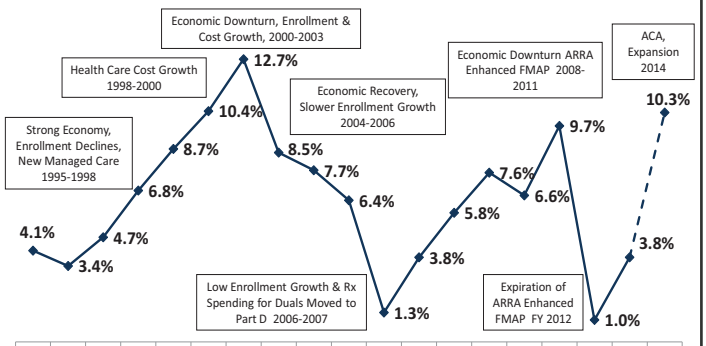
B. Total Medicaid Spending Growth

Total Medicaid spending includes all payments to Medicaid providers for Medicaid covered services provided to enrolled Medicaid beneficiaries. Included in total Medicaid spending are payments to "disproportionate share hospitals" that qualify for special "DSH payments" that subsidize the costs of care for persons on Medicaid or that are uninsured. Not included in total Medicaid spending are Medicaid administrative costs and state "Clawback" payments (the state obligation to finance a portion of the Medicare Part D prescription drug benefit for Medicare-Medicaid enrollees.) Total Medicaid spending includes payments financed from all sources, including federal matching funds, state funds and local contributions.

Historical Spending Growth. By its design, Medicaid spending and enrollment are counter-cyclical meaning that more individuals qualify for Medicaid when the economy suffers a downturn as unemployment rises and family incomes fall. Conversely, when the economy recovers and economic activity is robust, growth in Medicaid enrollment and spending slows. Changes in enrollment are generally the most significant driver of Medicaid spending; however, other important drivers include growth in overall health care costs and policy changes made within Medicaid programs.

Figure 15

Total Medicaid Spending Growth, FY 1996 – FY 2014



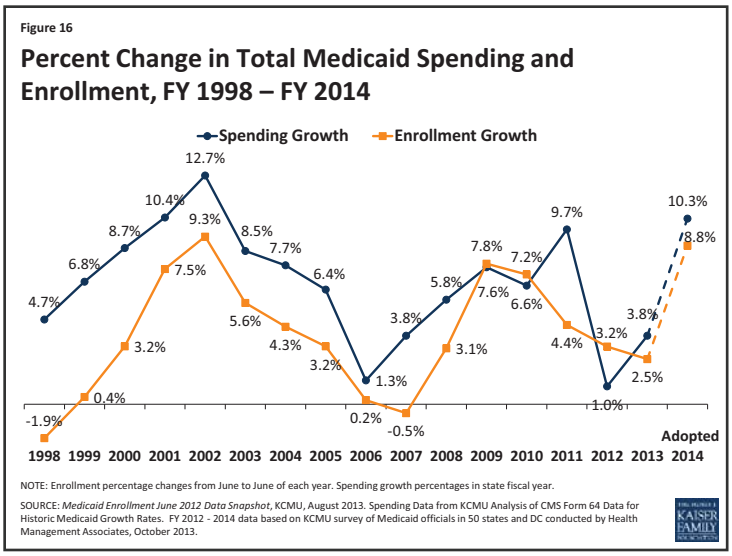
NOTE: Data for State Fiscal Years, for total Medicaid spending, including state, local, and federal funds.
SOURCE: For FYs 2000-2011 - Historic Medicaid Growth Rates, KCMU Analysis of CMS Form 64 Data; FYs 2012-2014 - KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2013.

During the economic downturn from 2001-2004, Medicaid spending growth peaked at over 12 percent in 2002 and then steadily declined. Medicaid spending growth hit a near record low of 1.3 percent in FY 2006 primarily due to the implementation of Medicare Part D, which shifted responsibility for the cost of prescription drugs for dual eligible beneficiaries from Medicaid to Medicare, but also tied to low enrollment growth during to a robust economy.

In the middle of SFY 2008, the economy dropped into a deep recession, causing Medicaid enrollment and spending growth to increase sharply. Responding to the dire fiscal situations across the states, the Congress adopted ARRA, which provided over $100 billion in fiscal relief to the states through higher federal Medicaid matching funds from October 2008 to June 2011, helping states support their Medicaid programs during a time of declining state revenues, high unemployment and high growth in Medicaid enrollment. State actions (such as shifting payment dates) to maximize the ARRA-enhanced FMAP before it expired contributed to high 9.7 percent growth for FY 2011 and the very low 1.0 percent growth for FY 2012.

FY 2013 Total Medicaid Spending Growth. In state fiscal year 2013, total annual Medicaid spending growth across all states averaged 3.8 percent. The 3.8 percent growth for FY 2013 was modest compared to historical spending patterns, but higher than the historic low 1.0 percent rate of growth in FY 2012, when the observed spending growth was influenced by state actions related to the end of the ARRA-enhanced FMAP in June 2011. Over half of states listed continuing improvement in the economy and slow enrollment growth as the primary factor contributing to the rate of Medicaid spending in FY 2013 (as discussed further in the next section.) Other factors influencing spending growth included benefit restorations or expansions, provider rate increases and overall health care inflation.

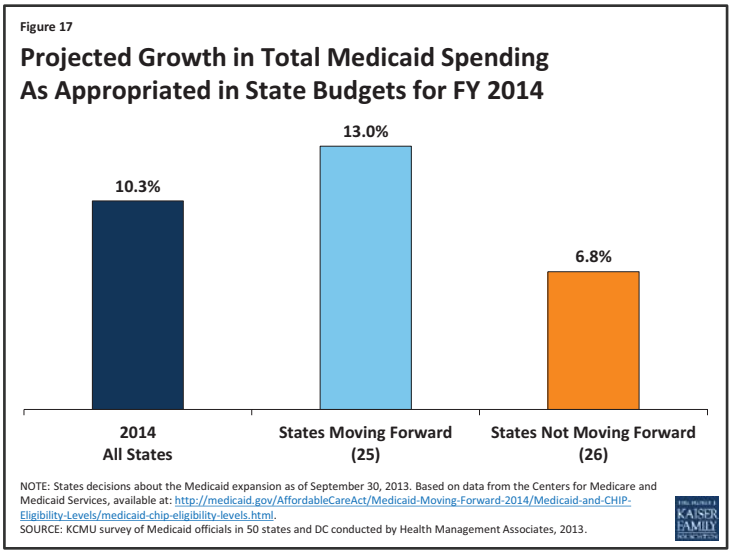
FY 2013 spending growth matched the original legislative appropriations that averaged growth of 3.8 percent. When surveyed mid-way through FY 2013, no state reported spending well above original projections and 39 states reported that their spending trend was about the same or below initial appropriations. This resulted in only three states that needed to make mid-year restrictions, and four states made mid-year expansions or restorations that were not adopted at the beginning of the fiscal year.[12]



FY 2014 Total Medicaid Spending Growth. The implementation of the ACA, state initiatives for delivery system reform or managed care, and targeted cost containment actions were the major drivers of Medicaid spending for FY 2014. Nearly all states expected to see higher enrollment, reflecting increases in participation among individuals currently eligible for coverage but not enrolled due to streamlined eligibility systems, referrals from the new Marketplaces and the expected stream of information about health reform that would raise awareness of insurance options, including Medicaid. State spending for these individuals would be matched at the regular Medicaid match rates. Across all states, legislatures adopted FY 2014 Medicaid budgets that authorized growth in total Medicaid spending that averaged 10.3 percent. (Figure 16)

Following the Supreme Court decision, states effectively can decide whether to implement the ACA Medicaid expansion up to 138 percent of the federal poverty level. States implementing the Medicaid expansion had to authorize appropriations that accounted for increases in federal funds tied to those made newly eligible for coverage. States will receive 100 percent federal matching dollars for individuals made newly eligible by the ACA expansion from January 2014 through December 2016; the federal match then phases down to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent in 2020 and each year thereafter.

Across the 25 states that are moving forward with the Medicaid expansion, the increase in total Medicaid spending averaged 13.0 percent for FY 2014. For most of these states, this growth includes one-half year of coverage at current eligibility levels (July through December 2013) and one-half year of expanded coverage (January through June 2014.)[13] Across the 26 states that are not moving forward with the Medicaid expansion at this time, legislatures authorized growth in total Medicaid spending for FY 2014 that averaged 6.8 percent. The large difference in total Medicaid spending growth across these groups reflects the 100 percent federal funding for newly eligible enrollees that states moving forward will receive for their newly eligible population. (Figure 17)



The vast majority of Medicaid officials believed that the amount of funding appropriated for FY 2014 would be adequate, a sharp contrast with expectations during the recent recession, when state budget shortfalls were commonplace, and a majority of Medicaid officials had expected a Medicaid budget shortfall in the upcoming fiscal year.

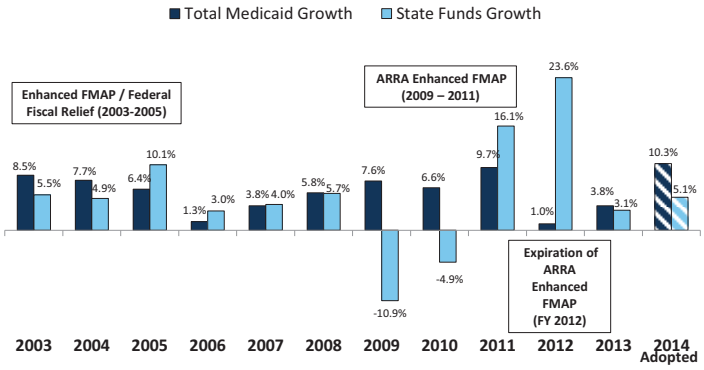
C. State Spending for Medicaid

Medicaid is financed with a combination of state funds and federal matching funds. The federal government provides matching funds to help pay for total Medicaid expenditures. State officials focus on the state general fund cost of Medicaid and the implications for federal funds (or revenue). Historically, state and federal Medicaid spending increase at similar rates. Differences between total and state spending growth rates are usually related to factors such as annual changes in the state-specific FMAPs, changes in contributions from local governments, special financing arrangements, provider taxes or tobacco tax funds.

Historical State Spending Growth. During each of the past two recessions, Congress enacted temporary enhancements to the FMAP to provide fiscal relief to states by reducing the state share of Medicaid spending. In 2003 and 2004, FMAPs were increased by 2.95 percentage points for five quarters, providing $10 billion in fiscal relief to states. The more recent recession was deeper, and the ARRA passed by Congress increased FMAPs by larger percentages, providing states with an additional $100 billion in federal funds over eleven quarters from October 2008 to June 2011. The magnitude of the enhanced federal financing allowed actual state spending on Medicaid to fall by 10.9 percent in FY 2009 and by 4.9 percent for FY 2010, even though total spending increased in each of these years. These are the only two years in the history of Medicaid when annual state fund spending on Medicaid decreased. (Figure 18) State efforts to maximize the ARRA-enhanced FMAP contributed to the relatively higher observed rate of growth in Medicaid spending for FY 2011. For FY 2012, the return to regular FMAP rates meant that states had to finance a higher share of program costs than one year earlier, and state fund costs increased dramatically (on average by 23.6 percent) relative to FY 2011. Some states adopted policy actions to mitigate the increase in the state cost of Medicaid, which also contributed to the low rate of growth in total Medicaid spending for FY 2012.

Figure 18

Total and State Funds Medicaid Spending Growth FY 2003 – FY 2014



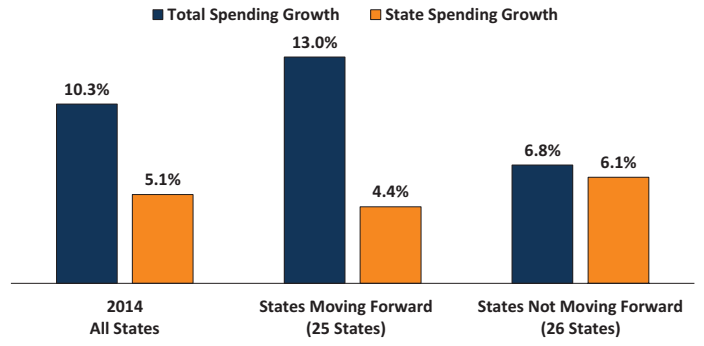
NOTE: State Fiscal Years.
SOURCE: For FYs 2000-2011 - Historic Medicaid Growth Rates, KCMU Analysis of CMS Form 64 Data; FYs 2012-2014 - KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

FY 2013 and FY 2014 State Spending Growth. Without the implications of the ARRA financing, the increase in state funds averaged 3.1 percent across all states for FY 2013, about the same pace as total spending growth of 3.8 percent.

For FY 2014, legislatures appropriated increases in the state share of Medicaid funding that averaged 5.1 percent (compared to 10.3 percent total growth.) (Figure 19) In accounting for the 5.1 percent growth in state costs, some states pointed to declines in the formula-driven FMAP as well as increased participation among individuals currently eligible for Medicaid but not enrolled as drivers of state spending for Medicaid. While states will receive 100 percent federal financing for those newly eligible under the ACA Medicaid expansion for 2014-2016, states will receive the regular Medicaid matching rate for those currently eligible for Medicaid, including the increased take-up or participation among this group.

Figure 19

Projected Growth in Total and State Medicaid Spending As Appropriated in State Budgets for FY 2014



NOTE: States decisions about the Medicaid expansion as of September 30, 2013. Based on data from the Centers for Medicare and Medicaid Services, available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

While total spending growth for the 25 states moving forward with the Medicaid expansion was higher compared to those not moving forward (13.0 percent compared to 6.8 percent), these states had lower rates of growth for state funds (4.4 percent compared to 6.1 percent). Most of the 25 states moving forward with the expansion indicated that the state would achieve net state savings from the expansion. State budget savings were most frequently attributed to reductions in spending for state funded services such as mental health, corrections health, uncompensated care or care from other state programs for the uninsured (including limited benefit programs) due to increased Medicaid coverage.

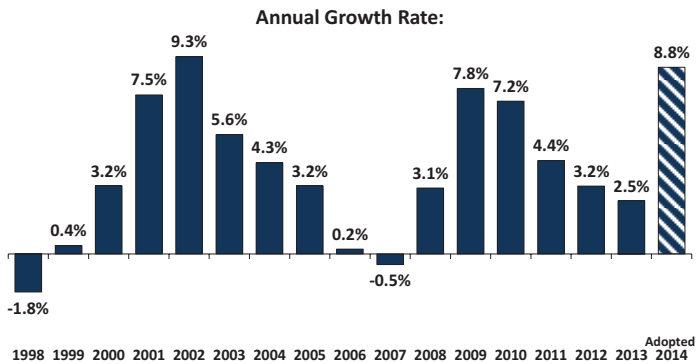
In some states the non-federal share of Medicaid spending includes both state and local funds.[14] The 2013 survey asked states to indicate if local contributions were mandatory to help finance Medicaid. A total of 21 states indicated that county or other local units of government were required by law to contribute to the non-federal share of Medicaid, although the survey did not capture the level of this contribution. Contributions are usually tied to services that historically were the responsibility of these local units of government, such as mental health, for which Medicaid had become a significant source of financing in recent years. In some cases, such as in New York and California, counties have had a long-standing role in financing Medicaid. As the fiscal burden has increased, the financing role of counties has become an issue in some states, such as Iowa, New York, and North Carolina, where state legislatures have enacted measures to phase down the local financial obligation for Medicaid, shifting it to the state level.

D. Medicaid Enrollment Growth

The number of individuals who enroll with Medicaid coverage is directly related to the economy as well as state policy changes. As a means-tested program, more persons enroll in Medicaid when the economy worsens, and enrollment growth slows when the economy improves. Enrollment growth peaked in 2001 and 2009 during economic downturns. In FY 2013, states experienced average enrollment growth of only 2.5 percent in large part reflecting a slowly improving economy. Growth of 2.5 percent represents the lowest rate of growth in six years, and the fourth year in a row that growth in the number of persons on Medicaid was less than in the previous year.[15] (Figure 20) The actual growth of 2.5 percent tracked closely with the 2.7 percent projected by states at the beginning of fiscal year 2013.[16]

Figure 20

Change in Medicaid Enrollment, FY 1998 – FY 2014



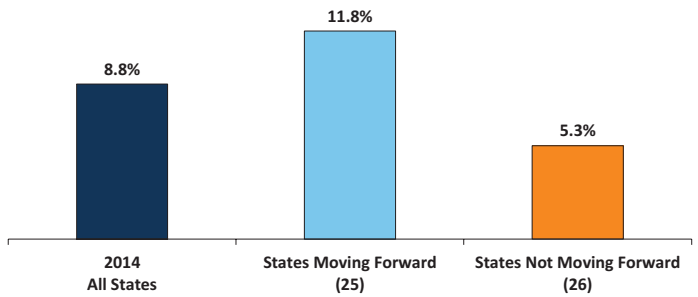
NOTE: Enrollment percentage changes from June to June of each year.
SOURCE: For 1998-2012, Medicaid Enrollment June 2012 Data Snapshot, KCMU, August 2013. FY 2013 and FY 2014 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

In FY 2013, Medicaid enrollment declined in 9 states, with the largest declines occurring in Arizona due the enrollment freeze for their adult without dependent children population and in Maine due to a reduction in coverage for parents from 200 percent FPL to 100 percent FPL beginning in March 2013. On the other end of the spectrum, Colorado experienced high enrollment growth in FY 2013 due to implementation of an eligibility expansion in FY 2012 for adults without dependent children.

For FY 2014, Medicaid enrollment growth is projected to grow across all states on average by 8.8 percent, reflecting primarily the impact of the changes in the ACA. Nearly all states, regardless of the state decision on the Medicaid expansion, reported anticipated increases in take-up among individuals currently eligible for coverage but not enrolled. For some states, these increases were significant. States not moving forward or still debating the expansion anticipated 5.3 percent growth. Only three states (Louisiana, Maine, and Wisconsin) projected that Medicaid enrollment would decrease in FY 2014. Each of these states is planning to reduce eligibility levels in FY 2014 (more details on these cuts can be found in the eligibility section.) States moving forward with the ACA Medicaid expansion reported anticipated average enrollment growth of 11.8 percent in FY 2014 due primarily to increased take-up as well as enrollment of newly eligible beneficiaries. California reported growth of 14.4 percent tied to the implementation of the ACA as well as transition of children in Healthy Families (CHIP) to Medicaid coverage. (Figure 21)

Figure 21

Change in Medicaid Enrollment, FY 2014



NOTE: States moving forward with the ACA Medicaid expansion reported anticipated growth due primarily to increased take-up as well as enrollment of newly eligible beneficiaries. California reported growth of 14.4 percent tied to the implementation of the ACA as well as transition of children in Healthy Families (CHIP) to Medicaid coverage. States decisions about the Medicaid expansion as of September 30, 2013. Based on data from the Centers for Medicare and Medicaid Services, available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

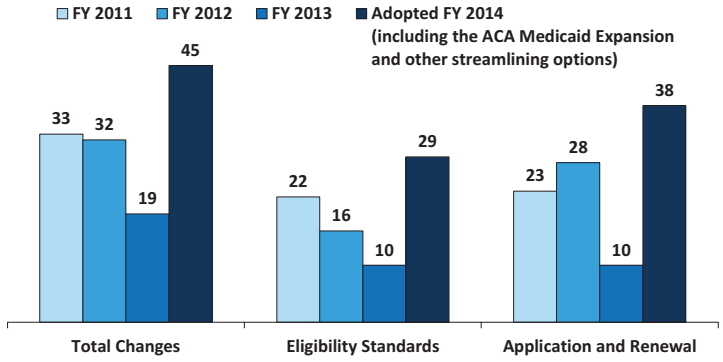
2. 2013 and 2014 Eligibility and Enrollment Changes including The Medicaid Expansion

Key Section Findings:

- Leading up to 2014, states were generally limited from making eligibility cuts or restrictions due to the maintenance of eligibility (MOE) provisions in the ACA, which helped to maintain coverage during the economic downturn. A total of 19 states made positive eligibility or enrollment changes during FY 2013. Ten states expanded eligibility standards and ten states simplified application and renewal processes (largely through the use of express lane eligibility and adding or enhancing online applications). Under an exemption to the MOE for states that cover adults with incomes above 133 percent FPL that are facing a documented budget deficit, five states reduced coverage for adults in FY 2013.
- In FY 2014, states will implement some of the most significant modifications to eligibility and enrollment standards in the Medicaid program's history. All states are required to transition to a uniform income eligibility standard using Modified Adjusted Gross Income (MAGI), transition children with income above 100 and up to 138 percent FPL from CHIP to Medicaid and implement new streamlined application, enrollment and renewal processes. While effectively a state option, the ACA calls for an expansion in Medicaid for nearly all adults up to 138 percent FPL.
- The most significant reported change in eligibility standards for FY 2014 is the Medicaid expansion. Twenty-five states are moving forward with the Medicaid expansion while 26 states are not moving forward at this time.[17] Additionally, eight states reported plans to implement eligibility expansions aside from the ACA Medicaid expansion. A record number of states (38) are simplifying application and renewal processes outside of the changes required by the ACA, largely by taking advantage of streamlined enrollment strategies outlined by CMS in May 2013. Combined, a total of 45 states are making positive eligibility expansions and enrollment simplifications outside of those required by the ACA.
- Thirteen states are implementing Medicaid eligibility restrictions in FY 2014; many people losing coverage from these restrictions in Medicaid eligibility will be eligible for subsidies to purchase coverage in the new Marketplaces.
- While states were in the process of reviewing regulations released in July related to benefits and the ACA, the vast majority of states planning to implement the Medicaid expansion in 2014 (21 of 25) reported plans to use the Secretary-approved coverage option to establish an Alternative Benefit Plan for the expansion population. Of these, three-quarters (16) reported plans to use the state's Medicaid State Plan adult benefit package and adjust the benefit as necessary to include all 10 Essential Health Benefits.

Figure 22

States With Eligibility Expansions / Enhancements FY 2011 – FY 2014



NOTE: Past survey results indicate adopted actions are not always implemented. Included in the counts for FY 2014 are states adopting the ACA Medicaid expansion as well as states adopting the enrollment streamlining options made available to states by CMS starting May 17, 2013.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011, October 2012 and 2013.

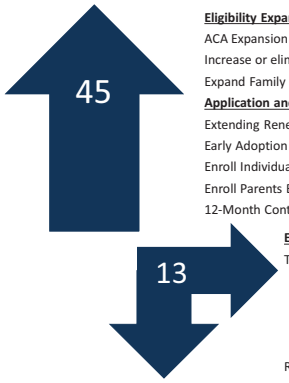
Each year this survey captures changes in eligibility and enrollment policies. Medicaid eligibility standards determine who can qualify for the program. The enrollment and renewal procedures outline how individuals who are eligible for Medicaid coverage access the program. The ACA has and will continue to have profound effects on Medicaid eligibility and enrollment. Since the enactment of the ACA, the Maintenance of Eligibility (MOE) provisions have helped to preserve eligibility standards and enrollment procedures during a time of economic downturn. States have also been able to take advantage of new options to expand coverage ahead of January 2014.

In FY 2014, states will implement some of the most significant modifications to eligibility and enrollment standards in the Medicaid program's history. As enacted in the ACA, Medicaid's role was broadening to become the foundation of coverage for nearly all non-elderly low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) ($15,856 per year for an individual in 2013). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. Beyond the expansion of Medicaid, all states are required to transition to a uniform income eligibility standard using Modified Adjusted Gross Income (MAGI), transition children with income above 100 and up to 138 percent FPL from CHIP to Medicaid and implement new streamlined application, enrollment and renewal processes. In addition to these changes, Medicaid agencies will be required to coordinate with new Marketplaces. Working with the new Marketplaces, states will provide outreach to educate people about new health care options and assist consumers in navigating the enrollment process.

States also reported adopting a wide array of eligibility and enrollment changes aside those required by the ACA. Figure 23 shows the number of states adopting eligibility standard changes as well as changes to enrollment procedures that are not required by law. For example, the conversion to MAGI and many enrollment simplifications are required and therefore not included in the counts in this section, but the decision to implement the Medicaid expansion and the take-up of optional enrollment simplification measures are included in the counts in this section. Responses to eligibility and enrollment changes are summarized below and captured in more detail in Appendix Tables A-1A and A-1B as well as Appendix Tables A-2A and A-2B.

Figure 23

FY 2014 Eligibility Standard and Application & Renewal Process Changes



Eligibility Expansions (29 states)
ACA Expansion (25 states)[1]
Increase or eliminate income or assets for LTC (4 states)
Expand Family Planning (2 states)

Application and Renewal Simplifications (38 states)
Extending Renewals Set for Q1 of 2014 (31 states)
Early Adoption of MAGI (15 states)
Enroll Individuals Based on SNAP eligibility (7 states)
Enroll Parents Based on Children's Income Eligibility (4 states)
12-Month Continuous (3 states)

Eligibility Transitions and Restrictions (13 states)
Transitioning Coverage from Medicaid to Marketplaces
Reducing eligibility for adults (10)
Reducing eligibility for family planning coverage (3)
Reducing Medicaid eligibility for pregnant women (2)
Eliminating Working Disabled Program (2)
Reducing coverage for Aged and Disabled groups (1)

NOTES: 1 – Three of the states moving forward with the expansion (DC, HI, and VT) had previously expanded to this group.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

A. Eligibility Standards

Medicaid 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 qualifies for health coverage under the Medicaid program. Major changes related to eligibility standards for FY 2014 are the conversion to a new income methodology that is required by the ACA, the requirement to align coverage for children up to 138 percent FPL, and the ACA Medicaid expansion which is now effectively a state option.

New Income Methodology. Effective January 1, 2014 the Medicaid income eligibility limits for most non-elderly non-disabled individuals will be computed based on Modified Adjusted Gross Income (MAGI). MAGI calculations are generally comparable to the adjusted gross income definitions used by the Internal Revenue Service with some modification, such as the addition of Social Security benefits as countable income. The complex income disregard rules currently used by most state Medicaid programs will be replaced by a single five percentage points of income disregard applicable if individuals are at the highest income limits for coverage.[18] This new methodology applies not only to the individuals who will be newly eligible for Medicaid due to the Medicaid expansion under the ACA, but also to currently eligible populations of parents, children, pregnant women and low-income adults.

Each state has been engaged with the federal government and its contractor to compute the MAGI equivalent values of their current income standards for pregnant women, parents, children, and other low-income adults (if applicable.) Relative to the conversion for pregnant women and children, the calculation of a MAGI equivalent income standard for parents is more complex because states allow for a variety of income disregards for this group and because income eligibility levels for different household sizes may not represent the same percentage of the federal poverty level.

The conversion to the MAGI methodology has significant implications for the application process in each state, including the information collected to determine eligibility, the definition of households and income, and for the design and structure of eligibility systems in each state. In responding to this survey, many states commented that the process for setting the new MAGI income thresholds was complicated. A number of states, especially those interviewed earlier on, were still in discussions with CMS regarding the conversion. Many states noted that they were relying on CMS calculations based on data from the Census Bureau's Survey of Income and Program Participation (SIPP) due to either limited time and resources or a lack of available timely state data. Subsequent to the survey, final MAGI converted eligibility income levels were published October 1, 2013 for all states.[19]

Some states, including those not implementing the Medicaid expansion, expect to see increases or decreases in enrollment due to the standardization of income limits under the MAGI methodology. Several states mentioned that the elimination of very specific income disregards will result in some individuals losing eligibility (who had high income disregards) while other individuals would gain eligibility due to the higher gross income threshold. The most commonly mentioned changes in how income would be counted were 1) child support and certain other unearned income that will no longer be counted (which generally will result in more people qualifying), and 2) step-parent income will now be counted (which will generally result in fewer people qualifying). In addition, states that currently use gross income with no disregards (most frequently for pregnant women) noted that more individuals will be eligible under MAGI. Most states indicated that the aggregate impact of the changes was hard to predict.

In addition, as of January 1, 2014, states can no longer place limits on allowable assets for low-income parents or apply a "deprivation" test where parents were only eligible for Medicaid if their child was deprived of parental care or support due to either living with only one parent, or not having at least one parent employed full time.

Because the conversion to MAGI and other eligibility standard changes are required, these changes are not counted as positive or negative eligibility changes in the survey.

Stairstep Children. The ACA requires that Medicaid cover children under age 19 with incomes up to 138 percent FPL (about $26,951 for a family of three in 2013) as of January 2014. Today, there are "stairstep" eligibility rules for children. States must cover children under the age of six in families with income of at least 133 percent FPL in Medicaid while older children and teens with incomes above 100 percent FPL may be covered in separate state Children's Health Insurance Programs (CHIP) or Medicaid at state option.[20] While many states already cover children in Medicaid with income up to 138 percent FPL, as required by the ACA, 21 states will need to transition some children from CHIP to Medicaid. New York and Colorado implemented an early transition of children from CHIP to Medicaid. New Hampshire and California moved or are in the process of transitioning all CHIP kids to Medicaid. The remaining 17 states will transition an estimated 13 to 48 percent of their CHIP kids.[21] Because the alignment of the stairstep children is required, these changes are not counted as positive or negative eligibility changes in the survey. (These changes did have some implications, especially for California, in Medicaid enrollment growth.)

FY 2013 Eligibility Changes

Leading up to 2014, states were generally limited from making eligibility cuts or restrictions due to the MOE provisions in the ACA, which helped to maintain coverage during the economic downturn. Despite the recession, states made a number of eligibility expansions in FY 2011 and FY 2012, taking advantage of options made available under the Children's Health Insurance Program Reauthorization Act (CHIPRA) or the ACA to expand coverage early as well as other limited expansions. However, activity in this area slowed a bit in FY 2013 as states were preparing for changes coming in FY 2014. Ten states expanded eligibility standards in FY 2013. Such expansions included expanded coverage for pregnant women, individuals needing long-term care, and family planning services. Additionally, two county-based expansions for adults without dependent children were implemented during this period in Cook County, IL and Cuyahoga County, OH.

At the same time, five states reduced coverage for adults in FY 2013. In general, these restrictions were made under an exemption to the MOE that allows states to restrict coverage for non-disabled, non-pregnant adults with incomes above 133 percent FPL if the state is facing a documented budget deficit. Specifically:

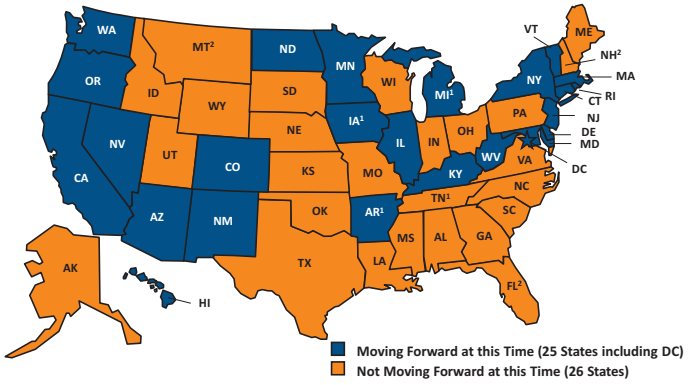
- **Hawaii** reduced income eligibility for non-pregnant adults from 200 percent to 133 percent FPL in July 2012, affecting approximately 5,000 individuals.
- **Illinois** reduced the income limit for parents from 185 percent FPL to 133 percent FPL in July 2012. The state also enhanced an asset transfer limit for individuals eligible for long-term care services.
- **Maine** reduced coverage for parents from 200 percent FPL to 133 percent FPL in March 2013. The state also reduced Medicare buy-in income levels by 10 percentage points for each category.
- **Minnesota** transitioned adults without dependent children with income between 200 percent FPL to 250 percent FPL from Medicaid waiver coverage to state-subsidies for private market coverage.
- **Wisconsin,** in July 2012, reduced eligibility for non-pregnant, non-disabled adults in BadgerCare Plus (both parents and adults without dependent children) to 133 percent FPL if they have access to employer-sponsored insurance and the premium contribution is at or below 9.5 percent of income, affecting approximately 7,100 individuals. The state also eliminated retroactive eligibility for non-pregnant, non-disabled adults in BadgerCare Plus with incomes between 133 and 150 percent FPL, affecting 7,600 individuals. The state also instituted a 12 month waiting period before individuals can attempt to reenroll if they fail to pay a premium, affecting approximately 1,830 individuals.

FY 2014 Eligibility Changes - Medicaid Expansion and Beyond

The most significant change in eligibility standards for FY 2014 is the Medicaid expansion. Twenty-five states are moving forward with the Medicaid expansion, while 26 states are not moving forward at this time. (Figure 24)

Figure 24

Current Status of State Medicaid Expansion Decisions

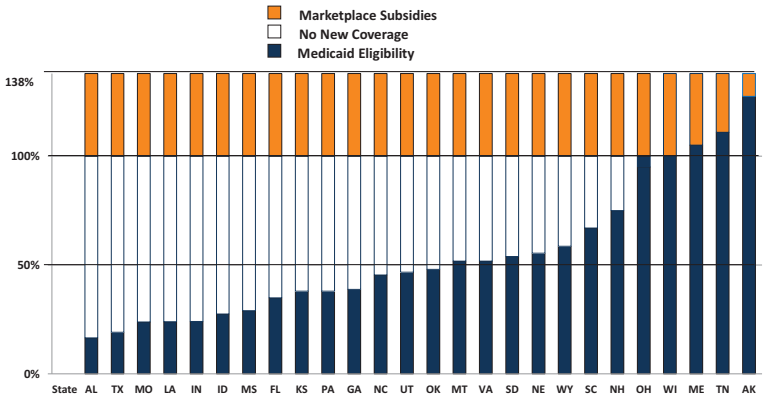


NOTES: 1 - Exploring an approach to Medicaid expansion likely to require waiver approval. 2- Discussion of a special session being called on the Medicaid expansion.
SOURCES: States decisions on the Medicaid expansion as of September 30, 2013. Based on data from the Centers for Medicare and Medicaid Services, available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

Most states (39) currently do not provide full Medicaid coverage for parents below the new Medicaid eligibility threshold. Only nine states offer comprehensive Medicaid coverage to adults without dependent children (often below the new eligibility threshold.) For nearly all states moving forward, the Medicaid expansion will result in increases in eligibility for parents and adults without dependent children. Almost all states that are not implementing the expansion will see large gaps in coverage for adults. (Figure 25)

Figure 25

Coverage Options for Parents as of January 2014 in States Not Moving Forward with the Medicaid Expansion at this Time



SOURCE: Based on data from the Centers for Medicare and Medicaid Services, available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

Additionally, in FY 2014, eight states are planning eligibility expansions apart from the Medicaid expansion:

- Three states plan to increase income and/or asset limits for long-term care or medically needy groups. (Florida, Louisiana, and New Jersey) Additionally, Arkansas reported plans to eliminate income and resources tests for the Workers with Disabilities group.
- Two states plan to expand family planning coverage. (New Hampshire and New York)
- California plans to maintain eligibility for former foster youth who age out of Medi-Cal at age 21 between July 2013 and January 2014, ahead of the ACA requirement in 2014.
- Wisconsin is planning to eliminate the current waiting list for its adults without dependent children waiver coverage, although they are also restricting Medicaid coverage for adults over 100 percent FPL.

Thirteen states are implementing Medicaid eligibility restrictions in FY 2014 which are described below. Changes that result in people losing Medicaid eligibility are counted as restrictions in this report. Most individuals that lose Medicaid eligibility with incomes above 100 percent FPL will be eligible for subsidies to purchase coverage through the Marketplace; individuals with incomes under 100 percent FPL in states that do not implement the ACA Medicaid expansion will generally be left with no option for coverage.

- Nearly half of states restricting Medicaid eligibility in FY 2014 are reducing their Medicaid eligibility levels to the new ACA floor of 138 percent FPL (Massachusetts, Minnesota, New Mexico, New York, Rhode Island, and Vermont.) Three of these states (Massachusetts, New York, and Vermont) are seeking to further subsidize coverage obtained through the Marketplace for individuals previously covered under their Medicaid programs. In Minnesota, parents with incomes above 200 percent FPL who have been covered under the MinnesotaCare waiver program will no longer be eligible for Medicaid coverage. However, the state plans to maintain existing Medicaid waiver coverage of individuals between 138 and 200 percent FPL at the state's regular matching rate.
- Four states (Indiana[22], Maine, Oklahoma, and Wisconsin[23]) not adopting the Medicaid expansion have plans to reduce current Medicaid waiver coverage to 100 percent FPL, below the new ACA floor of 138 percent FPL.[24] Individuals with incomes above 100 percent FPL will be eligible to purchase coverage through the Marketplace. Maine also reported plans allow their current waiver to expire, ending existing coverage for adults without dependent children.
- Three states are reducing eligibility for family planning coverage to 138 percent FPL (Illinois, New Mexico and Oklahoma); two states (Oklahoma and Louisiana) reported reducing eligibility for pregnant women down to 138 percent FPL. Additionally, Kentucky is eliminating its Working Disabled program, which currently covers individuals with disabilities up to 250 percent FPL; those with income above 138 percent FPL will be eligible for subsidies in the new Marketplace while the rest will remain in Medicaid as the state is implementing the ACA Medicaid expansion.
- Louisiana plans to eliminate optional coverage for aged and disabled individuals with incomes up to 100 percent FPL. However, those that qualify for Supplemental Security Income (SSI) will be eligible for Medicaid services. This restriction is estimated to affect 9,400 individuals. Louisiana also plans to restrict income and resources standards for their Medicaid Purchase Plan, coverage for individuals with disabilities who are working.

A number of states are phasing out or ending limited benefit programs such as breast and cervical cancer coverage, and "spend-down" eligibility. States noted that most individuals covered by these initiatives will have access to comprehensive coverage through the new ACA Medicaid adult eligibility group or the Marketplace, raising questions about whether there will still be demand for these programs.

For more information on eligibility and enrollment process changes in FY 2013 and FY 2014, see Appendix Tables A-1A and A-1B. Further description of the changes in both FY 2013 and FY 2014 is also located in Appendix Tables A-2A and A-2B.

B. Enrollment Procedures

The ACA requires states to implement new streamlined application and enrollment processes that will allow individuals to apply online, by phone, by mail, or in-person, use new MAGI-based income standards, and rely on electronic data matches to the greatest extent possible to verify eligibility criteria. In all states, implementation of these changes will result in at least some simplification compared to current Medicaid enrollment and renewal processes once fully implemented.

By January 1, 2014 at the latest, states are required both to have eligibility systems that interface with the Marketplaces and to use MAGI-based Medicaid eligibility rules for most non-elderly applicants and beneficiaries. Nearly all states indicated challenges related to timelines, resources, and guidance (either issued late or still outstanding.) Most states indicated that work was in progress to be ready by October 1, 2013 for their eligibility systems upgrades to both interface with the Marketplace and implement the new MAGI-based eligibility rules. However, a few states said they were targeting January 1, 2014 instead.

For states that planned to be up and running by October 1, most indicated that systems would likely not be perfect and there would likely be several "work-arounds" and issues that would be smoothed out over time. A few states noted that there will be more manual processing at the start or applications will not be processed in "real time" as they will when all system components are in place. A number of states indicated that they were working closely with federal officials to ensure they meet minimum compliance and, in some cases, states were developing "mitigation plans" with CMS. Challenges in meeting the new requirements have been exacerbated when states have a legacy eligibility system, a legacy MMIS system, or both.

Beyond changes required by the ACA, CMS sent a letter to state officials on May 17, 2013 offering several new options to states under expedited waiver authority that would further streamline application and renewal processes and facilitate the enrollment of individuals in the program.[25] While some states indicated interest and are pursuing implementation of one or more of these options, other states indicated that the options were released too late for consideration given implementation deadlines.

- The most popular option (with 32 states having already adopted or planning to adopt) is the extension of eligibility renewal dates for individuals who would otherwise have their eligibility status reexamined between January 1 and March 31, 2014. By moving these renewal dates forward, states reduce the workload during the period when new MAGI-based eligibility is being implemented. (As of October 1, 23 states have received CMS approval to implement.)[26]
- Fifteen states adopted or plan to adopt the option to use MAGI rules early, starting on October 1, 2013. States adopting this option will eliminate the need to operate both MAGI and non-MAGI rules at the same time for low income parents, children, and pregnant women between October 1, 2013 and January 1, 2014. (As of October, 13 states have received CMS approval to implement.)
- Seven states adopted or plan to adopt the option to enroll individuals in Medicaid based on the fact that they are receiving benefits from the Supplemental Nutrition Assistance Program (SNAP). (As of October, four states have received CMS approval to implement.)
- Three states plan to adopt the option to offer 12 months continuous eligibility for parents and other adults and one additional state is considering this option.[27] (As of October, no states have received CMS approval to implement.)
- Four states adopted or plan to adopt the option to enroll parents based on income data available from their children's eligibility application. (As of October, two states have received CMS approval to implement.)

Additionally, 10 states in FY 2013 reported enhancements or simplifications to their application and renewal processes. Such changes focused on implementation or expanded use of Express Lane Eligibility (ELE) (Colorado, Massachusetts, Oregon and South Carolina) and expansion or implementation of new online enrollment and renewal systems (Minnesota, North Dakota, South Dakota and West Virginia) as well as automated renewal processes and electronic data matching in advance of the ACA requirements.

In FY 2014, 6 states reported application and renewal simplifications outside of these ACA streamlining options, which included further expansion of ELE and implementing further simplifications beyond those required by the ACA, such as using future projected income for renewals (California), accepting client statements for current income (Nevada), expanding the use of prepopulated renewal forms statewide (Nebraska), and having an online application for non-MAGI groups as well as a dedicated application for long-term care (Connecticut.) No states in either year reported enrollment restrictions.

For more information on eligibility and enrollment process changes in FY 2013 and FY 2014, see Appendix Tables A-1A and A-1B. Further description of the changes in both FY 2013 and FY 2014 is also located in Appendix Tables A-2A and A-2B.

Coordination with the Marketplace. Under the ACA, states have new requirements to coordinate enrollment across health insurance programs (Medicaid, CHIP and the new Marketplaces). This survey asked states about the single streamlined application for health coverage programs, multi-benefit applications and how eligibility determinations will be coordinated across Medicaid and the Marketplace.

While it is a requirement that an individual be able to apply for Medicaid through a Marketplace, states may choose to have the actual determination of Medicaid eligibility performed by either a state agency responsible for Medicaid eligibility determinations or the Marketplace. On October 1, 2013, CMS reported how determinations would work for states with the Federally Facilitated Marketplace (FFM) and FFM Partnership models:

- 24 states have elected to have the Marketplace do an initial assessment of Medicaid eligibility and then allow the Medicaid agency to do the final determination, and
- 12 states indicated that the Marketplace will make final Medicaid eligibility determinations for MAGI-based eligibility groups, including seven states (Idaho, Louisiana, New Jersey, Pennsylvania, Tennessee, Texas and Wisconsin) where the FFM will be permitted to make final Medicaid eligibility determinations temporarily as a mitigation strategy while Medicaid eligibility system upgrades are completed.

Under the ACA, states are also required to have a single streamlined application that can be used to apply for Medicaid, CHIP, or Marketplace subsidies. The Secretary of the Department of Health and Human Services developed a template of the streamlined application that states can use. States have the option to develop, with approval, alternative streamlined applications. About half of the states indicated that they will have their own alternative streamlined application (although some states indicated that they are only making minor changes to the Secretary's application). The remaining states reported that they would use the Secretary's application or were undecided at the time of the interview.

While states are required to have a health-only application, states were also asked whether they would have a multi-benefit application that could be used by individuals applying for MAGI-based Medicaid and other assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Twenty-nine states indicated they would have a multi-benefit application, 12 will not, and eight are undecided.[28] Some states that are moving away from a multi-benefit application indicate that they hope to have an integrated application in the future. The differences in income rules between Medicaid, SNAP and TANF were cited as reasons for at least temporary suspension of availability of a multi-benefits application. A number of Medicaid directors indicated that they were implementing online applications in phases, the first phase being to develop an online application for Medicaid, incorporating the ACA changes; phase two would add other programs such as SNAP and TANF.

Outreach and Consumer Assistance. States were asked about marketing and outreach efforts related to the Medicaid expansion, and other consumer assistance initiatives. While there is a range of activity in these areas, many states were not able to provide funding for outreach and consumer assistance beyond the funding available through the State-Based or Federally-Facilitated Marketplaces.

Some state strategies to provide Medicaid enrollment assistance include hiring permanent or temporary staff, increasing funding for their enrollment assistance programs, relying on partner agencies and federally qualified health centers to assist applicants, training volunteer application assisters, operating expanded call centers or producing enrollment materials.

States were asked about marketing and outreach efforts specific to Medicaid and also whether Medicaid outreach was being coordinated with the Marketplace. More than half of states plan to do some form of Medicaid outreach although some of the Medicaid outreach is imbedded in marketing and outreach for the Marketplace. The scope of these efforts varies widely across states.[29] Some Medicaid agencies in states that are defaulting to a FFM specifically noted that there were challenges in learning about the marketing plans for the Marketplace.

C. Alternative Benefit Plans

In addition to asking about benefit policy changes (discussed in a later section), this year's survey asked the 25 states that are moving forward with the ACA Medicaid expansion about the Alternative Benefit Plans (ABPs) they are planning to offer the expansion population.

Since the passage of the DRA, states have been permitted, in the case of certain groups of Medicaid beneficiaries, to substitute their traditional Medicaid benefits with "benchmark" benefits that meet certain statutory requirements under Section 1937 of the Social Security Act. The ACA refers to Section 1937 to define the ABP that most adults in the newly eligible Medicaid population will receive, and adds requirements that Medicaid benefits under Section 1937 must include the ten "essential health benefits" (EHBs) that Qualified Health Plans (QHPs) in the Marketplaces must cover, and meet the mental health parity requirements that also apply to the QHPs.[30] States implementing the ACA Medicaid expansion in 2014 are required to enroll newly eligible adults in an ABP based on one of the four benchmark options:

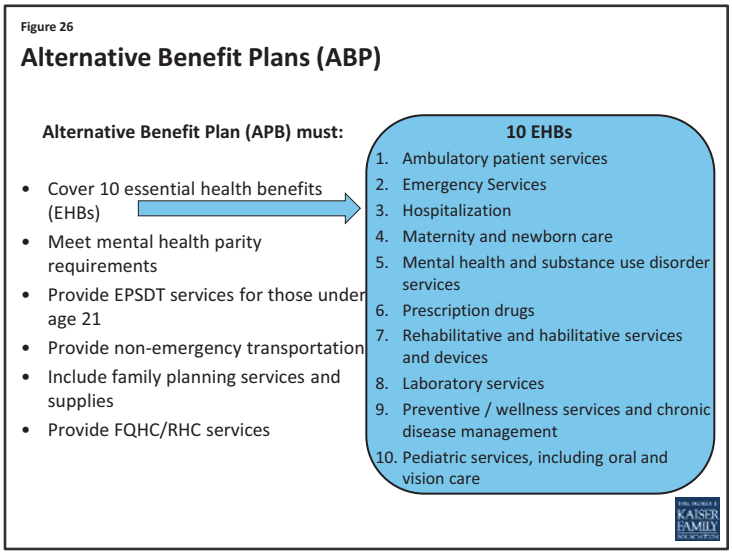
1. The Standard Blue Cross Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program (FEHBP);
2. State employee coverage that is offered and generally available to state employees;
3. The health maintenance organization (HMO) plan that has the largest insured commercial, non-Medicaid enrollment in the state; or
4. Secretary-approved coverage: a benefit package that the HHS Secretary has determined provides appropriate coverage to meet the needs of the population. This can include the Medicaid State Plan benefit package offered to adults in the state.

Regardless of the benchmark option selected, the state must supplement the benefits as necessary to ensure that all 10 ACA-required EHBs along with certain other mandatory services are included and that the mental health parity requirements are met. (Figure 26)

Final regulations related to the ABP were released in July in the midst of the survey period. States were reviewing these regulations when they were asked to identify which benchmark option they chose for the expansion population's ABP. The vast majority of states moving forward with the Medicaid expansion in 2014 (21 of 25) reported plans to use the Secretary-approved coverage option. Three states (Arizona, Delaware and Michigan) indicated that a final decision was still pending and one state (North Dakota) selected the largest commercial HMO as its benchmark.

Figure 26

Alternative Benefit Plans (ABP)



Of the 21 states using the Secretary-approved coverage option, 16 reported plans to use the state's Medicaid State Plan adult benefit package and adjust the benefit as necessary to include all 10 EHBs. At the time of the survey, states were still in the process of working with CMS to determine whether changes were needed to their Medicaid adult State Plan benefits to ensure coverage of all 10 EHBs. Several states commented on the need to supplement their State Plan benefits by adding habilitative services (commonly provided under home and community-based waivers rather than as a State Plan service), and a few states indicated plans to cover additional mental health and substance use disorder services in their ABPs.

Five states reported plans to use the Secretary-approved coverage option to offer ABPs based on something other than Medicaid adult state plan benefits:

Arkansas received approval to provide the expansion population with premium assistance to purchase QHPs offered in the individual market through the Arkansas Insurance Marketplace under a Section 1115 demonstration waiver.[31]

Iowa is seeking a Section 1115 demonstration waiver to offer persons with incomes between 101 percent and 138 percent FPL premium assistance to purchase coverage through QHPs in the state's Marketplace. Those with incomes up to 100 percent FPL would be covered through existing Medicaid delivery systems.

Massachusetts reported plans to use two ABPs: one will be equivalent to the state's current MassHealth Standard benefit and the other – MassHealth CarePlus – will be similar to Commonwealth Care or MassHealth Family Assistance.

New Mexico is planning to use the benefit package developed for its pre-existing State Coverage Initiative Medicaid expansion (which contains limitations on some services) supplemented as necessary to meet the EHB requirement.

West Virginia is planning to offer a benefit benchmarked to the largest plan, by enrollment, of the three largest small group insurance products in the state's small group market.

States were also asked whether the ABP would include long-term services and supports (LTSS). Responses were nearly evenly mixed. However, a few states that answered "yes" referenced the requirement that certain medically frail groups be exempted from ABP enrollment and instead given the option to receive regular Medicaid State Plan benefits, which would include LTSS. Also, New York responded that its ABP would include community-based LTSS but not nursing home care and California reported that its ABP would include LTSS but that the state planned to seek federal waiver authority to apply an asset test.

Finally, most of the expanding states had not yet determined the process that would be used to identify individuals and/or groups who are exempt from mandatory enrollment in ABPs. A few states commented that since they intended to offer the expansion population the State Plan benefit package, it would not be necessary to identify exempt individuals.

ABP Exempted Groups

Medically frail individuals or individuals with special medical needs including:

- Disabling mental disorders
- Serious and complex medical conditions
- Physical, intellectual or developmental disabilities that significantly impair functional abilities
- Chronic substance abuse disorders
- Current and former foster care children
- Persons meeting SSI disability criteria.

Source: 42 CFR §440.315 (f) and (h)

D. Coordination Across Medicaid and the Marketplace in 2014

Under health reform, an important issue is the extent to which individuals on Medicaid will experience changes in income that might cause them to lose Medicaid eligibility and then need to obtain health insurance coverage through the Marketplace. Some individuals also will experience decreases in income and move from the Marketplace into Medicaid. In either case, continuity of care may be affected if individuals must change health plans and providers each time they move to or from Medicaid. This year's survey asked whether health plans participating in the Marketplace would be required by the state to participate in Medicaid or if one or more Medicaid health plans would be required to offer a Qualified Health Plan (QHP) in the Marketplace.

Across all states, only Nevada reported having either requirement: Nevada is contractually requiring both of its two Medicaid MCOs to offer a Silver Plan in the Nevada Marketplace. A few states indicated that such requirements were still under consideration and others commented that overlap between Medicaid health plans and Marketplace QHPs would likely occur without a state requirement.

While the survey did not specifically ask states about measures to mitigate churn between Medicaid and Marketplace coverage, some states reported additional info about such efforts. For example, in Washington, participating Qualified Health Plans in Healthplanfinder, the state's Marketplace, will have an option to participate in Washington's Medicaid managed care delivery system on a limited basis to serve both those who transition between Medicaid and Marketplace coverage and families with mixed Marketplace and Medicaid or CHIP coverage (for more detail, see the Washington case study in Appendix B.) Officials in Arkansas noted that the state's ACA Medicaid expansion model (which proposes to use premium assistance for enrollees to purchase QHP coverage) would promote continuity of coverage and expanded provider access by allowing households to stay enrolled in the same plan whether their coverage is funded through Medicaid or Marketplace subsidies. The District of Columbia and Minnesota are both seeking to renew existing 1115 waivers to continue covering adults up to 200 percent FPL; Minnesota specifically mentioned plans to eventually transition this group to coverage under the Basic Health Plan option. Connecticut is also maintaining existing Medicaid coverage for parents above 138 percent FPL. Other states such as Massachusetts, New York, and Vermont, that had previously extended coverage above 138 percent FPL to at least some adults (either parents, adults without dependent children, or both) reported plans to further subsidize coverage for populations that will now seek subsidies to purchase coverage in the Marketplace.

3. Delivery System Changes

Key Section Findings

In FY 2013 and FY 2014, state Medicaid programs focused attention on delivery system and payment reforms designed to improve quality and control costs through managed care or other care coordination strategies. Many of these initiatives focus on coordinating physical and behavioral health care or long-term care and acute care. Strategies were often focused on specific Medicaid populations, such as persons with chronic conditions or "dual eligible beneficiaries" who are enrolled in both Medicare and Medicaid.

Managed Care. In FY 2013 and FY 2014, 28 and 35 states, respectively, reported an initiative to expand managed care or to improve care through a managed care focused quality initiative. Managed care expansions include adding new geographic areas and / or eligibility groups (including those made newly eligible for coverage under the ACA.) States also reported expansions in managed long-term care in five states in FY 2013 and 14 states in FY 2014. As state Medicaid managed care programs continue to grow and expand in terms of both services and populations covered, states are developing more sophisticated quality metrics and performance measures to ensure that care is being delivered effectively and efficiently. New or enhanced quality initiatives in managed care were implemented in 20 states in FY 2013 and 22 states in FY 2014, one of the most commonly mentioned managed care policy changes.

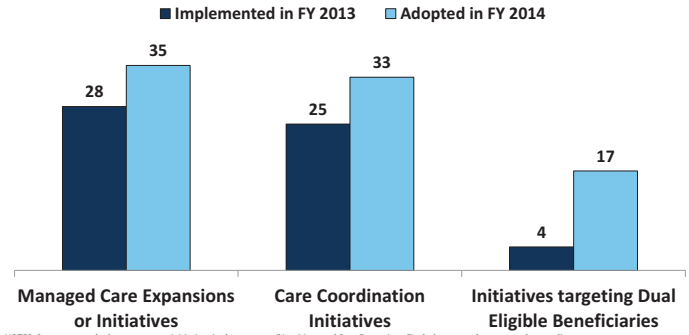
Other Care Coordination. Outside of managed care, new care coordination efforts were underway in 25 states in FY 2013 and 33 states in FY 2014 (40 states in one or both years.) Over a third of states (21) planned to implement Medicaid health homes in FY 2014, established by the ACA, up from six states in FY 2013. A common focus of the health home initiatives is coordinating care for persons with serious mental health conditions. Twelve states in FY 2013 and 9 in FY 2014 were implementing or expanding patient centered medical homes (PCMH). Six states in FY 2013 and 8 states in FY 2014 were implementing or expanding Accountable Care Organizations (ACO) in Medicaid.

Dual Eligible Beneficiaries. In this survey, a total of 14 states indicated they planned to coordinate and integrate care and financing for dual eligible beneficiaries through implementation of a CMS financial alignment demonstration in FY 2014. Separate from the CMS demonstrations, a total of seven states indicated that they had other dual eligible coordination initiatives in place or planned to implement in FY 2014. Examples of current initiatives to coordinate care for dual eligible beneficiaries include: voluntary enrollment into existing PCCM and MCO plans, enhancing performance and quality metrics for existing plans, aligning existing plans, carving dual eligible beneficiaries into managed care plans, and coordinating care through PCMH.

Balancing Long-term Care Services. In FY 2013 and FY 2014, 33 and 35 states, respectively, took actions that expanded the number of persons served in a home and community-based setting. By comparison, 26 states reported taking such action in FY 2012. Most states reported using Section 1915(c) waiver authority to expand HCBS. Seven states in FY 2013 and three states in FY 2014 reported implementing or expanding PACE programs,[32] which serve persons dually eligible for Medicare and Medicaid. Also several states reported that their managed LTSS programs (some of which were new or expanded) were expected to increase the availability of HCBS. Additionally, 21 states reported taking up one or more of the new ACA long-term care options in either FY 2013 or FY 2014.

Figure 27

States With Managed Care, Care Coordination and Dual Eligible Initiatives, FY 2013 – FY 2014



NOTES: States were asked to report new initiatives in these areas. "Any Managed Care Expansions "includes states that reported expanding to new geographic areas, adding new eligibility groups to managed care, transitioning groups from voluntary to mandatory participation in managed care and implementation or expansion of managed long term care. "Any Care Coordination Initiatives" includes states that reported new initiatives or expansions of PCMHs, Health Homes, ACOs, additional quality efforts among other actions in care coordination. These counts for care coordination are not exclusive, some initiatives are counted in multiple areas. Duals initiatives include those participating in the financial alignment model through CMMO as well as other initiatives targeting this population.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

Delivery system changes and payment reforms to align financial incentives with health system performance goals have become a major focus of Medicaid programs in recent years as states seek to better manage and enhance the quality of care provided to beneficiaries and drive program effectiveness and efficiency. States have employed a number of approaches including traditional risk-based managed care, managed long-term care, enhanced quality measurement and contract requirements, as well as other care coordination models such as patient-centered medical homes, health homes, and accountable care organizations. States continue to enhance and expand their use of these strategies, which have the potential to improve care especially for populations with more complex needs, including behavioral health, chronic care, and long-term care needs, and dual eligible beneficiaries. Some initiatives related to long-term care are also tied to state efforts to balance the provision of long-term services and supports away from institutional settings and toward community-based settings.

Delivery and payment system reforms often take years of planning and must be adapted to state specific circumstances and needs. Consequently, states are at different stages of implementation on a wide array of initiatives in this area. This survey attempts to capture new actions that either were or are going to be implemented during FYs 2013 and 2014; the information presented generally does not reflect longstanding initiatives or efforts whose planned implementation is beyond 2014.

A. Managed Care

Medicaid continues to increase its reliance on managed care. Medicaid officials have indicated that managed care provides significant benefits, including assurance of access to care, a structure to measure and improve quality, a way to reduce program costs and get greater value for the cost of Medicaid, and a vehicle to promote important health objectives such as improved birth outcomes, obesity reduction, or reduction in non-emergency use of emergency rooms.[33]

Over the past two decades, the share of Medicaid beneficiaries enrolled in either Managed Care Organizations (MCOs) or Primary Care Case Management (PCCM) programs has increased dramatically. In 1991, nine percent of all enrollees were in some form of managed care arrangements, increasing to 51 percent in 2000.[34] By July 2011, the proportion of Medicaid beneficiaries enrolled in some form of managed care exceeded 74 percent. In FY 2013, all states except four (Alaska, Connecticut, New Hampshire and Wyoming) had some form of a comprehensive Medicaid managed care program. Connecticut implemented its own system of coordinated care in 2012, using an ASO (Administrative Services Only) contractor to manage services. New Hampshire plans to implement statewide managed care using MCOs in December 2013.

The most common Medicaid managed care is through risk-based, capitated Medicaid health plans (i.e. MCOs.) A total of 37 states indicated they operated this type of managed care program at the beginning of FY 2014. North Carolina, which currently operates a PCCM program, is exploring the possibility of shifting to contracts with MCOs in FY 2015.

A total of 22 states indicated that at the beginning of FY 2014 they operated a PCCM program, in which each beneficiary enrolls with a primary care provider and Medicaid pays a nominal case management fee to the primary care provider for care management. Ten states had only a PCCM program, and 12 states with a PCCM program also contracted with MCOs.

Recent trends indicate that Medicaid programs are increasingly reliant on MCOs, and less reliant on PCCM programs. A number of states have recently phased out or are in the process of phasing out PCCM programs to move toward more capitation including Delaware, Florida, Georgia, Kentucky, Illinois, Nebraska, New York, Pennsylvania, Texas and Virginia. On the other hand, some states are moving away from managed care and are implementing tailored delivery system and payment system models (like Connecticut and Oregon).

A total of 22 states, all of which had either MCOs or PCCM programs, also reported having contracts with prepaid inpatient or ambulatory care plans – risk-based plans that cover a limited set of benefits, such as behavioral health care, dental care, or non-emergency medical transportation.

Types of Medicaid Managed Care Arrangements

Managed Care Organizations (MCOs). MCOs are the most prevalent form of Medicaid managed care. States contract with MCOs to provide a defined set of benefits to enrolled Medicaid beneficiaries, pay them on a prepaid, capitated basis, and hold them accountable for performance on a contractually specified set of quality metrics. Federal rules require that Medicaid capitation payment rates be "actuarially sound." [35] MCOs bear the financial risk for the cost of delivering care. MCOs participating in Medicaid are subject to a broad set of federal regulations and standards, which require that they have an adequate network of credentialed providers, meet standards of timely access, demonstrate quality of care, participate in quality improvement projects, and participate in an independent external quality audit of health plan records to document that the data and the care meet all standards and requirements.

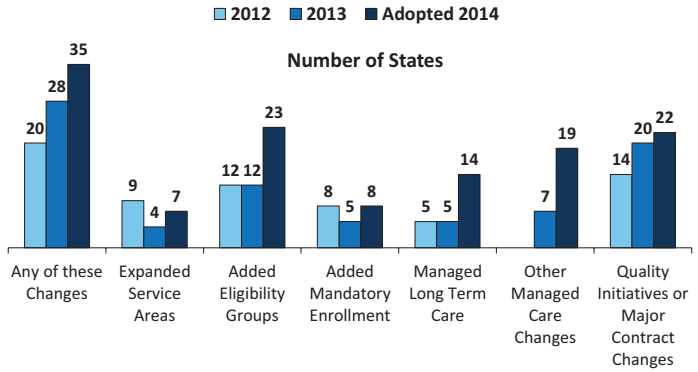
Primary Care Case Management (PCCM) Programs. PCCM programs, which build on the fee-for-service system, are administered by the Medicaid agency itself or a contractor. Each Medicaid beneficiary in a PCCM program is enrolled with a primary care provider (PCP) or practice, which is responsible for providing the beneficiary's primary and preventive care, as well as arranging specialist referrals when needed. The state generally pays PCPs a small per-member-per-month case management fee in addition to regular fee-for-service payments. Some states have "Enhanced PCCM" that involves added care coordination, care management, medical home standards and quality improvement.

Prepaid Health Plans (PHPs). PHPs are risk-based (capitated) health plans that provide a limited set of Medicaid services, such as behavioral health services, dental care, or non-emergency medical transportation. Federal regulations recognize two types of PHPs: those that include any inpatient hospital services are Prepaid Inpatient Health Plans (PIHPs), and those that do not include any inpatient hospital services are Prepaid Ambulatory Health Plans (PAHPs). States sometimes provide services that are "carved-out" of MCOs through these non-comprehensive PHPs; they may also use PHPs to provide selected types of services to beneficiaries who receive most of their care on a fee-for-service basis.

Changes in Managed Care. Over the survey period (FY 2013 and FY 2014), 39 states expanded or made significant changes in their managed care programs, including 28 states in FY 2013 and 35 states in FY 2014. These initiatives included expansions of managed care into new geographic regions, new eligibility groups being enrolled into managed care, adopting mandatory enrollment for specific populations, and new quality-related efforts or requirements. (Figure 28)

Figure 28

Medicaid Managed Care Changes FY 2012 – FY 2014



NOTE: States were asked to report new initiatives or expansions in these areas; this does not reflect ongoing state efforts in these areas.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012 and September 2013.

Geographic coverage of Medicaid managed care expanded in four states in FY 2013, and is planned in seven states in FY 2014. In recent years, geographic expansions have predominantly extended managed care to rural counties in a state. For example, Nebraska and Virginia expanded managed care statewide in FY 2013, and California extended managed care to 28 rural counties in FY 2014. New Hampshire will implement managed care statewide when its new program takes effect in FY 2014.

New eligibility groups were added into managed care in 12 states in FY 2013. Most frequently, the new eligibility groups were seniors and persons with disabilities and children in foster care. For FY 2014, a total of 23 states indicated that new eligibility groups were being enrolled in managed care. States most frequently reported the addition of the new Medicaid expansion population as well as other previously excluded groups (i.e. those receiving limited benefits, foster children, as well as some aged and disabled groups.) Five states in FY 2013 and eight states in FY 2014 shifted from voluntary to mandatory enrollment either for specific eligibility groups or, in the case of New York, Oregon and Pennsylvania, for all groups in all parts of the state.

More states are moving to capitated managed long-term services and supports (MLTSS), or expanding existing programs, including five states in FY 2013 and 14 states in FY 2014. The current focus on coordinating and integrating care for dual eligible beneficiaries has been associated with an increased interest across states for adopting MLTSS programs. Many of these states planning to implement or expand MLTSS in FY 2014 are planning to do so as part of the Financial Alignment Initiative through the Medicare and Medicaid Coordination Office (MMCO)[36] while other states are either planning to incorporate MLTSS into their comprehensive MCO contracts or planning to create stand-alone MLTSS programs.

A number of states also reported other types of managed care changes not previously tracked in this report. In FY 2013, seven states reported such other changes, largely related to carving-in behavioral health services, expanding behavioral health services covered under existing managed care arrangements or implementing new Behavioral Health Organizations (BHOs). In FY 2014, 19 states reported other changes, again, largely concerning the incorporation of enhanced management of behavioral health services. These managed care policy changes are discussed in more detail in a later section.

Managed Care Quality. Managed care provides a structure that allows a state Medicaid agency to establish specific quality benchmarks, to measure performance relative to those benchmarks, and to relate reimbursement to quality of care, quality improvement activities and health care outcomes. As state Medicaid managed care programs continue to grow and expand in terms of services and populations covered, states shift their focus to developing more sophisticated quality metrics and performance measures to ensure care is being delivered effectively and efficiently. The survey did not attempt to catalog all managed care quality strategies, only those that were new or enhanced during this survey period. New or enhanced quality initiatives in managed care were implemented in 20 states in FY 2013 and 22 states in FY 2014, one of the most commonly mentioned managed care policy changes. Policy changes reported generally fell into the following categories:

- Adding new quality metrics and reporting requirements.
- Adding or enhancing pay for performance requirements.
- Increasing the portion of managed care payments withheld or at risk based on managed care performance on quality measures.

In some instances, states noted the additional pay for performance and new quality metrics focused on integrating care across physical and behavioral health as well as acute and long-term care. Additional information on managed care changes implemented in FY 2013 or planned for FY 2014 can be found in Appendix Table A-3. Quality initiatives taken in managed care as well as in care coordination are also reported in Appendix Table A-5A (FY 2013) and Appendix Table A-5B (FY 2014.)

B. Care Coordination Initiatives

State Medicaid programs increasingly are developing strategies and initiatives -- sometimes outside of managed care and sometimes within it -- to further facilitate the coordination and integration of care across the continuum of services. States have expressed growing awareness that lack of communication and information-sharing between providers hinders good quality care and increases the risk of duplication, unnecessary care, and higher costs. The ACA heightened state interest in care coordination by providing new opportunities and in some cases enhanced federal matching rates or other federal funds for strategies such as health homes, patient-centered medical homes, Accountable Care Organizations, and initiatives focused on improving systems of care for dual eligible beneficiaries. These opportunities coincided with increasing state interest in approaches to reduce costs and improve care and health outcomes for higher cost groups within Medicaid, particularly through efforts to coordinate physical and behavioral health care, and coordinate acute and long-term care, and improve care for persons with multiple chronic conditions.

Models of Care Coordination Strategies

Health Homes. Section 2703 of the ACA provides a new state plan option for Medicaid programs to establish "health homes," designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and community-based long-term services and supports, for beneficiaries who have at least two chronic conditions, or one and at risk of a second, or a serious and persistent mental health condition. To implement a health home program, a state must obtain CMS approval of a state plan amendment (SPA). In the SPA, the state must specify health home arrangements that meet CMS standards pertaining to their capacity to provide health home services. A 90 percent federal match rate is available for qualified expenditures for health home services for the first eight quarters of a state's program. The ACA defines health home services to include: comprehensive care management; care coordination and health promotion; transitional care from inpatient to other settings; support for patients and families; referral to community and social support services; and use of Health Information Technology (HIT) to link services.[37]

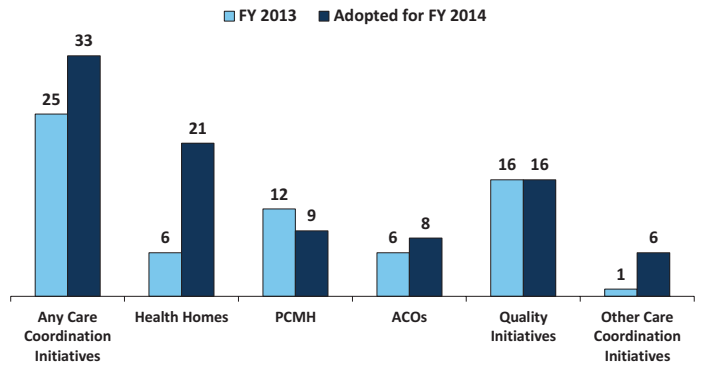
Patient-Centered Medicaid Homes (PCMH). The PCMH model has evolved in recent years from the earlier medical home concept. In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released key principles that define a PCMH: (1) the personal physician leads a team that is collectively responsible for the patient's ongoing care; (2) the physician is responsible for the whole person in all stages of life; (3) care is coordinated and/or integrated; (4) quality and safety are hallmarks of a medical home; (5) enhanced access to care is available through all systems; and (6) payment appropriately recognizes the added value to the patient. The National Committee for Quality Assurance (NCQA) has issued specific standards that the PCMHs must meet to receive its recognition.[38]

Accountable Care Organizations (ACOs). An ACO is a group of health care providers that agree to share responsibility for the delivery of care to and the health outcomes of a defined group of people, and the cost of care. The organizational structure of ACOs varies, but all ACOs would include primary and specialty care physicians and at least one hospital. Providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency, and the ACO as an entity is accountable for that care. An ACO that meets quality performance standards that have been set by the payer, and achieves savings relative to a benchmark, can share savings among its providers. Some states that are pursuing ACOs for Medicaid beneficiaries are building on existing care delivery programs (e.g., PCCM, medical homes, MCOs) that already involve some degree of coordination among providers and may have some of the infrastructure (e.g., electronic medical records) that would facilitate coordination among ACO providers. States may use different terms for their Medicaid ACO initiatives, such as Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado.[39]

Care coordination is now almost universal across state Medicaid programs. While this survey does not attempt to catalog all existing care coordination policies, a total of 40 states reported some form of new or enhanced care coordination activity or initiative in either FY 2013 or FY 2014, including 25 states in FY 2013 and 33 states in FY 2014. (Figure 29) States are also pursuing an array of approaches to care coordination and integration at the same time. Strategies for care coordination and integration available to Medicaid programs under specific statutory authorities are discussed below. By their nature, any specific initiative may address more than one population group or care priority. For example, a health home initiative is one strategy to coordinate care for individuals with severe and persistent mental illness, as well as for persons with chronic conditions. Another state may coordinate physical and behavioral health through a PCMH, managed care or an ACO. An initiative targeting dual eligible beneficiaries may include various approaches to coordinate and integrate physical, behavioral health and long-term care, such as health homes, managed care or other methods. Each Medicaid program can develop the approach or approaches that work best to address the policy priorities in that state.

Figure 29

States With New or Expanded Care Coordination Initiatives FY 2013 – FY 2014



NOTES: States reported new initiatives in these areas ; this does not reflect ongoing state efforts in these areas.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

Health Home Initiatives. Section 2703 of the ACA provided a new state option to establish "health homes." The health home model, focused on individuals with multiple chronic conditions, including serious and persistent mental health conditions, requires coordination of primary and acute care, behavioral health care, community-based long-term care, and social services. As of July 2013, CMS had approved Medicaid state plan amendments for health homes for twelve states: Alabama, Idaho, Iowa (two plans approved), Maine, Missouri (two plans approved), New York, North Carolina, Ohio, Oregon, Rhode Island (two plans approved), Washington and Wisconsin. Some of these states received approval and implemented in FY 2012, which is outside of the survey period and therefore not reflected as new initiatives.

In this survey a total of six states indicated adoption or expansion of existing health homes in FY 2013, and 21 states indicated that they planned to adopt or expand their use of health homes in FY 2014. Several of these states are planning to adopt a health home approach to address the specialized needs for persons with serious and persistent mental illness, who are at high risk of poor health outcomes and whose costs are high.

> ***"We are seeing cost savings on the behavioral health side, and we are seeing good clinical outcomes [in reference to health homes]."***

Patient-Centered Medical Home (PCMH) Initiatives. Medicaid programs continue to develop PCMHs as a strategy to ensure that each Medicaid beneficiary has a primary care provider who is expected to coordinate all needed services. A number of states have adopted the use of PCMHs in past years in a number of ways. In this survey, twelve states indicated that they had adopted or enhanced PCMHs in FY 2013, and nine states indicated that they planned to implement or enhance PCMHs in FY 2014. States indicated that PCMHs could be a stand-alone initiative, or were a part of other initiatives, such as ACOs, health homes, managed care, or focused on a specific group. For example, Rhode Island is planning to develop a PCMH model for pediatrics in FY 2014. Colorado continues to expand its use of PCMH through its Accountable Care Collaborative. Minnesota continues to expand PCMHs, and had 250 certified health care homes as of July 2013 out of some 700 primary care providers statewide. Some states, such as Oregon, provide extra reimbursement for recognized PCMHs for Medicaid patients receiving care through their practice. Oregon required all Coordinated Care Organizations (CCO) to develop plans to promote the delivery of care through recognized PCMHs, including targets for performance, and these were incorporated into the CCO contracts.

Accountable Care Organizations (ACOs). The ACA created the opportunity to develop ACOs through the CMS Center for Medicare and Medicaid Innovation.[40] Several state Medicaid programs have worked with providers to develop ACOs in Medicaid. For FY 2013, six state Medicaid programs implemented or expanded their use of ACOs. Oregon began implementation of its Coordinated Care Organization (CCO) model. California implemented an ACO demonstration in San Mateo County. Minnesota implemented provider-led risk-gain sharing contracts covering non-dual Medicaid populations, including both managed care and FFS populations. Pennsylvania and South Carolina participated in local ACO projects such as the Children's Hospital of Philadelphia ACO and the Healthy Opportunity Greenville program. Utah implemented an ACO for physical health and pharmacy in January 2013.

For FY 2014, eight states indicated new or enhanced ACO initiatives. Iowa plans to use ACOs along with other forms of managed care to serve the newly eligible Medicaid expansion population below 100 percent FPL. California will add the Rady Children's Hospital of San Diego ACO in November 2013. Minnesota will expand existing contracts in January 2014, with the next phase to include complex populations and integration of behavioral health, long-term care and social services into the cost and quality model. Utah will be adding performance measures in BHO and ACO contracts that relate to coordination of care. ACOs are also to be implemented in Massachusetts, New Jersey, New York, and Vermont.

In addition, state officials indicated that ACOs are being developed or explored in other states such as Pennsylvania, Rhode Island, and Texas. In Alabama, a new state law was passed in the 2013 session to move to Regional Care Organizations by October 2016. In several states model design work is being done under a CMS State Innovation Model (SIM) initiative, or through the participation in the Advancing Accountable Care Organizations Learning Collaborative being led by the Center for Health Care Strategies, Inc.[41]

Quality and Performance in Care Coordination. As states expand their use of care coordination initiatives and strategies, they are applying techniques developed to measure and enhance quality and performance in managed care to these new care coordination strategies as well. Over the period of FY 2013 and FY 2014, a total of 26 states indicated they implemented or plan to implement or expand care coordination quality initiatives, including 16 states in both FY 2013 and in FY 2014. Quality strategies include:

- Initiatives focused on re-hospitalizations and post-discharge care;
- Initiatives focused on reducing non-emergency use of the emergency room;
- Use of grant opportunities, such as the Strong Start initiative targeting pregnancy outcomes as well as the Million Heart grant;
- Establishment of new offices or teams focused on quality metric, data analysis, and communicating with providers about best practices; and
- Use of CMS grants to develop and analyze data on an initial core set of health care quality measures for adults in Medicaid.[42]

Additional information on care coordination initiatives implemented in FY 2013 or planned for FY 2014 can be found in Appendix Table A-4. Quality initiatives taken in care coordination as well as managed care are also reported in Appendix Tables A-5A and Appendix Table A-5B.

C. Special Initiatives for Managed Care and Care Coordination

States are working to innovate and improve care in a variety of ways, with a particular focus on reducing fragmentation and improving coordination of care across behavioral and physical health care, as well as across long-term care. States have expressed a growing awareness of how lack of communication between providers hinders good quality care and increases the risk for duplication and higher costs.

Comprehensive new plans for coordination. One way that states are pursuing to better coordinate care is to transition any remaining populations out of fee for service into existing or new forms of managed care and care coordination. This includes states such as New York and Illinois, each of which has set target dates for transitioning all remaining populations out of fee for service programs. Additionally, Alabama passed legislation requiring the Medicaid program to move all beneficiaries to Regional Care Organizations (RCOs) by 2016. As these states continue to make advances toward their goals, one state in FY 2013 (Kansas) and two states in FY 2014 (Florida and New Mexico), will implement new comprehensive systems of managed care that are intended to foster coordination and integration of care by including all services. Both the Florida model and the New Mexico model include the full array of Medicaid services, from primary and acute physical health care, to behavioral health care and long-term care.

> ***"The implementation of the Statewide Medicaid Managed Care Program has been a huge undertaking…We are proud of the successful and coordinated approach that our Agency has taken….***

Comprehensive Managed Care and Care Coordination Initiatives

The **Florida** Statewide Medicaid Managed Care model began its phase-in in August 2013 and is scheduled to be fully implemented statewide in March 2014. It will enroll all populations, including those sometimes excluded from managed care arrangements such as Medicaid and Medicare dual eligible beneficiaries and children in foster care. Separate managed long-term care plans will enroll individuals requiring long-term services and supports. Care will be coordinated across all settings, and the performance of the health plans will be monitored through new performance measures and the use of performance improvement projects.

The **New Mexico** "Centennial Care" model is to be implemented in January 2014, and will integrate all Medicaid services into the managed care program, including physical health, behavioral health and long-term care services. The number of MCOs will be reduced from seven to four, each of which will provide all services statewide, and all Medicaid enrollees are required to enroll (with exceptions limited to Native Americans, individuals in ICF-IDs, PACE, foster children who are out of state, undocumented individuals and QMB, SLMB and QI-1 individuals.) Specific measures have been selected to measure MCO performance.

In July 2012, CMS approved **Oregon**'s request to extend and amend its Section 1115 waiver to launch new Coordinated Care Organizations (CCOs) to replace the current managed care delivery system. CCOs are managed care entities that will operate on a regional basis with enhanced local governance. CCOs will integrate physical, mental and dental health services and also provide care coordination and a menu of flexible non-medical services under a global budget. Long-term services and supports will not be included initially. The payment system includes quality outcome-based incentives and, eventually, shared savings between the state and contracted entities. The waiver also allows the state to pay for the services of non-traditional health care workers, such as community health workers, doulas, client navigators and peer wellness workers, in Medicaid. It also allows Oregon to train 300 community health workers by 2015 and to provide a loan repayment program for primary care physicians who agree to work in rural or underserved communities.

Coordination of Physical and Behavioral Health. Medicaid is the largest single source of financing for behavioral health services, accounting for over a quarter of spending for behavioral health. Among non-elderly adults, spending per enrollee is significantly higher for those with a co-occurring mental health diagnosis than for similar beneficiaries without a diagnosed mental health condition. Over six in ten non-elderly Medicaid adults diagnosed with a mental health condition also have a diagnosed physical chronic condition, such as diabetes or heart disease.[43] Some state Medicaid programs are working with their state mental health authorities to create systems or strategies to improve coordination of physical and behavioral health services.

> ***"Previously, we had a gap serving those in need of mental health or substance abuse benefits, and we are integrating these areas to help coordinate care in these areas."***

One strategy states are pursuing is to end existing "carve-outs" of behavioral health services from managed care and integrate these services into the managed care benefit package. Previously discussed approaches implemented in Kansas in FY 2013 and being implemented in FY 2014 in Florida and New Mexico are examples of this approach. Other states carving-in some or all behavioral health services include California, Colorado, Illinois, Mississippi, New Hampshire, South Carolina, Washington and West Virginia. In other states, the approach has been to create or expand the use of a specialized Behavioral Health Organization (BHO.) BHOs are accountable to provide a specific set of services, and to coordinate care across physical acute and primary care services; they are evaluated on a specific set of metrics focused on care for the population with behavioral health diagnoses. States that added or enhanced their BHOs include: Hawaii, Iowa, Maryland, Nebraska, and North Carolina.

In other states, special processes have been established to ensure that coordination occurs. For example, in FY 2014 Arizona's AHCCCS, in coordination with its Department of Health Services/ Division of Behavioral Health, plans to implement an Integrated Regional Behavioral Health Authority in Maricopa County for adults with severe mental illness, with the goal of fully integrating physical and behavioral health care. The state plans to expand this initiative to other parts of the state in FY 2015.[44] Nevada will use a care management organization to coordinate care and information exchange between medical and behavioral health providers. Both New Jersey and Virginia are also planning to implement an Administrative Service Organization (ASO) to manage behavioral health services.

A number of states are using health homes to improve coordination care across behavioral and physical health. States such as Connecticut, Iowa, Maine, Maryland, Missouri Rhode Island, South Dakota and Wisconsin reported health home initiatives specifically targeting individuals with severe and persistent mental illness (SPMI) as well as substance abuse disorders. Maryland plans to implement health homes for adults with SPMI, adolescents with severe emotional disturbances (SED) and those receiving treatment for opioid dependencies. A few states mentioned using their patient-centered medial homes to improve coordination across these services.

Some states implementing broader initiatives to coordinate care across physical health, behavioral health, and long-term care services. In FY 2013, Texas implemented a Money Follows the Person Behavioral Health Pilot in the San Antonio and Austin areas where cognitive adaptation training, specialized rehabilitative services to help individuals learn or re-learn skills of independent living, and substance abuse services were provided to individuals leaving nursing facilities six months before discharge and 12 months after discharge. The next phase of Minnesota's Health Care Delivery Systems, an ACO, will focus on complex populations and the integration of behavioral health, long-term care and social services. Additionally, integration of behavioral and physical health services along with long-term care services is a goal of the financial alignment demonstration for dual eligible beneficiaries discussed later.

Coordinating Long-term Care with Primary and Acute Care. States are exploring new ways to minimize fragmentation, improve coordination, encourage the use of home and community based services (HCBS), and control costs for individuals needing long-term services and supports (LTSS). One common method reported by states is the use of capitated managed care arrangements. Interest in this strategy has grown in response to the financial alignment demonstration for dual eligible beneficiaries through Medicare-Medicaid Coordination Office (MMCO, described further below) which required participating states to adopt capitated or managed fee-for-service models that integrate primary, acute and behavioral health care and LTSS. In this survey, five states in FY 2013 and 14 states in FY 2014 reported implementing or expanding a capitated managed long-term services and supports (MLTSS) program. These include New York and Kansas which implemented mandatory MLTSS enrollment in FY 2013, Florida (mentioned earlier) which will implement mandatory MLTSS enrollment in FY 2014, and New Jersey that will make enrollment into MLTSS mandatory for HCBS beneficiaries (but not nursing home residents) in FY 2014. Also, nine of the 14 states planning MLTSS implementations or expansions in FY 2014 have proposed to do so through the Financial Alignment Demonstrations described below.

Two states also reported on enhancements to their current MLTSS contracts. In FY 2014, Texas is strengthening service coordination between acute care and LTSS by requiring all MCOs to have an approved Service Coordination Plan that addresses planning based on the needs of the member, expertise across designated fields and training of service coordination teams every two years. Also, Minnesota will impose new contract requirements in FY 2014 for "Integrated Care System Partnerships" (ICSPs) between providers and health plans tied to financial and quality metrics that focus on delivery system and payment reforms including integration of primary care and LTSS for seniors and primary care and behavioral health for persons with disabilities.

A few states reported other initiatives to integrate acute care and LTSS, including four states in FY 2014 that are implementing or have proposed to implement a Financial Alignment Demonstration for dual eligible beneficiaries using a managed fee-for-service model. In FY 2013, Colorado reported implementing an initiative to increase collaboration between its Accountable Care Collaboratives and the LTSS single entry points and Oregon began requiring its Coordinated Care Organizations, as a condition of certification, to have a Memorandum of Understanding with the associated long-term care offices, and instituted other specific accountability measures to monitor coordination between acute and long-term care services.

In FY 2014, Arkansas plans to expand its "episode of care" payment reform initiative to include long-term care and is also targeting long-term care in its statewide patient-centered medical home program. In addition to a proposed managed fee-for-service Financial Alignment Demonstration, in FY 2014 Iowa is developing an ACO model for Medicaid under a CMS State Innovation Model grant that focuses on accountability for quality and cost, and a key aspect is the incorporation of LTSS into the arrangement.

Care Coordination and Integration of Care for Dual Eligible Beneficiaries. Many states are working specifically on initiatives to coordinate the care for individuals with dual enrollment in Medicaid and Medicare, made possible by one of the significant provisions of the ACA that provides the opportunity for state Medicaid programs to coordinate care for enrollees who also have coverage under Medicare. In the past, such coordination has been difficult to pursue for states in part because the savings from acute care (such as reduced inpatient admissions and emergency room visits) that would result from better coordination accrued to Medicare and were not shared with state Medicaid programs. Under Section 2602 of the ACA, CMS established the MMCO and initiated financial alignment demonstrations with interested states to coordinate and improve care and control costs for this population. The importance of coordinating care for this population is underscored by the fact that this population has significant health needs, a high prevalence of chronic conditions and a high use of long-term care. For Medicaid, the dual eligible beneficiaries are 14 percent of all enrollees, but accounted for 36 percent of Medicaid spending in 2010. For Medicare, dual eligible beneficiaries are 20 percent of all enrollees and accounted for 33 percent of Medicare spending in 2009.[45] About 65 percent of all spending for duals is for long-term care, largely covered by Medicaid, and about 25 percent is on acute care services, primarily covered by Medicare.[46]

In 2013 and 2014, state Medicaid programs continued to develop strategies to coordinate and integrate care and financing for dual eligible beneficiaries. To date, the CMS has approved memoranda of understanding for seven states to implement financial alignment demonstrations.[47] Six states are slated for implementation in FY 2014, with Washington the first in July 2013 and Massachusetts in October 2013, Illinois in January 2014, Virginia in February 2014, Ohio in March 2014, and California in April 2014. New York's implementation will be in July 2014, which will be during the state's FY 2015. Washington has a managed fee-for-service model that will focus on high-risk and high cost beneficiaries that began July 2013; the state also has a capitated financial alignment model still pending approval. The other six approved financial alignment states will use capitated delivery systems. A total of 14 other states remain in negotiations with CMS on their proposed demonstrations, with proposed implementation dates in 2014 and in 2015.[48]

> ***"We are working on "blind spots" in the system. If a plan is providing part of a benefit, we will share data across plans, including Medicare Parts A, B and D to deal with fragmentation in the system. We are moving toward one entity to hold accountable for all***

In this survey, a total of 14 states indicated they planned to coordinate and integrate care and financing for dual eligible beneficiaries through implementation of a CMS financial alignment demonstration in FY 2014, assuming final approval of Memoranda of Understanding (MOUs) with CMS. In addition to the CMS financial alignment demonstrations, a total of seven states indicated that they had other new or expanded dual eligible coordination initiatives implemented in FY 2013 or planned for FY 2014. Examples of such initiatives include:

- **Voluntary enrollment into existing PCCM and MCO plans.** Alabama will allow Dual Eligible beneficiaries in select geographic locations to enroll in their PCCM program as part of the state's health home state plan amendment. Michigan began allowing dual eligible beneficiaries to voluntarily enroll into existing Medicaid managed care plans. By August 2013 over 40,000 of the 200,000 Michigan dual eligible beneficiaries statewide had opted to enroll.
- **Enhancing performance and quality metrics for existing plans.** As mentioned earlier, Minnesota will impose new contract requirements in FY 2014 for "Integrated Care System Partnerships" (ICSPs) between providers and health plans tied to delivery system and payment reforms; the quality measures will focus both on duals and non-duals. The state entered into an MOU with CMS for an administrative alignment demonstration.
- **Aligning existing plans.** Arizona had originally submitted a proposal as part of the CMS Financial Alignment Initiative but later withdrew. Instead, the state is planning to better align existing plans for its dual eligible beneficiaries. In FY 2014, acute care dual eligible members currently served by Medicaid and Medicare D-SNP Plans will be enrolled (with option to stay in their current plan) into the Medicaid managed care plan that aligns with their current Medicare D-SNP Plan. This will affect 11,000 acute care dual eligible members.
- **Carving dual eligible beneficiaries into managed care plans.** Kansas carved in dual eligible beneficiaries as part of their roll out of KanCare, the statewide managed care plan in FY 2013. Florida will begin the phase-in of Statewide Medicaid Managed Care Long-Term Care Plans in FY 2014. When the phase-in is complete, the dual eligible care coordination delivery system will be operational statewide.
- **Coordinating care through Patient Centered Medical Homes.** Vermont in FY 2013 coordinated long-term care and acute care via Community Health Teams under its Blueprint for Health PCMHs.

Additionally, 7 states in FY 2013 and 3 states in FY 2014 reported implementing or expanding PACE programs, which serve dual eligible beneficiaries. These changes are captured in the next section.

Additional information on initiatives targeting dual eligible beneficiaries can be found in Appendix Table A-6.

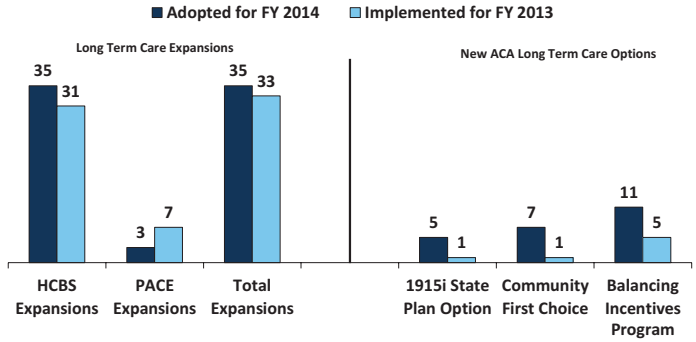
D. Balancing Institutional and Community Based Long-term Care

Medicaid is the nation's primary payer for long-term services and supports (LTSS) 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 (ICF-ID). LTSS consumes nearly one-third of total Medicaid spending and therefore is an important focus for state policymakers. This year's survey shows that the long-term trend of expanding HCBS continues with states employing a variety of tools and strategies including traditional Section 1915 (c) HCBS waivers, PACE programs, managed LTSS.

States' efforts to expand HCBS options for LTSS are driven by consumer demand, the United States Supreme Court's 1999 decision in *Olmstead v. L.C.*, which found that the unjustified institutionalization of people with disabilities violates the Americans with Disabilities Act,[49] and an effort to control growth in LTSS costs. In FY 2013 and FY 2014, 33 and 35 states, respectively, took actions that expanded the number of persons served in an HCBS setting, notably larger than the number of states taking such action in FY 2012 (26). Most states reported using Section 1915(c) waiver authority to expand HCBS. However, seven states in FY 2013 and three states in FY 2014 reported implementing or expanding PACE programs.[50] Also several states reported that their managed LTSS programs (some of which were new or expanded) were expected to increase the availability of HCBS services (including Delaware, Kansas and New York in FY 2013 and California, Delaware, New Jersey and New York in FY 2014). Additionally, an increased number of states are taking up some of the ACA options to expand the use of community-based care (discussed below.)

Figure 30

Medicaid Long-Term Care Expansions and Adoption of new ACA Options, FY 2013 – FY 2014



NOTE: HCBS Expansions include counts of states that in general increase the number of individuals served in the community. Examples of such expansions include increasing slots in existing waivers, eliminating waiting lists, increasing individuals served through the implementation of managed long term care among others.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

States' ability to impose certain restrictions on HCBS in FY 2013 and part of FY 2014 was limited by the ACA maintenance of eligibility (MOE) requirements (a continuation of the MOE requirements previously imposed by ARRA) requiring states to maintain eligibility for adults until Marketplaces are certified (expected in January 1, 2014), and for children in Medicaid and CHIP until October 1, 2019. Because eligibility for specific Medicaid LTSS and overall Medicaid eligibility is linked (for example through the use of functional eligibility criteria for both determinations), CMS has determined that the following actions violate the MOE requirement: increasing the stringency of the institutional level of care (LOC) determination processes; switching from an aggregate to an individual cost neutrality methodology for HCBS waivers; reducing HCBS waiver capacity, or reducing or eliminating HCBS waiver slots that were funded but unoccupied as of July 1, 2008.

Long-Term Services and Supports Options in the ACA

The ACA created and expanded several LTSS-related options intended to promote long-term care balancing. State utilization of these options is discussed below.

HCBS State Plan Option. The DRA gave states a new option to offer HCBS through a Medicaid state plan amendment rather than through a Section 1915(c) waiver. Responding to low state take-up, effective October 1, 2010, the ACA built on the DRA authority authorizing states to expand eligibility under this option to individuals with incomes up to 300 percent of the maximum SSI federal benefit rate, allowing states to target benefits to specific populations, and authorizing states to offer the same range of HCBS under Section 1915(i) as are available under Section 1915(c) waivers. The Section 1915(i) option, as amended by the ACA, also eliminates the states' ability to cap enrollment, maintain a waiting list or waive the requirement for the benefit to be offered statewide. However, states retain the ability to constrict their Section 1915(i) needs-based eligibility criteria if they exceed their projected number of beneficiaries served, subject to advance notice and grandfathering of existing beneficiaries.

Ten states (California[51], Connecticut, District of Columbia, Florida, Iowa, Idaho, Louisiana, Nevada, Oregon and Wisconsin) reported having the HCBS state plan option in place in FY 2012. One state (Montana) reported implementing the HCBS state plan option in FY 2013, five states (Arkansas, Delaware, Indiana, Maryland and Texas) reported plans to implement in FY 2014, and one state (Colorado) reported a planned FY 2015 implementation.

Balancing Incentive Program (BIP). Beginning in October 2011, the Balancing Incentive Program (BIP) makes enhanced Medicaid matching funds available to certain states that meet requirements for expanding the percentage of LTSS spending for HCBS (and reducing the percentage of LTSS spending for institutional services). Funding is available through September 2015.[52] To qualify, states must: have devoted less than 50 percent of their LTC spending to HCBS in FY 2009, develop a "no wrong door/single entry point" system for all long-term care services, create conflict-free case management services, and develop core standardized assessment instruments to determine eligibility for non-institutionally based LTSS.

In this year's survey, three states reported having implemented the program in FY 2012 (Iowa, Maryland and New Hampshire), 11 states reported implementation in FY 2013 (Arkansas, Connecticut, Georgia, Illinois, Indiana, Louisiana, Missouri, Mississippi, New Jersey, New York and Texas), and five states reported plans to implement in FY 2014 (Delaware, Maine, Nevada, Ohio and Rhode Island).

Community First Choice (CFC) State Plan 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. However, the final federal rule implementing this option was not released by CMS until May 2012[53], inhibiting state take-up of this option prior to FY 2013. In this year's survey, California was the only state to report having this option in place in FY 2012[54] and New York was the only state reporting implementation in FY 2013. Seven states reported plans to implement the CFC option in FY 2014 (Arkansas, Maryland, Minnesota, Montana, Oregon, Texas and Wisconsin).

Additional information on long-term care expansions implemented in FY 2013 or planned for FY 2014 can be found in Appendix Table A-7.

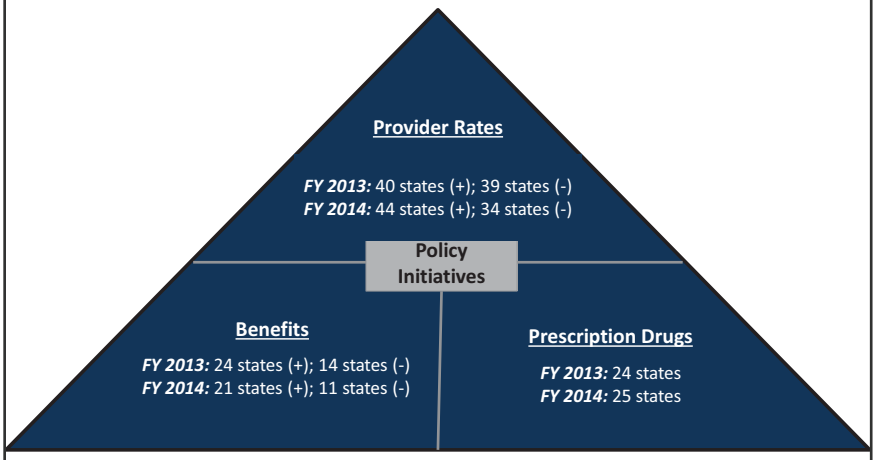
4. Other Medicaid Policy Initiatives for FY 2013 and FY 2014

Key Section Findings:

- As the economy has continued to improve, states have been able to restore some restrictions made in prior years as well as make some improvements. In both FYs 2013 and 2014, more states plan to implement program improvements or expansions (46 and 47 states respectively) compared to states implementing or planning to implement at least one new policy to control Medicaid costs (43 states in both years).
- As the economy has continued to improve, more states are reporting increasing provider rates than restricting provider rates for the first time in several years. In FY 2013, more states (40 states) ended up increasing provider rates than the number of states that restricted one or more rates (39 states.) This trend is expected to continue in FY 2014 as 44 states reported plans to increase at least one provider rate compared to 34 states that planned at least one rate restriction.
- More states reported benefit expansions or enhancements (21 states in FY 2013 and 24 states in FY 2014) than benefit limitations or eliminations (14 states in FY 2013 and 11 states in FY 2014.) Actions taken by states related to benefits tended to be focused in home and community-based services, dental, behavioral health, and vision services. Some states also noted that they were able to restore some benefit cuts enacted during the economic downturn.
- About half the states continue to take steps to refine their pharmacy programs. Frequently cited focus areas include refinements to PDL and supplemental rebate programs, utilization or reimbursement initiatives relating to specialty and physician administered drugs, managed care-related changes including efforts to "carve-in" the pharmacy benefit into capitated manage care arrangements and continued state interest in adopting the "Actual Acquisition Cost" reimbursement methodology for ingredient costs.
- States also reported on an array of new program integrity initiatives including the use of advanced data analytics and predictive modeling, enhanced provider screening, and data sharing initiatives.

Figure 31

State Policy Initiatives Implemented in FY 2013 and Adopted for FY 2014



Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

Appendix Tables A-8A and A-8B provide a listing of Medicaid policy actions taken in FYs 2013 and 2014.

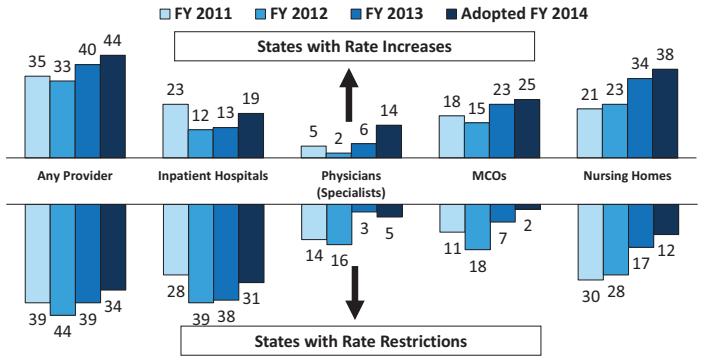
A. Changes in Provider Reimbursement

Rate Changes. State fiscal conditions continue to have a direct impact on Medicaid provider rates. During the Great Recession, states again turned to provider rate cuts to control costs, just as they did during the economic downturn from 2001 to 2004. States reported that the enhanced funding from the American Recovery and Reinvestment Act of 2009 (ARRA) helped states mitigate or avoid some rate cuts in FY 2009-2011.[55] However, the expiration of the ARRA funds resulted in more provider rate cuts in FY 2012 compared to FY 2011 despite slight improvements in the economy.

Improving state finances in 2013 and 2014 resulted in more states enhancing rates than restricting rates overall. In FY 2013, 39 states reported rate restrictions for any provider type and 40 states reported rate increases for any provider. For FY 2014, 34 states have planned provider rate restrictions while 44 states are planning or have implemented at least one rate increase. There were more rate increases in FY 2013 and FY 2014 across all major categories of providers (physicians, MCOs and nursing homes) compared to rate restrictions except inpatient rates for hospitals.[56] (Figure 32) For the purposes of this report, provider rate restrictions include cuts to rates for physicians, dentists, outpatient hospitals, and managed care organizations as well as both cuts or freezes in rates for inpatient hospitals and nursing homes.

Figure 32

Provider Rate Changes Implemented in FY 2013 and Adopted for FY 2014



NOTE: Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. FY 2014 rates were had not been determined for hospitals, MCOs and nursing homes in Florida and for MCOs in Mississippi and Wisconsin at the time of the survey.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.

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. States are also more likely to use provider tax arrangements to bolster Medicaid payment rates for these provider groups. Even with the use of hospital provider taxes in most states, hospitals are not seeing increases in their Medicaid rates in the majority of states. A total of 38 states restricted inpatient hospital rates in FY 2013 (31 states froze rates and seven states reduced rates) and a total of 31 states planned inpatient hospital rate restrictions for FY 2014 (26 states plan to freeze rates and 5 states are cutting rates). In contrast, only 17 states restricted rates for nursing homes in FY 2013 (14 rate freezes and 3 cuts) while just 12 states plan restrictions for FY 2014, with only two states planning to actually cut any nursing home rates. This is a marked change from FY 2012 in which 16 states froze nursing home rates and 12 states cut them.

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 as well. In FY 2013, 23 states reported MCO rate increases (up from 15 states in FY 2012), seven states reported MCO rate cuts (down from 18 states in FY 2012), and seven states reported flat MCO rates. For FY 2014, 25 states reported plans to increase MCO rates and only 2 states reported plans to cut rates, while rates will be unchanged in seven states. (Three states have not yet set MCO rates that will be implemented later in FY 2014.)

In prior recessions, physician rates typically have not been increased, but have seldom been cut by many states. In the recent recession however, while a few states increased physician rates, over a third of states reduced rates in at least one year between FY 2010 and FY 2012. However, as the economy has continued to improve, fewer states are reporting physician rate cuts and more states are reporting rate increases. Additionally, starting in January 2013, states were prevented from cutting primary care physician rates as part of the requirement in the ACA to increase such rates to 100 percent of Medicare rates (see below for further discussion.) In FY 2013, only three states reported cuts to specialist physician rates while six states reported increasing rates for specialists. An even larger number of states (14) plan to increase rates for specialists in FY 2014. Five states reported plans to cut specialist rates in FY 2014; however, states generally reported that such cuts are very selective, targeted at only certain procedures or specialties.

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 13 states that adopted cuts to dental rates in FY 2012. Similar to the trend with physicians, fewer states reported cuts while more states reported increases as economic conditions began to improve. Only two states report cuts for any dental rates for FY 2013 and five states reported plans to cut dental rates in FY 2014. At the same time, five states reported increasing dental rates in FY 2013 while 13 states reported plans to increase dental rates in FY 2014.

In addition, this survey asked states for the first time to report changes to outpatient hospital rates. A similar number of states reported increasing such rates in both FY 2013 (14 states) and FY 2014 (16 states). At the same time, five states reported cutting such rates in FY 2013 and nine states reported plans for such cuts in FY 2014. Changes in payment rates for specialists, dentists, and outpatient hospitals are reported in the table below.

Number of States Changing Specialist, Dental, and Outpatient Hospital Payment Rates FY 2012 - FY 2014

Provider Type	FY 2012 Rates		FY 2013 Rates		FY 2014 Rates	
	Increase	Decrease	Increase	Decrease	Increase	Decrease
Specialists	2	16	6	3	14	5
Dentists	3	13	5	2	13	5
Outpatient Hospital	N/A	N/A	14	5	16	9

The survey also provided states with an opportunity to provide information about rate changes to other categories of providers. Most states (35) reported additional rate changes, with a mix of rate cuts and rate increases. Most commonly mentioned were rate increases to long-term care providers, namely home health, personal care or home and community-based service providers as well as ICF-IDs and Private Residential Treatment Facilities. Some states reported across-the-board cuts or increases.

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:

California is implementing a ten percent provider rate reduction for most outpatient providers. This ten percent rate reduction was initially enacted under legislation in 2011, subsequently approved by CMS but not implemented due to a court injunction. That injunction was lifted in June 2013. Because the rate reduction was approved effective June 2011, the state will be implementing this reduction retroactively. Therefore, the state will be making retroactive payment recoveries in addition to cutting payment rates for current and future claims for these providers. Since the survey, the state has posted an implementation schedule for the provider rate reductions; reductions in rates will be phased in between September 2013 and January 2014 by provider type. Reductions to Medi-Cal managed care rates will be implemented October 1, 2013. The state has also announced some exemptions to the original rate cuts such as nonprofit dental pediatric surgery

centers, select nursing facilities, and certain prescription drugs. Retroactive payment recoveries will not occur until after the rate reductions go into effect for each provider and providers will be given 60 day advance notice of scheduled recoveries.[57]

Illinois reduced most provider rates (including inpatient hospitals, outpatient hospitals, MCOs and nursing homes) on average by 2.7 percent for fiscal year 2013 as part of its Medicaid reform plan which (including all components of the plan) was designed to save $1.6 billion. Physicians and dentists were exempted from these cuts as were twenty safety net hospitals.[58]

Maine is reducing outpatient hospital rates by 10 percent in FY 2014. Several rate cuts that were made in FY 2013 in Maine are being restored in FY 2014.

North Dakota increased all but physician rates by three percent in FY 2013. For FY 2014 the state is increasing all provider rates by four percent.

Ten states (Alaska, Idaho, Kentucky, Massachusetts, North Dakota, Nebraska, South Carolina, Virginia, Vermont, and West Virginia) reported no rate restrictions for in either year. In addition, two states (Missouri, South Dakota) had no restrictions in FY 2013, and seven states (Colorado, Florida, Iowa, Indiana, Maryland, Montana, and New Jersey) reported no restrictions for major provider groups in FY 2014.

Primary Care Rate Increases. The ACA included a provision to increase Medicaid payment rates for primary care services to Medicare rates from January 1, 2013 through December 31, 2014. The federal government is to pay 100 percent of the difference between Medicaid rates that were in effect as of July 1, 2009 and the full Medicare rates for these two years.

States were asked about their experience in implementing this provision. The provision offers an opportunity for states to improve payments to critical Medicaid providers and learn how payment increases influence provider participation and access to care. However, states reported implementation challenges including: short timeframes for implementation (with guidance issued in November 2012 for a January 1, 2013 effective date); difficulty determining whether a particular provider qualified (i.e. if their specialties were clearly identifiable); and problems determining methodologies for physicians not directly reimbursed by the state (such as those providing services through Medicaid MCOs, staff of federally qualified health centers and hospital-employed physicians). Other concerns included: tracking the rate differential between Medicaid and Medicare when Medicaid uses a different structure for its physician payments; applying the rate increase to the Medicaid expansion CHIP programs (for which state matching funds are required); and providing timely notice to providers.

At the time of the survey, many states were just beginning to make retroactive payments to fee-for-service Medicaid providers and some had not made any payments yet. Thirty-two of the 37 states that use contracted MCOs for part of their Medicaid program indicated that changes to their Medicaid MCO contracts were required; New Hampshire also reported making changes to their new managed care contracts. While most states had received federal approval of their methodologies for fee-for-service payments, many did not yet have approved plans for MCO physician payments. However, as of mid-September, nearly all states reported currently paying the enhanced primary care rate.[59] Although some states are reprogramming their MMIS systems to make the enhanced payments, several states have chosen to pay the rate differential via supplemental lump-sum payments to the providers. Use of these lump-sum payments avoids MMIS programming issues and makes the differential more easily identifiable for purposes of claiming the federal funding. A few states noted that implementation of this provision has resulted in some state administrative costs.

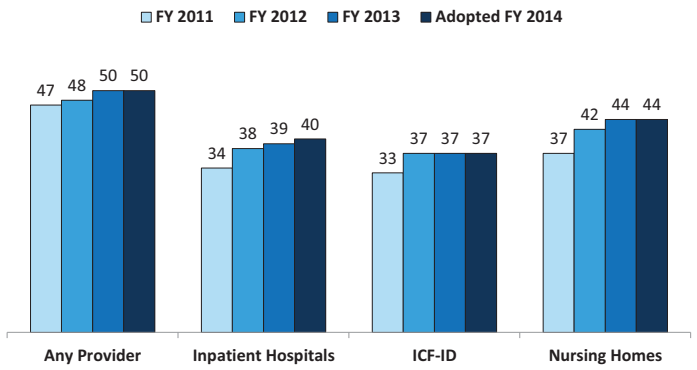
In FY 2013, four states (Alaska, South Dakota, Utah, and Washington) reported increasing primary care physician rates outside of the ACA required increase. In FY 2014, 12 states (Alaska, Arizona, Colorado, Iowa, Massachusetts, Minnesota, Montana, North Dakota, Oklahoma, Oregon, South Dakota, and Vermont) reported increasing primary care physician rates outside of the ACA required increase. Primary care rates in a number of these states were already at or close to Medicare rates.[60]

B. Provider Taxes

States continue to rely 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.) Over the past decade, a majority of states imposed new taxes and increased existing taxes to raise revenue. By FY 2013, all but one state (Alaska) has one or more provider taxes in place.[61] (Figure 33)

Figure 33

States With Medicaid Provider Taxes FY 2011 – FY 2014



NOTES: ICF-ID facilities are Intermediate Care Facilities for persons with intellectual disabilities.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011, October 2012 and 2013.

During FY 2013, states increased the number and size of their Medicaid provider taxes, but at a slower pace than recent years. In FY 2013 there were three new provider taxes and increased rates for 22 existing provider taxes, compared to 11 new taxes and 58 provider tax increases reported for FY 2012. For FY 2014, one new hospital tax will be added and rates for 14 existing taxes will have rates increased or otherwise expanded.

Provider taxes are currently limited by federal law to not more than six percent of the net patient revenues of all providers in the category that is being taxed. That limit was temporarily reduced to 5.5 percent but returned to six percent on October 1, 2011. Many provider taxes were increased when the temporary limit expired. As part of the discussions around federal deficit reduction, both the President and some in Congress have proposed reductions 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. Another version would permanently cap provider taxes at 5.5 percent of provider revenues. This survey asked Medicaid officials whether existing Medicaid provider taxes would be affected by either of these proposals. Those results are reflected in the table below, which also reflects changes in provider taxes beyond the decisions to implement new provider taxes or eliminate existing provider taxes.

Number of States with Changes in Provider Taxes, by Provider Type, FY 2013 and FY 2014

Provider Taxes	Tax Rate Decreases		Tax Rate Increases		States with Taxes in FY 2014	Taxes as a Percent of Net Patient Revenues (FY 2014):[62]	
	FY 2013	FY 2014	FY 2013	FY 2014		>3.5%	>5.5%
Hospital	1	3	7	5	40	15	3
ICF – ID	1	0	4	2	37	32	18
Nursing Facility	2	2	8	4	44	35	19
MCO	0	0*	2	2	12	3	0
Other	2	1	1	1	13	6	3

*Oregon eliminated their MCO provider tax in FY 2014.

In prior surveys 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. This year, states were asked to estimate the proportion of the non-federal share of their Medicaid expenditures that are funded through provider taxes. For the 30 states that provided an estimate, responses ranged from less than one half of a percent to slightly more than 40 percent. Thirteen states reported relying on provider taxes for more than 10 percent of their non-federal Medicaid funds and for six states, provider taxes represent more than 20 percent of non-federal Medicaid funding. These responses show that policy changes for provider taxes would have a differential impact across states.

Appendix Table A-9 provides a complete listing of Medicaid provider taxes in place for FYs 2013 and 2014.

C. Premiums and Cost-sharing

Medicaid beneficiaries tend to be poorer and sicker than those enrolled in private insurance. Given these characteristics, federal law limits the extent to which states can charge premiums and cost-sharing, particularly for pregnant women, children and low-income adults but allows flexibility for individuals with higher incomes. Over the years, Medicaid premiums and cost-sharing have been used to limit state program costs, to encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage. The use of premiums has been targeted to certain populations while copayments have been used more broadly across states.

In July 2013, CMS released final rules that streamlined and simplified existing regulations around premiums and cost-sharing while also making some changes to regulations for cost-sharing. The table below summarizes the current new cost-sharing rules.

Federal Maximum Allowable Cost-sharing			
Notable Cost-Sharing Changes	Individuals with family income:		
	≤ 100% FPL	101 – 150% FPL	≥ 150% FPL
Outpatient Services (physician visit, physical therapy, etc.) Inpatient Stay	$4 (Will be updated annually based on the CPI-U) $75 (Will be updated annually based on the CPI-U)	10% of cost for entire stay	20% of cost for entire stay
Preferred Drugs	$4	$4	$4
Non-Preferred Drugs	$8	$8	20% of cost
Non-emergency Use of the ER	$8	$8	No Limit

Federal Register Vol. 78, No. 135, July 15, 2013, pp. 42307-42310.

Premiums

While states are generally limited to charging premiums to Medicaid beneficiaries with incomes over 150 percent FPL, there are certain higher income populations for which premiums may be charged (sometimes labeled as "buy-in" programs). As of FY 2013, 39 states reported that they have at least one group that is able to participate in Medicaid by paying a premium; 12 states (Alabama, the District of Columbia, Florida, Hawaii, New Jersey, New Mexico, New York, North Carolina, South Carolina, South Dakota, Tennessee, and Virginia) do not currently require premiums in the Medicaid programs. In total, states have 59 different premium programs. There were no new premium initiatives in FY 2013. The ACA MOE provisions that were designed to help maintain coverage for individuals during the economic downturn ahead of the ACA, also prevent states from increasing premiums (beyond inflationary increases) since the level of the premium charged can also affect eligibility. The major ways states use premiums are discussed below:

- The most common premiums allow Medicaid beneficiaries with disabilities continue their Medicaid coverage by paying premiums as they begin to earn income or accumulate assets that would otherwise make them ineligible for Medicaid. Generally these programs are called **Ticket to Work or Medicaid for Employed Persons with Disabilities**. In addition, states now have the option to allow individuals who were enrolled in one of these premium programs to remain in the program when they reach age 65, or when their health status improves, as long as they continue paying a premium. Thirty-five states have at least one premium programs for working people with disabilities.
- The **Family Opportunity Act (FOA)** allows families with uninsured children with disabilities who do not otherwise qualify for Medicaid to pay a premium for Medicaid coverage for their children. The FOA is optional for states. Only four states (Colorado, Louisiana, North Dakota, and Texas) report that they have chosen this option.
- Two states (Arkansas and Maine) also have coverage options that involve premiums for higher income families for their medically fragile persons with disabilities (**TEFRA or Katie Beckett**).

- Some Medicaid Section **1115 Waivers** cover parents, adults without dependent children, or even infants with incomes above the limits that are typical for Medicaid programs. Nine states (Iowa, Massachusetts, Minnesota, Oklahoma, Oregon, Rhode Island, Utah, Vermont, Wisconsin) have twelve waivers that allow them to charge premiums to these higher income populations.
- Three states (Nebraska, Washington, Wisconsin) have initiatives that allow parents with increased income to pay premiums and remain on Medicaid after the expiration of their **"Transitional Medical Assistance"** coverage. In FY 2014, Washington is eliminating this program and Wisconsin is increasing the level of the premiums.
- Two states have other premium initiatives, one for individuals with HIV (Maine) and one for those with breast or cervical cancer (Massachusetts).

States reported limited changes to premiums for FY 2013 and FY 2014. In FY 2013, Missouri increased premiums in its Ticket to Work program and Minnesota and Iowa reported decreases in premiums. For FY 2014: Arkansas, Iowa, Kentucky, Louisiana, Oregon, Rhode Island, and Wisconsin reported the elimination of programs that had premiums; Minnesota reported additional decreases in MinnesotaCare and Missouri reported an increase in premiums in its Ticket to Work Program. Additionally, Iowa is currently seeking a waiver as part of the ACA Medicaid expansion that would require enrollees with incomes over 50 percent FPL to pay monthly premiums (more detail is located in the following section.)[63]

Copayment Requirements

Copayment requirements are used to varying degrees by most state Medicaid programs: a total of 46 states (including DC) have copayment requirements, including five states (Delaware, Louisiana, Maryland, New Hampshire and West Virginia) that impose copayments only on drugs. Only five states (Hawaii, Nevada, New Jersey, Rhode Island and Texas) reported having no copayment requirements at all.

Consistent with the findings in last year's survey, only a small number of states reported actual or planned changes to cost-sharing requirements: four states reported new or higher copayments requirements for FY 2013 and eight states reported plans to raise or impose new copayment requirements in FY 2014. The new requirements and increases are highlighted below:

Pharmacy. Consistent with previous surveys, new or increased pharmacy copayments were the most frequently cited. Three states (Illinois, South Dakota and Wyoming) increased pharmacy copayment requirements in FY 2013. Three states (Maine, Tennessee and West Virginia) planned to impose or increase pharmacy copayment requirements in FY 2014.

Emergency Room. Two states (Illinois and Wyoming) planned to implement or increase copayments for non-emergency use of the emergency room in FY 2013 and three states (California, Connecticut and West Virginia) planned to do so in FY 2014.

Increases to Federal Maximum Amounts. One state in FY 2013 (Illinois) and two states in FY 2014 (Alabama and North Carolina) reported plans to increase their copayment amounts to the maximum federal level. These levels were adjusted in the final regulations release in July 2013.

Additionally, as discussed further below, four states (Arizona, Arkansas, Iowa, and Michigan) reported plans to impose cost-sharing requirements on their ACA Medicaid expansion populations.

Two states in FY 2013 (Kansas and Vermont) and four states in FY 2014 (Maryland, Minnesota, Vermont and Wisconsin) reported plans to decrease or eliminate a copayment requirement. In two cases, the decreases are related to the transition of current waiver expansion populations to coverage under the ACA Medicaid expansion in 2014:

Maryland is eliminating the policy that makes copayment requirements enforceable for Maryland waiver enrollees as it transitions this population to the new ACA Medicaid expansion group.

Minnesota is reducing copayments (along with premiums as mentioned earlier) in its MinnesotaCare program to align with Basic Health Plan requirements.

Enforceability and Alternative Cost-sharing Requirements. Since the passage of the DRA, Medicaid agencies have been allowed to make cost-sharing enforceable (that is, to allow a provider to deny rendering services if the copayment requirement is not met.) Subject to certain limits and exemptions, the DRA also permits states to charge greater than nominal cost-sharing for certain eligibility groups and most services and also allows states to vary the cost-sharing requirements by eligibility group. Other than the policies discussed below for ACA-related expansion groups, in this year's survey, no state reported imposing greater than nominal copayment requirements and only West Virginia reported plans to vary copayment obligations by eligibility group. Eleven states (Arizona, Idaho, Kentucky, Maryland, Nebraska, New Hampshire, North Carolina, Oklahoma, Utah, Wisconsin and Wyoming) reported that copayment requirements were enforceable in FY 2013 for at least one eligibility group as allowed by the DRA. Maine reported plans to make pharmacy copayments enforceable in FY 2014 and Arkansas indicated that its proposed copayment requirements for the Medicaid expansion population with incomes above 100 percent FPL will be enforceable.

Cost-sharing and the ACA Medicaid Expansion. In this year's survey, states moving forward with the ACA Medicaid expansion in January 2014 were asked if the cost-sharing requirements for the expansion population would be different compared to those currently eligible. The majority of expanding states (16 of 25) reported that there would be no difference, two states (Arkansas and Arizona) indicated cost-sharing requirements would be higher, one state (Minnesota) reported that cost-sharing requirements would be lower to align with Basic Health Plan requirements, and three states (Kentucky, North Dakota and New Mexico) indicated that a decision on cost-sharing was still pending. West Virginia reported plans to adopt new copayment requirements for all MAGI-based eligibility groups including the adult expansion population.

Finally, Iowa and Michigan are seeking Section 1115 demonstration waiver authority relating to cost-sharing. The "Iowa Wellness Plan," which proposes to use Medicaid as premium assistance to purchase coverage through QHPs in the state's insurance Marketplace for those with incomes from 101 - 138 percent FPL while those under 100 percent FPL would be covered through existing Medicaid delivery systems, includes emergency room copayments and premium requirements. There would be no copayment requirements except for non-emergency use of the emergency department. Enrollees with incomes over 50 percent FPL would be required to make a monthly premium contribution (indexed to three percent of income), beginning in the second year of coverage, which could be waived if the member completes specified wellness activities. Cost-sharing and premiums are capped at five percent of income. Iowa's waiver application is pending with CMS.[64] Recently, Michigan passed legislation calling for the state to seek waiver authority to impose copays and other contribution requirements for persons between 100 and 138 percent FPL utilizing Health Savings Account (HSA)-like accounts, not to exceed 5 percent of income. Cost-sharing would not apply during the first six months and contributions may be reduced if enrollees meet certain health goals. After 48 months of cumulative Medicaid eligibility, these enrollees would be required to either purchase private coverage through the Marketplace or pay higher Medicaid cost-sharing not to exceed 7 percent of income.

Additional information on FY 2013 or FY 2014 changes to premiums and copayments is reported in Appendices A-10A and A-10B.

D. Benefits Changes

Largely due to improvements in the economy, more states adopted expansions or enhancements to benefits than restrictions in FY 2013 and FY 2014. Twenty-four states in FY 2013 and 21 states in FY 2014 reported expanding benefits. These totals include nine states in FY 2013 and eight states in FY 2014 adding or expanding home and community-based services, six states in FY 2013 and seven states in FY 2014 adding or expanding behavioral health services and four states in FY 2013 and three states in FY 2014 that are restoring or expanding dental benefits.

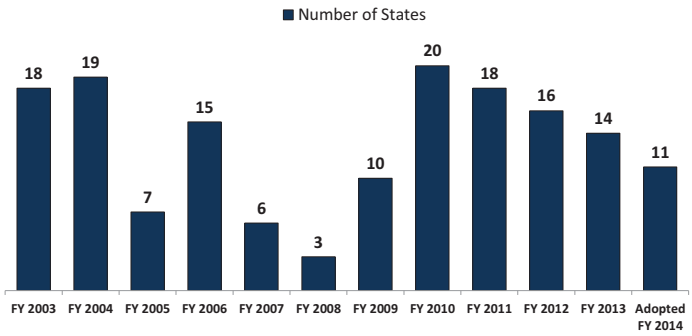
> ***"We are especially proud of the benefits we are able to add back to the program, such as the restoration of adult dental health"***

The number of states cutting or restricting benefits – 14 in FY 2013 and 11 in FY 2014 – continues to decline from the highpoint of 20 states in FY 2010 (Figure 34).

Benefit restrictions reflect the elimination of a covered benefit or the application of utilization controls for existing benefits. Of the 14 states in FY 2013 and 11 states in FY 2014 reporting cuts or eliminations, five states in FY 2013 and one in FY 2014 reported one or more benefit eliminations as described in the table below. Eleven states in FY 2013 and ten in FY 2014 (including two of the FY 2013 states listed in the table below), applied more narrowly targeted limits or utilization controls to existing benefits.

Figure 34

States Cutting or Restricting Benefits FY 2003 – FY 2014



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004, 2005, 2006, 2007, 2011, 2012 and 2013 and September 2008, 2009, 2010.

Benefit Eliminations by State	
State	**FY 2013**
Colorado	Vision therapy services
Illinois*	Non-emergency dental and chiropractic services as well as bed hold payments for nursing facilities
Louisiana	Dental benefits and rehabilitation clinic services
Maine*	Ambulatory surgical center, STD screening clinic services and smoking cessation products and services
Mississippi	Escorted transportation in the Elderly and Disabled Waiver
State	**FY 2014**
West Virginia	Weight management services

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

The most commonly cited benefits targeted for cuts or restrictions were home and community-based services (three states in FY 2013 and four in FY 2014), nursing facility related services (two states in FY 2013 and two states in FY 2014), dental services (four states in FY 2013 and one in FY 2014), and outpatient hospital/ER (two states in FY 2013 and one state in FY 2014). Illinois, Florida and Maine were notable for the number of reductions reported, all in FY 2013.

Additional information on FY 2013 or FY 2014 changes to benefits is reported in Appendices A-11A and A-11B.

E. Prescription Drug Utilization and Cost Control Initiatives

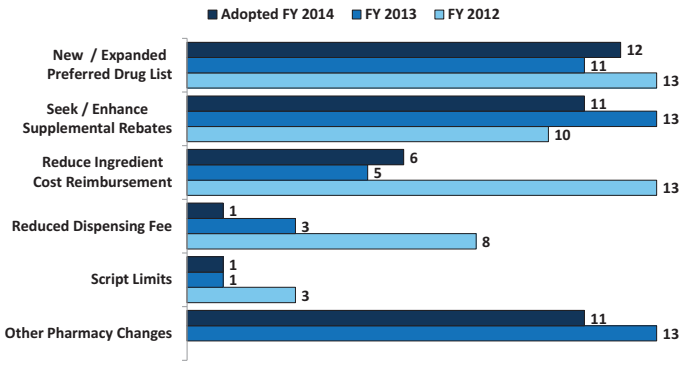
Almost all state Medicaid programs employ a sophisticated array of pharmacy management tools including preferred drug lists (PDLs), supplemental rebate programs, prior authorization programs, state maximum allowable cost ("state MAC") programs, generic incentives and other utilization management controls. This year's survey finds that about half the states continue to take steps to refine their pharmacy programs. Frequently cited focus areas include refinements to PDL and supplemental rebate programs, utilization or reimbursement initiatives relating to specialty and physician administered drugs, managed care-related changes including efforts to "carve-in" the pharmacy benefit into capitated manage care arrangements and continued state interest in adopting the "Actual Acquisition Cost" reimbursement methodology for ingredient costs.

Pharmacy Management Policies in Place. In FY 2013, a total of 46 states indicated that they had adopted a Preferred Drug List (PDL) and obtained supplemental rebates – the same number that was reported in 2011 and 2012. Of the remaining five states that have not adopted a PDL or implemented a supplemental rebate program, three states (Arizona, Hawaii, and New Jersey) have less of an incentive to do so because they rely heavily or completely on capitated managed care organizations (MCOs) to administer the Medicaid pharmacy benefit. The number of states with limits on the number of prescriptions that Medicaid will pay for each month rose slightly to 18 states in FY 2013 from 16 in FY 2011 and 2012.

Summary of FY 2013 and FY 2014 Pharmacy Policy Changes and Cost Containment Efforts. Twenty-four states in FY 2013 and 25 states in FY 2014 implemented cost-containment initiatives in the area of prescription drugs, fewer than the number of states taking such actions in FY 2012 (33), FY 2011 (31 states) or FY 2010 (38 states). As PDL and related supplemental rebate programs have matured in most states and as more states have carved the pharmacy benefit into capitated managed care arrangements (see discussion under "Managed Care Pharmacy Policies" below), the number of states reporting PDL or supplemental rebate changes (e.g., adding new PDL drug classes or joining a multi-state rebate pool) has stabilized at a lower level (11 to 13 states) compared to 24 to 28 states in FY 2009. A small number of states reported reductions in ingredient cost reimbursement (5 states in FY 2013 and 6 states in FY 2014), often associated with the adoption of an Actual Acquisition Cost (AAC) methodology (discussed further below), and an even smaller number reported dispensing reductions or imposing new limits on the number of monthly prescriptions. (Figure 35)

Figure 35

Medicaid Prescription Drug Policy Changes, FY 2012-2014



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004, 2005, 2006, 2007, 2011, 2012 and 2013 and September 2008, 2009, 2010.

AWP Ingredient Cost Pricing. State Medicaid programs reimburse pharmacies for the "ingredient cost" of each prescription, plus a dispensing fee.[65] In recent years, states have increasingly moved away from the "Average Wholesale Price" (AWP) benchmark for ingredient cost reimbursement. As a result of a court challenge questioning the validity of the AWP methodology, one AWP publishing firm (First Databank) discontinued its AWP publishing after September 2011[66] which was an impetus for a number of states to change their ingredient cost reimbursement methodology at that time. One alternative benchmark to AWP is the "Average Acquisition Cost" (AAC). Alabama and Oregon were the first two states to develop an AAC methodology that relies on periodic random sampling of enrolled pharmacies to collect actual pricing information. In this year's survey, three states in FY 2013 (Colorado, Iowa and Louisiana) and three states in FY 2014 (New York, Texas and Wyoming) reported adopting, or plans to adopt, the AAC methodology.[67]

Responding to the urging of a number of states[68], in June 2012 CMS launched its outpatient drug acquisition cost survey of retail community pharmacies[69] for the purpose of developing a database of National Average Drug Acquisition Costs (NADACs) that states could then use for Medicaid pharmacy pricing. CMS also issued a proposed rule in February 2012 that would require Medicaid programs to adopt the AAC methodology for non-multi-source drugs.[70] In this year's survey, several states indicated that future reimbursement changes may occur if CMS published final NADACs and finalized the proposed rule.

Managed Care Pharmacy Policies. Prior to the passage of the ACA, states were unable to collect rebates on prescriptions purchased for Medicaid beneficiaries by MCOs operating under capitated arrangements. As a result, states sometimes "carved-out" the pharmacy benefit from MCO contracts to maximize state rebate collections. States can now collect rebates on prescription drug expenditures by MCOs causing the number of states with full or partial MCO pharmacy carve-outs to decline.

In this year's survey, five states in 2013 (Illinois, Kansas, Louisiana, Utah and West Virginia) reported that most or all of the Medicaid pharmacy benefit had been "carved-in" to MCO contracts.[71] Utah indicated, however, that mental health and a few other drugs continued to be carved-out. New Hampshire, which will be implementing a statewide managed care program in December 2013, plans to carve pharmacy into their managed care contracts. Also, Michigan reported that MCO drug carve-outs were expanded in FY 2013 (including anti-hemophilic clotting factors and select drugs for metabolic diseases) to facilitate continuity of care for children with special health care needs migrating to MCO coverage. States also reported on other managed care pharmacy policy changes:

Four states reported on policies to standardize pharmacy administration across MCOs: Florida adopted and Texas renewed a common PDL for all plans in FY 2014; Mississippi reported plans to adopt a common pharmacy listing for fee-for-service and all MCOs in FY 2014, and New York reported adoption of a standardized pharmacy prior authorization form in FY 2013.

Two states reported on new FY 2013 policies relating to retail pharmacy access: New York adopted a specialty pharmacy program provision enabling MCO enrollees to obtain mail order specialty drugs at any retail network pharmacy if the network pharmacy agrees to a comparable price. Texas began allowing members (both in managed care and fee-for-service) to access a limited set of home health supplies through a pharmacy (e.g. diabetic supplies and asthma spacers for inhalers) in FY 2013 and plans to allow MCO and fee-for-service members to access certain vitamins and minerals for children with select conditions through a pharmacy (described as increasing costs).

New York expanded its managed care "prescriber prevails" provision in FY 2013 to include drugs in a number of new classes such as the anti-depressant, antiretroviral, and seizure classes among others. This initiative enables the prescriber's reasonable professional judgment to prevail for the above therapeutic drug classes that are not on plan formularies or have prior authorization requirements.

Texas reported on a number of other managed care policy changes planned for FY 2014 including 1) eliminating PBM spread pricing (i.e. PBMs charging MCOs higher prices than they pay pharmacies); 2) requiring MCOs to disclose more about how they set maximum allowable cost pricing; 3) requiring MCOs to use their own point-of-care web based application to allow providers to access the universal formulary and PDL, including MCO-specific clinical prior authorizations; 4) allowing MCOs to implement more stringent clinical prior authorizations than in fee-for-service; 5) requiring MCOs to use a shared-savings approach for reimbursing providers participating in the HRSA 340B Drug Pricing Program, and 6) prohibiting MCOs from using extrapolation when auditing pharmacies.

Other Pharmacy Policy Changes. Thirteen states in FY 2013 and 11 in FY 2013 reported on a wide range of additional pharmacy cost containment measures; a summary of which are listed in the table below.

Other Pharmacy Changes	
Policy Change	**State**
Adding Prior Authorization Requirements	Arkansas, Connecticut, Illinois, Montana, New York, North Carolina and Texas
Imposing Dosage or Quantity Limits	Alabama, Georgia, Illinois, Mississippi*, New York* and Vermont
Initiatives focused on hemophilia and other specialty drugs	Hemophilia - Illinois, North Carolina, Missouri and Texas* Others – Alabama, Delaware, Georgia, Indiana, Kansas*, Minnesota and Ohio
Initiatives to control behavioral health drug utilization	Connecticut, Maryland, Mississippi, New York* and Texas
Changes to prior authorization or pricing of physician administered drugs	Minnesota, Oregon and South Carolina
Implementing or expanding a 340B initiative	Vermont, Minnesota and Missouri

(*States described action as "fiscally neutral")

In addition, two states (Indiana and Vermont) reported implementing e-prescribing services or support[72]; Wisconsin reported implementing a medication therapy management program; Vermont reported increasing third party liability collection efforts; the District of Columbia reported implementing a dedicated pharmacy network in its Healthcare Alliance program; Michigan reported rolling out face-to-face prescriber visits to conduct "EnhanceMed" psychotropic DUR/academic detailing; South Carolina reported plans to adopt a broad range of value-based benefit design strategies; Montana reported plans to allow pharmacies to bill for vaccine administration and New Mexico reported plans (fiscally neutral) to offer paid training for pharmacists to administer vaccines; Maine reported implementing a "Generic First" policy and Tennessee and Arkansas reported changing their PBM vendor.

Finally, a few states reported pharmacy-related expansions or reversals of previous pharmacy cost containment actions including:

Five states increased dispensing fees in FY 2013 (Colorado, Hawaii, Iowa, Louisiana and Maine) and six states planned to increase dispensing fees in FY 2014 (Iowa, Indiana, Montana, New York, South Dakota, and Texas). In five of these states (Colorado, Iowa, Louisiana, New York, and Texas), dispensing fee increases were intended to partially offset reimbursement decreases resulting from the adoption of the AAC ingredient cost reimbursement methodology. One other state transitioning to AAC (Wyoming) indicated that future dispensing fee changes related to the AAC change were possible.

Two states in FY 2013 (Nevada and South Dakota) and two states in FY 2014 (Colorado and Nevada) increased, or reported plans to increase ingredient cost reimbursement.

South Carolina reported plans to exempt some chronic medications from its monthly prescription cap but expects this change to generate medical savings that will offset increased pharmacy costs. North Carolina eliminated its monthly cap in FY 2013 and West Virginia reported that the elimination of the Mountain Health Choices benchmark plan in January 2014 would result in the elimination of the related monthly prescription cap.

See Appendix Tables A-12a and A-12b for more detail on pharmacy cost containment actions.

F. Section 1115 Demonstration Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive certain federal Medicaid requirements and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. This authority is used for experimental, pilot, or demonstration projects that the Secretary determines will promote the objectives of the Medicaid program. States may seek "comprehensive" Section 1115 waivers that make broad changes in Medicaid eligibility, benefits, cost-sharing, and provider payments, but can also obtain narrower waivers that focus on specific services, such as family planning. Longstanding administrative policy requires 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 seek to renew or amend the waiver to continue operations.

Expiring Eligibility-Related Waivers. In light of the ACA Medicaid expansion planned for FY 2014 in many states, this year's survey asked states about their plans for Section 1115 waivers that include an eligibility expansion component and that are set to expire in FY 2014. The majority of states with expiring waivers are states planning to implement the ACA Medicaid expansion.

Of the states moving forward with the Medicaid expansion, most of the waiver coverage would be transitioned to the ACA Medicaid expansion coverage or to Marketplace coverage. A few states are pursuing new waivers to cover the expansion population (like Arkansas[73], Iowa and Michigan), planning to maintain waivers to cover select groups (Family Planning waiver group in Illinois, HIV, Breast & Cervical Cancer and premium assistance coverage groups in Massachusetts and Family Planning waiver beneficiaries and pregnant women up to 250 percent FPL in Maryland), or planning to renew eligibility components of current waivers with ACA conforming changes.

Among the states that are not implementing the ACA expansion, some indicated that they planned to renew the eligibility components of their current waiver or transition coverage to Marketplace coverage. Idaho reported that its premium assistance waiver enrollees would be transitioned to subsidized Marketplace coverage. Indiana was approved for a one-year extension of its Healthy Indiana Program waiver with a reduced coverage level (100% FPL). Waiver coverage in Oklahoma was also renewed for a one-year extension with eligibility generally reduced to 100% FPL. Wisconsin is pursuing a replacement waiver with a reduced coverage level for adults without dependent children (100% FPL), and Maine reported that it would allow its waiver to expire (as of December 31, 2013) resulting in the loss of coverage for approximately 10,000 adults.

Other Section 1115 Waiver Actions. In this year's survey, State Medicaid officials were also asked if they were planning to implement any other comprehensive Section 1115 waiver or waiver amendments in FY 2014 (other than a family planning waiver). The following states reported additional Section 1115 plans:

- Seven states (California, Florida, New Jersey, New Mexico, New York, Rhode Island and Texas) reported seeking a Section 1115 waiver or waiver amendment to implement or expand managed care including managed long-term care in four states (Florida, New Jersey, New Mexico and Rhode Island).
- Seven states (California, Louisiana, Maryland, New Jersey, New Mexico, New York and Rhode Island) reported seeking waiver authority for safety-net delivery system improvement initiatives.
- Alabama reported seeking waiver authority to implement Regional Care Organizations.
- Minnesota reported plans to use waiver authority to provide more flexible LTSS.
- Montana reported plans to amend its Basic Medicaid waiver to expand eligibility by adding major depression as an eligible diagnosis and by increasing the enrollment cap from 800 to 2,000.
- Nevada indicated plans to use waiver authority to provide care management for persons with chronic conditions in the fee-for-service delivery system.
- New York reported plans to use waiver authority to implement delivery system and payment reforms.

G. Program Integrity Initiatives

Medicaid has always had a primary focus on fraud and abuse, but budget pressures, spending increases as well as Congressional oversight has intensified the focus in this area.[74] Most recently, the ACA included a number of provisions aimed at preventing fraud and abuse in the Medicare, Medicaid and CHIP programs. According to CMS, these measures will help shift fraud and abuse efforts "from a 'pay and chase' approach to one that makes it harder to commit fraud in the first place."[75]

Key Fraud and Abuse Provisions from the Affordable Care Act[76]	
Provision	**Description**
New funding	Additional $350 million to CMS to detect and fight fraud and abuse over 10 years from October 1, 2010, through September 30, 2020
Enhanced screening requirements	Includes licensure checks, criminal background checks, fingerprinting, and unscheduled and unannounced site visits for providers enrolling in Medicare, Medicaid, and CHIP
Required compliance plans	Medicare, Medicaid, or CHIP provider enrollment conditioned on having a compliance plan focused on preventing fraud
RAC audits expanded	Federal recovery audit contractor (RAC) efforts expanded to Medicaid, Medicare Advantage, and the Medicare Part D prescription drug program
New enforcement tools	New authority for HHS to impose stronger civil and monetary penalties for fraudulent activities and enforce temporary payment moratoria to prevent or combat fraud in Medicare, Medicaid, and CHIP

The tools for addressing fraud and abuse and for ensuring program integrity have changed and become more sophisticated with the availability of electronic technology that is better able to keep pace with integrity risks in a rapidly changing health care system. In this year's survey, states were asked to describe new and enhanced program integrity efforts including initiatives that employ advanced data analytics and predictive modeling, enhanced provider screening (beyond ACA required efforts) and public/private data sharing.

Advanced Data Analytics and Predictive Modeling. Medicaid claims data contains a wealth of information that can be "mined" to detect aberrant and suspicious billing patterns. Predictive modeling and other analytical technologies can be used both to prevent improper payments from occurring and to flag specific claims and providers for post-payment review and investigation. Twenty states in FY 2013 and 25 states in FY 2014 reported plans to implement or enhance predictive modeling or other analytical technologies. In some cases, states reported on data analytics procurements or planned procurements, while other states reported that these capabilities were included as part of a larger MMIS (Medicaid Management Information System) procurement or implementation. Texas commented specifically on its implementation of "Graph Pattern Analysis" technology that uses large data sets to identify hidden connections and patterns that otherwise would not be discoverable and New Mexico commented on its plans to expand the use of its data analytics capabilities to include managed care encounter claims in FY 2014.

Enhanced Provider Screening. New and enhanced provider screening initiatives are designed to avoid payment of fraudulent claims by preventing dishonest entities from enrolling as providers. Eleven states in FY 2013 and 15 states in FY 2014 reported plans to implement or expand an enhanced provider screening initiative (beyond ACA requirements.) For example, two states (California and Florida) noted adding advanced data analytics to screenings, three states (Iowa, New Mexico and Texas) reported more extensive background checks and/or collection of more extensive ownership and control disclosures, Massachusetts reported increased coordination with the Board of Registration in Medicine, Arizona and Mississippi indicated plans to expand or improve on-site provider visits, Virginia reported new requirements for personal care providers to be Medicare certified or state licensed, Arizona reported expanding requirements for attendant care agencies and non-emergency transportation providers, Wisconsin reported enhanced screening of personal care agencies, and Illinois and Minnesota reported new surety bond requirements.

Public/Private Data Sharing Initiatives. All health care payers, public and private, are vulnerable to fraud and abuse and therefore have an incentive to share data and information that could enhance their

detection and prevention efforts. In this year's survey, 14 states in FY 2013 and 20 states in FY 2014 reported on new or enhanced public/private data sharing initiatives. For example, three states (Arkansas, Virginia and West Virginia) reported plans to participate in an all-payer claims database that could be used for program integrity purposes, three states (Arizona, Iowa and Mississippi) mentioned Medi-Medi programs (Medicaid – Medicare data sharing programs), three states (DC, Illinois and Texas) reported on new interagency agreements, three states (DC, California and Missouri) reported enhanced coordination efforts with the state Medicaid Fraud Control Unit, two states (Alaska and New Jersey) reported data-sharing with correctional authorities, Alaska reported data-sharing with Homeland Security, Immigration and Customs, North Dakota reported working closely with an in-state insurance provider to discuss providers with questionable billing practices, Wisconsin reported participating with other private payers on the U.S. DOJ Health Care Fraud Task Force and Massachusetts and Virginia reported enhanced PARIS[77] activities.

Other Program Integrity Initiatives. Eighteen states in FY 2013 and 28 states in FY 2014 reported on a wide range of other program integrity efforts or initiatives. The most common activities mentioned (10 states) were enhanced audit or investigation activities including implementation or enhancement of the federally required Recovery Audit Contractor (RAC) program. Six states reported on efforts to enhance program integrity efforts in managed care programs, five states reported implementing new program integrity case management systems, four states mentioned staff increases, and three states (Massachusetts, Virginia and Wisconsin) indicated focusing greater attention on recipient issues. A focus on specific provider groups was reported by Maryland (behavioral health), Minnesota (HCBS), New Jersey (FQHCs) and Virginia (HCBS). Two states (Arkansas and Rhode Island) reported the creation of a new program integrity or Inspector General office. Arizona reported a legislative grant of new law enforcement status and authority and Illinois reported that the legislature had enhanced the OIG's authority to prevent and remedy the unauthorized use of medical assistance. Oregon reported plans to increase efforts to assure appropriate FMAP claiming and Massachusetts reported plans to increase the use of data matches with the IRS and the federal data services hub and other data checks.

5. Medicaid Administration and Perspectives of Medicaid Directors

Medicaid Administration. For the past three years state Medicaid agencies have increasingly focused on a complex set of new requirements related to the implementation of the ACA. The administrative challenges have been extensive, regardless of whether a state is moving forward with the Medicaid expansion. Implementation of new requirements has been coupled with limited resources (both in terms of staffing and funding), lack of staff expertise, a compressed timeframe, delayed federal guidance and public deadlines to implement changes.

Specifically, Medicaid directors listed the following as the major administrative challenges facing their programs: the move to a universal Medicaid eligibility system using Modified Adjusted Gross Income (MAGI), updating and replacing enrollment systems (including legacy systems which in some cases were designed decades ago), coordinating and collaborating the development and implementation of the new health insurance Marketplaces, implementing an array of delivery system and payment reforms including patient centered medical homes, health homes, and the enhanced payments for primary care providers.

These changes require new systems, new interfaces with programs within and outside of Medicaid, revisions to policies and procedures, manuals, instructions and training materials, updates to forms and publications, and many other edits and changes to state MMIS and other systems. State Medicaid programs have historically operated with limited resources and staffing, and the need to implement these major initiatives did not always mean additional resources. When asked about administrative capacity to implement the ACA-related changes, the most common response was that the number of staff was limited, but that they were working doubly hard to accomplish the required changes.

> ***"Serious staff shortages and inability to hire quickly have made it extremely challenging to meet the ACA mandates. Very few staff are handling enormous workloads."***

Across all states, a total of 30 states indicated that they were not provided additional resources to implement the ACA-related changes. Even those with additional resources mentioned it was challenging to find qualified staff, particularly in the IT and policy areas, and getting staff hired and trained. Over the long-term, the vast majority of directors indicated that the investment in new online and automated MAGI eligibility systems had the potential to make the work easier and less complex for eligibility workers and for applicants. However, the magnitude of the changes, short-timeframes and delays in federal guidance have been difficult in the short term.

> ***"We are not 24/7 yet, but we are definitely working seven days a week." "We have met tough deadlines in the past, and we will meet this one.***

Perspectives. Across all states, the biggest challenges facing Medicaid programs in 2013 and 2014 are those relating to the ACA, in particular the eligibility policy and system changes and the coordination and integration of the new systems with the new health insurance Marketplace and other health and social service programs. These challenges were identified across all states, regardless of the state decision on the Medicaid expansion. Among the 25 states that are moving forward with the Medicaid expansion at this time, preparing for this expanded coverage is an added ACA-related priority.

The second challenge listed by Medicaid directors is the development and implementation of significant payment and delivery system reforms. States are focused various strategies to coordinate and integrate care, particularly for individuals on Medicaid with chronic conditions, persons with behavioral health needs, persons with dual Medicaid-Medicare eligibility, and persons in long-term care. To improve health care services and health care outcomes, states have placed a high priority on addressing the fragmentation commonplace in the health care system and are focused on finding approaches that align the incentives of the reimbursement systems with the outcomes desired for Medicaid enrollees in these groups.

The third most common current issue among Medicaid directors is a continued focus on the cost of Medicaid, its impact in the state budget, and strategies designed to slow or reduce program growth. The fiscal pressures may have eased somewhat across the states, but since economic recovery has been slow in the short term and many states face structural budget issues related to pensions and retiree health in the long-term, pressure to control costs remains a high priority. Directors pointed to payment and delivery system reforms that could "bend the cost curve" while also improving care.

The fourth issue related to administrative capacity. States point to limited resources in terms of staff and funding as well as the needs for staff with new expertise related to IT, Medicaid policy and managed care as key administrative challenges. Finding, keeping and training qualified staff was listed by many Medicaid directors as a significant issue.

> ***"It's just the volume of change." The administrative and policy development demands on Medicaid have been unrelenting.***

Even with all of these challenges, Medicaid directors were proud of the performance, staff, impact and accomplishments of their Medicaid program. Directors also pointed to beginning successes tied to payment and delivery system reform, efforts to control costs, and implementation of the ACA. Medicaid directors were proud of the positive difference the program makes in the lives of beneficiaries, and in the health care system where they receive their care. Emerging from the severe fiscal challenges of the last few years, Medicaid directors were relieved to have weathered the storm while minimizing adverse impacts on the beneficiary population, and in some cases restoring benefit cuts in FY 2014.

> ***"I am most proud of the commitment that our team has to continuously improve the program. These efforts include being better able to report and monitor spending, improving the quality of care that our beneficiaries receive, and identifying areas where our program is not working and striving to address the issues."***

CONCLUSION

FY 2013 and FY 2014 are transformative years for the Medicaid program. After three years of development of complex systems to streamline enrollment processes and to coordinate and expand eligibility, changes will begin to take effect. States moving forward with the Medicaid eligibility expansion as provided in the ACA up to 138 percent of the federal poverty level will see the number of persons with Medicaid coverage increase substantially in 2014, but enrollment will increase for all states as participation in Medicaid by those already eligible is expected to increase as outreach campaigns increase awareness and participation.

For FY 2014, Medicaid enrollment is expected to increase on average by almost nine percent, with growth of almost 12 percent in states expanding Medicaid eligibility, and growth averaging 5 percent in states opting not to expand eligibility. Medicaid spending is expected to increase by about 10 percent across all states, including growth that will average 13 percent among the 25 states that had opted to expand eligibility at the time of the survey and 6.8 percent among the 26 states not expanding in FY 2014. Reflecting the 100 percent federal funding for newly eligible enrollees, states expanding Medicaid are projecting growth in the state general fund cost of Medicaid that is less than that projected for states not expanding: 4.4 percent for states expanding compared to 6.1 percent for states not expanding.

Nearly all states are implementing delivery and payment system reforms designed to integrate and coordinate care, and to have the reimbursement system encourage and reinforce improvements in quality of care and health care outcomes. Managed care continues to be the primary vehicle for implementing these reforms, but significant reforms are also occurring through health homes, patient-centered medical homes, ACOs, and other initiatives that coordinate acute and primary care with behavioral health care and with long-term care. States remain focused on initiatives to improve care for dual Medicare – Medicaid enrollees, which are expected to be implemented in about one-third of states by the end of FY 2014. In FY 2013 and FY 2014, delivery and payment reform initiatives overshadowed previous efforts to control costs through more traditional policy changes such as changes in provider rates and benefits. States are also implementing new sophisticated analytic tools to ensure program integrity and to address fraud and abuse.

At the start of FY 2014, Medicaid directors were relieved to have weathered the storm of the economic downturn while striving to minimize adverse impacts on the beneficiary population and, in some cases, restoring earlier program cuts. State Medicaid programs are dynamic and evolving, but never more so than looking ahead to 2014 and beyond. The scope and volume of change related to the implementation of the ACA, payment and delivery system reforms and controlling costs create enormous opportunities and challenges. These changes have placed intense pressure on Medicaid agencies that have already been operating with limited resources due to the effects of the recent recession. States face additional challenges and uncertainty as the federal budget and debt ceiling debate go unresolved and federal deficit reduction efforts loom. Notwithstanding intense challenges, Medicaid faces new opportunities to make improvements in program administration that underpin improvements in delivery systems, quality, outcomes and coverage.

APPENDIX A: SURVEY RESPONSES

APPENDIX TABLE A-1A: CHANGES TO ELIGIBILITY STANDARDS AND APPLICATION RENEWAL PROCESSES, FY 2013

	Eligibility Standard Changes		Application and Renewal Changes		Total	
STATES	Eligibility Expansions (+)	Eligibility Restrictions (-)	Application and Renewal Process Simplifications (+)	Application and Renewal Process Restrictions (-)	(+)	(-)
Alabama						
Alaska						
Arizona						
Arkansas						
California						
Colorado	X		X		X	
Connecticut						
Delaware						
District of Columbia						
Florida	X				X	
Georgia						
Hawaii	X	X			X	X
Idaho			X		X	
Illinois	X	X			X	X
Indiana	X				X	
Iowa						
Kansas						
Kentucky						
Louisiana						
Maine		X				X
Maryland						
Massachusetts			X		X	
Michigan						
Minnesota		X	X		X	X
Mississippi						
Missouri						
Montana						
Nebraska						
Nevada						
New Hampshire	X				X	
New Jersey	X				X	
New Mexico						
New York			X		X	
North Carolina						
North Dakota			X		X	
Ohio	X				X	
Oklahoma						
Oregon			X		X	
Pennsylvania						
Rhode Island						
South Carolina			X		X	
South Dakota			X		X	
Tennessee						
Texas						
Utah						
Vermont						
Virginia	X				X	
Washington	X				X	
West Virginia			X		X	
Wisconsin		X				X
Wyoming						
Totals	10	5	10	0	19	5

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-1B: CHANGES TO ELIGIBILITY STANDARDS AND APPLICATION RENEWAL PROCESSES, FY 2014

	Eligibility Standard Changes			Application and Renewal Changes						Total	
STATES	Medicaid Expansion (+)	Other (+)	Medicaid Eligibility Restrictions[2] (-)	Early adoption of MAGI[3] (+)	Extend Renewals Set in the First Quarter 2014[3] (+)	Enroll Individuals based on SNAP eligibility[3] (+)	Enroll parents based on children's income eligibility[3] (+)	12 month continuous eligibility for adults[3] (+)	Other (+)	(+)	(-)
Alabama									X	X	
Alaska					X*			X		X	
Arizona	X									X	
Arkansas	X	X			X*	X*				X	
California	X	X			X	X	X		X	X	
Colorado	X			X*						X	
Connecticut	X				X*				X	X	
Delaware	X									X	
District of Columbia	X			X*	X*					X	
Florida		X			X*				X	X	
Georgia					X					X	
Hawaii	X			X*	X*					X	
Idaho					X*					X	
Illinois	X		X	X*	X*	X*				X	X
Indiana			X								X
Iowa	X				X					X	
Kansas				X*	X*					X	
Kentucky	X		X		X*					X	X
Louisiana		X	X	X*	X*					X	X
Maine			X								X
Maryland	X				X*					X	
Massachusetts	X		X							X	X
Michigan	X				X					X	
Minnesota	X		X							X	X
Mississippi					X*					X	
Missouri				X*	X*					X	
Montana					X*					X	
Nebraska									X	X	
Nevada	X			X*	X				X	X	
New Hampshire		X								X	
New Jersey	X	X		X*	X*	X	X			X	
New Mexico	X		X							X	X
New York	X	X	X					X		X	X
North Carolina					X*					X	
North Dakota	X				X*					X	
Ohio					X*					X	
Oklahoma			X	X*	X*					X	X
Oregon	X			X*	X*	X*	X*	X		X	
Pennsylvania				X						X	
Rhode Island	X		X		X*					X	X
South Carolina					X	X				X	
South Dakota											
Tennessee											
Texas											
Utah					X					X	
Vermont	X		X		X*					X	X
Virginia				X*						X	
Washington	X			X*	X					X	
West Virginia	X			X	X	X*	X*			X	
Wisconsin		X	X							X	X
Wyoming											
Totals	25	8	13	15	32	7	4	3	6	45	13

NOTES: DC, HI and VT are counted as expanding coverage through the adoption of the ACA Medicaid expansion even though these three states had expanded full coverage to this group previously. 2 - These are restrictions to Medicaid eligibility; many of the individuals that will lose Medicaid eligibility as a result of these restrictions will be eligible for subsidies to purchase coverage in the new Marketplace. 3 - These are simplifications outlined in guidance released by CMS on May 17, 2013; they are intended to help streamline enrollment into Medicaid for those eligible. For more information, see Section 2 of this report.
X* - State had received approval for this streamlining option as of October 1, 2013.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013. Centers for Medicare and Medicaid Services, Targeted Enrollment Strategies, (Washington, DC: Department of Health and Human Services,) October 1, 2013. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html.

Appendix A-2a: Eligibility and Application Renewal Process Actions Taken in the 50 States and the District of Columbia, FY 2013[1]

State	Eligibility and Application Changes in FY 2013
Alabama	
Alaska	
Arizona	
Arkansas	
California	
Colorado	Disabled Children (+): Added the Disabled Buy-In for Children (FOA). (281; 7/12) Pregnant Women (+): Expanded Medicaid for pregnant women to 185% FPL. (1,200; 1/13) Application & Renewal (+): Implemented Express Lane Eligibility (ELE) for children (approved in 2012.)
Connecticut	
Delaware	
District of Columbia	
Florida	Aged & Disabled (+): Increased the average private pay nursing home rate (divisor) that is used to determine the number of penalty months for institutional care and HCBS waiver applicants for uncompensated transfers. (9/12) Aged & Disabled (+): Lowered age from 60 to 18 for Assisted Living HCBS waiver. (10/12)
Georgia	
Hawaii	Adults (-): Reduced income limit to 133% for non-pregnant adults. (5,000, 7/12) Adults (+): Expanded asset limit for non-pregnant adults (from $2000 to $5000). (7/12)
Idaho	Application & Renewal (+): Implemented or expanded automated renewal process.
Illinois	Parents (-): Income limit for parents reduced from 185% to 133% of FPL. (unknown, 7/12) Aged & Disabled (-): Enhanced an asset transfer limit for long-term care (unknown, 7/12) Adults (+): Expanded eligibility for adults in Cook County. (unknown, 11/12) Application & Renewal (nc): Eligibility verification by an outside vendor, which only affects beneficiaries if there are discrepancies in data. Passive renewal changed to ex-parte renewals; if ex-parte data shows no income change, family is notified of renewal.
Indiana	Adults (+): Expanded Family Planning only to uninsured up to 133% FPL. (21,400; 1/13)
Iowa	
Kansas	
Kentucky	
Louisiana	
Maine	Parents (-): Reduced coverage for parents from 200% to 133% FPL. (3/13) Aged & Disabled (-): Reduced Medicare buy-in levels 10 percentage pts. per group. (3/13)
Maryland	
Massachusetts	Application & Renewal (+): Implemented a new MA Division of Revenue (DOR) Job Update process using electronic match with quarterly wage data. This process identifies households with DOR-reported income over 300% FPL and sends the job update form, which will only need to be returned if the reported income is not accurate. Will utilize DOR quarterly data at the point of application to attempt to verify earnings. Application & Renewal (+): Implemented ELE with SNAP data as basis for family renewal. Application & Renewal (+): Launched a limited Telephonic Renewal Pilot.

[1] 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).

Michigan	
Minnesota	Adults without Dependent Children (-): Moved such adults between 200%-250% FPL to "Healthy Minnesota Contribution" program. (4,000 to 7,000; 7/12) Application & Renewal (+): Implemented/expanded online real time application decisions.
Mississippi	
Missouri	
Montana	
Nebraska	
Nevada	
New Hampshire	Aged & Disabled (+): Increased the amount aged, blind, and disabled individuals eligible for HCBS living independently or with family are able to retain up to 300% SSI. (11/12)
New Jersey	Aged & Disabled (+): Eliminated the Transfer of Assets / 5yr Look Back restrictions for those under 100 percent FPL as part of the state's Comprehensive Waiver. (5,500; 3/13)
New Mexico	
New York	Application & Renewal (+): Automated enrollment in Medicare Savings Program under MIPPA (NYC and Upstate). Application & Renewal (+): Expanded automated administrative renewals for aged, blind and disabled recipients receiving pensions; including cases with a spend-down.
North Carolina	
North Dakota	Application & Renewal (+): Implemented new online system for application and renewals.
Ohio	Adults (+): Expanded eligibility for adults in Cuyahoga County through the MetroHealth Care Plus 1115 Waiver. (unknown, 2/13)
Oklahoma	
Oregon	Application & Renewal (+): Simplified eligibility by using SNAP income for renewals.
Pennsylvania	
Rhode Island	
South Carolina	Application & Renewal (+): Implemented ELE for children for new applications. Work Support Strategies Grant received by SCDHHS & SCDSS led to simplified redeterminations and auto-enrollment of Medicaid children utilizing SNAP and TANF data (ELE program).
South Dakota	Application & Renewal (+): Implemented of online eligibility application process.
Tennessee	
Texas	Children & Pregnant Women (nc): Provided Medicaid coverage to children under 19 and pregnant women who are inmates and become a patient of a medical institution. (3/13)
Utah	
Vermont	Application & Renewal (nc): Eliminated of 2nd verification request.
Virginia	Children & Pregnant Women (+): Adopted the CHIPRA option to cover legally-residing immigrant pregnant women in Medicaid without five-year waiting period. (7/12)
Washington	Adults (+): Increased family planning waiver limit from 200 to 250% FPL. (3,000, 10/12)
West Virginia	Application & Renewal (+): Included adult Medicaid groups on the state's web-based application process called inROADS.
Wisconsin	Adults (-): Reduced BadgerCare Plus levels for non-pregnant, non-disabled parents and caretakers over 133% FPL who have access to employer-sponsored plans where premium contribution is under 9.5% of income for employee-only plan. (7,100; 7/12 - 12/13) Adults (-): Eliminated retroactive eligibility for BadgerCare Plus non-pregnant, non-disabled parents and caretakers between 133-150% FPL. (7,600; 7/12 through 12/13) Adults (-): Added 12 month restrictive reenrollment period for non-pregnant, non-disabled adults over 133% FPL who do not pay premium. (1,830; 7/12 -12/13) Application & Renewals (nc): Along with the new premium, Core Plan members (adults without dependent children) must now report and verify income changes. These changes will not affect eligibility but do affect premium levels. (end 12/13)
Wyoming	

Appendix A-2b: Eligibility and Application Renewal Process Actions Taken in the 50 States and the District of Columbia, FY 2014[2]

State	Eligibility and Application Changes in FY 2014
Alabama	Application & Renewal (+): Plan to automate ELE renewals for Plan First (family planning) and children.
Alaska	Application & Renewal (+): Plan to implement 12 months continuous eligibility for parents and other MAGI adults. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Arizona	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver to the new adult expansion group.
Arkansas	Adults (+): Plan to implement the Medicaid expansion through an 1115 waiver, increasing eligibility for adults up to 138% FPL. Waiver approval is pending. Disabled Adults (+): Plan to eliminate the income and resource tests for the Workers with Disabilities group. (unknown, 1/14) Parents (nc): Plan to eliminate the deprivation requirement for an adult to be covered in the Parent/Caretaker group. (minimal; 1/14) Application & Renewal (+): Plan to implement the streamlining option to enroll individuals based on SNAP eligibility. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (nc): Plan to change the renewal process for MAGI based eligibility groups to be in accordance with the ACA requirements of ex-parte renewals. Application & Renewal (nc): Plan to no longer allow self-declaration of income in the children's groups; will be verified through data sources or paper documentation.
California	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver to the new adult expansion group. Youth (+): Plan to maintain eligibility for former foster care youth who age out of Medi-Cal at age 21 between 7/1/13 and 12/31/13. (about 166 individuals per month, 7/13) Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (+): Plan to implement the streamlining option to enroll individuals based on SNAP eligibility. Application & Renewal (+): Plan to implement the streamlining option to enroll parents based on children's income eligibility. Application & Renewal (+): Plan to use of projected future changes in income to help minimize churning. (1/14) Application & Renewal (+): Plan to reset renewal dates with changes in circumstances. (1/14) Application & Renewal (nc): Plan to continue policy that residency status must be verified either using an electronic data source and if not available, via paper documentation.

[2] Positive changes counted in this report are denoted with (+). States that reported plans to adopt the streamlining options made available by CMS in May 2013 are reported as positive changes here.

Negative changes to Medicaid eligibility counted in this report are denoted with (-). Many of the individuals that will lose Medicaid eligibility as a result of the restrictions reported here will be eligible for subsidies to purchase coverage in the new Marketplaces.

Changes that were not counted as positive or negative in this report, but were mentioned by states in their responses, are denoted with (nc). This includes changes that are required by law, such as the conversion to new MAGI-based income rules required by the ACA.

A new category of (unknown) was added this year to reflect changes to eligibility standards for which the effect is unknown due largely to the implementation of the Expansion in some states and the availability of subsidies to purchase coverage in the new Marketplaces.

Colorado	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Application and Renewal (+): Plan early adoption of MAGI income counting rules.
Connecticut	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Application & Renewal (+): Plan to implement an on-line Medicaid application for non-MAGI populations. Application & Renewal (+): Plan to implement a dedicated long-term care application. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Delaware	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver to the new adult expansion group.
District of Columbia	Adults (+): Plan to convert their early expansion state plan group to the new adult expansion group, which will cover individuals with incomes up to 138% FPL. The state is also planning to renew their 1115 waiver that extends coverage up to 200% FPL. Application and Renewal (+): Have already adopted MAGI income counting rules. Application & Renewal (+): Have adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (nc): Automated, streamlined application and passive renewals.
Florida	Aged & Disabled (+): Plan to increase minimum monthly maintenance income allowance and excess standard for community spouses of institutionalized people. (7/13) Application & Renewal (+): Have adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (+): Plan to implement no-touch application and renewal processing which will enable applications and renewals to enter into an electronically driver system, with verification completed through the federal hub, and benefits approved without the intervention of eligibility processers. This process will enable many individuals to receive and renew assistance more quickly. Application & Renewal (nc): Plan to allow applicants to apply via telephone.
Georgia	Application & Renewal (+): Have adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Hawaii	Adults (+): Plan to convert their existing 1115 waiver program to the new adult expansion group, which will cover individuals up to 138% FPL. Application and Renewal (+): Have already adopted MAGI income counting rules. Application & Renewal (+): Have adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Idaho	Application & Renewal (+): Plan to implement option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (nc): Plan to implement or expand automated verification and streamlined standards (reasonable compatibility.)
Illinois	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Parents (unknown): Plan to eliminate parent/caretaker spend-down. (TBD, 1/1/14) Adults (-): Plan to renew the Family Planning waiver, but restrict eligibility to 138% FPL. (Current waiver might possibly be extended with renewal at later date.) (Jan 2014) Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (+): Plan to implement the streamlining option to enroll individuals based on SNAP eligibility. Application & Renewal (nc): Redetermination process adjustments are possible.
Indiana	Adults (-): Plan to reduce levels for Healthy Indiana Plan adults from 200% to 100% FPL per waiver renewal. The enrollment freeze for non-caretaker adults remains. (1/14) Application & Renewal (nc): Plan to implement automatic electronic renewals when possible as required by federal regulations.

Iowa	Adults (+): Plan to implement the Medicaid expansion through an 1115 waiver, increasing eligibility for adults up to 138% FPL. Waiver approval is pending. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (nc): Plan to end TMA quarterly reporting requirement. (1/14)
Kansas	Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Kentucky	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Adults (unknown): Plan to eliminate spend-down eligibility for adults. (unknown, 4/14) Adults (unknown): Plan to eliminate breast and cervical cancer eligibility group. (1/14) Disabled (-): Plan to eliminate working disabled eligibility. (unknown, 1/14) Application & Renewal (+): Have adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Louisiana	Aged & Disabled (+): Plan to implement spend-down eligibility for four HCBS waivers (allow individuals to spend down to 300% federal SSI waiver eligibility level). (Fall 2013) Aged & Disabled (-): Plan to no longer determine eligibility for the optional coverage of aged and disabled individuals under 100% FPL. Will be referred to SSA for determination under our 1634 agreement. (9,400; 1/14) Pregnant Women (-): Plan to eliminate optional coverage of pregnant women with incomes between 138% and 200% FPL. (2,692 current enrollees, but all will remain covered through the end of the pregnancy, 1/14) Disabled (-): Plan to reduce income and resource standards for TWWIIA Basic coverage group (Medicaid Purchase Plan). (1/14) Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Maine	Adults (-): Plan to reduce parent levels from 133% to 100% FPL. Plan to let current 1115 waiver that covers adults without dependent children up to 100% FPL, expire. (1/14)
Maryland	Adults (+): Plan to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver to the new adult expansion group. Application & Renewal (+): Have adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Massachusetts	Adults (+): Plan to convert their existing 1115 waiver coverage with limited benefits to the new adult expansion group, which will cover individuals up to 138% FPL. Adults (-): Plan to reduce Medicaid eligibility to 138% FPL. Many of the individuals currently covered under the state's existing 1115 waiver incomes above 138% FPL will be eligible for subsidies to purchase coverage in the Marketplace. The state is seeking to continue the following under its 1115 waiver: 1) certain expansion programs, including for those with HIV or breast or cervical cancer with income over Medicaid expansion floor (up to 200% FPL and 250% FPL respectively), 2) premium assistance for certain employees of small businesses up to 300% FPL ineligible for APTCs, and 3) claim federal matching funds for additional subsidies to QHP enrollees up to 300% FPL to maintain affordability levels established in 1115 Waiver program Commonwealth Care.
Michigan	Adults (+): Plan to implement the Medicaid expansion through an 1115 waiver, increasing eligibility for adults up to 138% FPL. Waiver submission is pending. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Minnesota	Adults (+): Plan to implement the Medicaid expansion. The state will also convert their existing MinnesotaCare 1115 waiver program to the new adult expansion group, which will cover individuals up to 138% FPL. Adults (nc): Seeking waiver renewal to maintain coverage for 138 to 200% FPL group. Adults (-): The state is reducing Medicaid eligibility levels to 200% FPL. Many of the individuals currently covered under the state's existing 1115 waiver incomes above 200% FPL will be eligible for subsidies to purchase coverage in the Marketplace.

Mississippi	Application & Renewal (+): Implementing option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Missouri	Application & Renewal (+): Implementing option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application and Renewal (+): Plan early adoption of MAGI income counting rules.
Montana	Application & Renewal (+): Implementing option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Nebraska	Application and Renewal (+): Expanding the use of prepopulated forms statewide.
Nevada	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Application & Renewal (+): Waiting for CMS approval to accept client statement for current income. Application & Renewal (+): Post eligibility verification. Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
New Hampshire	Adults (+): Adopt new Family Planning State Plan Option. (date TBD)
New Jersey	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Medically Needy (+): "217 like Spend-down" allows medically needy individuals to receive state plan and home and community-based waiver services based on hypothetical medical expenses (used to demonstrate that they would be eligible if they were in an institution). (unknown, TBD) Parents (nc): Parents that were covered with Title XXI funds (CHIP) above 138% of poverty will be moved to the Marketplace. Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (+): Plan to implement the streamlining option to enroll individuals based on SNAP eligibility. Application & Renewal (+): Plan to implement the streamlining option to enroll parents based on children's income eligibility.
New Mexico	Adults (+): Sun-setting State Coverage Initiative 1115 waiver program, converting coverage for adults with incomes below 139% FPL to the new adult expansion group. (31,500, 1/1/14) Adults (-): Sun-setting State Coverage Initiative 1115 waiver program, transitioning adults with incomes above 138% FPL to the Marketplace. (13,500, 1/1/14) Adults (+): Sun-setting Family Planning Medicaid, converting coverage for adults with incomes below 139% FPL to the new adult expansion group. (37,000, 1/31/14) Adults (-): Sun-setting Family Planning Medicaid, transitioning adults with income above 138% FPL to the Marketplace. (15,000, 1/31/14) Adults (nc): Plan to close Breast and Cervical Cancer Program to new enrollment (350, TBD)
New York	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing Family Health Plus 1115 waiver program to the new adult expansion group, which will cover individuals up to 138% FPL. Adults (-): The state is reducing Medicaid eligibility for levels down to 138% FPL. Many of the individuals currently covered under the state's existing 1115 waiver with incomes above 138% FPL will be eligible for subsidies to purchase coverage in the Marketplace. The state is planning to further subsidize coverage in the Marketplace for these individuals to help make coverage more affordable.[78] Adults (+): Adopt new Family Planning State Plan Option. (Unknown, TBD) Application & Renewal (+): Continuous coverage for MAGI adults. (unknown, 1/1/14)
North Carolina	Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.

North Dakota	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Ohio	Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Oklahoma	Pregnant Women (-): Plan to reduce levels from 185% to 138% FPL. (4,731; 1/14) Adults (-): Plan to reduce family planning waiver from 185% to 138% FPL. (8,762; 1/14) Adults (-): As part of a one-year extension, eligibility for individuals under the Individual Plan will be reduced from 200% FPL to 100% FPL. (8,000; 1/14) Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (nc): Dropping proof of pregnancy requirement and accepting all forms of applications as pursuant to ACA.
Oregon	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver coverage to the new adult expansion group. MAGI Adults (nc): Eliminate resource requirement for TANF-related and OHP Standard Medicaid Programs. (unknown, 10/13) Parents (nc): Eliminate deprivation requirement for TANF-related medical. (10/13) Application & Renewal (+): Plan to implement 12 month continuous eligibility for parents and other MAGI adults. Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (+): Plan to implement the streamlining option to enroll individuals based on SNAP eligibility. Application & Renewal (+): Plan to implement the streamlining option to enroll parents based on children's income eligibility.
Pennsylvania	Application and Renewal (+): Plan early adoption of MAGI income counting rules.
Rhode Island	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver coverage to the new adult eligibility group for those with incomes under 138% FPL. Parents (-): Eliminate coverage for parents from 138% to 175% FPL. (6,500, 1/14) Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
South Carolina	Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. Application & Renewal (+): Plan to expand ELE to adults per May 2013 CMS guidance.
South Dakota	
Tennessee	
Texas	Children (nc): Cover former foster care individuals to age 26. (4,366, 1/14) Will also adopt 12 month certification period. (86,873, 1/14) Application & Renewal (nc): Adopting administrative renewal process in 42 CFR 435.916.
Utah	Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
Vermont	Adults (+): Planning to convert their existing 1115 waiver program to the new adult expansion group, which will cover individuals up to 138% FPL. Adults (-): Planning to reduce Medicaid eligibility levels to 138% FPL. Many of those currently covered under the state's existing 1115 waiver incomes above 138% FPL will be eligible for subsidies to purchase Marketplace coverage. The state is seeking to use its existing1115 waiver to further subsidize Marketplace coverage up to 300% FPL.[79] Application & Renewal (+): Implementing option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.

Virginia	Application and Renewal (+): Plan early adoption of MAGI income counting rules.
Washington	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. The state will also convert their existing 1115 waiver to the new adult expansion group. Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014.
West Virginia	Adults (+): Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL. Application and Renewal (+): Plan early adoption of MAGI income counting rules. Application & Renewal (+): Plan to implement the option to extend renewal dates of current enrollees to delay renewals set for Q1 of calendar year 2014. The state is also requesting a waiver to extend renewals for 12 months instead of 3 months. Application & Renewal (+): Plan to implement the streamlining option to enroll individuals based on SNAP eligibility. Application & Renewal (+): Plan to implement the streamlining option to enroll parents based on children's income eligibility. Application & Renewal (nc): Electronic Application process.
Wisconsin	Parents (-): Reducing the income limit for parents/caretakers from 200% FPL to 100% FPL. (72,000, 1/1/14) Childless Adults (-): Reducing the income limit for childless adults from 200% FPL to 100% FPL. (5,000, 1/1/14) Childless Adults (+): Eliminate waitlist for Childless Adults up to 100% FPL. (80,000, 1/1/14)
Wyoming	Application & Renewals (nc): Improvement of online application and renewal process.

APPENDIX TABLE A-3: MANAGED CARE INITIATIVES TAKEN IN ALL 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013 and 2014

States	Geographic Expansions		Add Eligibility Groups		New Mandatory Enrollment		Expansion or Implementation of MLTC		Other Manged Care Expansions		Quality		Any Change in Medicaid Managed Care		
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	Either Year
Alabama															
Alaska															
Arizona				X						X		X		X	X
Arkansas															
California		X	X	X		X		X		X	X	X	X	X	X
Colorado				X						X	X	X	X	X	X
Connecticut															
Delaware				X										X	X
District of Columbia											X		X		X
Florida	X	X				X		X		X		X	X	X	X
Georgia				X								X		X	X
Hawaii									X	X	X		X	X	X
Idaho								X		X				X	X
Illinois		X		X		X	X	X	X	X		X	X	X	X
Indiana											X	X	X	X	X
Iowa	X	X							X	X			X	X	X
Kansas			X	X	X	X	X		X				X	X	X
Kentucky															
Louisiana															
Maine															
Maryland											X	X	X	X	X
Massachusetts				X		X	X	X	X		X	X	X	X	X
Michigan			X	X				X			X		X	X	X
Minnesota			X										X		X
Mississippi			X	X	X				X		X		X	X	X
Missouri															
Montana															
Nebraska	X		X							X		X	X	X	X
Nevada				X						X		X		X	X
New Hampshire		X		X		X				X		X		X	X
New Jersey			X			X		X		X	X		X	X	X
New Mexico				X				X		X	X	X	X	X	X
New York			X	X	X		X	X		X	X	X	X	X	X
North Carolina												X		X	X
North Dakota				X		X						X		X	X
Ohio								X						X	X
Oklahoma															
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
South Dakota															
Tennessee							X						X		X
Texas				X						X	X	X	X	X	X
Utah										X	X	X	X	X	X
Vermont				X										X	X
Virginia	X		X	X				X		X	X	X	X	X	X
Washington			X	X				X			X	X	X	X	X
West Virginia				X						X	X		X	X	X
Wisconsin		X		X				X		X	X	X	X	X	X
Wyoming															
Totals	4	7	12	23	5	8	5	14	7	19	21	22	28	35	39

NOTES: Delivery and payment system reforms often take years of planning and must account state specific circumstances and needs. Given this, states are at different stages of implementation at any given point in time on a variety of initiatives in this area. This survey attempts to capture new actions that either were implemented or are going to be implemented during FYs 2013 and 2014; the information presented generally does not capture long-standing initiatives that have been in place or efforts with planned implementation beyond 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-4: CARE COORDINATION INITIATIVES TAKEN IN ALL 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013 and 2014

States	Health Homes		PCMH		ACOs		Other Actions		Quality		Any New or Expanded Care Coordination Initiatives		
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	Either Year
Alabama	X*								X		X		X
Alaska													
Arizona								X				X	X
Arkansas		X		X			X		X		X	X	X
California					X	X			X		X	X	X
Colorado									X		X		X
Connecticut		X										X	X
Delaware		X										X	X
District of Columbia		X										X	X
Florida													
Georgia								X				X	X
Hawaii			X	X							X	X	X
Idaho	X*		X								X		X
Illinois		X								X		X	X
Indiana													
Iowa	X					X				X	X	X	X
Kansas		X	X								X	X	X
Kentucky													
Louisiana													
Maine	X*	X	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	X
Mississippi													
Missouri		X*							X		X	X	X
Montana													
Nebraska			X						X		X		X
Nevada													
New Hampshire		X								X		X	X
New Jersey		X				X				X		X	X
New Mexico			X	X				X		X	X	X	X
New York	X*	X				X		X	X		X	X	X
North Carolina													
North Dakota										X		X	X
Ohio													
Oklahoma		X								X		X	X
Oregon			X	X	X				X	X	X	X	X
Pennsylvania					X				X		X		X
Rhode Island		X*		X					X	X	X	X	X
South Carolina			X		X					X	X	X	X
South Dakota		X										X	X
Tennessee													
Texas									X		X		X
Utah					X				X	X	X	X	X
Vermont		X	X	X		X			X	X	X	X	X
Virginia			X								X		X
Washington		X*						X		X		X	X
West Virginia		X								X		X	X
Wisconsin	X*	X		X				X	X	X	X	X	X
Wyoming		X										X	X
Totals	6	21	12	9	6	8	1	6	16	16	25	33	40

NOTES: Delivery and payment system reforms often take years of planning and must account state specific circumstances and needs. Given this, states are at different stages of implementation at any given point in time on a variety of initiatives in this area. This survey attempts to capture new actions that either were implemented or are going to be implemented during FYs 2013 and 2014; the information presented generally does not capture long-standing initiatives that have been in place or efforts with planned implementation beyond 2014.
Health Homes: States marked with "X*" are states that have received approval from CMS of at least one Health Home SPA. As this survey catalogs new or expanded activities in FY 2013 or FY 2014, there are three additional states (North Carolina, Ohio and Oregon) that have approved SPAs not reflected here as they adopted this option in FY 2012 and did nto report any new policies related to Health Homes in FY 2013 or FY 2014.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

Appendix A-5a: Quality Initiatives Taken in the 50 States and the District of Columbia, FY 2013

State	Quality Initiatives in FY 2013
Alabama	Care Coordination (+): State received Adult Quality measures grant.
Alaska	
Arizona	
Arkansas	Care Coordination (+): State received Adult Quality measures grant.
California	Managed Care (+): 1) Identified new 2014 HEDIS Performance Measures. 2) Used certain HEDIS Measures to give more default enrollments to higher-performing plans. 3) Implemented an All Cause Readmissions (ACR) statewide collaborative--intervention stage. 4) Required individual plan Quality Improvement Projects (QIPs) based on HEDIS scores. 5) Added 5% cost factor to default algorithm which is used to assign non-choosers to health plans. 6) Required individual Improvement Plans (IPs) based on plan performance on HEDIS indicators below the Minimum Performance Level (MPL). Care Coordination (+): In 2013, DHCS will finalize its one-year update to the DHCS Strategy for Quality Improvement in health care that was launched in November 2012.
Colorado	Managed Care (+): Implemented incentive payments in PCCM program. Care Coordination (+): State received Adult Quality Measures grant. State implemented quality surveys and pilot programs aimed at improving quality.
Connecticut	
Delaware	
District of Columbia	Managed Care (+): For new plans as of 7/1/13, enhanced quality measures (reducing preventable hospital admits and low-acuity ER visits) and some P4P changes.
Florida	
Georgia	
Hawaii	Managed Care (+): Changed withhold from $1 to $2 PMPM.
Idaho	
Illinois	
Indiana	Managed Care (nc): The MCOs have performance withholds for the following categories: ER bounce back, well child visits, follow-up after hospitalization for mental illness, post-partum visits, diabetes care, physician advising smokers to quit, cesarean deliver rates, generic dispensing rate bonus, medication utilization trend rate bonus. Care Coordination (+): Indiana Medicaid is participating with the CMS Adult Quality Measures Grant.
Iowa	
Kansas	Managed Care (nc): Continued operating Pay for Performance requirements.
Kentucky	
Louisiana	
Maine	
Maryland	Managed Care (+): Increased withhold from 0.5 percent to 1 percent.
Massachusetts	Managed Care (+): New PCC Plan Managed Behavioral Health contract, effective 10/1/12, included new Integrated Care Management Program (ICMP) for PCC Plan members. The contractor has enrolled ~3,200 members to date in three tiers of Care Management. The contractor receives a per participant per month payment for members enrolled in the ICMP. The new contract also expanded risk to 50% share in 2013. Additionally, there are 8 new P4P initiatives under the new contract to address improvement in treating relevant and prevalent conditions for the population served. Four Care Management Program Outcomes: 1) Reduction in Preventable Hospitalizations; 2) Reduction in Polypsychopharm; 3) Member Experience / Satisfaction; and 4) Improvement in Participant Health-Related Quality of Life.

	Four Behavioral Health Pay for Performance metrics: 1) Follow-up after Hospitalization for Mental Illness; 2) Initiation and Engagement for Treatment of Alcohol and other Drug Dependency; 3) Follow-up Care for Children Prescribed ADHD Meds; and 4) Improving the percentage of primary care visits for members who are clients of DMH with diabetes. Implemented Quality Improvement (QI) Goals which included a measurement and intervention component. The QI Goal measures are organized into 5 domains - 1) population identification 2) access and availability, 3) wellness/health promotion, 4) disease management and 5) coordination of care. Care Coordination (+): Re-designed the Health Needs Assessment (HNA).
Michigan	Managed Care (+): New quality measured instituted and used in algorithm for determining auto-enrollment. Additionally, the state obtained the Adult Quality Measures grant, doing work on health care disparities. Implemented new "Healthcare for a Diverse Membership" Pay for Performance measures and bonus program. Requires the Medicaid Health Plan to fully and accurately report race/ethnicity/language diversity in the annual HEDIS report; collect and report on race/ethnicity/language for network providers; and submit HEDIS data analyzed by race/ethnicity for specified measures. Care Coordination (+): 1) Three separate initiatives/efforts to improve quality: CSHCS focus study, health care for diverse membership, and developmental screening. 2) Adult Quality Measures Grant, early elective delivery, adult asthma, quality measures from encounter data. Established a set of core competencies to determine health plan readiness and competence to enroll CSHCS (medically complex) children into their plan. The 2013 focus study assesses health plan implementation of policies and procedures for access to care, IT systems, member rights, and quality of care.
Minnesota	
Mississippi	Managed Care (+): Added new performance measures which include the Dec 2012 expanded services of behavioral health, and pregnant women and newborn populations.
Missouri	Care Coordination (+): State implemented quality initiatives focused on IMD Demonstration, Healthcare Acquired Conditions, Provider Preventable Conditions
Montana	
Nebraska	Care Coordination (+): Formed Quality Team.
Nevada	
New Hampshire	
New Jersey	Managed Care (+): Developed a new quality strategy.
New Mexico	Managed Care (+): Implemented a total of ten (10) performance measures (PM); five (5) for Salud members only and five (5) for Salud and SCI members.
New York	Managed Care (+): Implemented the Managed Long-term Care Quality Incentive. The Managed Long-term Care Quality Incentive is a pool of money available due to a reduction in the administrative surplus that will be redistributed to managed long-term care plans with higher levels of quality. Using quality measures, measures of satisfaction, measures of compliance and a measure on preventable hospitalizations, a composite quality score has been developed. Health plans in the highest tier will receive the highest reward; plans in second and third tier will also be rewarded. Health plans in the bottom tier receive no quality payment. Care Coordination (+): Working with the Office of Health Systems Management to develop statewide regulation that supports ACOs ability to integrate health care services and provide comprehensive care coordination. Working with Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) to implement an Integrated Licensing Pilot Program to enable providers to offer a broader mix of behavioral and physical health services at a single site.
North Carolina	
North Dakota	
Ohio	
Oklahoma	

Oregon	Managed Care (+): As part of terms for Section 1115 waiver, new quality measures and withholds to reward improved performance. Care Coordination (+): With Oregon's new Transformation Center, Quality Improvement staff and Transformation Center staff will coordinate Learning Collaboratives to support quality initiatives efforts. All performance improvement initiatives currently fall under the following categories: reducing preventable re-hospitalizations, deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by "super-users", ensuring appropriate care is delivered in appropriate settings, improving perinatal and maternity care and Addressing population health issues within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and state programs.
Pennsylvania	Managed Care (+): In January 2013, an enhanced monitoring structure was implemented to provide for a performance-based and outcomes-driven model of oversight of the program. In addition, a new area was formed called the Quality Improvement Unit with staff responsible for gathering the MCO performance data and other monitoring data to form a baseline, and utilize the information to engage in quarterly dialogue with all MCOs. These meetings are called Quarterly Quality Review Meetings (RMs). The information gathered from these meetings is used to identify opportunities for improvement and also best practice areas that can be shared program wide for overall quality improvement of the HealthChoices Program. Care Coordination (+): Coordinating with the PA Department of Health on the million heart grant.
Rhode Island	Care Coordination (+): The state implemented the following quality initiatives in FY 2013: 1) Established a collaborative measurement portal for FQHCs to submit EHR-derived quality measures. 2) Initiated study on EHR-derived quality measurement with Brown University. 3) Began provider-directed intervention on anti-depressant medication management with the University of RI School of Pharmacy. 4) Began initiative with hospitals and primary care providers to improve communication at hospital discharge.
South Carolina	Managed Care (+): Implemented both withholding and various incentives for the health plans in SC. Managed Care Organizations (MCOs) and providers earn incentives by meeting certain criteria within a number of programs including Patient-Centered Medical Homes (PCMH) and the Birth Outcome Initiative. SCDHHS initially withholds a portion of premium payments from all the MCOs and rewards higher performing plans at the end of the withhold period.
South Dakota	
Tennessee	
Texas	Managed Care (+): Implemented a 5% At-Risk/Quality Challenge Measures. The state continues its ongoing quality initiatives - Quality Assurance and Program Improvement, Performance Improvement Projects, Summary of Activity and Quality of Care report, MCO profiles. Texas Health Learning Collaborative (THLC) portal is a secure web portal developed for use for HHSC and its Medicaid providers to give up-to-date reporting on MCO performance on key quality care measures, including potentially preventable events (PPEs). The interface includes many interactive maps and charts, allowing users to drill-down through metrics based on millions of Medicaid performance records, customizing the views and reports by time period, service type, line of business, area, etc. HHSC also monitors health plans' performance through the dashboard to assess the quality of care provided to Medicaid members. The Performance Indicator Dashboard includes a list of selected HEDIS, CAHPS and AHRQ quality indicators. Care Coordination (+): Payment reductions for hospitals' potentially preventable readmissions (PPRs) in fee-for-service took effect.
Utah	Managed Care (+): Utah Medicaid implemented a public process to identify focused performance measures for the ACOs. Care Coordination (+): Also conducting a public process to establish performance measures for reduction of non-emergent use of the ED and performance measures for services to clients with special health care needs.

Vermont	Care Coordination (+): Conducted "Gap in evidence based care analysis" for five select chronic conditions; with PCP reports; patient outreach/intervention. Performance Improvement Project: Increasing Adherence to Evidence-Based Guidelines in Members with congestive Heart Failure. Completed in June 2013. Improvement noted although not statistically significant. Pediatric Palliative Care Program including care coordination and case management
Virginia	Managed Care (+): New managed care contract built on managed care life cycle; New technical manual and reporting requirements; automated reporting; enhancements on ABD assessments and coordination, chronic care, maternity, wellness/preventive care, program integrity, quality, and innovation
Washington	Managed Care (+): All managed care plans collaborating on common Health Transitions Performance Improvement Project.□All health plans collaborating on common Practice Guideline for developmental and behavioral health screens (mental and CD).
West Virginia	Managed Care (+): Implemented new pay-for-performance in MCO contract for 2013.
Wisconsin	Managed Care (+): Included two new pregnancy-related measures in HMO Pay for Performance. The state is also implementing CAHPS for BadgerCare Plus and SSI populations. Care Coordination (+): Implemented Hospital pay-for-performance (P4P) initiative in SFY 2013 with a 1.5% withhold of inpatient and outpatient claims with 5 P4P measures and one pay-for-reporting measure.
Wyoming	

Appendix A-5b: Quality Initiatives Actions Taken in the 50 States and the District of Columbia, FY 2014

State	Quality Initiatives in FY 2014
Alabama	
Alaska	
Arizona	Managed Care (+): The state is implementing new quality measures as well as a payment reform initiative.
Arkansas	
California	Managed Care (+): State plans to implement the following quality-related initiatives in FY 2014: 1) Identify new 2014 and 2015 HEDIS Performance Measures, 2) Use certain HEDIS Measures to give more default enrollments to higher-performing plans, 3) Continue the ACR statewide collaborative, 4) Require individual plan QIPs based on HEDIS scores, 5) Encounter data reporting measurements established and implemented, 6) Approximately 100 quality measures for Cal Medi Connect plans. Approximately ten of which are withhold measures, 6) Creation of a Medi-Cal managed care dashboard, and 7) Establishment of new performance measures related to plan performance.
Colorado	Managed Care (+): Implementation of shared savings program in PCCM program. Addition of well child visit metric for incentive payments under ACO program. Care Coordination (nc): State is continuing efforts under the Adult Quality Measures grant it received in FY 2013. State implemented quality surveys and pilot programs aimed at improving quality.
Connecticut	
Delaware	
District of Columbia	
Florida	Managed Care (+): SMMC/MMA program will implement new performance measures and performance improvement projects.
Georgia	Managed Care (+): As part of the Foster Care/Adoption Assistance and the ABD care coordination, we will be using a value based purchasing contract with withholds and add backs for meeting pre-determined quality metrics.
Hawaii	
Idaho	
Illinois	Managed Care (nc): Performance measures for all FY'14 plans are still being refined. Care Coordination (+): The Department is working on streamlining and coordinating quality standards across the various delivery systems.
Indiana	Care Coordination (nc): Continued participation under Adult Quality Measure grantee.
Iowa	Care Coordination (+): Iowa has been awarded grant funding to develop two quality improvement processes aimed at improving the outcomes for the Medicaid Core Adult Quality Measurement set.
Kansas	Managed Care (nc): Continue operating Pay for Performance program.
Kentucky	
Louisiana	
Maine	
Maryland	Managed Care (+): We added some new performance measures for Value Based Purchasing Program.
Massachusetts	Managed Care (+): Develop and implement MCO P4P initiatives for implementation during CY 2014. Care Coordination (nc): MassHealth will measure the success of the Care Management Program via the Quality Improvement Goals. Each goal will have a measurement and intervention component.
Michigan	
Minnesota	

Mississippi	Care Coordination (nc): Planning efforts are underway.
Missouri	
Montana	
Nebraska	Managed Care (+): New BHO contract includes quality measures and a withhold.
Nevada	Managed Care (+): 25% holdback on Primary Care Case Management (PCCM) to be returned proportionate to success in achieving savings goals. The state is also closing out HEDIS measures that have achieved 90% while adding new measures.
New Hampshire	Managed Care (+): Reporting only in FY 2014; withholds begin in FY 2015. Care Coordination (nc): NH has a CMS AMQ [Adult Measure Quality]grant and is currently developing robust data analytics and public reporting for an increased number of quality measures
New Jersey	Managed Care (nc): Performance based incentive announced for SFY 2015 Care Coordination (+): DSRIP, Revised quality strategy in place. Building a more comprehensive quality plan, to be a cornerstone of the program, aligning all efforts across agencies, to be more strategic to place spotlight on quality.
New Mexico	Managed Care (+): Total of Eight (8) performance measures (PM) Care Coordination (+): Implement Super Utilizers grant for overutilization, Robert Wood Johnson (RWJ) technical assistance for performance measures, and Adult Medicaid Quality grant for trending data for 15 different performance measures and 2 quality improvement projects.
New York	Managed Care (+): For mainstream MCO, intend to increase quality incentive payment.
North Carolina	Managed Care (+): Being developed for BHO contract.
North Dakota	Managed Care (+): Building quality into current PCCM program. Care Coordination (nc): North Dakota Medicaid is planning to issue an RFP to solicit a vendor for utilization review, evidence-based guidelines and quality improvement reporting. Changed from a disease management program to a health management program, for COPD, CHF, diabetes and asthma.
Ohio	
Oklahoma	Care Coordination (+): Adult Health Quality grant targeting care & reporting of adult clients. The state also received a Strong Start grant targeting pregnancy outcomes.
Oregon	Managed Care (nc): Continued efforts as part of 1115 Waiver part of Special Terms & Conditions. Care Coordination (+): Dental Performance Metrics are being developed to include in quality initiatives for Jan 2014 contracting.
Pennsylvania	
Rhode Island	Managed Care (+): New Integrated Care Initiative arrangement Care Coordination (+): The state plans to 1) submit at least 15 of the Adult Core Measures to CMS as part of Quality Grant and 2) expand measurement and reporting activities across Medicaid programs through Adult Quality Grant program.
South Carolina	Care Coordination (+): The state is seeking approval from CMS to add quality improvement plan and tie it to a portion of DSH funding. Hospitals will be required to work with local providers and community partners, focusing on the uninsured who are frequent users of the ER. The state is planning to implement value-based benefit design.
South Dakota	
Tennessee	
Texas	Managed Care (+): Pay for Quality-Program (P4Q) and provider incentive initiatives. The redesigned P4Q Program focuses on shared savings and/or an incremental improvement approach. Shared savings models are based on providers (MCOs) achieving health care expenditure reductions below predetermined targets. Plans that reach these targets would receive a portion of the savings. The quality of care measures used in this initiative would be primarily outcome measures such as Potentially Preventable Events (PPEs).

	HHSC will publish MCO report cards online in Fall 2013 showing how STAR, STAR+PLUS and CHIP health plans in each service area compare on health care quality measures. The report cards will be included in the member enrollment packets in early 2014. Additional quality efforts include public reporting of MCO Profiles, which provide individual health plan results on the HHSC Performance Indicator Dashboard for Quality Measures by the participating service area and program. Dashboard plan results will be on the HHSC website for 2014. The state continues its ongoing quality initiatives - Quality Assurance and Program Improvement (QAPI), Performance Improvement Projects (PIPs), Summary of Activity and Quality of Care report, MCO profiles.
Utah	Managed Care (+): Utah will be adding consequences in the ACO contracts for performance outcomes Care Coordination (+): Will be including performance measures in both BHO and ACO contracts that require coordination of care.
Vermont	Care Coordination (+): Continue provider registries/gap in care reports on diabetes, CAD, asthma, CHF and depression. 2 Performance Improvement Projects begin in FY 2014 focusing on: 1. Increasing Initiation and Engagement in Substance Abuse Treatment and 2. Increasing Breast Cancer Screenings. High risk pregnancy case management to improve pregnancy outcomes
Virginia	Managed Care (+): Yes, beginning to implement a quality withhold on performance and process measures.
Washington	Managed Care (+): Expand P4P using performance measures. New performance measures defined in Health Homes, Strategy 1 and Strategy 2 programs. Care Coordination (+): Submission of first year Transitions PIP to include re-hospitalization data, including evidence of 7-day post-discharge follow-up visit (correlation analysis comparing re-hospitalizations with post-discharge visit). Primary care provider training on Common Practice Guideline - as required by Contract.
West Virginia	Care Coordination (+): Perinatal quality initiative.
Wisconsin	Managed Care (+): Significant changes to HMO P4P in 2014 including simplifying reporting requirements, retiring a few measures, adding new measures (to align them with CMS Core Set measures), and increasing the P4P withhold percentage. Changes are being discussed with HMOs and defined in the Fall of 2013. Care Coordination (+): Continued with the hospital P4P initiative for SFY2014 at the same withhold amount with six P4P measures.
Wyoming	

APPENDIX TABLE A-6: INTIATIVES TARGETING COORDINATION OF CARE FOR DUAL ELIGIBLE BENEFICIARIES, FY 2013 and 2014

States	MMCO Financial Alignment Demonstration			Other Initiatives		Any Initiatives Targeting Dual Eligible Beneficiaries		
	2013	2014	Later implementation	2013	2014	2013	2014	Either Year
Alabama				X		X		X
Alaska								
Arizona					X		X	X
Arkansas								
California		X*					X	X
Colorado		X					X	X
Connecticut		X					X	X
Delaware								
District of Columbia								
Florida					X		X	X
Georgia								
Hawaii			X					
Idaho		X					X	X
Illinois		X*					X	X
Indiana								
Iowa			X					
Kansas				X		X		X
Kentucky								
Louisiana								
Maine								
Maryland								
Massachusetts		X*					X	X
Michigan		X*		X		X	X	X
Minnesota					X*		X	X
Mississippi								
Missouri			X					
Montana								
Nebraska								
Nevada								
New Hampshire								
New Jersey								
New Mexico								
New York			X*					
North Carolina			X					
North Dakota								
Ohio		X*					X	X
Oklahoma		X					X	X
Oregon								
Pennsylvania								
Rhode Island			X					
South Carolina		X					X	X
South Dakota								
Tennessee								
Texas			X					
Utah								
Vermont		X		X		X	X	X
Virginia		X					X	X
Washington		X*					X	X
West Virginia								
Wisconsin		X					X	X
Wyoming								
Totals		14	7	4	3	4	17	19

NOTES: In 2013 and 2014, state Medicaid programs continued to develop strategies to coordinate and integrate care and financing for dual eligible beneficiaries. X*- As of September 30, CMS has approved memoranda of understanding for these states to implement financial alignment demonstrations. A total of 14 other states remain in negotiations with CMS on their proposed demonstrations, with proposed implementation dates in 2014 and in 2015; those with planned implementations in FY 2014 are included in the counts above while the others are noted as having later implementation dates. The counts above also include strategies states are pursuing to coordinate care for this population outside of the CMMO financial alignment demonstration.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-7: LONG TERM CARE EXPANSIONS IN ALL 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013 and 2014

States	Long Term Care Expansions						ACA Options					
	HCBS Expansions		PACE Expansions		Total		1915(i) State Plan Option		Community First Choice		Balancing Incentives Program	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Alabama	X	X			X	X						
Alaska	X	X			X	X						
Arizona												
Arkansas		X				X		X		X	X*	
California		X		X		X						
Colorado	X				X							
Connecticut	X	X			X	X					X*	
Delaware	X	X	X		X	X		X				X
District of Columbia	X	X			X	X						
Florida	X	X	X		X	X						
Georgia											X*	
Hawaii	X	X			X	X						
Idaho												
Illinois	X	X			X	X					X*	
Indiana								X			X*	
Iowa	X		X		X							
Kansas	X	X			X	X						
Kentucky	X	X			X	X						
Louisiana		X				X					X*	
Maine												X*
Maryland	X	X			X	X		X		X		
Massachusetts	X	X			X	X						
Michigan		X	X	X	X	X						
Minnesota	X	X			X	X				X		
Mississippi											X*	
Missouri	X				X						X*	
Montana	X	X			X	X	X			X		
Nebraska	X	X	X		X	X						
Nevada		X				X						X
New Hampshire												
New Jersey		X				X					X*	
New Mexico	X	X			X	X						
New York	X	X			X	X			X		X*	
North Carolina	X	X			X	X						
North Dakota	X	X		X	X	X						
Ohio	X	X			X	X						X*
Oklahoma	X		X		X							
Oregon		X				X				X		
Pennsylvania	X	X			X	X						
Rhode Island												X
South Carolina	X	X			X	X						
South Dakota		X				X						
Tennessee	X				X							
Texas		X				X		X		X	X*	
Utah	X	X			X	X						
Vermont												
Virginia	X	X			X	X						
Washington		X				X						
West Virginia	X				X							
Wisconsin	X	X			X	X				X		
Wyoming			X		X							
Totals	31	35	7	3	33	35	1	5	1	7	11	5

NOTES: HCBS Expansions include counts of states that in general increase the number of individuals served in the community outside of those outlined in other columns on this table. Examples of such expansions include increasing slots in existing waivers, eliminating waiting lists, increasing individuals served through the implementation of managed long term care among others. X* - indicates that a state has had their application approved. For the Balancing Incentives Program, three additional states (Iowa, Maryland, and New Hampshire) have also been approved; this occurred before the survey period.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-8A: POLICY INITIATIVES TAKEN BY ALL 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013

States	Provider Rate Changes		Benefits		Pharmacy	Totals	
	Increase Rates	Restrict Rates	Expansions or Enhancements	Restrictions or Eliminations	Cost Containment	Improvements	Cost Containment Actions
Alabama	X	X		X		X	X
Alaska	X					X	
Arizona	X	X	X			X	X
Arkansas	X	X			X	X	X
California	X	X				X	X
Colorado	X	X	X	X	X	X	X
Connecticut		X	X		X	X	X
Delaware	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
Hawaii		X	X		X	X	X
Idaho	X		X			X	
Illinois		X		X	X		X
Indiana	X	X	X	X	X	X	X
Iowa	X	X			X	X	X
Kansas	X	X	X		X	X	X
Kentucky	X					X	
Louisiana	X	X		X	X	X	X
Maine	X	X		X	X	X	X
Maryland	X	X		X		X	X
Massachusetts	X		X			X	
Michigan	X	X	X		X	X	X
Minnesota		X	X		X	X	X
Mississippi	X	X	X	X	X	X	X
Missouri	X		X			X	X
Montana		X	X		X	X	X
Nebraska	X					X	
Nevada		X	X			X	X
New Hampshire		X	X	X	X	X	X
New Jersey	X	X				X	X
New Mexico	X	X	X			X	X
New York	X	X	X	X	X	X	X
North Carolina		X			X		X
North Dakota	X					X	
Ohio	X	X				X	X
Oklahoma	X	X				X	X
Oregon		X			X		X
Pennsylvania	X	X				X	X
Rhode Island	X	X	X			X	X
South Carolina	X		X			X	
South Dakota	X			X		X	X
Tennessee		X					X
Texas	X	X	X	X		X	X
Utah	X	X	X		X	X	X
Vermont	X				X	X	X
Virginia	X		X		X	X	X
Washington	X	X	X			X	X
West Virginia	X					X	
Wisconsin	X	X			X	X	X
Wyoming		X					X
Totals	40	39	24	14	24	46	43

NOTES: For the purposes of this report, provider rate restrictions include cuts to rates for physicians, dentists, outpatient hospitals, and managed care organizations as well as both cuts or freezes in rates for inpatient hospitals and nursing homes. Also, mandatory requirements, such as the increase in primary care rates under the ACA, were excluded from these counts.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-8B: POLICY INITIATIVES TAKEN BY ALL 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2014

States	Provider Rate Changes		Benefits		Pharmacy	Totals	
	Increase Rates	Restrict Rates	Expansions or Enhancements	Restrictions or Eliminations	Cost Containment	Program Improvements	Cost Containment
Alabama	X	X			X	X	X
Alaska	X				X	X	X
Arizona	X	X	X			X	X
Arkansas	X	X			X	X	X
California	X	X	X	X		X	X
Colorado	X		X			X	
Connecticut		X			X		X
Delaware	X	X	X			X	X
District of Columbia	X	X		X	X	X	X
Florida			X			X	
Georgia	X	X	X	X		X	X
Hawaii		X	X			X	X
Idaho	X					X	
Illinois	X	X	X		X	X	X
Indiana	X		X		X	X	X
Iowa	X			X		X	X
Kansas	X	X				X	X
Kentucky	X					X	
Louisiana	X	X	X		X	X	X
Maine	X	X				X	X
Maryland	X				X	X	X
Massachusetts	X		X			X	
Michigan	X	X			X	X	X
Minnesota	X	X	X	X	X	X	X
Mississippi	X	X	X		X	X	X
Missouri	X	X	X		X	X	X
Montana	X		X		X	X	X
Nebraska	X					X	
Nevada	X	X	X			X	X
New Hampshire		X	X	X	X	X	X
New Jersey	X					X	
New Mexico	X	X	X			X	X
New York	X	X	X	X	X	X	X
North Carolina		X		X	X		X
North Dakota	X					X	
Ohio	X	X			X	X	X
Oklahoma	X	X				X	X
Oregon	X	X				X	X
Pennsylvania	X	X				X	X
Rhode Island	X	X				X	X
South Carolina	X				X	X	X
South Dakota	X	X				X	X
Tennessee		X					X
Texas	X	X	X	X	X	X	X
Utah	X	X			X	X	X
Vermont	X				X	X	X
Virginia	X			X	X	X	X
Washington	X	X	X			X	X
West Virginia	X			X	X	X	X
Wisconsin	X	X				X	X
Wyoming		X			X		X
Totals	44	34	21	11	25	47	43

NOTES: For the purposes of this report, provider rate restrictions include cuts to rates for physicians, dentists, outpatient hospitals, and managed care organizations as well as both cuts or freezes in rates for inpatient hospitals and nursing homes. Also, mandatory requirements, such as the increase in primary care rates under the ACA, were excluded from these counts.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-9: PROVIDER TAXES IN PLACE IN THE 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013 AND 2014

States	Hospitals		Intermediate Care Facilities		Nursing Facilities		Manged Care Organizations*		Other		Any Provider Tax	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Alabama	X	X[1]			X	X[2]			X	X	X	X
Alaska												
Arizona		X[DK]			X	X[1]	X	X			X	X
Arkansas	X	X	X	X[2]	X	X[2]					X	X
California	X	X[2]	X	X[2]	X	X[2]	X	X[1]			X	X
Colorado	X	X[1]	X	X[1]	X	X[1]					X	X
Connecticut	X	X[1]	X	X[2]	X	X[1]					X	X
Delaware					X	X					X	X
District of Columbia	X	X	X	X[1]	X	X[1]	X	X			X	X
Florida	X	X	X	X[2]	X	X[2]					X	X
Georgia	X	X	X	X[2]	X	X[2]					X	X
Hawaii	X	X			X	X					X	X
Idaho	X	X	X	X[1]	X	X[2]					X	X
Illinois	X	X	X	X[2]	X	X[1]					X	X
Indiana	X	X[1]	X	X[2]	X	X[2]					X	X
Iowa	X	X	X	X[1]	X	X					X	X
Kansas	X	X			X	X					X	X
Kentucky	X	X	X	X[2]	X	X[2]			X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X[1]	X	X[1]	X	X[1]			X	X	X	X
Maryland	X	X[1]	X	X[2]	X	X[2]	X	X			X	X
Massachusetts	X	X			X	X[1]					X	X
Michigan	X	X			X	X[1]					X	X
Minnesota	X	X	X	X[1]	X	X	X	X	X	X	X	X
Mississippi	X	X[1]	X	X[2]	X	X[2]	X	X[DK]	X	X[2]	X	X
Missouri	X	X[2]	X	X[2]	X	X[2]			X[3]	X[1]	X	X
Montana	X	X	X	X	X	X[1]					X	X
Nebraska			X	X[2]	X	X					X	X
Nevada					X	X[2]					X	X
New Hampshire	X	X[1]			X	X[1]					X	X
New Jersey	X	X	X	X[2]	X	X	X	X	X[3]	X	X	X
New Mexico							X	X[1]			X	X
New York	X	X[1]	X	X[1]	X	X[1]			X[3]	X	X	X
North Carolina	X	X	X	X[1]	X	X[2]					X	X
North Dakota			X	X[2]							X	X
Ohio	X	X	X	X[2]	X	X[2]					X	X
Oklahoma	X	X	X	X[2]	X	X[2]					X	X
Oregon	X	X[1]			X	X[2]	X				X	X
Pennsylvania	X	X	X	X[2]	X	X[2]			X	X[2]	X	X
Rhode Island	X	X[1]			X	X[1]	X	X			X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X[1]							X	X
Tennessee	X	X[1]	X	X[1]	X	X[1]	X	X[1]			X	X
Texas			X	X			X	X			X	X
Utah	X	X	X	X[1]	X	X[1]					X	X
Vermont	X	X[2]	X	X[2]	X	X[2]			X[3]	X[2]	X	X
Virginia			X	X[1]							X	X
Washington	X	X	X	X	X	X[1]	X	X			X	X
West Virginia	X	X	X	X[1]	X	X[1]			X[3]	X[1]	X	X
Wisconsin	X	X	X	X[1]	X	X			X	X[1]	X	X
Wyoming					X	X[2]					X	X
Totals	39	40	37	37	44	44	13	12	13	13	50	50

NOTES: This table includes Medicaid provider taxes as reported by states. It is possible that there are other sources of revenue from taxes collected on health insurance premiums or health insurance claims that are not reflected here.* California, Mississippi, Oregon, and Washington State reported having Medicaid MCO taxes in place; these are not new taxes for this year but have not been included in past counts.

X[1] - States reported that these taxes would be impacted were the safe harbor threshold to drop to 3.5%.

X[2] - States reported that these taxes would be impacted were the safe harbor threshold to drop to 5.5%.

X - Provider tax in FY 2014 was at or below 3.5% of net patient revenues.

X[DK] - State was unsure if the provider tax rate was above 3.5% of net patient revenues.

X[3] - State reported multiple "Other" provider taxes for both FY 2013 and FY 2014.

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

Appendix A-10a: Premium and Copayment Actions Taken in the 50 States and the District of Columbia, FY 2013[3]

State	Premium and Copayment Changes in FY 2013
Alabama	
Alaska	
Arizona	
Arkansas	
California	
Colorado	
Connecticut	
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	
Illinois	Copayments (Increased): Increased copays (on all non-pregnant/ non-institutionalized adults) for medical services including doctor and clinic visits as well as non-emergent ER visits and brand name drugs to the federal maximum amount. Also increased drug copays for generics and OTCs (0 to $2). (7/12)
Indiana	
Iowa	Premiums (Decreased): Premiums for Medicaid Employed Persons with Disabilities were reduced in FY 2013.
Kansas	Copayments (Eliminated): Copayment requirements eliminated for enrollees in the KanCare managed care program. (1/13)
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	
Michigan	
Minnesota	Premiums (Decreased): Premium levels will be decreased for adults in MinnesotaCare in 2013.
Mississippi	
Missouri	Premiums (Increased): Premiums for the Ticket to Work Health Assurance program were increased in FY 2013.
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	

[3] 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).

North Dakota	
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	
South Dakota	Copayments (Increased): For all non-exempt groups, increased pharmacy copayments on brands (from $3 to $3.30). (7/12) Copayments (New): For all non-exempt groups, imposed new pharmacy copayments on generics ($1). (7/12)
Tennessee	
Texas	
Utah	
Vermont	Copayments (Eliminated): Eliminated $75 copay per inpatient hospital visit. (8/12) Copayments (Increased): Increased copayment requirements for non-exempt groups for DME/Supplies based on cost (i.e. increased copay to $1 for DME/Supplies costing under $30, $2 for DME/Supplies costing $30 or more but less that $50 and $3 for DME/Supplies costing $50 or more.) (8/12)
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	Copayments (Increased): Increased the following adult copay requirements: physician office visits (to $2.45), Rural Health Clinic visits (to $3.65), non-emergency outpatient hospital visits (to $3.65), generic medications (to $.65) and brand medications (to $3.65). (8/12)

Appendix A-10b: Premium and Copayment Actions Taken in the 50 States and the District of Columbia, FY 2014[4]

State	Premium and Copayment Changes in FY 2014
Alabama	Copays (Increased): Increased copay amounts up to the federal maximum amount non-pregnant, non-institutional, non-dual adults. (7/13) This will result in the following: doctor visits ($1.30 up to $3.90 each visit), optometric visits ($1.30 up to $3.90 each visit), certified nurse practitioner visits ($1.30 up to $3.90 each visit), health care center visits (up to $3.90 each visit), rural health clinic visits (up to $3.90 each visit), inpatient hospital (up to $50.00 each admission), outpatient hospital (up to $3.90 each visit), prescription drugs ($0.65 up to $3.90 each prescription), medical equipment ($1.30 up to $3.90 for each item), supplies and appliances ($0.65 up to $3.90 for each item), ambulatory surgical centers (up to $3.90 each visit).
Alaska	
Arizona	Copays (Increased): The state plans to increase cost-sharing for adults without dependent children as well as the new ACA Medicaid expansion population.
Arkansas	Premiums (Eliminated): Coverage through ARHealthNet premium program ends 12/13. Copays (New): New cost-sharing for ACA "Private option" will be higher than current Medicaid; copays will be enforceable for adults over 100% FPL. (pending waiver approval)
California	Copays (New): Will implement a $15 copayment on non-emergency services rendered in the ER for adults at or above 100% FPL and enrolled in managed care. (11/13 or 12/13)
Colorado	
Connecticut	Copays (New): Imposed a cost-sharing requirement for non-emergent use of the hospital emergency department on all non-exempt enrollees. (7/13)
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	
Illinois	
Indiana	
Iowa	Premiums (Eliminated): The IowaCare waiver ends as of December 1, 2013. Premiums (New): Under the Iowa Wellness Plan, enrollees with incomes over 50 percent FPL will be required to make a monthly premium contribution, starting in second year of coverage, which could be waived if the member completes specified wellness activities. Premium amounts will be indexed to approximately 3% of income for a 2-person household where both are enrolled in the Iowa Wellness Plan. (pending waiver approval) Copays (New): Iowa Wellness Plan enrollees will have $10 copay for non-emergent use of the ER. Cost-sharing will be waived the first year of coverage. (pending waiver approval)
Kansas	
Kentucky	Premiums (Eliminated): The Ticket to Work program will end as of January 1, 2014.
Louisiana	Premiums (Eliminated): The Medicaid Purchase Plan will be ended in FY 2014.
Maine	Copays (New): Plan to make pharmacy copays enforceable for those over 100% FPL.
Maryland	Copays (Decrease): Will end copay enforceability for waiver group as they transition to ACA expansion coverage. (1/14).
Massachusetts	

[4] 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).

Michigan	Copays (New): Legislation calls for the state to seek waiver authority to impose copays and other contribution requirements on persons at 100-138% FPL utilizing HSA-like accounts not to exceed 5% of income. Cost-sharing would not apply during the first six months and contributions may be reduced if enrollees meet certain health goals. After 48 months of cumulative Medicaid eligibility, an enrollee with income at 100-138% FPL would be required to either purchase coverage through the Marketplace or pay higher Medicaid cost-sharing not to exceed 7% of income. (pending waiver approval)
Minnesota	Premiums (Decreased): Premium levels will be reduced for MinnesotaCare adults. (2014) Copays (Decreased): Copayment requirements will be reduced for adults in MinnesotaCare to align with BHP requirements. (1/14)
Mississippi	
Missouri	Premiums (Increased): Premiums for the Ticket to Work Health Assurance program are being increased in FY 2014.
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	Copays (Increased): Increasing copays to federal maximum for all non-exempt. (10/13)
North Dakota	
Ohio	
Oklahoma	
Oregon	Premiums (Eliminated): Coverage for childless adults ends as of December 1, 2013 as these individuals move to Medicaid expansion.
Pennsylvania	
Rhode Island	Premiums (Eliminated): Plan to end premiums for Medicaid and CHIP eligible children and families between 150-250% FPL participating in RIte Care. (1/14)
South Carolina	
South Dakota	
Tennessee	Copays (New): For non-LTC adults and Standard Kids, new copay for generics. (7/13)
Texas	
Utah	
Vermont	Copays (Eliminated): Eliminated copayment requirements for DME/Supplies. (7/13)
Virginia	
Washington	Premiums (Eliminated): Eliminating extended TMA premium program. (1/14)
West Virginia	Copays (New): Imposing new copays on all non-exempt MAGI-based groups including: 0-50%FPL: $2 for non-preferred drugs and $8 for non-emergency use of the ER 50-100% FPL: $4 for non-preferred drugs, $8 for non-emergency use of the ER, $2 on outpatient services and $35 for inpatient hospital Over 100% FPL: $8 for non-preferred drugs, $8 for non-emergency use of the ER, $4 on outpatient services and $75 for inpatient hospital
Wisconsin	Premiums (Eliminated): Eliminating premium-based program for infants in families with incomes over 300% FPL. (1/14) Premiums (Increased): Premiums for parents and caretakers on TMA will increase. Copays (Eliminated): Eliminating copays on some preventive services for enrollees in the BadgerCare Plus Standard Plan. (1/14)
Wyoming	

Appendix A-11a: Benefit Related Actions Taken in the 50 States and the District of Columbia, FY 2013[5]

State	Benefit Changes in FY 2013
Alabama	Adults (-): Limit adults age 21 years and older to 1 routine eye exam every 3 years (previously once every 2 years) and to 1 pair of eyeglasses every 3 years (previously 1 pair every 2 years.) (3/13)
Alaska	
Arizona	Aged & Disabled (+): Implemented Agency with Choice consumer-directed model. (1/13)
Arkansas	
California	
Colorado	Aged and Disabled (+): Expanded services in the Children with Life Limiting Illnesses waiver. (1/13) Adults (+): Augmented coverage for communication devices. (8/12) Adults (-): Eliminated coverage for vision therapy services. (8/12)
Connecticut	Aged and Disabled (+): Added Adult Family Living to Elder and PCA waivers; implemented independent support broker. (7/12) Aged and Disabled (+): Added Money Follows the Person services. (1/13)
Delaware	
District of Columbia	
Florida	Non-Pregnant Adults (-): Reduce the number of primary care physician visits covered per recipient from unlimited to 2 per month. (8/12) Non-Pregnant Adults (-): Reduce the number of hospital emergency department visits covered per recipient from unlimited to 6 per year. (8/12) All (+): Increased maximum number of FQHC visits per person per day from 1 regardless of reason to 1 each per day for medical, dental and mental health. (8/12)
Georgia	Aged and Disabled (-): Added new level of care review process for HCBS waivers. (8/12)
Hawaii	Expansion Adults (+): Expand benefits of QUEST-ACE and QUEST-Net to equal those for adults in QUEST. (7/12)
Idaho	Aged and Disabled (+): Restored dental benefits for enrollees under the Aged and Disabled and Developmentally Disabled HCBS waivers. (7/12) Aged and Disabled (+): Restored psychosocial rehabilitation cuts for dually diagnosed individuals. (7/12)
Illinois	Adults (-): Add prior authorization requirement for all therapy services and applied a 20 visit limit (per discipline) for Occupational Therapy, Physical Therapy and Speech Therapy. (7/12) Adults (-): Limit eyeglasses to one pair every 2 years. (7/12) Adults (-): Eliminate coverage of group psychotherapy (procedure codes 90853 and 90857) for participants who are residents in a nursing facility, including a nursing facility classified as an institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act. (7/12) Adults (-): Reimbursement for inpatient detoxification admission stays will not be approved if there is a previous inpatient detoxification stay in the last 60 days. (7/12) Adults (-): Apply stricter quantity limits for incontinence supplies. (7/12) Adults (-): Subject Cesarean Section codes to prepayment review (payment to be reduced to vaginal rate if not medically necessary). (9/12) Adults (-): Eliminate non-emergency dental and chiropractic coverage. (7/12) Adults (-): Limit podiatry coverage to only adults with diabetes. (7/12) Aged and Disabled (-): Ended bed reserve payments for all nursing facility residents and ICF/DD residents over aged 21 and over. (7/12)

[5] 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).

Indiana	Aged and Disabled (-): Physical, Occupational and Speech Therapy removed from the TBI waiver. (1/13) Aged and Disabled (+): A separate allocation was established for transportation with annual limits placed on levels of nonmedical waiver transportation. (1/13) Aged and Disabled (+): The Family Supports Waiver increased the maximum individual annual allocation to $16,500 and added case management as a waiver service, rather than an administrative service.(9/12) Aged and Disabled (+): Added assisted living services to the Traumatic Brain Injury Waiver. (1/13)
Iowa	
Kansas	Managed Care Adults (+): Added coverage for bariatric surgery and lung, heart and heart/lung transplants. (1/13) Managed Care Adults (+): Added limited dental coverage for adults. (1/13)
Kentucky	
Louisiana	Pregnant Women (-): Eliminated dental benefits. (2/13) Adults (-): Eliminated rehabilitation clinic services (occupational, physical, speech or other therapies). (Does not include rehabilitation services provided by hospital-based and home health providers.) (2/13) Adults (nc): Eliminated target case management for the First-Time Mothers Home Visit program. (However, comparable MCO services accessible by Bayou Health enrollees.) (2/13)
Maine	Adults (-): Imposed a limit on chiropractor visits. (9/12) Adults (-): Reduced vision exams from once every 2 years to once every 3 years. (9/12) Adults (-): Eliminated coverage for ambulatory surgical centers. (9/12) Adults (-): Eliminated coverage for STD Screening clinic services. (9/12) Non-Pregnant Adults (-): Eliminated smoking cessation products and services. (9/12)
Maryland	Aged and Disabled (-): Eliminated payments to nursing facilities for bed-holds for hospitalizations. (7/12)
Massachusetts	Adults (+): Restored coverage for composite fillings for front teeth for adults. (1/13)
Michigan	Children (+): Added coverage for Autism Therapy. (4/13) All (+): Expanded coverage for full vision services. (10/12)
Minnesota	All (+): Added coverage of services provided by a community paramedic. (7/12) All (+): Added coverage for hospital in-reach service coordination to reduce instances of emergency department (ED) and other non-medically necessary health care utilization. (7/12)
Mississippi	Aged and Disabled (-): Ended escorted transportation in Elderly & Disabled waiver. (7/12) Aged and Disabled (+): Replaced Homemaker services with Personal Care Attendant Services in the Elderly & Disabled waiver. (7/12) Children (+): Removed 6 visit limit on Emergency Department services. (9/12) Adults (+): Removed 30 day limit on adult inpatient services. (10/12)
Missouri	Aged and Disabled (+): Added services to the Autism waiver. (7/12)
Montana	Children (+): Implemented 1915i HCBS services for Seriously Emotional Disturbed (SED) children to include services previously provided under a PRTF 1915(c) waiver plus 3 new services: co-occurring, crisis intervention, and specialized evaluation. (1/13) Children (nc): Implemented new 1915(c) PRTF Bridge Waiver for SED children enrolled in the PRTF Demonstration 1915(c) waiver that expired on September 30, 2012. (10/12)
Nebraska	
Nevada	Aged and Disabled (+): Added Behaviorally Complex Rate Requirements to Nursing Facility Policy (to incentivize facilities to serve this population). (3/13)
New Hampshire	Children (+): Lifted prior authorization requirements on Miraflex frames. (8/12) Adults (-): Reinstated prior authorization on binaural hearing aids for adults. (6/13)
New Jersey	
New Mexico	Adults (+): Added coverage for methadone clinic services and related non-emergency transportation to access those services. (9/12)

New York	All Adults (+): Expand coverage of podiatry services, to include private office-based podiatrists, for adults age 21 and older with diabetes mellitus. (11/12) All (+): Add coverage of medical language interpretation. (10/12) All (-): Eliminate coverage of arthroscopy for osteoarthritis of the knee when mechanical derangement is not present; eliminated payment for treatments for low back pain where evidence suggests there is no benefit or no evidence for benefit, and eliminated coverage of growth hormone for idiopathic short stature. (6/12)
North Carolina	
North Dakota	Pregnant women (nc): Expand coverage for smoking cessation services (ACA requirement for pregnant women). (7/12)
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	Adults (+): Added coverage for behavioral health services provided by a network of behavioral health therapists co-located with PCPs participating in the state's PCCM program. (Previously, services available only through community mental health providers.) (1/13) Disabled (+): Added coverage for nutritional therapy (individual and group counseling.) (7/12)
South Carolina	Aged and Disabled (+): Implemented a complex care program for nursing facility patients. (7/12)
South Dakota	Adults (-): Imposed a $1,000 annual limit on adult dental services. (7/12)
Tennessee	Aged and Disabled (nc): Restricted existing nursing home level of care (LOC) standard but added a new "Level 3" LOC standard for less complex HCBS enrollees. (7/12)
Texas	All (+): Added telehealth to include non-physician and mental health providers, and expanded telemedicine to urban areas. (Spring 2013) All (+): Added licensed midwives as an obstetric services provider. (Spring 2013) All (+): Added coverage of shingles vaccines. (Spring 2013) Adults (+): Added coverage of exhaled nitric oxide testing for asthma management. (Spring 2013) Adults (-): Remove coverage of binaural hearing aids and related services. (Spring 2013) Children (-): Limit coverage of cranial molding orthoses to a diagnosis of synostotic plagiocephaly or documentation of medical necessity. (Spring 2013) Children (-): Gold foil restorations, porcelain/ceramic inlays/onlays, and implants were removed as dental benefits due to standard of care or consideration as a cosmetic procedure. (Spring 2013)
Utah	Non-Pregnant Adults (+): Added emergency dental coverage. (7/12)
Vermont	
Virginia	Children (+): Expanded coverage of transition coordination services from 3 to 12 months for children enrolled in PRTF waiver.
Washington	Children (+): Added coverage of Applied Behavioral Analysis for children with autism. (1/13). Aged and Disabled (+): Partial restoration of add-on personal care hours for off-site laundry and essential shopping when residence is more than 45 minutes away. These add-on hours were reduced in FY 2012. (7/12)
West Virginia	
Wisconsin	
Wyoming	

Appendix A-11b: Benefit Related Actions Taken in the 50 States and the District of Columbia, FY 2014[6]

State	Benefit Changes in FY 2014
Alabama	
Alaska	
Arizona	Adults (+) Restoring coverage for well visits. (10/13)
Arkansas	
California	Aged and Disabled (-): Reduced in-home supportive services hours by 8%. (7/13) Adults (+): Will restore adult dental coverage. (5/14) All (+): Will restore coverage for enteral nutrition. (5/14) All (+): Will expand coverage of mental health services (such as individual, family and group therapy) and substance abuse disorder benefits to achieve parity with the selected EHB benchmark plan (the Kaiser Small Group plan). (1/14)
Colorado	Aged and Disabled (+): Will add Consumer Directed Attendant Support Services to the Brain Injury Waiver. (1/14) Adults (+): Will add adult dental coverage. (4/14) Adults (+): Will enhance the substance abuse disorder benefit.
Connecticut	Adults (nc): Allowed use of refurbished parts for repair of customized wheelchairs and other DME. (7/13)
Delaware	Aged and Disabled (+): Adding supported employment for a small group under the Developmentally Disabled waiver. (10/13) Aged and Disabled (+): Increasing long-term care home maintenance. (Date TBD)
District of Columbia	Aged and Disabled (-): Planning to implement a new more restrictive level of care standard. Children (nc): Add coverage for nonpublic school-based services, early intervention services and targeted case management services for children enrolled with the Children and Family Services Agency.
Florida	Children (+): Planning to add coverage for a second cochlear implant. All (nc): Add coverage of smoking cessation counseling (an ACA requirement).
Georgia	Adults (+): Added coverage for medically necessary emergency transportation of medically indigent citizens 21 years and older by rotary wing air ambulance. (7/13) Adults (+): New behavioral health services added under MRO. (7/13) Adults (-): Removed failure to thrive as a primary terminal illness for hospice services. (10/13)
Hawaii	Adults (+): Adding specialized behavioral health services including supported employment, supportive housing, peer specialist and representative payee as part of Section 1115 waiver renewal.
Idaho	
Illinois	Aged and Disabled (+): Reinstated bed reserve payments for ICF/DD residents over aged 21 and over. (7/13)
Indiana	Aged and Disabled (+): The Aged and Disabled Waiver was renewed to include the addition of two new services, Environmental Assessment and Structured Family Care-giving. (7/13).
Iowa	Aged and Disabled (-): Transitioning Consumer Directed Attendant Care (currently self-directed personal care) to Personal Care provided by an agency; transitioning Individual CDAC services to the Self Direction Option-Consumer Choice Option or agency CDAC services. (10/13)
Kansas	
Kentucky	

[6] 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).

Louisiana	Aged and Disabled (+): Increased access to autism-related services. (Summer 2013) Aged and Disabled (+): Adding housing support services to HCBS waivers. (10/13) Aged and Disabled (+): Expanding self-direction for community-based long-term care. (1/14)
Maine	Non-Pregnant Adults (nc): Restoring coverage of smoking cessation products and services as required by the ACA. (1/14)
Maryland	
Massachusetts	Adults (+): Added a hospice benefit for members in MassHealth Basic and Essential. (7/13)
Michigan	
Minnesota	All (+): Added certified family peer specialist as a behavioral health benefit. (7/13) All (+): Adding coverage for services provided by certified doulas. (1/14) All (+): Expanded coverage of communication devices to include electronic tablets. (7/13) Aged and Disabled (-): Planning to implement a new more restrictive level of care standard. (1/14)
Mississippi	Aged and Disabled (+): Adding Assisted Residential Care services to the Assisted Living waiver. (10/13)
Missouri	Aged and Disabled (+): Increasing limit for cost of specialized medical equipment and supplies/vehicle modification in the Children with Developmental Disabilities waiver. (10/13)
Montana	Aged and Disabled (+): Added new employment related services, day supports and activities, remote monitoring, and retirement services to the DD waiver. (7/13) Aged and Disabled (+): Added new services to the Supports for Community, Working and Living Waiver. (8/13)
Nebraska	
Nevada	Adults Non-Citizens (+): Adding coverage for emergency ESRD services. (8/13) All (nc): Adding coverage for habilitative day treatment. (4/14)
New Hampshire	All (+): Eliminating 4 visit limit per state fiscal year on emergency room services. (8/13) All (-): Instituting a limit of 12 outpatient hospital visits per year. (8/13)
New Jersey	
New Mexico	All (+): Removed restrictions on telemedicine services. (1/14) Aged and Disabled (+): Added agency-based community benefit and self-directed community benefit for long-term care. (1/14)
New York	All (-): Discontinuing coverage for Functional Electrical Stimulators (FES) for Spinal Cord and Head Injury, Cerebral Palsy, and Upper Motor Neuron Disease. (10/13) All (-): Discontinuing coverage of lumbar discography for chronic low back pain. (10/13) All (-): Limiting coverage of Transcutaneous Electrical Nerve Stimulation for pain associated with knee osteoarthritis. (10/13) All (-): Discontinuing coverage of implantable infusion pumps, except in cases of intractable cancer pain. (10/13) Adults (+): Expanded coverage of enteral formula to include underweight adults requiring oral formula supplementation. (6/13) Pregnant women (+): Add coverage for lactation counseling for eligible pregnant women. (4/13)
North Carolina	All (-): Reducing the annual limit on doctor visits from 22 to 10 except for those chronically ill or in the case of an emergency.
North Dakota	Children (nc): At the request of CMS, state is converting hospice benefit currently provided under a waiver to a State Plan benefit.
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	

South Carolina	
South Dakota	
Tennessee	
Texas	All (+): Adding provisionally licensed psychologists as a behavioral health services provider. (Fall 2013) All (+): Adding telemonitoring as a benefit for certain hypertension and diabetes diagnoses. (Fall 2013) Adults (-): Limiting coverage of behavioral health counseling for certain Alzheimer's and dementia categories. (Fall 2013) MLTSS Adults (-): Adding 30 day spell of illness limitation (for reimbursement of hospital inpatient services) to the STAR+PLUS Program. (9/13) MLTSS Adults (+): Adding coverage of cognitive rehabilitation therapy services to the STAR+PLUS Program. (3/14) Aged and Disabled (+): • Removing soft caps on certain services in Community Based Alternatives, Medically Dependent Children Program, Home and Community-based Services, and Community Living Assistance. (9/13) • Adding Licensed Clinical Social Workers and Licensed Professional Counselors as qualified providers of behavioral support services in the Home and Community-based Services program. (9/13) • Adding employment assistance and the consumer directed services option for supported employment in the Community Living Assistance and Support Services program. (9/13) • Revising the definition of adult foster care provider to include family members, with the exception of spouses, in the Community Based Alternatives program (9/13) and in the STAR+PLUS HCBS Waiver (12/13). • Adding rules that will allow individuals to travel outside of the program's service area while continuing to receive certain services from their providers in the Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, Community Based Alternatives, and Medically Dependent Children Program. (9/13) • Adding the consumer directed services option for supported employment and employment assistance in the Deaf Blind with Multiple Disabilities program. (9/13) • Adding the following services to the Home and Community-based Services program: employment assistance, cognitive rehabilitation therapy, and the consumer directed services option for supported employment, employment assistance, and nursing. (3/14) • Adding cognitive rehabilitation therapy to the STAR+PLUS HCBS Waiver. (3/14)
Utah	
Vermont	
Virginia	LTC Adults (-): Limited dental utilization in LTC settings by modifying allowable deductions for dental expenses. (7/13)
Washington	Adults (+): Expanding dental coverage. (1/14) Adults (+): Adding coverage of services provided by naturopath providers. (1/14) Pregnant Women (nc): Expanded coverage for smoking cessation services (ACA required for pregnant women). (7/13)
West Virginia	Children and AFDC-related Adults (-): Will eliminate the Mountain Health Choices Basic and Enhanced benchmark benefit plans resulting in the elimination of coverage for weight management services. (12/13)
Wisconsin	
Wyoming	

APPENDIX TABLE A-12A: PHARMACY COST CONTAINMENT IN PLACE IN THE 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013

States	Preferred Drug List	Supplemental Rebates	Script Limits
Alabama	X	X	X
Alaska	X	X	
Arizona			
Arkansas	X	X	X
California	X	X	X
Colorado	X	X	
Connecticut	X	X	
Delaware	X	X	
District of Columbia	X	X	
Florida	X	X	X
Georgia	X	X	
Hawaii			
Idaho	X	X	
Illinois	X	X	X
Indiana	X	X	
Iowa	X	X	
Kansas	X	X	X
Kentucky	X	X	X
Louisiana	X	X	X
Maine	X	X	X
Maryland	X	X	
Massachusetts	X	X	
Michigan	X	X	
Minnesota	X	X	
Mississippi	X	X	X
Missouri	X	X	
Montana	X	X	
Nebraska	X	X	
Nevada	X	X	
New Hampshire	X	X	
New Jersey			
New Mexico	X	X	
New York	X	X	
North Carolina	X	X	X
North Dakota			
Ohio	X	X	
Oklahoma	X	X	X
Oregon	X	X	
Pennsylvania	X	X	X
Rhode Island	X	X	
South Carolina	X	X	X
South Dakota			
Tennessee	X	X	X
Texas	X	X	X
Utah	X	X	X
Vermont	X	X	
Virginia	X	X	
Washington	X	X	
West Virginia	X	X	X
Wisconsin	X	X	
Wyoming	X	X	
Totals	46	46	18

NOTES: These are cost containment initiatives in place at the start of FY 2013.
SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX TABLE A-12B: PHARMACY COST CONTAINMENT ACTIONS TAKEN IN THE 50 STATES AND THE DISTRICT OF COLUMBIA, FY 2013 AND 2014

States	Impose Script Limits		Reduce Dispensing Fee		Reduce Ingredient Costs		Preferred Drug List Changes		Supplemental Rebate Changes		Other Pharmacy Actions		Total Pharmacy Actions Taken	
	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
Alabama		X				X						X		X
Alaska						X								X
Arizona														
Arkansas											X	X	X	X
California														
Colorado					X		X		X				X	
Connecticut			X									X	X	X
Delaware											X		X	
District of Columbia								X		X		X		X
Florida														
Georgia											X		X	
Hawaii					X								X	
Idaho														
Illinois	X		X				X	X	X	X	X		X	X
Indiana									X		X	X	X	X
Iowa					X								X	
Kansas									X				X	
Kentucky														
Louisiana					X		X	X	X	X			X	X
Maine											X		X	
Maryland												X		X
Massachusetts														
Michigan							X	X			X		X	X
Minnesota											X	X	X	X
Mississippi								X	X	X			X	X
Missouri												X		X
Montana							X	X	X	X	X	X	X	X
Nebraska														
Nevada														
New Hampshire							X	X	X				X	X
New Jersey														
New Mexico														
New York						X	X		X				X	X
North Carolina			X	X	X	X	X	X	X	X	X		X	X
North Dakota														
Ohio												X		X
Oklahoma														
Oregon											X		X	
Pennsylvania														
Rhode Island														
South Carolina												X		X
South Dakota														
Tennessee														
Texas						X		X		X		X		X
Utah							X	X	X	X			X	X
Vermont							X	X	X	X	X		X	X
Virginia							X	X	X	X			X	X
Washington														
West Virginia										X				X
Wisconsin											X		X	
Wyoming						X								X
Totals	1	1	3	1	5	6	11	12	13	11	13	12	24	25

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2013.

APPENDIX B: PROFILES OF SELECTED STATES:

- **Arizona**
- **Florida**
- **Kentucky**
- **Washington**

Arizona Case Study

Like other states, Arizona continues to recover from the effects of the Great Recession. After four years of budget shortfalls totaling over $13.6 billion[80], the state achieved modest surpluses in both FY 2013 and FY 2014.[81] State revenues have stabilized after years of decline and unemployment, while still high, fell from a high of 10.8 percent in January 2010 to 8.0 percent in July 2013. With the state's fiscal picture improving, Governor Jan Brewer's budget proposal for FY 2014 laid out several priorities, including public safety and child protection, education and modernizing state government. Another key priority was the expansion of Medicaid in 2014.

ACA Medicaid Expansion

Compared to other states, Arizona was in a unique position as it considered whether to implement the Affordable Care Act (ACA) Medicaid expansion during its 2013 legislative session. Arizona voters had previously approved a ballot initiative to expand Medicaid coverage to adults without dependent children under the poverty level, making Arizona one of the few states covering this group prior to the passage of the ACA. However, as part of its deficit reduction efforts, the state froze enrollment for these adults in July 2011 when it renewed its Section 1115 Medicaid waiver[82] causing enrollment to decline from 227,000 to 86,000. By January 2014, only 50,000 adults without dependent children are expected to remain enrolled.[83]

With the waiver authority for the current adult coverage expansion set to expire on December 31, 2013, the state faced an important decision heading into the 2013 legislative session: allow the waiver authority to expire ending coverage for 50,000 adults, renew the authority but forego the enhanced federal funding only available under the ACA to states that expand coverage up to 138 percent FPL, [84] or implement the full ACA Medicaid expansion. After considering a number of factors, Governor Brewer, who otherwise opposed the ACA, recommended in her January 2013 State of the State address that the state implement the full ACA Medicaid expansion.[85] The Governor pointed to a number of factors in her decision, including:[86]

- Upholding the will of voters who had twice before voted to expand coverage by continuing to cover those with incomes under 100 percent FPL while also extending coverage to approximately 57,000 individuals with incomes between 100 and 138 percent FPL.
- Providing coverage to an additional 240,000 individuals and preventing approximately 50,000 adults without dependent children from losing existing Medicaid coverage on January 1, 2014.
- Injecting nearly $8 billion into the Arizona economy over the first four years.
- Creating an estimated 21,000 jobs in Arizona.[87]
- Maintaining economic competitiveness with neighboring states that have chosen to expand.
- Guarding against increased uncompensated care costs that are borne by hospitals, including rural and safety-net hospitals, as well as the insured through higher premiums.[88]

The expansion is projected to bring in over $3.6 billion in new federal Medicaid funds by the end of FY 2016. To offset new General Fund costs associated with the expansion (estimated to total $286 million by the end of FY 2016),[89] the Governor proposed a new, narrowly tailored statewide hospital provider assessment to be used solely for the coverage expansion.[90] Taking into account the new federal revenues, the new revenue generated by the provider assessment and other ACA-related savings, the state estimates net state savings for FYs 2014, 2015 and 2016 totaling almost $4 billion.[91] The Governor's plan also included a "circuit breaker" that would automatically repeal the coverage expansion if the federal matching rate for newly eligible adults dropped below 80 percent. [92]

After the State of the State address, the Governor held several public rallies in support of her proposal, garnering support from over 400 organizations including provider groups, business leaders, economists, Tribal leaders, and advocacy groups across the state.[93] Intense debate continued throughout the entire legislative session, but after significant pressure from the Governor and the public, the legislature passed a

budget that included the Medicaid expansion in a Special Session on June 13, 2013.[94] At the bill signing four days later, the Governor stated[95],

> ***"Today, I had the pleasure of signing into law Arizona's most sweeping health care legislation in decades, as well as a State budget that is conservative, comprehensive and responsible…More important long term, the Medicaid plan will employ federal assistance to reduce pressure on our General Fund, allowing us to finally stop facing the false choice between supporting health care or education."***

Care Management

Arizona's managed care program began at the inception of the Arizona Health Care Cost Containment System, or "AHCCCS" (the state's Medicaid program) in 1982. It currently serves nearly all AHCCCS beneficiaries and will include the ACA Medicaid expansion population beginning in 2014. New managed care contracts taking effect in FY 2014 include new quality measures focused on select outcomes such as readmission rates as well as a one percentage point withhold to be used for performance-based rewards. In addition, new contracts focus on improving service delivery for three populations:[96]

Seriously Mentally Ill. AHCCCS and the Arizona Department of Health Services (ADHS) collaborated to establish a new service delivery model for the Regional Behavioral Health Authority System that integrates acute and behavioral health care for persons with serious mental illness and requires plans to become Medicare Special Needs Plans (D-SNPs). The new integrated model will be limited to Maricopa County before expanding statewide and is slated to begin October 1, 2013.[97]

Dual-Eligible Beneficiaries. Although the state withdrew from the CMS Financial Alignment Demonstration in April 2013 citing timeline and other concerns,[98] it continues to pursue an alternative model to better align services for members dually eligible for Medicare and Medicaid services. Working with the National Association of Medicaid Directors, the state plans to align each member's Medicaid managed care plan with a Medicare D-SNP plan. Currently, all AHCCCS health plans are required to have Medicare plans and approximately one-third of Arizona's dual eligible population receives their Medicare and Medicaid benefits from the same plan.[99] Starting January 1, 2014, all dual eligibles will be enrolled in a Medicaid plan that aligns with their current Medicare D-SNP plan, although members will have the option to stay in their current plan rather than transition.

Children's Rehabilitative Services. Beginning October 1, 2013, the majority of enrollees in the Children's Rehabilitative Services program (25,000 children) will be served under one contract that integrates their acute and behavioral health care with the other services provided by the program.

Additional policy actions the state either implemented in FY 2013 or planned to implement in the current fiscal year are detailed in the table that follows:

Arizona Medicaid Policy Changes FY 2013 and FY 2014

Eligibility, Application and Renewal Changes

- Plan to implement the Medicaid expansion in January 2014.
- Will be implementing new Health-e-Arizona Plus application October 1, 2013.

Provider Rates and Provider Taxes

- Increased payment rates for MCOs and ambulatory surgical centers in FY 2013, holding all other rates flat.
- FY 2014 provider rates were still being determined at the time of the survey.
- Implemented a new provider tax on nursing facilities in FY 2013.
- Planning to implement a new hospital provider tax in FY 2014.

Cost-Sharing

- Planning to pursue ACA cost-sharing plus additional cost-sharing pursuant to legislative directive for childless adults and expansion population.

Benefits

- Implemented Agency with Choice, a consumer-directed program similar to Community First Choice option, in January 2013.
- Planning to add well visits for adults beginning October 1, 2013.

Managed Care and Care Coordination

In FY 2014:

- The state will add the Medicaid expansion population (both those newly eligible and adults without dependent children for whom coverage was restored) to managed care.
- The state plans to implement an integrated Regional Behavioral Health Authority (RBHA) in Maricopa County for Adults with Severe Mental Illness (SMI).
- The State plans to integrate acute and behavioral health services and children's rehabilitative services into one package.
- Acute Care dual eligible members who are currently served by differing Medicaid and Medicare D-SNP Plans will be enrolled (with an option to stay in current plan) into the Medicaid Plan that aligns with their current Medicare D-SNP Plan. A total of approximately 11,000 acute dual eligible members will be affected.
- The state is implementing new quality measures as well as a payment reform initiative.
- Arizona plans to implement a direct care workforce training initiative.

Program Integrity

- Implemented Intelligent Investigator v6.9 in FY 2013 and plan to implement LexisNexis Accurint in FY 2014.
- In FY 2013, expanded registration requirements for attendant care agencies to include collection of identifying employee information; all employees are now verified with the federal exclusion list.
- In FY 2014, plan to increase registration requirements for non-emergency transportation providers.
- In FY 2013, began using the Fraud Investigation Database, a new federal tool containing provider Medicare cases, as well as Medi-Medi, which consolidates Medicare and Medicaid data.
- In FY 2014, plan to implement a new program integrity case management system.

Other

- The state will be transitioning its inpatient hospital reimbursement methodology from a per-diem system to an All Patient Refined Diagnostic Related Grouper (APR-DRG). Implementation is set for October 2014 (outside of the period of this survey report.)
- Plan to implement a Direct Care Workforce Training Initiative in October 2013.

Florida Case Study

State Budget Overview

Florida enacts a state budget annually. Governor Rick Scott signed the $74.1 billion FY 2014 budget (dubbed the "Florida Families First Budget") into law on May 20, 2013, while exercising line item veto authority to remove approximately $368 million in total appropriations.[100] Governor Scott described the budget as "one of the smallest budgets in this century" and reflecting the "smallest state government workforce per 1,000 residents in Florida in this century."[101] The budget includes funding to provide a pay increase to state employees for the first time in seven years and also $480 million to fund K-12 teacher pay increases. While, the Governor vetoed a 3 percent tuition increase for state universities, he increased higher education funding too, by restoring in full prior cuts from the Great Recession.

The Medicaid budget for FY 2014 – $23.1 billion (total state and federal funds) will serve approximately 3.4 million beneficiaries. This represents an increase of 11.6 percent over the most recent estimate for FY 2013 of $20.7 billion.[102] The budget provides additional federal appropriations to increase primary care provider pay as required under the ACA, and also includes funding to address waiver waiting lists and for those at risk of entering a nursing home:[103]

- $36.3 million for approximately 750 individuals waiting for Developmental Disabilities Medicaid Waiver services
- $25.2 million for the Nursing Home Diversion and Aged and Disabled Adult Waiver which would serve approximately 2,000 people on the waitlist
- $3.7 million for the Community Care for the Elderly program to serve over 1,000 individuals at the highest risk for nursing home placement.

Other 2013 legislation changed hospital reimbursement from a cost basis to a diagnostic related group (DRG) reimbursement methodology.

ACA Medicaid Expansion

In February 2013, Governor Rick Scott announced his support of the ACA Medicaid expansion, (despite continuing to oppose other aspects of the ACA health care reform law), noting that the expansion would provide 1.3 million uninsured Floridians with coverage, mostly at the expense of the federal government.[104] Scott expressed reluctance to deny coverage for these individuals, stating[105]:

> ***"Quality health care services must be accessible and affordable for all — not just those in certain ZIP codes or tax brackets. No mother, or father, should despair over whether or not they can afford — or access — the health care their child needs. While the federal government is committed to paying 100 percent of the cost of new people in Medicaid, I cannot, in good conscience, deny the uninsured access to care. We will support a three-year expansion of our Medicaid program under the new healthcare law, as long as the federal government meets their commitment …"***

Two weeks later, the state's Social Services Estimating Conference updated its projections related to the ACA Medicaid expansion estimating that an expansion would pull down $51.5 billion in federal funds and cost the state $3.5 billion over ten years, serving approximately one million uninsured.[106] The Republican-controlled legislature, however, rejected the Governor's traditional Medicaid expansion proposal and offered alternative bills. The House bill proposed a state-funded program to provide $2,000 to uninsured adults with children to fund a health savings account. The Senate rejected the House bill and passed a Medicaid expansion using private insurers for coverage, which the House then rejected. In the end, the legislature did not include either proposal for federal funding for the expansion in the FY 2014 budget, thus denying an expansion, at least in 2014.

Statewide Medicaid Managed Care

In 2011 the Florida legislature directed the Agency for Health Care Administration (AHCA) to develop and implement a Statewide Medicaid Managed Care program (SMMC).[107] The SMMC has two primary tracks which together will transform the state's current primary care case management delivery system to comprehensive, state-wide managed care: the Long-Term Care Managed Care Program (LTC-MC) and the Managed Medical Assistance program (MMA).

Long-Term Care Managed Care: In February 2013, Florida received approval from CMS for 1915 (b)/(c) combo waivers to implement the LTC-MC. The 3-year waivers, effective July 1, 2013, will provide HCBS and nursing home services to nearly 90,000 recipients who are aged 65 and older and individuals with physical disabilities aged 18 through 64 years. The program includes HCBS waiver recipients and those dually eligible for Medicare and Medicaid. Enrollment is mandatory with some exceptions.[108] Only Medicaid long-term care services are provided through the LTC-MC program.

Florida issued an Invitation to Negotiate in June 2012 for risk-based MLTC services and selected five companies (American Eldercare, Amerigroup, Coventry, Sunshine State Health Plan (Centene), and United Healthcare) through a competitive solicitation worth an estimated $3 billion.[109] Florida added two more companies, Molina and Humana, through a competitive procurement process. The state began enrollment on a regional basis, starting with Region 7 (Orlando) in August 2013 and statewide by March 1, 2014.

Managed Medical Assistance: CMS approved Florida's amendment to its Section 1115 waiver in June 2013, allowing mandatory statewide Medicaid managed care. Although the waiver is approved only through June 2014 under the original three year extension, it allows the state to move forward with the MMA program. AHCA will need to apply to CMS for subsequent waiver extensions to continue the program.

The MMA provides all Medicaid services through managed care plans, except long-term care, which is provided through the LTC-MC program described above. Enrollment is mandatory (with exceptions), for families and children, children in foster care, full benefit duals, and the aged, blind and disabled. [110] Mandatory enrollees must choose a plan within 30 days or be auto-assigned. They can change plans within the first 90 days, but then are locked into a plan for the remainder of the 12-month period. Individuals that enroll voluntarily can do so at any time and can leave the program at any time.[111]

AHCA released an ITN for MMA plans in December 2012 and the procurement is expected to conclude by October 2013. Nearly 2.9 million beneficiaries should begin enrolling in managed care plans in April 2014, with statewide enrollment expected by October 2014. As a condition of CMS' waiver approval, HMOs will have to adhere to an 85 percent minimum medical loss ratio.

Program Integrity

In this year's survey, Florida Medicaid officials highlighted program integrity initiatives as an area of particular strength that continues to be developed. For example, the state is preparing a $3 million procurement for advanced analytics capability to be implemented in FY 2014. This initiative builds on an enhanced provider background screening initiative put in place in FY 2013 that standardized data structures and formats and provided the basis to access and share data across state agencies and relevant databases.[112]

In a related action, on July 26, 2013 CMS issued a notice that it would exercise, for the first time, authority granted under the ACA to impose a temporary moratorium on enrollment of new home health agency providers in Miami-Dade County to prevent fraud, waste and abuse in the Medicare, Medicaid and CHIP programs.[113] The ACA provided the Secretary with new tools to combat fraud, waste and abuse where CMS determines significant potential exists. Working with HHS-Office of Inspector General and the Department of Justice, the Medicare Fraud Strike Force team uses advanced analytics to identify aberrant billing patterns that suggest potential fraud. The U.S. Attorney's Office for the Southern District of Florida has filed 41 home health fraud cases since 2011, with 98 individuals charged, 85 guilty pleas, and 8 trial convictions.[114]

Other Medicaid policy actions reported by Florida for FYs 2013 and 2014 are described below.

Florida Medicaid Policy Changes FY 2013 and FY 2014

Eligibility, Application and Renewal Changes

FY 2013:

- Lowered the age requirement from 60 to 18 for the Assisted Living HCBS waiver. (October 1, 2012)
- Changed the average private pay nursing home rate (divisor) that is used to determine the number of penalty months for institutional care program and home and community based waiver applicants/ recipients for uncompensated transfers. (September 1, 2012)

FY 2014:

- Increased the minimum monthly maintenance income allowance and excess standard for community spouses of institutionalized individuals. (July 1, 2013)
- Adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of CY 2014.
- Medicaid applicants will be able to apply via telephone.
- No-touch application and renewal processing will enable applications and renewals to enter into an electronically driven system, with verification completed through the federal hub, and benefits approved without the intervention of eligibility processers. This process will enable many individuals to receive and renew assistance more quickly.

Benefit Changes

FY 2013:

- Reduced the number of primary care physician visits for each recipient from unlimited to 2 per month. (August 1, 2012)
- Reduced hospital emergency room visits for each recipient from unlimited to 6 per year. (August 1, 2012)
- Increased the maximum number of visits to FQHCs for recipients from 1 per day regardless of reason to 1 each per day for medical, dental, and mental health. (August 1, 2012)

FY 2014:

- Planning to add coverage for a second cochlear implant for children.
- Adding coverage of smoking cessation counseling (an ACA requirement).

Provider Rates and Provider Taxes/Assessments

FY 2013:

- Decreased inpatient hospital rates slightly.
- Increased rates for outpatient hospitals, managed care organizations, and Nursing homes.
- Increased the nursing facility provider quality assessment rate slightly.

FY 2014: A number of payment rates for FY 2014 were still being determined at the time of the survey.

Managed Care, Care Coordination, and Long Term Care

FY 2013:

- Health Maintenance Organizations and Pre-Paid Inpatient Hospital Plans expanded acute care services to additional counties.
- Increased funding for the Nursing Home Diversion & HCBS waiver slots, and for PACE.

FY 2014:

- The state will begin implementing SMMC LTC program in August 2013; statewide by March 2014.
- Florida will begin phased-in implementation of SMMC MMA plans in April 2014; statewide by October 2014. The State Medicaid Managed Care (SMMC) program will: 1) provide coordinated physical and behavioral health care services, 2) ensure coordinated long-term and acute care services, 3) provide coordinate care for members dually eligible for Medicaid and Medicare, and 4) implement new plan performance measures and performance improvement projects.
- The State will require all health plans to use a single Preferred Drug List.
- Prepaid mental health plan contracts will be terminated with implementation of MMA.
- Increased funding to Nursing Home Diversion, Aged and Disabled, and Developmentally Disabled waiver slots.
- Merging the Aged/Disabled Adult, Assisted Living, Channeling and Nursing Home Diversion waivers into the Long-Term Care Managed Care program.

Kentucky Case Study

State Budget Issues

On April 11, 2012, Governor Steve Beshear signed into law the Kentucky state budget for the 2013-2015 biennium after issuing several line-item vetoes to eliminate provisions that expanded the state's budget gap or limited his ability to manage the budget.[115] The cumulative impact of these cuts includes:

- No state employee raises since 2009 and the smallest state workforce since 1974;
- Cumulative cuts of 15 to 38 percent for a number of state agencies;
- Six years of flat per pupil funding under the primary school funding program and large cuts in other school appropriations (compared to 2008 funding levels); and
- Reductions in local aid impacting local libraries, jails, public transportation and area development districts.[116]

Having addressed the state's immediate budget shortfalls during the 2012 legislative session, the top priority for the governor and state lawmakers heading into the 2013 "short" legislative session was state pension reform. With more than $30 billion in state pension unfunded liabilities, the Commonwealth has one of the most severely underfunded systems in the nation leading Moody's Investment Services to downgrade the Commonwealth's credit rating in 2011[117] and Standard and Poor's to move the state's outlook from "stable" to "negative" in February 2013.[118] After extensive debate of various reform options, the legislature passed a structural reform bill and a companion funding measure in the waning hours of the 2013 session that moves new hires into a hybrid 401(k) plan and provides approximately $100 million in additional yearly revenue.[119] The Kentucky Center for Economic Policy notes, however, that even after the new reform measures are implemented, more revenues will be needed to fund the state's obligations going forward.

Looking ahead, state revenue forecasters in August 2013 projected continued sluggish revenue growth through the next state budget – 2.7 percent growth in FY 2015 and 2.8 percent in FY 2016[120] – less than what the state budget director says is needed to replace the one time funds used to write the current budget, make full payments towards the state pension system and cover the cost of health care inflation, even before considering restoring prior budget cuts, or providing state employee pay raises.[121]

Medicaid Managed Care

Driven, in part, by the need to address a $100 million Medicaid budget deficit, the Commonwealth executed a rapid statewide implementation of Medicaid managed care in 2011: authorizing legislation was passed in March 2011; an RFP was released on April 7; proposals were due on May 25, and contracts were finalized with three health plans on July 8 leaving just four months for the plans to establish their Kentucky operations by the November 1, 2011 implementation date.[122] The November 2011 implementation included the transition of approximately 550,000 Medicaid enrollees, including low income families and children and the aged, blind and disabled, from a fee-for-service delivery system with a primary care case management component into capitated managed care contracts. Observers have noted that the implementation was carried out over a short period of time; there were also some issues implementation issues related to disruptions in care and communication between partners among others that the state continues to address.[123]

When the managed contracts were executed in July 2011, Governor Beshear announced that the Commonwealth's new managed care program would save Kentucky's state General Fund $375 million over the three-year contract term.[124] After implementation, however, the contracted health plans expressed dissatisfaction with their monthly capitation rates and one plan (Kentucky Spirit Health Plan) told the state in 2012 that it would pull out a year before its contract was to expire, citing a larger-than-expected.[125] In July 2013, Kentucky Spirit withdrew requiring the state to transfer more than 124,000 members into a new plan. At the time of the survey, the state had issued a new RFP to procure additional health plans to serve the regions of the state outside of the Louisville area.

Kentucky Health Benefit Exchange

On July 17, 2012, Governor Beshear issued an Executive Order establishing the Kentucky Health Benefit Exchange (KHBE) within the Cabinet for Health and Family Services, becoming one of only 17 states electing to operate a state-based exchange and joining Maryland as the only Southern states to do so.[126] After the 2013 General Assembly failed to ratify the exchange (causing the order to become invalid 90 days after the session), Governor Beshear issued a new Executive Order in June 2013 including a number of organizational changes.[127]

The KHBE is governed by a 19 member Advisory Board appointed by the Governor including three representatives of insurers that offer plans in the state, one representative of insurance agents licensed to sell in the state, three representatives of non-facility based health care providers licensed in the state, four representatives of facility based health care providers licensed in the state, one small business representative, one representative of an individual purchaser of health plans, and three consumer representatives. The Commissioners of the Department of Medicaid Services, the Department of Insurance, and the Department for Behavioral Health and Developmental and Intellectual Disabilities also serve as ex-officio members.[128]

In October 2012, the KHBE awarded a contract for development of an eligibility and enrollment system that will process all Medicaid beneficiaries and Exchange enrollees. The integrated system will have the capability to screen applications, determine eligibility, complete enrollment and provide consumer support for individuals, employers, Navigators and agents. The Commonwealth also intends to include SNAP and TANF in future phases of implementation. In May 2013, the state released final regulations detailing requirements for participating Qualified Health Plans and announced that its online marketplace would be called "kynect."

ACA Medicaid Expansion

Calling it "the single-most important decision in our lifetime for improving the health of Kentuckians," Gov. Steve Beshear announced on May 9, 2013, that Kentucky would implement the ACA Medicaid expansion extending coverage to over 300,000 Kentucky citizens.[129] Citing "exhaustive research," Governor Beshear also stated that during the first seven years, the Medicaid expansion was expected to create nearly 17,000 new jobs, have a $15.6 billion positive economic impact on the state, and generate a positive $802.4 million state budget impact. The Governor pointed to other key reasons for expanding the program, including the need to make drastic improvements to Kentucky's low health rankings, preventing costly penalties to businesses, protecting hospital funding, and broad support from health care advocates, county officials, and medical providers. As of September 3, 2013, Kentucky is one of only a few Southern states (joining Arkansas, West Virginia and Maryland) that are planning to implement the ACA Medicaid expansion in January 2014.[130]

Both the Governor's decision to expand Medicaid and to establish a state-based health insurance exchange (kynect) were challenged in court by Tea Party activists who argued that the Governor's actions must be ratified by the Kentucky legislature. In separate rulings on September 3, 2013, Franklin Circuit Court Judge Phillip Shepherd upheld both decisions stating that the Governor acted well within his authority.[131] The lead plaintiff has indicated his intent to appeal both rulings to the Kentucky Supreme Court.

In this year's survey, Kentucky reported the following Medicaid policy changes for FYs 2013 and 2014.

Kentucky Medicaid Policy Changes FY 2013 and FY 2014

Provider Rates and Provider Taxes/ Assessments

- Increased reimbursement rates for hospitals and nursing homes, and increased capitation rates for MCOs in both FY 2013 and 2014.
- Also, the two MCOs operating outside the Louisville region received a one-time 7% capitation increase in January 2013 in settlement of all 2011 procurement-related issues.

Eligibility, Application and Renewal Changes

FY 2014:

- Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138% FPL
- Eliminating spend-down eligibility for adults. (April 1, 2014)
- Eliminating special eligibility group for those with breast and/or cervical cancer. (January 1, 2014)
- Eliminating working disabled eligibility. (January 1, 2014)
- Adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of CY 2014.

Managed Care, Care Coordination, and Long Term Care

- FY 2013: Increased the number of MCOs serving the Louisville region from one to four. (January 1, 2013)
- FY 2014: One of the state's three MCOs serving regions outside of the Louisville area elected to terminate its contract one year early and withdraw from the state. (July 1, 2013)
- Increased waiver capacity for the Supports for Community Living waiver in both FY 2013 and FY 2014.

Washington Case Study

State lawmakers working to craft a 2013-2015 state biennial budget faced a daunting $2.3 billion revenue shortfall in order to fund a budget that would preserve current programs and services while making modest education funding enhancements. After failing to pass a budget during the regular session that ended in April 2013 or during a special session that ended June 11th, the legislature succeeded in passing a budget at the end of a second special session on June 28, 2013. Governor Jay Inslee signed the budget bill into law on June 30, 2013, just hours before the end of the state's fiscal year allowing the state to avoid a state government shut-down.[132]

The enacted budget closes the revenue shortfall through $1.6 billion in program savings, and by using state fund balances, funds from the state's capital budget, and changes in tax policy. The most significant source of state budget savings is $351.0 million in estimated expenditure reductions resulting from the implementation of the ACA Medicaid coverage expansion. Additional savings are derived from the continuation of the Hospital Safety Net Assessment for an additional four years. Funds generated through a tax on Washington hospitals are used to support Medicaid services, offsetting the need for state funds.[133]

Basic Health Program and Bridge Plan Waiver

The State of Washington has a long history of state efforts, beyond Medicaid, to expand health care coverage for the uninsured. Since 1993, the state has operated the Basic Health Program (BHP), a statewide health coverage program for uninsured individuals with income below 200 percent FPL who are not Medicaid eligible. Beneficiaries were enrolled with a private insurer and required to pay an income-based sliding scale premium. State fiscal pressures brought on by the Great Recession, however, made it increasingly difficult for the state to sustain BHP funding making its future unpredictable.[134] After the ACA was enacted, the state requested, and in January of 2011 received, approval of the federal 1115 "Transitional Bridge Plan" waiver designed to provide greater financial stability for the BHP until 2014 when it would be replaced by the ACA Medicaid expansion and subsidized coverage available through the Marketplace.

The ACA option for early expansion of Medicaid to adults without dependent children made it possible for Washington to secure federal assistance for this program. The Transitional Bridge waiver outlines necessary system modification milestones to ensure readiness for the ACA and provides federal funding ($35.2 million over the three year waiver period) to support the health coverage costs for those who would be eligible for the ACA Medicaid expansion in 2014. The new funding supports those with income below 133 percent of poverty in BHP, Medical Care Services (a state funded program that provides health coverage to individuals with a physical or mental incapacity that prevents them from working for at least 90 days), and ADATSA, the state's substance use disorder treatment program.

Implementation of the waiver required changes in mandated subsidies and cost sharing. Monthly premiums for the lowest income BHP enrollees (below 65% FPL) were rolled-back to 2009 levels and all premium and point-of-service cost sharing was eliminated for individuals determined to be American Indian/Alaskan Native.[135]

ACA Medicaid Expansion

Passage of a state budget that included the Medicaid expansion came with broad bipartisan support.[136] The new Washington state budget for the 2014-15 biennium assumes coverage for all eligible individuals with incomes below 138 percent of poverty. The state estimates an expansion of Medicaid program enrollment of about 325,000 individuals (250,000 new eligibles and 75,000 of those currently eligible but not enrolled) by 2017.

Health Insurance Marketplace and Apple Health Plus

The State of Washington is one of only 17 states to elect to operate a state-based Marketplace. The development of a Health Benefit Marketplace was authorized in 2011 as a public-private partnership, initially located within Washington's Health Care Authority. The Marketplace was spun off from the public agency in 2012 and went live October 1st, 2013, serving Marketplace and Medicaid enrollees under the name Healthplanfinder.

Washington has also developed Apple Health Plus, a public health coverage option to minimize the impact of enrollment churn between the Marketplace and Medicaid.[137] Participating Qualified Health Plans in Healthplanfinder will have an option to participate in Washington's Medicaid managed care delivery system on a limited basis to serve both those who transition between Medicaid and Marketplace coverage and families with mixed Marketplace and Medicaid or CHIP coverage. Health plans with "Limited Medicaid Plan" contracts would be permitted to cover:

- Medicaid or CHIP-eligible children of parents enrolled in a Healthplanfinder QHP
- Women enrolled in a QHP who become Medicaid eligible during pregnancy
- QHP enrollees who become Medicaid-eligible due to income fluctuations

Integrated Care for Dual Eligibles

The State of Washington is currently working on multiple efforts to improve care for those dually eligible for Medicare and Medicaid. In October of 2012, the state signed a Memorandum of Understanding (MOU) with CMS to establish a new managed fee-for-service structure for duals (known as HealthPath Washington) in 37 of 39 of the state's counties. Through HealthPath Washington, eligible high-cost, high-risk duals are permitted to enroll into a health home, and receive services through a health home coordinator (a multi-disciplinary entity with a background in physical health, behavioral health, pharmacy and long-term care supports.) These coordinators will be responsible for the coordination of member care from both Medicare and Medicaid. The effort is approved from April of 2013 through December of 2016, though enrollment did not start until July 2013.[138]

Washington is continuing negotiation with CMS for a second and separate MOU to establish a capitated model to manage care for dual eligible beneficiaries residing in the remaining two counties (King and Snohomish.) completed a procurement process to identify Medicare-Medicaid Integrated Plans (MMI Plans). These plans will be provided a full risk capitated payment for individuals (passively enrolled with the plan) who meet the enrollment criteria. The plans will be responsible for coordination of their enrollees Medicare and Medicaid medical services, behavioral health and long-term care services and supports.

In June 2013, the Washington State Health Care Authority announced initial selection of bidders to serve as MMI Plans in King and Snohomish Counties (Regence Blue Shield and United HealthCare). The current proposal has elective enrollment starting in May of 2014, passive enrollment in July of 2014, and will run through December of 2017; however, the timeline would be dependent upon completion of a signed MOU with CMS and therefore is subject to change. The MOU signed in October 2012 for the managed fee-for-service model (HealthPath Washington) does allow for the state to expand this initiative into King and Snohomish counties if the state has not moved forward with the capitated model by November 1, 2013.[139]

Additional policy actions the state either implemented in FY 2013 or planned to implement in the current fiscal year are detailed in the table that follows:

Washington Medicaid Policy Changes FY 2013 and FY 2014

Provider Rates and Provider Taxes/ Assessments

- FY 2013:
  - Increased MCO rates.
  - Increased nursing facility rates
  - Increased primary care rates beyond the ACA increase.
  - Specialty physician rates were cut by 2.2 percent.
  - All other rates were flat.
- FY 2014:
  - The prior year primary care rate increase is being reversed for adult services from an annual rate setting update, but increased further for children's services.
  - Plan to reduce inpatient and outpatient hospital rates.
  - Plan to increase nursing facility rates.
  - Plan to hole all other rates flat.

Eligibility, Application and Renewal Changes

FY 2013: Increased income limit for Family Planning Waiver (Take Charge) from 200 percent to 250 percent of poverty. (3,000 individuals, 10/1/12)

FY 2014:

- Planning to implement the Medicaid expansion, increasing eligibility for adults up to 138 percent FPL
- New single application for all MAGI enrollees (Medicaid and the Marketplace) through Healthplanfinder with appropriate referrals to other needed services/benefits.
- Adopted the option to extend renewal dates of current enrollees to delay renewals set for Q1 of CY 2014.
- Plan early adoption of MAGI Income counting rules.

Benefit Changes

FY 2014:

- Planning to align benefits for the Medicaid expansion population with current Medicaid benefits for adults.
- Dental services and naturopathic providers are being added for all adults as of January 1, 2014.

Premium Changes

The premium-based extension of Transitional Medical Assistance is ending January 1, 2014.

Managed Care and Care Coordination

FY 2013: Added SSI Blind and Disabled population into managed care arrangements.

In FY 2014:

- Health homes implemented in three geographic areas.
- Expanding pay for performance using new measures.

APPENDIX C: SURVEY INSTRUMENT

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2013 AND 2014

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. Medicaid Expenditure Growth: State Fiscal Years 2012, 2013 and 2014

a. Has the legislature enacted a budget for FY 2014? <choose one>

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 of Each Fund Source			
	State	Local or Other	Federal	All Fund Sources
FY ending in 2012 (FY 2012) b. Percentage change: FY 2012 over FY 2011	%	%	%	%
FY ending in 2013 (FY 2013) c. Percentage change: FY 2013 over FY 2012	%	%	%	%
FY ending in 2014 (FY 2014) d. Percentage change: FY 2014 over FY 2013	%	%	%	%

Comments: _____

e. Are local or county governments *required under state law* to contribute to the non-federal share of Medicaid financing through IGTs, CPEs or other funding mechanisms (excluding DSH payments)? <choose one>

i. If "yes" is local or county government financing for Medicaid increasing, decreasing, or staying the same relative to state funding? <choose one>

f. Looking at the FY 2014 Medicaid appropriation (or the expected appropriation), how likely is a 2014 Medicaid budget shortfall in your opinion? (Check one)

☐ Almost certain no shortfall ☐ Not Likely ☐ Possible ☐ Likely ☐ Shortfall is almost certain

2. ACA Medicaid Expansion

a. **Expansion Decision:** Does your state plan to implement the ACA Medicaid expansion starting January 1, 2014? <choose one>

b. **Expansion Authority and Financial Impact:** If your state plans to expand as of January 1, 2014:

i. Was the expansion included in the enacted budget, passed as separate legislation, or was no new legislation required? <choose one>

ii. Does your state expect net state budget savings or net state budget costs from the expansion? <choose one>

A. If net savings are expected, please briefly list the top 2 program areas where the most significant savings are expected (e.g., Medicaid, state-spending on mental health not reimbursed by Medicaid, corrections, etc.)

1. _____
2. _____

B. If net costs are expected, please briefly identify other areas, beyond the anticipated increase in enrollment, where significant costs are expected. _____

Comments: _____

3. Factors Driving Expenditure Changes

What would you consider the most significant factors that were upward and downward pressures on your total (federal and state) Medicaid spending in FY 2013, and that will be in FY 2014 (e.g., ACA Medicaid expansion and/or related enrollment growth among those currently eligible but not enrolled, other enrollment growth, healthcare inflation, rate changes, utilization, specific policy changes, etc.)?

Total Medicaid Spending		FY 2013	FY 2014
a. ***Upward*** Pressures	i. Most significant factor?		
	ii. Other significant factors?		
b. ***Downward*** Pressures	i. Most significant factor?		
	ii. Other significant factors?		

c. **State GF/GR Spending:** Please briefly identify any other significant factors affecting state (non-federal) Medicaid spending other than those listed above: _____

4. Medicaid Enrollment

a. Overall percentage enrollment growth/decline (+/-):

2013 over 2012	2014 over 2013 (proj.)
i. %	**ii. %**

b. About how much (an estimate or description) of expected change in 2014 over 2013 is due to:
   i. Increased enrollment among those ***currently eligible*** for the program but not enrolled? _____
   ii. Increased enrollment among those ***newly eligible*** under the ACA Medicaid expansion? _____

c. Which specific eligibility groups are contributing most to overall enrollment increase or decline?

_____

d. In the table below, please describe what you believe were the *key factors that were upward and downward pressures* on enrollment in FY 2013, and will be in FY 2014.

	FY 2013	FY 2014
i. ***Upward*** Pressures		
ii. ***Downward*** Pressures		

5. Medicaid Eligibility Standards

a. Please identify MAGI-based income eligibility levels to be in effect on January 1, 2014. Indicate the percent of FPL before the uniform 5% income disregard is applied; if yet to be determined, please indicate TBD.

	% of FPL (Exclude 5% of FPL Disregard)
i. Pregnant Women	
ii. 1931 Parents	
iii. Other Section 1115 Waiver Coverage for Parents	
iv. Other Section 1115 Waiver Coverage for Other Adults	
v. Other Non-Disabled Adults (Adult Expansion Group)	
vi. ☐ **MAGI conversion is not yet completed**	

b. Please briefly describe your experience in converting your current Medicaid eligibility levels to the new MAGI standard (issues or challenges, opportunities or positive benefits):

_____

c. If your state is not implementing the ACA Medicaid expansion, do you anticipate that use of MAGI-based income eligibility will have any impact on eligibility? <choose one> If "yes," please briefly describe:

_____

d. Describe changes in Medicaid eligibility standards* implemented in FY 2013 or planned for FY 2014 (other than the ACA expansion to 133% of FPL or elimination of asset tests for certain groups as required by the ACA.) Use drop down boxes to indicate "Nature of Impact" ("Expansion," a "Restriction," or a change with a "Neutral" effect from the beneficiary's perspective.) If no eligibility changes to report, please check box on line "vii." (Please **exclude** changes in CHIP-funded programs, including the movement to Medicaid of CHIP-funded children with incomes below 133% of FPL to Medicaid.)

Nature of Eligibility Change and Affected Eligibility Groups	Year	Effective Date	Est. Number of People Affected	Nature of Impact	By 1115 Waiver Authority?
i.	<choose one>			<choose one>	☐
ii.	<choose one>			<choose one>	☐
iii.	<choose one>			<choose one>	☐
iv.	<choose one>			<choose one>	☐
v.	<choose one>			<choose one>	☐
vi.	<choose one>			<choose one>	☐
vii. ☐ **No changes in either FY 2013 or FY 2014**					

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

Comments: _____

6. Medicaid Application and Renewal Process

Application for MAGI-based non-elderly, non-disabled population

a. Does your state plan to use the single streamlined application form developed by the HHS Secretary or use an alternative application? <choose one>

b. Does your state plan to develop a multi-benefit application to allow applicants to apply for MAGI-based Medicaid and other human services programs (i.e. SNAP)? <choose one>

Comments: _____

Eligibility Process Modifications: By January 1, 2014 at the latest, states are required to have eligibility systems that interface with the Marketplaces/Exchanges and to use MAGI-based Medicaid eligibility rules for most non-elderly Medicaid applicants and beneficiaries.

c. What is the status of work to upgrade your Medicaid eligibility system to interface with the Marketplace/Exchange? <choose one>

d. What is the status of work to upgrade your system to use the new MAGI-based eligibility rules? <choose one>

e. Do you plan to adopt any of the following application and renewal streamlining options released by CMS on May 17, 2013?

   i. Early adoption of MAGI-based rules <choose one>
   ii. Extend renewals of current enrollees to delay renewals set for Q1 of CY 2014 <choose one>
   iii. Enroll individuals based on SNAP eligibility <choose one>
   iv. Enroll parents based on children's income eligibility <choose one>
   v. Adopt 12-month continuous eligibility for parents and other adults <choose one>
      a. If yes or planning to adopt, please indicate the groups that will have 12-month continuous eligibility: _____

Comments: _____

Coordination with Marketplace/Exchange

f. As of January 1, 2014, will the state agency responsible for Medicaid eligibility determinations also be responsible for making final eligibility determinations for the Marketplace/Exchange subsidies? <choose one>

g. As of January 1, 2014, will the Marketplace/Exchange make final determinations or assessments of Medicaid eligibility? <choose one>

Comments: _____

Consumer Assistance

h. Has your state budgeted state funding for consumer assistance? _____

i. Is there a marketing and outreach effort focused on the Medicaid population (either those currently eligible but not enrolled or those newly eligible if your state has decided to implement the Medicaid expansion)?

_____

j. Are marketing and outreach efforts being coordinated between the Marketplace and the Medicaid agency?

_____

k. How would you describe the adequacy of resources that will be available for consumer assistance when enrollment opens on October 1, 2013? _____

Comments: _____

Other Changes

l. Describe any changes to the Medicaid application or renewal process ***other than those discussed above***. Use drop down boxes to indicate "Nature of Impact" (a "Simplification," a "Restriction," or a change with a "Neutral Effect" from the perspective of the beneficiary.) If there are no changes, check the box on line "iii."

Application or Renewal Process Change	Year	Nature of Impact
i.	<choose one>	<choose one>
ii.	<choose one>	<choose one>
iii. ☐ **No other changes in either FY 2013 or FY 2014**		

7. Provider Payment Rates

Compared to the prior year, please indicate by provider type any rate increases or decreases implemented in FY 2013 or to be implemented in FY 2014. 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 2013	FY 2014
a. Inpatient hospital		
b. Outpatient hospital		
c. Doctors – primary care (other than the ACA required increase)		
d. Doctors – specialists		
e. Dentists		
f. Managed Care Organizations		
g. Nursing Homes		

h. Please list any other provider rates subject to reimbursement increases or reductions:

i. For FY 2013. _____

ii. For FY 2014. _____

ACA-Required Payment Increases for Primary Care Services.

i. Were other primary care payment rates increased beyond those that were required? <choose one>
If yes, please describe. _____

j. Were managed care contract changes needed to incorporate the payment change? <choose one>

k. Please describe any implementation issues or challenges: _____

8. Provider Taxes / Assessments

Please use the drop down boxes in the table below to indicate provider taxes in place in FY 2012 and new taxes or changes for FY 2013 and FY 2014. In the far right columns, indicate whether caps of 3.5% or 5.5% of net patient revenues would require the state to decrease its established rate(s).

Provider Group Subject to Tax	In place in FY 2012 (Yes, No)	Provider Tax Changes (New, Increased, Decreased, Eliminated, No Change or N/A) in:		Does tax exceed either 3.5% or 5.5% of Net Patient Revenues	
		FY 2013	FY 2014	Exceeds 3.5%	Exceeds 5.5%
a. Hospitals	☐	<choose one>	<choose one>	<choose one>	<choose one>
b. ICF/ID	☐	<choose one>	<choose one>	<choose one>	<choose one>
c. Nursing Facilities	☐	<choose one>	<choose one>	<choose one>	<choose one>
d. MCOs	☐	<choose one>	<choose one>	<choose one>	<choose one>
e. Other:	☐	<choose one>	<choose one>	<choose one>	<choose one>
f. Other:	☐	<choose one>	<choose one>	<choose one>	<choose one>

g. Please estimate the proportion (%) of the non-federal share of your state's Medicaid expenditures that are funded through provider tax revenue. If unknown, please indicate "don't know". _____

9. Premiums

Please list any Medicaid eligibility group subject to a premium requirement (including a Ticket to Work or other buy-in program) and use the drop down boxes to indicate the nature of any changes made in FY 2013 or planned for FY 2014 and if the premium requirement is in place under "Waiver Authority." (Do not include premiums for CHIP-funded programs or premium assistance programs where Medicaid pays premiums to other insurers on behalf of beneficiaries.) If there are no Medicaid premiums in your state, please check the box on line "d."

Eligibility Group Subject to a Premium Requirement	In Place in FY 2012?	Changes in:		Waiver Authority?
		FY 2013?	FY 2014?	
a.	☐	<choose one>	<choose one>	<choose one>
b.	☐	<choose one>	<choose one>	<choose one>
c.	☐	<choose one>	<choose one>	<choose one>
d. ☐ **No premiums in either FY 2013 or FY 2014**				

10. Cost-Sharing

a. Does your state require Medicaid copayments? <choose one>

b. Are Medicaid copayments enforceable in your state for any eligibility group? <choose one>

c. If yes, for what group(s) are copayments enforceable? _____

d. If your state plans to apply different cost-sharing requirements to the ACA Medicaid expansion population in 2014 (compared to current eligibles), please briefly describe those requirements. (enter "N/A" if not different or if your state is not implementing the ACA Medicaid expansion): _____

Changes in Cost-Sharing: In the table below, please describe any cost-sharing policy changes in FY 2013 or planned for FY 2014 (other than those described in 10(d) above). Use drop down boxes to indicate Year, Nature of Impact ("New," "Increase," "Decrease," or "Elimination" of an existing cost sharing requirement, or a "Neutral Effect") and if the change would be completed "By Waiver Authority. If there are no cost-sharing changes to report for either year (other than those described in 10(d) above), check the box on line "h."

Cost-Sharing Action	Fiscal Year	Effective Date	Eligibility Groups Affected	Nature of Impact	Waiver Authority?
e.	<choose one>			<choose one>	<choose one>
f.	<choose one>			<choose one>	<choose one>
g.	<choose one>			<choose one>	<choose one>
h. ☐ **No cost-sharing changes in either FY 2013 or FY 2014 (other than any listed in 10.d. above.)**					

Comments on cost sharing: _____

11. Benefits

ACA Medicaid Expansion Benefits

a. If your state is implementing the ACA Medicaid expansion, indicate below which Alternative Benefit Package will be used for the non-exempt expansion population (*check one*):

i. ☐ State's largest commercial HMO
ii. ☐ A State Employee Health Plan
iii. ☐ Federal Employee Health Benefit Plan BCBS Standard PPO Plan
iv. ☐ Secretary-approved coverage: Medicaid adult State Plan benefit
v. ☐ Other Secretary-approved coverage _____
vi. ☐ Undetermined at this time
vii. ☐ N/A: State not expanding

Comments on Alternative Benefit Package (including any plans to implement a premium assistance model):

_____

b. Does your state intend to align the Alternative Benefit Package (APB) for newly-eligible adults with your Medicaid adult State Plan benefit? <choose one>
   i. If yes, please list the benefits (if any) that you will add to the ABP in order to align with your current Medicaid state plan. _____
   ii. If not, please list the key differences between the ABP for newly-eligible adults and your current state plan benefit. _____
c. Will the benefit package include long term services and supports (LTSS)? <choose one>
   i. If "Yes," please describe the LTSS benefits: _____
d. Please briefly describe how ABP-exempt beneficiaries in the newly eligible group be identified:

_____

Coordination across Medicaid and the Marketplace/Exchange

e. Is your state considering requirements that one or more QHPs operating in the Marketplace/Exchange participate in Medicaid? _____
f. Is your state considering requirements that one or more Medicaid plans be QHPs offering coverage through Marketplaces/Exchanges? _____

Other Benefit Actions

Describe below any change in benefits *implemented* during FY 2013 or planned for FY 2014 (other than ACA Medicaid expansion-related changes reported above). Use drop down boxes to indicate Year, Nature of Impact (from perspective of beneficiary, is it an "Expansion," "Limitation," a benefit "Elimination," or a change with a "Neutral Effect"), and Waiver Authority (yes or no). If there are no benefit changes for either year (other than ACA Medicaid expansion-related changes reported above), please check the box on line "h."

Benefit Change	Year	Effective Date	Eligibility Groups Affected	Nature of Impact	By Waiver Authority?
g.	<choose one>			<choose one>	<choose one>
h.	<choose one>			<choose one>	<choose one>
i.	<choose one>			<choose one>	<choose one>
j.	<choose one>			<choose one>	<choose one>
k.	<choose one>			<choose one>	<choose one>
l. ☐ **No changes in either FY 2013 or FY 2014**					

Comments on benefit changes: _____

12. Prescription Drug Policy

a. **Ingredient Cost Reimbursement Methodology.** Other than the specialty drug actions reported below, did/will ingredient cost reimbursement increase, decrease, or stay about the same:

i. In FY 2013? <choose one> **ii.** In FY 2014? <choose one>

iii. Briefly describe any change in ingredient cost reimbursement methodology (e.g., a change from/to AWP, WAC, AAC, or other benchmark): _____

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

ii. In FY 2013? <choose one> **ii.** In FY 2014? <choose one>

iii. Briefly describe any change and indicate whether an increase in dispensing fees was associated with a change in ingredient cost methodology: _____

Selected Pharmacy Management Tools. For the pharmacy management tools listed below, please indicate changes implemented in FY 2013 or planned for FY 2014. Under "Fiscal Impact" please use the drop down boxes to indicate if the change will "generate savings," "increase costs," or be "fiscally neutral." Check the box on line "f" if there are no changes to report for either year.

Program Tool/Policy	In place at the end of FY 2012?	FY	Program Change In Fiscal Year	Fiscal Impact
c. Preferred Drug List (PDL)	☐	2013		<choose one>
		2014		<choose one>
d. Supplemental Rebates	☐	2013		<choose one>
		2014		<choose one>
e. Prescription Cap	☐	2013		<choose one>
		2014		<choose one>
f. ☐ **No changes in either FY 2013 or FY 2014**				

g. **Managed Care Pharmacy Policies.** For states with capitated MCO contracts for comprehensive benefits as of July 1, 2013, please briefly describe below any pharmacy policy changes in those MCO contracts implemented in FY 2013 or planned for FY 2014 (including but not limited to changes to pharmacy carve-outs or implementation of a universal PDL applicable to all plans).

Year	MCO Pharmacy Policy Changes
i. **FY 2013**	
ii. **FY 2014**	

Other Pharmacy Program Changes. In the table below, please indicate any other pharmacy program changes implemented in FY 2013 or planned for FY 2014, including those related to specialty drug cost containment. Use drop boxes to indicate year and fiscal impact (the change will "generate savings," "increase costs," or be "fiscally neutral.") Check box on line "k" if no changes for either year.

Pharmacy Program Changes	Fiscal Impact	FY 2013 or FY 2014
h.	<choose one>	<choose one>
i.	<choose one>	<choose one>
j.	<choose one>	<choose one>
k. ☐ **No changes in either FY 2013 or FY 2014**		

Other comments on pharmacy policy changes: _____

13. Medicaid Managed Care

a. What managed care programs are used by Medicaid in FY 2014 (Check all that apply):

☐ Capitated comprehensive health plans
☐ Capitated non-comprehensive plans (e.g. behavioral health, dental, non-emergency transportation, etc.)
☐ PCCM
☐ Other _____
☐ None

Please indicate managed care policy actions implemented during FY 2013 or to be implemented in FY 2014. Please briefly describe those that apply.

Managed Care Program or Policy Actions	Implemented in FY 2013	Planned for FY 2014
b. Expand/reduce PCCM or MCO geographic service area		
c. Add/reduce eligibility groups enrolled in managed care (please specify)		
d. Change from voluntary to mandatory enrollment, or vice-versa (specify eligibility category)		
e. Implement, expand or reduce use of managed long term care		
f. New performance measures or performance-based contract changes (e.g., quality measures, withhold percentage, P4P, etc.)		
g. Other managed care policy changes		

Comments on managed care: _____

h. **Behavioral Health Managed Care Policies.** Please describe any contract of policy changes related to behavioral health in capitated MCO contracts or in separate Behavioral Health Organization (BHO) plans implemented in FY 2013 or planned for FY 2014 (including but not limited to changes to behavioral health carve-ins, behavioral health carve-outs, additional groups or geographic locations included in BHO contracts, or other significant contracting changes related to behavioral health).

Year	Behavioral Health Managed Care Policy Changes
i. **FY 2013**	
ii. **FY 2014**	

14. Care Coordination and Quality Initiatives

Please indicate and briefly describe new Medicaid care coordination or quality initiatives in place or implemented in FY 2013 or planned to be implemented in FY 2014:

Care Coordination or Quality Initiatives	In place at beginning of FY 2013	Implemented new or expanded in FY 2013	Planned for FY 2014
a. **Patient-centered medical home** initiative	☐		
b. **Health Homes** for persons with chronic conditions (ACA Sec. 2701)	☐		
c. Other initiative to **improve delivery of behavioral health services, such as coordination of physical health and behavioral health care**	☐		
d. Initiative to **coordinate long-term care and acute care services**	☐		
e. **Dual Eligible** demonstration through the CMS Medicaid-Medicare Coordination Office	☐		
f. Any other **Dual Eligible** care coordination, payment or delivery system initiative (briefly describe)	☐		
g. **Accountable Care Organizations**	☐		
h. New or expanded **quality** efforts (briefly describe)	☐		
i. **Other care coordination** or quality improvement actions or initiatives	☐		

Comments on Care Coordination: _____

15. Long Term Care Policy

Briefly identify LTC actions taken during FY 2013 or planned for FY 2014. Under "Community or Institutional Action," use the drop down boxes to indicate if the action affects "Community-based" services, "Institutional" services, or "Both." Under "Nature of Impact," use the drop down boxes to indicate if the action is an "Expansion," a new or more restrictive service "Limitation" or "Elimination," a change that "Shifts clients from institution to community" settings, or a change with a "Neutral Effect." If there are no changes for either year, check the box on line "g." (Exclude rate, tax, or benefit changes already reported in questions 7, 8, or 11).

Long Term Care Policy Action	Year	Community or Institutional Action?	Effective Date	Nature of Impact
a.	<choose one>	<choose one>		<choose one>
b.	<choose one>	<choose one>		<choose one>
c.	<choose one>	<choose one>		<choose one>
d.	<choose one>	<choose one>		<choose one>
e.	<choose one>	<choose one>		<choose one>
f.	<choose one>	<choose one>		<choose one>
g. ☐ **No changes in either FY 2013 or FY 2014**				

ACA LTC State Options	In Place in FY 2012	New in FY 2013	Plan to implement in FY 2014	No Plans to Implement	Don't Know
h. HCBS State Plan Option (Not HCBS waiver)	☐	☐	☐	☐	☐
i. State Balancing Incentive Payment Program	☐	☐	☐	☐	☐
j. Community First Choice Option	☐	☐	☐	☐	☐

16. Section 1115 Waivers

Expiring Waivers

a. Does your state have an 1115 waiver that included an eligibility expansion that is scheduled to expire in FY 2014? <choose one>

b. If so, please briefly describe any actions the state is planning to take with regard to the waiver (e.g., plans to request an extension, plans to allow the waiver to expire, plans to convert the covered eligibility group to an ACA expansion category, or whether plans for the waiver are currently undetermined):

_____

New Waivers or Waiver Amendments

c. Is your state currently planning to implement a comprehensive Section 1115 Medicaid waiver or waiver amendment, other than a Family Planning waiver , in FY 2014? <choose one> **If yes:**

d. What is the status of the waiver or waiver amendment? <choose one>

e. Please indicate the types of changes you are seeking? (*Check and describe all that apply*):

i. ☐ Eligibility changes _____

ii. ☐ Benefit or cost sharing changes _____

iii. ☐ Premium Assistance changes _____

iv. ☐ Dual Eligible Initiatives (outside of 1115A's through CMMI) _____

v. ☐ Expansion of managed care (please specify populations/services) _____

vi. ☐ Safety-net delivery system improvement initiatives (e.g. DSRIP) _____

vii. ☐ Other delivery/payment system reforms (e.g. ACO, episodic payments, etc.) _____

viii. ☐ Other _____

f. Indicate the primary goal of your 1115 waiver (i.e. reduce costs, expand coverage, etc.)

_____

17. Medicaid Administrative Capacity for ACA Implementation Efforts

a. Regarding mandatory Medicaid ACA-related requirements for FY 2014, please briefly describe your state's administrative capacity to implement the requirements: _____

b. Did your state add administrative staff in either FY 2013 or FY 2014? _____

c. Please identify any administrative challenges for your state related to the implementation of the Medicaid ACA requirements: _____

d. How has your agency addressed the need for staff training and change management to prepare for the eligibility and enrollment changes? _____

e. Given the number of changes in systems and operations of Medicaid due to the ACA, are there parts of program administration that you foresee becoming easier or more complex over time?

_____

Comments: _____

18. Program Integrity

Please identify and briefly describe any significant new program integrity initiatives or enhancements implemented or planned to be implemented in FY 2013 or FY 2014:

Care Coordination Initiatives	Implemented in FY 2013	Planned for FY 2014
a. Advanced data analytics and/or predictive modeling initiative or enhancement		
b. Enhanced provider screening initiative (beyond ACA required efforts)		
c. New or enhanced public/private data sharing initiative		
d. Other new or enhanced program integrity initiative		

Comments on current or new program integrity efforts: _____

19. Outlook for Medicaid in the Future?

What do you see as the two or three most significant issues or challenges Medicaid will face in your state over the next year or two? _____

20. Accomplishments and successes of your Medicaid program:

Looking at the administration, role and impact of your Medicaid program, what would you say are the things you are most proud of? _____

This completes the survey. Thank you very much.

[1] KCMU and Urban Institute estimates based on data from FY 2011 MSIS, 2013.

[2] Kaiser Commission on Medicaid and the Uninsured, *Federal Core Requirements And State Options In Medicaid: Current Policies And Key Issues*, (Kaiser Commission on Medicaid and the Uninsured,) April 2011. http://www.kff.org/health-reform/fact-sheet/federal-core-requirements-and-state-options-in/

[3] Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use file, 2009.

[4] Habilitation services are one of the 10 Essential Health Benefits; Medicaid as well as other insurers will be required to provide this coverage through the ACA.

[5] BIP is only available to states that spent less than 50% of Medicaid funds on non-institutional LTSS in FY2009.

[6] The previous annual budget survey report issued October 2012 is at: http://kff.org/medicaid/report/medicaid-today-preparing-for-tomorrow-a-look-at-state-medicaid-program-spending-enrollment-and-policy-trends-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2012-and-2013/. The FY 2013 mid-year report was issued in March 2013 at: http://www.kff.org/medicaid/report/a-mid-year-state-medicaid-budget-update-for-fy-2013/ . Also see report based on discussions with Medicaid directors, issued July 2013: http://kff.org/medicaid/issue-brief/a-discussion-with-leading-medicaid-directors-as-fy-2013-ends-looking-toward-health-care-reform-implementation-in-2014/

[7] State fiscal years begin on July 1 except for these states: NY on April 1; TX on September 1; AL, MI and DC on October 1.

[8] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment: June 2012 Data Snapshot,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) August 2013. http://kff.org/medicaid/issue-brief/medicaid-enrollment-june-2012-data-snapshot/.

[9] Economists believe that actions taken by taxpayers, particularly those with higher incomes, in response to the Fiscal Cliff at the end of calendar year 2012 may be artificially inflating these numbers. Additionally, national figures are influenced by the large increase in personal income tax revenues in California driven by the passage of Proposition 30 by voters in November 2012.

Lucy Dadayan and Donald J. Boyd, *Temporary "Bubble" in Income Tax Receipts*, (Albany, NY: The Nelson A. Rockefeller Institute of Government,) September 18, 2013. http://www.rockinst.org/newsroom/data_alerts/2013/2013-09-18_Data_Alert.pdf.

[10] Economists believe that actions taken by taxpayers, particularly those with higher incomes, in response to the Fiscal Cliff at the end of calendar year 2012 may be artificially inflating these numbers. Additionally, national figures are influenced by the large increase in personal income tax revenues in California driven by the passage of Proposition 30 by voters in November 2012.

Lucy Dadayan and Donald J. Boyd, *Temporary "Bubble" in Income Tax Receipts*, (Albany, NY: The Nelson A. Rockefeller Institute of Government,) September 18, 2013. http://www.rockinst.org/newsroom/data_alerts/2013/2013-09-18_Data_Alert.pdf.

[11] Chad Stone, *Statement by Chad Stone, Chief Economist, on the August Employment Report*, (Washington, DC: Center on Budget and Policy Priorities,) September 6, 2013. http://www.cbpp.org/cms/index.cfm?fa=view&id=4008.

[12] Kaiser Commission on Medicaid and the Uninsured, *A Mid-Year State Medicaid Budget Update for FY 2013*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) March 2013. http://www.kff.org/medicaid/report/a-mid-year-state-medicaid-budget-update-for-fy-2013/.

[13] Exceptions are New York and the District of Columbia. For New York, FY 2014 ends on March 31, 2014, so three months of the Medicaid expansion are reflected in FY 2014 spending. For the District of Columbia, FY 2014 ends on September 30, 2014, so nine months of the Medicaid expansion are included in spending for FY 2014. The same would be true for Michigan, which also ends FY 2014 September 30, 2014; however, Michigan will not be implementing the expansion until April 1, 2014 as the legislation was not passed with immediate effect.

[14] 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. For example, in some states, Medicaid-financed spending under the control of another agency such as a mental health or public health agency may be included, and in other states not included. The national rates of growth in Medicaid spending reported here are the weighted averages of growth rates reported by each state, with the weights based on actual expenditures for each state in FY 2011 as reflected in CMS Form 64 reports.

[15] This survey asked states to provide only the annual percentage change in enrollment for FY 2013 and FY 2014, not the actual count of enrollees. For a report on Medicaid enrollment, see: Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment: June 2012 Data Snapshot,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) August 2013. http://kff.org/medicaid/issue-brief/medicaid-enrollment-june-2012-data-snapshot/.

[16] Kaiser Commission on Medicaid and the Uninsured, *A Mid-Year State Medicaid Budget Update for FY 2013*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) March 2013. http://www.kff.org/medicaid/report/a-mid-year-state-medicaid-budget-update-for-fy-2013/.

[17] States Decisions about the Expansion are based on data from the Centers for Medicare and Medicaid Services as of September 30, 2013. Available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

[18] For more information about MAGI and other eligibility and enrollment changes under the ACA, see: Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) December 2012. http://www.kff.org/medicaid/issue-brief/medicaid-eligibility-enrollment-simplification-and-coordination-under-the-affordable-care-act-a-summary-of-cmss-march-23-2012-final-rule/.

[19] Centers for Medicare and Medicaid Services, *Medicaid and CHIP Eligibility Levels*, (Washington, DC: Department of Health and Human Services,) October 1, 2013. http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html.

[20] Children with incomes between above 100 and up to 138 percent FPL transferred from CHIP to Medicaid are still eligible for the enhanced CHIP match rate.

[21] Wesley Prater and Joan Alker, Georgetown University Center for Children and Families, *Aligning Eligibility for Children: Moving Stairstep Kids to Medicaid*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) August 2013. http://www.kff.org/medicaid/issue-brief/aligning-eligibility-for-children-moving-the-stairstep-kids-to-medicaid/.

[22] As part of the state's recent waiver renewal, the existing freeze on enrollment for adults without dependent children will remain in place. Most of the adults without dependent children with income under 100 percent FPL that are unable to enroll in Indiana's HIP waiver program due to the enrollment freeze will not be eligible for advanced premium tax credits offered through the Marketplace.

[23] Wisconsin reported plans to reduce eligibility levels for parents and adults without dependent children to 100 percent FPL but the state also plans to eliminate the current waiting list for adults without dependent children.

[24] The Indiana waiver renewal maintains a waiting list for adults without dependent children. Therefore, those that remain on the waiting list with incomes under 100 percent FPL will not have access to Medicaid coverage or coverage in the Marketplace.

[25] Plans to adopt these options were reported as application and renewal changes and recorded in Appendix Table A2-b.

[26] Centers for Medicare and Medicaid Services, *Targeted Enrollment Strategies*, (Washington, DC: Department of Health and Human Services,) October 1, 2013. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Targeted-Enrollment-Strategies/targeted-enrollment-strategies.html.

[27] There are a few states that have had waivers approved in the past to provide 12 month continuous eligibility to adults (for example, Kansas and New Hampshire) that applied to parents. This differs from the streamlining option listed in the guidance on May 17, 2013, which would have applied 12 month continuous eligibility to parents and other adults covered in the state. Therefore, Kansas and New Hampshire are not counted here as adopting this option. Additionally, New York received waiver approval April 2013 to provide 12 month continuous eligibility to parents and some other adults, but not their adult without dependent children population. The state reported plans to adopt the streamlining option for all MAGI populations and therefore was included in these counts.

[28] Two states, Maine and Vermont, did not respond to this question on the survey.

[29] Samantha Artiga and Jessica Stephens, Kaiser Commission on Medicaid and the Uninsured and Michael Perry and Sean Dryden of Perry Undem Research and Communication, *Getting into Gear for 2014: Insights from Three States Leading the Way in Preparing for Outreach and Enrollment in the Affordable Care Act,* (Washington, DC: Kaiser Family Foundation,) September 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8480-getting-into-gear-insights-from-three-states.pdf.

Jessica Stephens, Samantha Artiga, and Alexandra Gates. *Getting into Gear for 2014: An Early Look at Branding and Marketing of New Health Insurance Marketplaces,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) September 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8481-getting-into-gear-for-2014-an-early-look-at-branding-and-marketing.pdf.

[30] Federal Register Vol. 78, No. 135, July 15, 2013, pp. 42307-42310.

[31] Letter from Marilyn Tavenner, Dep't of Health & Human Servs., to Andy Allison, Ark. Dep't of Human Servs. (Sept. 27, 2013), available at http://posting.arktimes.com/media/pdf/arkansassignedapprovalltr.pdf.

Centers for Medicare and Medicaid Services, Ark. Health Care Independence Program Special Terms and Conditions (Sept. 27, 2013-Dec. 31, 2016), available at http://posting.arktimes.com/media/pdf/arkansasterms_conditions.pdf.

[32] 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 services in accordance with participants' needs. PACE programs are limited to those dually eligible for Medicare and Medicaid.

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

[34] 2000 Medicaid Managed Care Enrollment Report. CMS, 2001.

[35] 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.

[36] A number of the states that are planning to implement managed long-term care initiatives through their MMCO financial alignment demonstration are still negotiating with CMS and do not yet have an approved MOU to proceed.

[37] Julia Paradise, *Health Homes for Medicaid Beneficiaries with Chronic Conditions*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) August 2012. http://www.kff.org/medicaid/8340.cfm.

[38] Kaiser Commission on Medicaid and the Uninsured, *Decoding Medicaid Care Delivery and Financing Models: A Glossary of Widely Used Terms*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) May 2012. http://www.kff.org/medicaid/8313.cfm.

[39] Kaiser Commission on Medicaid and the Uninsured, *Decoding Medicaid Care Delivery and Financing Models: A Glossary of Widely Used Terms*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) May 2012. http://www.kff.org/medicaid/8313.cfm.

[40] Centers for Medicare and Medicaid Services, *Pioneer Accountable Care Organizations Succeed in Improving Care, Lowering Costs,* (Washington, DC: Department of Health and Human Services,) July 16, 2013. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html.

Additionally, Section 2706 of the ACA also provides Medicaid programs the opportunity to develop pediatric ACOs using the same incentive program described in Section 3022 of the ACA for the Pioneer Accountable Care Organizations in Medicare. Section 3021 of the ACA also establishes the Center for Medicare and Medicaid Innovation, to test innovative models for health care payment and delivery such as ACOs. The Center for Medicare and Medicaid Innovation announced in February State Innovation Model (SIM) grants, some of which will be used to develop or further enhance ACOs in select states. http://innovation.cms.gov/initiatives/state-innovations/.

[41] Participating state Medicaid programs include: Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas and Vermont. See: http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=1261402

[42] Twenty-six states were selected to participate in the program, which provides up to $1 million for each 12 month budget period over a two year project period. The Initial Core Set includes 26 different measures such as preventive screenings, medication management for select conditions, as well as admission rates and follow-up for common chronic conditions. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html.

[43] Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid for People with Behavioral Health Conditions,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) November 2012. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf.

[44] The contract was awarded in March; however, the contract award was being challenged at the time of this report and may result in delayed implementation.

[45] Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use file, 2009.

[46] Katherine Young, Rachel Garfield, MaryBeth Musumeci, Lisa Clemans-Cope, and Emily Lawton. *Medicaid's Role for Dual Eligible Beneficiaries*, (Kaiser Commission on Medicaid and the Uninsured,) August 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicaids-role-for-dual-eligible-beneficiaries.pdf.

[47] In addition to these seven, Minnesota has an approved MOU with CMS for administrative but not financial alignment.

[48] In addition to this count, NY is still negotiating with CMS over an MOU related to a separate capitated proposal for people with developmental disabilities who require more than 120 days of LTSS and Washington is also negotiating with CMS over an MOU for a separate capitated proposal. Minnesota has an approved MOU with CMS to implement an administrative alignment demonstration.

MaryBeth Musumeci, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) September 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8426-03-financial-alignment-demonstrations.pdf.

[49] *Olmstead v. L.C., 527 U.S. 581* (1999), available at http://www.law.cornell.edu/supct/html/98-536.ZS.html.

[50] 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 services in accordance with participants' needs.

[51] California received CMS approval of its § 1915(i) SPA in April 2013, retroactive to FY 2009 (when it was submitted).

[52] States can implement this option through a SPA or waiver. An enhanced FMAP is available and varies depending on the share of long term care spending dedicated to HCBS in 2009 ranging from an additional 5 percent for states that dedicated less than 25% of their long term care spending on HCBS in 2009 and an additional 2 percent for states that spent between 25 and 50 percent of long term care spending on HCBS in 2009.

[53] 77 *Fed. Reg*. 26828 (May 7, 2012).

[54] State of California Health and Human Services Agency, *CALIFORNIA RECEIVES FIRST-IN-THE-NATION APPROVAL OF NEW COMMUNITY-BASED CARE OPTION FOR AT-RISK SENIORS AND PERSONS WITH DISABILITIES*. (Sacramento, CA: State of California Health and Human Services Agency,) September 4, 2012. http://www.cdss.ca.gov/cdssweb/default.htm.

[55] Smith, V. et al. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) October 2011. http://www.kff.org/medicaid/8248.cfm.

[56] Rates not yet determined at the time of the survey included MCO rates for Florida, Mississippi, and Wisconsin, inpatient hospital, outpatient hospital and nursing facility rates in Florida.

[57] Department of Health Care Services, *Implementation of AB 97 Reductions*, (Sacramento, CA: Department of Health Care Services,) August 2013, http://www.dhcs.ca.gov/Documents/AB97ImplementationAnnouncemen081413.pdf.

[58] To achieve an average reduction of 2.7 percent for all hospitals, rates for the non-exempt hospitals were cut by 3.5 percent.

[59] National Association of Medicaid Directors, *State Medicaid Snapshot: Affordable Care Act Implementation*, (Washington, DC: National Association of Medicaid Directors,) September 15, 2013. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/snapshot_letterhead_9_16_13.pdf.

[60] Stephen Zuckerman and Dana Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees*, (Washington, DC: Urban Institute and Kaiser Commission on Medicaid and the Uninsured,) December 2012. http://www.kff.org/medicaid/issue-brief/how-much-will-medicaid-physician-fees-for/.

[61] 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 were reported by states but are not included in the tables in this report.

[62] 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.

[63] For more information on the Iowa Premium Assistance waiver, see:

MaryBeth Musumeci, *Medicaid Expansion Through Premium Assistance: Arkansas and Iowa's Section 1115 Demonstration Waiver Applications Compared*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) September 2013. http://kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/.

[64] MaryBeth Musumeci, *Medicaid Expansion Through Premium Assistance: Arkansas and Iowa's Section 1115 Demonstration Waiver Applications Compared*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) September 2013. http://kff.org/health-reform/fact-sheet/medicaid-expansion-through-premium-assistance-arkansas-and-iowas-section-1115-demonstration-waiver-applications-compared/.

[65] 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.

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

[67] Idaho also reported having adopted the AAC reimbursement methodology in October 2011, prior to this survey period.

[68] American Medicaid Pharmacy Administrators Association and National Association of State Medicaid Directors, *Post AWP Pharmacy Pricing and Reimbursement: White Paper,* (American Medicaid Pharmacy Administrators Association and National Association of State Medicaid Directors, June 2010. http://hsd.aphsa.org/home/doc/SummaryofWhitePaper.pdf.

[69] CMCS Informational Bulletin, "Medicaid Pharmacy – Survey of Retail Prices," May 31, 2012.

[70] 77 *Fed. Reg*. 5318-5367 (Feb. 2, 2012).

[71] This is in addition to states that had reported carving pharmacy into their managed care contracts in prior years.

[72] Indiana indicated its e-prescribing initiative was expected to generate savings while Vermont described its initiative as increasing costs.

[73] The Arkansas Waiver proposal was approved by CMS on September 27, 2013.

[74] Kaiser Commission on Medicaid and the Uninsured, *Program Integrity in Medicaid: A Primer*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) July 2012. http://www.kff.org/medicaid/8337.cfm.

[75] Department of Health and Human Services, *HHS announces new tools and resources from the Affordable Care Act to prevent fraud and strengthen Medicare, Medicaid and CHIP,* (Washington, DC: Department of Health and Human Services,) September 20, 2010, http://www.hhs.gov/news/press/2010pres/09/20100920e.html.

[76] Centers for Medicare and Medicaid Services, *Final Rule: Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers*, (Washington, DC: Department of Health and Human Services,) February 2, 2011.

[77] The Public Assistance Reporting Information System (PARIS) is a federal and state partnership that collects, houses and matches public assistance eligibility information to improve program integrity among participating states.

[78] New York Department of Health, *3ADM-03 - Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010*, (Albany, NY: New York Department of Health,) September 2013. http://www.health.ny.gov/health_care/medicaid/publications/adm/13adm3.htm.

[79] Vermont Agency of Human Services, *Vermont Global Commitment 1115 Demonstration Extension Request Submitted to CMS.* (Montpelier, VT: Vermont Agency of Human Services,) revised May 13, 2013. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-pa.pdf.

[80] Phil Oliff, Chris Mai, and Vincent Palacios, *States Continue to Feel Recession's Impact,* (Washington, DC: Center on Budget and Policy Priorities,) June 27, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=711.

[81] Governor Janice K. Brewer, *State of Arizona Executive Budget: Summary Fiscal Years 2014 and 2015,* (Arizona: Office of the Governor,) January 2013. http://www.ospb.state.az.us/documents/2013/Summary%20Book%20FY14-FY15.pdf

[82] While states are generally prohibited from restricting eligibility under the Maintenance of Effort, Arizona was able to make certain eligibility cuts as part of waiver negotiations with CMS over its expiring waiver. The state also froze enrollment for the Medical Expense Deduction (spend-down) program in May 2011 before ending the program in October 2011.

[83] Office of the Governor, *Difficult Choice: Expanding Adult Medicaid Coverage, State of Arizona Executive Budget: Summary Fiscal Years 2014 and 2015,* (Arizona, Office of the Governor,) January 2013. http://azgovernor.gov/dms/upload/PR_011413_MedicaidBudgetMessage.pdf.

[84] Centers for Medicare and Medicaid Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid,* (Washington DC: Department of Health and Human Services,) December 10, 2012. http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf.

[85] Governor Janice K. Brewer, *State of the State,* (Arizona: Office of the Governor,) January 14, 2013. http://www.azahcccs.gov/reporting/Downloads/ChildlessAdults/STATEOFSTATE2013.pdf

Governor Janice K. Brewer, *The Four Cornerstones of Reform: Building a Framework of Effective and Responsible Governance,* (Arizona: Office of the Governor,) January 14, 2013. http://www.azahcccs.gov/reporting/Downloads/ChildlessAdults/FourCornerstones.pdf.

[86] Office of the Governor, *Governor Brewer's Medicaid Plan: The Conservative Choice for Arizona*, (Arizona, Office of the Governor,) accessed September 1, 2013, http://www.azgovernor.gov/Medicaid.asp.

[87] Governor Janice K. Brewer, *Time to Complete the People's Business: Statement from Governor Jan Brewer*, (Arizona: Office of the Governor,) June 12, 2013. http://www.azahcccs.gov/publicnotices/Downloads/PeoplesBusinessPR.pdf.

[88] Office of the Governor, *Difficult Choice: Expanding Adult Medicaid Coverage, State of Arizona Executive Budget: Summary Fiscal Years 2014 and 2015,* (Arizona, Office of the Governor,) January 2013. http://azgovernor.gov/dms/upload/PR_011413_MedicaidBudgetMessage.pdf.

Note: Arizona healthcare providers have already coped with over $1.8 billion in reductions in recent years from AHCCCS cuts, such as enrollment freezes, provider rate reductions, and benefit restrictions.

[89] Arizona is one of seven states that had expanded their Medicaid programs to include adults with incomes up to 100% FPL as of ACA enactment. These states will receive a phased-in increase of the FMAP for the adult without dependent children population they had previously covered; the matching rate will start at 85% and phase up to reach 93% in 2019 and 90% in 2020 and thereafter. For Arizona, this means that they will receive an 85% match rate for adults without dependent children

with incomes below 100% FPL and a 100% match rate for this group with incomes between 100 and 138% FPL. The 85% matching rate for adults without dependent children under 100% FPL is what drives the potential General Fund costs, which will be offset by the new provider tax funds.

[90] Arizona Health Care Cost Containment System (AHCCCS). *Provider Assessment 101*. http://www.azahcccs.gov/publicnotices/Downloads/ProviderAssessment.pdf.

[91] Net savings reported here include $3.6 billion in federal matching funds from the expansion and $353 million in net savings from the General Fund ($562 million generated from the provider tax and $77 million in additional savings netted of the $286 million in general fund costs described earlier.)

Office of the Governor, *Difficult Choice: Expanding Adult Medicaid Coverage, State of Arizona Executive Budget: Summary Fiscal Years 2014 and 2015,* (Arizona, Office of the Governor,) January 2013. http://azgovernor.gov/dms/upload/PR_011413_MedicaidBudgetMessage.pdf.

[92] Office of the Governor, *Difficult Choice: Expanding Adult Medicaid Coverage, State of Arizona Executive Budget: Summary Fiscal Years 2014 and 2015,* (Arizona, Office of the Governor,) January 2013. http://azgovernor.gov/dms/upload/PR_011413_MedicaidBudgetMessage.pdf.

[93] Governor Janice K. Brewer, Governor Jan Brewer Joined by Arizona Health Care, Business Leaders who Rally behind Medicaid Expansion, (Arizona: Office of the Governor,) January 16, 2013. http://azgovernor.gov/dms/upload/PR_011613_Medicaid.pdf;
Letter of Support from Business Leaders, May 13, 2013. http://www.azgovernor.gov/documents/Medicaid/MedicaidRestorationLetter.pdf;
Office of the Governor, *Governor Brewer's Medicaid Plan: The Conservative Choice for Arizona*, (Arizona, Office of the Governor,) accessed September 1, 2013, http://www.azgovernor.gov/Medicaid.asp;
Office of Intergovernmental Relations and Arizona Health Care Cost Containment System (AHCCCS), *Arizona Medicaid Moving Forward Presentation,* (Arizona: Office of Intergovernmental Relations and AHCCS,) July 30, 2013. http://www.azahcccs.gov/publicnotices/Downloads/MedicaidMovingForwardJuly2013.pdf.

[94] Governor Janice K. Brewer, Arizona Legislature Completes its Work on the State Budget, Medicaid: Statement from Governor Jan Brewer, (Arizona: Office of the Governor,) June 13, 2013. http://azgovernor.gov/dms/upload/PR_061313_MedicaidRestorationApproved.pdf.

[95] Governor Janice K. Brewer, Balanced, Conservative Budget Upholds Core State Priorities: Statement from Governor Jan Brewer, (Arizona: Office of the Governor,) June 17, 2013. http://azgovernor.gov/dms/upload/PR_061714_Budget.pdf.

[96] Thomas J. Betlach, Director of AHCCCS, *AHCCCS Strategic Plan: State Fiscal Years 2014-2018*, (Arizona: Arizona Health Care Cost Containment System,) July 2013. http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_14-18.pdf.

[97] The contract was awarded in March; however, the contract award was being challenged at the time of this report and may result in delayed implementation.

[98] Arizona Health Care Cost Containment System, *Letter to Melanie Bella: Arizona Capitated Financial Alignment Demonstration Withdrawal*, (Arizona: AHCCCS,) April 10, 2013. http://www.azahcccs.gov/reporting/Downloads/Integration/ArizonaCapitationFinancialAlignmentDemonstrationWithdrawal.pdf.

[99] Office of the Governor, *Governor Brewer's Medicaid Plan: The Conservative Choice for Arizona*, (Arizona, Office of the Governor,) accessed September 1, 2013, http://www.azgovernor.gov/Medicaid.asp;

[100] Office of Governor Rick Scott, *Governor Scott Signs Florida Families First Budget,* (Tallahassee, Florida: Office of the Governor,) May 20, 2013; accessed July 23, 2013 http://www.flgov.com/2013/05/20/governor-scott-signs-florida-families-first-budget/.

[101] Ibid.

[102] *Florida Social Services Estimating Conference: Medicaid Caseloads and Expenditures,* (Florida: Office of Economic & Demographic Research,) February 15 and 25, 2013. Accessed July 2013 http://edr.state.fl.us/content/conferences/medicaid/medsummary.pdf.

[103] Governor Rick Scott, *Letter to Secretary Ken Detzner, Department of State,* May 20, 2013, accessed at: http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf.

[104] Approximately one quarter of the 1.3 million have income between 100% and 133% FPL and will still be eligible for federal subsidies to purchase coverage through the exchange.

[105] Office of the Governor, *Governor Rick Scott: We Must Protect the Uninsured and Florida Taxpayers with Limited Medicaid Expansion*, (Florida: Office of the Governor,) February 20, 2013. http://www.flgov.com/wp-content/uploads/2013/02/2-20-13-REMARKSFORDELIVERY.pdf.

[106] Florida Social Services Estimating Conference, *Estimates Related to the Affordable Care Act: Title XIX (Medicaid) and Title XXI (CHIP)Programs,* (Florida: Florida Social Services Estimating Conference,) March 7, 2013. http://edr.state.fl.us/content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf.

[107] Chapter 409, Part IV Florida Statutes.

[108] Individuals in the following waivers and programs are not required to enroll but may do so voluntarily: Developmental Disabilities Waiver; Traumatic Brain and Spinal Cord Injury Waiver; Project AIDS Care Waiver; Adult Cystic Fibrosis Waiver; PACE; Familial Dysautonomia Waiver; and Model Waiver.

[109] The state established the number of plans in each region, ranging from two to five plans. The state requires at least one Provider Service Network (PSN) plan in each region.

[110] Agency for Health Care Administration, Division of Medicaid, *Florida Managed Medical Assistance Program: Program Overview,* (Florida: Agency for Health Care Administration,) accessed July 2013. http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Overview_of_Managed_Medical_Assistance_program_02-12-2013.pdf

[111] Beneficiaries excluded from MMA enrollment include those eligible for only family planning services or breast and cervical cancer services, aliens eligible only for emergency services, and children receiving services in a prescribed pediatric extended care center.

Medicaid beneficiaries that can enroll voluntarily include individuals: 1) with other comprehensive health insurance coverage other than Medicare, 2) residing in Department of Juvenile Justice residential commitment facilities, or mental health treatment facilities or disability center, 3) who are refugee assistance eligible, and 4) HCBS waiver and developmental disability waiver enrollees, or those on a waiting lists.

[112] Florida Agency for Health Care Administration, *Strategic Plan for Data Connectivity: Health Care Fraud Databases*, (Florida: Agency for Health Care Administration,) accessed July 2013. http://www.flstrikeforce.com/Documents/Strategic%20Plan%20for%20Data%20Connectivity%20-%20Health%20Care%20Fraud%20Databases.pdf.

[113] Centers for Medicare and Medicaid Services, *Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Temporary Moratoria on Enrollment of Ambulances Suppliers and Providers and Home Health Agencies in Designated Geographic Areas,* (Washington, DC: Federal Register,) accessed July 2013. https://www.federalregister.gov/articles/2013/07/31/2013-18394/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-temporary-moratoria-on. A moratorium was also placed on new home health provider enrollment in Cook County (Chicago) and for new ambulance suppliers and providers in Harris County (Houston).

[114] Ibid.

[115] Office of Governor Beshear, *Governor Beshear Issues Line-Item Vetoes on Executive Branch Budget,* (Kentucky: Office of Governor Beshear,) April 11, 2012. http://migration.kentucky.gov/Newsroom/governor/20120410vetos.htm.

[116] Presentation by Lt. Governor Jerry Abramson and Mary Lassiter, Secretary of the Governor's Executive Cabinet on behalf of Governor Beshear's Blue Ribbon Commission on Tax Reform to the Senate and House Committees on Appropriations and Revenue, February 5, 2013, accessed at http://www.osbd.ky.gov/NR/rdonlyres/810338E6-7B75-4A75-A94B-5AE381AD9C77/0/130205_ARPresentation_BlueRibbonTaxCommission.pdf.

[117] Mike Wynn, "Beshear says reforms include funding for Seven Counties," *Courier-Journal*, April 5, 2013. http://blogs.courier-journal.com/politics/2013/04/05/beshear-says-pension-reforms-include-funding-for-seven-counties/.

[118] Liz Farmer, "Kentucky's Outlook Downgraded," *Governing*, February 1, 2013. http://www.governing.com/news/state/gov-kentuckys-outlook-downgraded.html.

[119] Beth Musgrave and Jack Brammer, "Kentucky legislature passes plan to shore up state's pension system," Lexington Herald-Leader, March 26, 2013, accessed at http://www.kentucky.com/2013/03/26/2574940/video-house-nears-deal-on-pension.html.

[120] T. Loftus, "Forecast: Kentucky revenue growth to remain sluggish," *The Courier-Journal*, August 16, 2013. http://www.courier-journal.com/article/20130815/NEWS01/308150087/Forecast-Kentucky-revenue-growth-remain-sluggish.

[121] Anna Baumann, "Revenue Forecast Shows Continued Deterioration of State Tax System," *Kentucky Center for Economic Policy*, August 16, 2013. http://kypolicy.us/content/revenue-forecast-shows-continued-deterioration-state-tax-system.

[122] Ashley Palmer, Embry Howell, Julia Costich and Genevieve M. Kenney, *Evaluation of Statewide Risk-Based Managed Care in Kentucky: A First Year Implementation Report* (Urban Institute and University of Kentucky,) November 2, 2012. http://www.urban.org/UploadedPDF/412702-Evaluation-of-Statewide-Risk-Based-Managed-Care-in-Kentucky.pdf.

[123] Ibid. at pp. 30-31.

[124] Office of Governor Beshear, *Governor Beshear's Medicaid Plan to Save Taxpayers $1.3 Billion*, (Kentucky: Office of the Governor,) July 7, 2011. http://migration.kentucky.gov/Newsroom/governor/20110707medicaid.htm.

[125] Beth Musgrave, "Medicaid managed-care provider Kentucky Spirit pulls out of Kentucky," *Lexington Herald-Leader*, July 6, 2013. http://www.kentucky.com/2013/07/06/2706033/medicaid-managed-care-provider.html.

[126] *State Decisions for Creating Health Insurance Exchanges, as of September 30, 2013*, (Washington, DC: Kaiser Family Foundation State Health Facts,) http://kff.org/health-reform/state-indicator/health-insurance-exchanges/#map.

[127] Office of Governor Beshear, *Executive Order: Reorganization (Kentucky Health Benefit Exchange)*,(Kentucky: Office of the Governor,) June 19, 2013. http://apps.sos.ky.gov/executive/journal/(S(fd1obx4bdqxpyfwu2mehi4dk))/journal2.aspx?showtext=1&doc=228222&rtype=M.

[128] Kaiser Family Foundation, *State Health Exchange Profiles: Kentucky*, (Washington, DC: Kaiser Family Foundation,) May 23, 2013. http://kff.org/health-reform/state-profile/state-exchange-profiles-kentucky/.

[129] Office of Governor Beshear, *Gov. Beshear Expands Health Coverage to over 300,000 Kentuckians*, (Kentucky: Office of the Governor,) May 9, 2013. Press Release, Office of Governor Steve Beshear, accessed at http://migration.kentucky.gov/newsroom/governor/20130509medicaid.htm.

[130] Kaiser Commission on Medicaid and the Uninsured, *Status of State Action on the Medicaid Expansion Decision, as of September 30, 2013*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) updated September 30, 2013. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#map.

[131] Tom Loftus, "Kentucky Medicaid expansion, healthcare exchanges proceed with judge's approval: Judge upholds two decisions by Beshear, *The Courier-Journal*, September 3, 2013. http://www.courier-journal.com/article/20130903/NEWS01/309030083/Kentucky-Medicaid-expansion-healthcare-exchanges-proceed-judge-s-approval.

[132] Rachel La Corte, "Governor signs budget in time," *The Spokesman-Review*, July 1, 2013. http://www.spokesman.com/stories/2013/jul/01/governor-signs-budget-in-time/.

[133] Washington Legislative Evaluation and Accountability Program Committee, *2013-15 Operating Budget Overview,* (Washington: Washington Legislative Evaluation and Accountability Program Committee), 2013. http://leap.leg.wa.gov/leap/Budget/Detail/2013/soHighlights_0627.pdf.

[134] Ibid.

[135] Centers for Medicare and Medicaid Services, *Washington Transitional Bridge Demonstration,* (Washington, DC: Department of Health and Human Services,) January, 2011. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

[136]Washington Legislative Evaluation and Accountability Program Committee, *Proposed Senate 2013-15 Operating Budget,* (Washington: Washington Legislative Evaluation and Accountability Program Committee), 2013. http://leap.leg.wa.gov/leap/Budget/Detail/2013/SOSummary0403.pdf.

[137]The Affordable Care Act included a component to allow states to establish a Basic Health Plan option for uninsured individuals with income between 138-200% FPL, a provision designed to allow continuation of programs like Washington's Basic Health Plan, but with federal support. In 2013 the Washington State Legislature requested an analysis of Basic Health Plan or state-administered premium assistance as a method to ensure coverage affordability for this population. At the time of this report, the results of this analysis were not available.

[138] Washington State Department of Social and Health Services, *Washington State Health Care Authority Request for Application,* (Washington: Washington State Department of Social and Health Services), April 2013. http://www.adsa.dshs.wa.gov/duals/documents/RFA/RFA%20-%202013-003%20-%20HPW%20S2_Final.pdf.

[139] MaryBeth Musumeci, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured,) September 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8426-03-financial-alignment-demonstrations.pdf.

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This publication (#8498) is available on the Kaiser Family Foundation's website at www.kff.org.

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