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THE HENRY J. KAISER FAMILY FOUNDATION

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

Prepared by
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and

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October 2012

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kaiser commission medicaid and the uninsured

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

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Table of Contents

Executive Summary **5**

Introduction **10**

Background **11**

1. Medicaid Today 11
2. Medicaid and the Economy 15
3. Recent Legislative Action 15
4. National Health Reform and Medicaid 16

Methodology **18**

Survey Results for Fiscal Years 2012 and 2013 ..... **19**

1. State Fiscal Conditions and the Recession 19
   - A. Current State Fiscal Conditions 19
   - B. The Impact of the Recession 20
2. Medicaid Spending and Enrollment Growth Rates 21
   - A. Total Medicaid Spending Growth 22
   - B. State Spending Growth for Medicaid 23
   - C. Medicaid Enrollment Growth 25
3. Medicaid Policy Initiatives for FY 2012 and FY 2013 26
   - A. Changes in Provider Reimbursement 27
   - B. Eligibility and Enrollment Process Changes 35
   - C. Premium Changes and Buy-in Programs 39
   - D. Copayment Requirements 40
   - E. Benefits Changes 43
   - F. Long-Term Care and Home and Community–Based Services 45
   - G. Prescription Drug Utilization and Cost Control Initiatives 49
4. Delivery System and Quality Initiatives and Waivers 53
   - A. Managed Care Policy Changes and Initiatives 54
   - B. Care Coordination Initiatives 58
   - C. Initiatives for Dual Eligible Beneficiaries. 62
   - D. State Waivers 64
5. Medicaid Administration and Program Integrity Initiatives 66
6. Key Issues in Implementing Health Reform 68
7. Looking Ahead: Perspectives of Medicaid Directors 72

Conclusion **73**

Appendix A: State Survey Responses..... 74

Appendix A-1: Positive Policy Actions Taken in the 50 States and the District of Columbia, FY 2012 and FY 2013..... 75

Appendix A-2: Cost Containment Actions Taken in the 50 States and the District of Columbia, FY 2012 and FY 2013..... 76

Appendix A-3: Provider Taxes in Place in the 50 States and the District of Columbia, FY 2012 and FY 2013..... 77

Appendix A-4a: Eligibility and Application Renewal Process Related Actions Taken in the 50 States and the District of Columbia, FY 2012..... 78

Appendix A-4b: Eligibility and Application Renewal Process Related Actions Taken in the 50 States and the District of Columbia, FY 2013..... 82

Appendix A-5a: Premium and Copayment Related Actions Taken in the 50 States and the District of Columbia, FY 2012..... 85

Appendix A-5b: Premium and Copayment Related Actions Taken in the 50 States and the District of Columbia, FY 2013..... 87

Appendix A-6a: Benefit Related Actions Taken in the 50 States and the District of Columbia, FY 2012..... 89

Appendix A-6b: Benefit Related Actions Taken in the 50 States and the District of Columbia, FY 2013..... 92

Appendix A-7a: Pharmacy Cost Containment Actions in Place in the 50 States and the District of Columbia, FY 2012..... 94

Appendix A-7b: Pharmacy Cost Containment Actions Taken in the 50 States and the District of Columbia, FY 2012 and FY 2013..... 95

Appendix A-8: Managed Care Actions Taken in the 50 States and the District of Columbia, FY 2012 and FY 2013..... 96

Appendix A-9: Managed Care Quality Initiatives and Contract Changes, FY 2012 and FY 2013..... 97

Appendix A-10: Care Coordination Actions in the 50 States and the District of Columbia, FY 2012 and FY 2013..... 99

Appendix B: Profiles of Selected States:..... 100

1. Massachusetts Case Study..... 101
2. Ohio Case Study..... 105
3. Oregon Case Study..... 108
4. Texas Case Study..... 112

Appendix C: Survey Instrument..... 116

Executive Summary

After experiencing the impacts of the worst economic downturn since the Great Depression, state policy makers were finally beginning to see signs of economic recovery at the end of state fiscal year (FY) 2012 and heading into FY 2013. State revenue growth was positive and neither Medicaid spending nor enrollment was growing at the high rates seen only a few years before. Cost pressure and cost containment were still dominant themes, but states were also now able to consider positive program changes, payment and delivery system reforms and continue efforts to re-orient long-term care programs to community-based care models. Eligibility rules for Medicaid remained stable due to the maintenance of eligibility (MOE) protections that were part of health reform legislation, and a number of states adopted targeted eligibility expansions or simplified enrollment procedures.

States now are also preparing for the new role for Medicaid in the implementation of the Patient Protection and Affordable Care Act (ACA). As passed, the ACA would expand Medicaid beginning in January 2014 to nearly all adults with incomes up to 133 percent of the federal poverty level (FPL) ($14,856 per year for an individual in 2012). The Congressional Budget Office (CBO) estimated that across all states the ACA changes would add 17 million new enrollees to Medicaid by 2016. Under the June 2012 Supreme Court ruling, the Secretary's authority to enforce the ACA Medicaid expansion requirement is limited, and state policy makers will decide whether or when to implement the Medicaid expansion. Election year politics and looming discussions about federal deficit reduction serve as a backdrop and context for state decision making.

The findings in this report are drawn from the 12th consecutive year of the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) budget survey of Medicaid officials in all 50 states and the District of Columbia. This survey reports on trends in Medicaid spending, enrollment and policy initiatives for FY 2012 and FY 2013. The report describes policy changes in reimbursement, eligibility, benefits, delivery systems and long-term care, as well as detailed appendices with state-by-state information, and a more in depth look through four state-specific case studies of the Medicaid budget and policy decisions in Massachusetts, Ohio, Oregon and Texas.

The top 5 key findings from the survey are highlighted below:

1. Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013.
2. Cost containment remained a strong focus for Medicaid, but with small improvements in the economy, a number of states were able to make some targeted program improvements, including continued expansions of community-based long-term care options.
3. Medicaid eligibility levels remained stable in most states, as the ACA maintenance of eligibility (MOE) provisions limited states from restricting Medicaid eligibility standards, methodologies or procedures. Despite tight budgets, a number of states reported targeted eligibility expansions or enrollment simplifications.
4. Medicaid programs are engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid.
5. Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion in the context of upcoming elections as well as potential Medicaid implications from an intense national debate about the federal budget deficit.

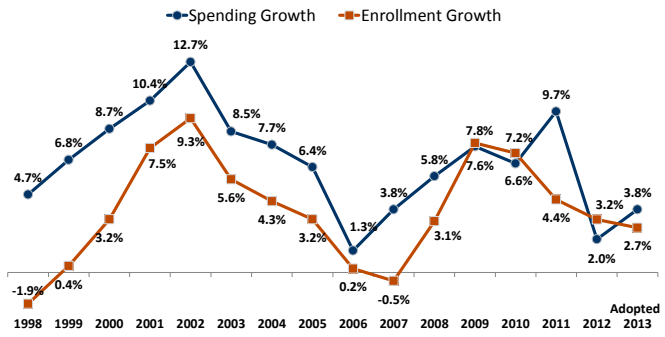
1. Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013. (Figure ES-1)

Total Medicaid spending growth hit a near record low in FY 2012, even as the state share of Medicaid spending spiked as states replaced expiring enhanced federal matching payments that were part of the American Recovery and Reinvestment Act (ARRA). FY 2012 total Medicaid spending increased by only 2.0 percent on average across all states. This was slightly less than original legislative appropriations of 2.2 percent set at the beginning of the fiscal year. Low spending growth was attributed to an improving economy which resulted in lower enrollment growth. The pace of Medicaid enrollment growth slowed in FY 2012 to 3.2 percent, the lowest rate of growth since 2008 at the beginning of the recent recession. Enrollment growth in FY 2012 was below initial projections for the second year in a row. Slow growth in FY 2012 was also attributed to intense state efforts to mitigate the increase in state spending driven by the expiration of enhanced federal matching payments on June 30, 2011. From October 2008 through June 2011, states received about $100 billion in federal fiscal relief from ARRA in the form of an enhanced federal match rate for Medicaid. The ARRA-enhanced federal matching rates (FMAP) reduced the state costs for Medicaid by increasing the federal share. This resulted in average declines in state spending for Medicaid of 10.9 percent in FY 2009 and 4.9 percent in FY 2010, the only declines in state spending for Medicaid in the program's history. Upon expiration of the enhanced federal Medicaid matching rate, the FMAP shifted back to statutory calculated levels and the state share of Medicaid spending increased by 27.5 percent in FY 2012 to make up for lost federal funds.

Headed into FY 2013, Medicaid spending and enrollment growth are much slower compared to rates during the height of the economic downturn. For FY 2013, legislatures authorized total spending growth on average of 3.8 percent across all states. While higher than for FY 2012, the 3.8 percent growth is one of the three lowest rates of growth in total Medicaid spending in the past 15 years. For FY 2013, states expected enrollment to continue to increase, but at an even slower pace than in FY 2012, with average growth across all states projected at 2.7 percent. Ten states budgeted for actual declines in Medicaid spending for FY 2013. Just over one-third of Medicaid officials reported a possible Medicaid budget shortfall, compared to more than half of states at the beginning of FY 2012. Growth among persons with disabilities and the elderly (groups with higher per capita costs) was cited as a group with significant growth in 15 states, largely driven by demographic trends.

ES - 1

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2013



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

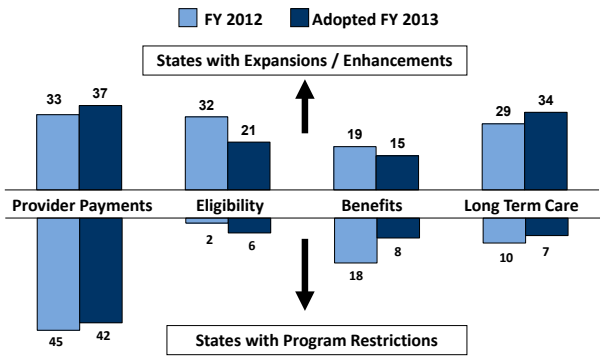
SOURCE: *Medicaid Enrollment June 2011 Data Snapshot*, KCMU, June 2012. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 and FY 2013 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

2. Cost containment remained a strong focus for Medicaid, but with small improvements in the economy, a number of states were able to make some targeted program improvements, including continued expansions of community-based long-term care options. (Figure ES-2)

In FY 2012 and FY 2013, limits on provider payments, benefits and strategies to control prescription drug spending were the most reported cost savings strategies. In FY 2012, 48 states implemented at least one new policy to control Medicaid costs and 47 states planned to do so in FY 2013. As in previous years, provider rate restrictions were the most commonly reported cost containment strategy. A total of 45 states restricted provider rates in FY 2012 and 42 states reported plans to do so in FY 2013. Some states, however, increased or imposed new provider taxes that helped to mitigate provider cuts. Eighteen states in FY 2012 and eight states in FY 2013 reported eliminating, reducing or restricting benefits. Limits on dental and vision services, therapies, personal care services, and medical supplies were most frequently reported. Nearly all states continue to implement and refine an array of sophisticated pharmacy management tools including preferred drug lists (PDLs), supplemental rebates and prior authorization to control drug spending. New efforts for FY 2013 include plans to adopt the "Actual Acquisition Cost" reimbursement methodology for pharmacy ingredient costs, to "carve-in" prescription drugs to capitated managed care arrangements and to better control behavioral health drug utilization.

ES - 2

State Policy Actions Implemented in FY 2012 and Adopted for FY 2013



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

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

For FY 2013, budgets included more program improvements compared to FY 2012 for provider rates and benefits; rates for primary care physicians will also increase to Medicare levels as part of the ACA in 2013. These positive changes demonstrate some improvements in the economy relative to FY 2012. Overall restrictions outnumbered increases in provider payments in FY 2013, but more states increased, rather than cut, rates for certain providers such as physicians, MCOs and nursing facilities. In addition to other rate improvements, the ACA provides federal funding to increase rates for primary care services to Medicare levels for 2013 and 2014. This provision will increase primary care payment rates in nearly all states, with increases exceeding 80 percent expected in six states. More states also enhanced benefits than made restrictions. Benefit improvements included adding or expanding behavioral health services and some dental restorations in Idaho, Kansas, Massachusetts and Washington.

States continue long-standing efforts to re-orient the delivery of long-term care from institutions and into community settings through traditional programs and new options in the ACA. In FY 2012 and FY 2013, 29 and 34 states, respectively, took actions to expand long-term care (LTC) services (primarily through home and community-based service (HCBS) programs). The ACA included a number of new LTC options that are now in effect. Joining seven other states, three states (Connecticut, Idaho and Louisiana) implemented the HCBS state plan option in FY 2012, and two states (Delaware and Maryland) reported plans to implement in FY 2013. A number of states are using this option to target services to persons with mental illness or intellectual disabilities. Four states implemented the Balancing Incentive Program (BIP) in FY 2012 (Georgia, Iowa, Maryland and New Hampshire) and 10 states reported plans to implement the program in FY 2013. BIP increases Medicaid matching funds for states that meet requirements for expanding the percentage of LTC spending for HCBS relative to spending for institutional services. California was the only state to implement the Community First Choice (CFC) Option in FY 2012, but six more states (Arkansas, Louisiana, Minnesota, Montana, New York and Oregon) reported plans to implement the option in FY 2013. Under the CFC option, states that provide Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services.

3. Medicaid eligibility levels remained stable in most states, as the ACA maintenance of eligibility (MOE) provisions limited states from restricting Medicaid eligibility standards or procedures. Despite tight budgets, a number of states reported targeted eligibility expansions or enrollment simplifications.

States continue to implement targeted eligibility expansions as well as simplifications to enrollment processes. Thirty-two states in FY 2012 and 21 states in FY 2013 reported moving forward with positive eligibility changes. For example, Minnesota, Colorado and New Mexico joined several other states in implementing Medicaid coverage for childless adults under a new option in the ACA or through a waiver. A waiver proposal has been submitted to expand coverage for adults in Cook County, Illinois. In addition to eligibility expansions, many states reported efforts to streamline their enrollment processes such as new or enhanced abilities to apply or renew Medicaid coverage through on-line applications, implementation or expansion of Express Lane Eligibility, and changes to administrative and passive renewals.

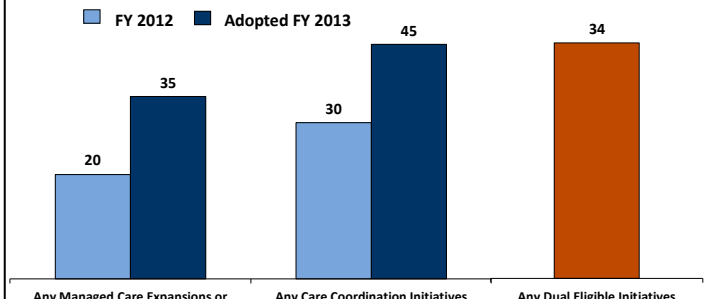
A few states are moving forward with restrictions to Medicaid eligibility that are exempt from the MOE provisions. Under the ACA, states must maintain eligibility and enrollment standards for Medicaid and CHIP that were in place at the time the ACA was enacted (March 23, 2010). These requirements apply until 2014 for adults and until 2019 for children in Medicaid and CHIP, with some limited exceptions. Under these exceptions related to expiring waivers and coverage for adults above 138 percent FPL in states certifying a budget deficit, a few states are implementing coverage restrictions. For example, Arizona froze enrollment for childless adults in their waiver program effective July 2011; Hawaii decreased the income limit to 133 percent of FPL for non-pregnant adults as of July 1, 2012; Illinois reduced the income limit for parents from 185 percent to 133 percent of FPL as of July 1, 2012, and Maine plans to eliminate coverage for non-disabled young adults ages 19 to 20 and reduce coverage for parents from 200 percent to 100 percent of FPL, effective October 1, 2012. Maine's plan is still pending at CMS.

4. Medicaid programs are engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid. (ES-3)

States continue to adopt policies to expand managed care and enhance quality. In FY 2012, a third of states (20 states) reported expanded use of managed care, primarily by expanding managed care into new geographic areas or by adding eligibility groups. For FY 2013, over two-thirds of states (35 states) reported they were expanding managed care, including 10 states that indicated plans to implement managed long- term care. Over the 2012 to 2013 period, a total of 40 states are adopting new managed care policies. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. In FY 2012, a total of 14 states adopted new quality improvement strategies, and for FY 2013, a total of 23 states are planning to implement new strategies. These strategies include the use of new quality metrics, linking payment to plan performance on contractually specified measures, linking auto-enrollment to plan quality performance, and undertaking performance improvement projects targeted to priority areas.

ES - 3

States With Managed Care, Care Coordination and Dual Eligible Initiatives, FY 2012 – FY 2013



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 more groups from voluntary to mandatory participation in managed care and as well as the 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, as well as initiatives to coordinate physical and behavioral health, long term care and acute care services, 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 the 25 states participating in the financial alignment model through CMMO as well as nine other states (AR, DE, FL, IN, KS, LA, NH, NJ, and NM).
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

States are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care. All states except six reported that they have new care coordination efforts underway in FY 2012 or FY 2013. In FY 2013, health home initiatives were reported in 31 states, patient-centered medical homes in 32 states, and Accountable Care Organizations in 13 states, as well as initiatives to coordinate physical and behavioral health in 28 states, or to coordinate long-term care and acute care services also in 14 states.

New initiatives related to systems of integrated, coordinated care to serve dual eligible beneficiaries (individuals enrolled in both Medicaid and Medicare) were a top priority in FY 2012 and FY 2013. The ACA established the Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation. Together, these offices are working with states to develop new approaches to improve care for dual eligible beneficiaries. In this survey, 34 states reported that they will be developing new payment or delivery system options for dual eligible beneficiaries. This includes 25 states actively working with MMCO on financial alignment demonstration proposals, plus nine other states that are developing initiatives outside the financial alignment demonstrations to coordinate care for some or all dual eligible beneficiaries in their states. To date only one state, Massachusetts, has finalized a Memorandum of Understanding (MOU) with CMS to implement its capitated financial alignment demonstration. In the survey, states reported a number of challenges in moving forward with efforts for this population such as complexities in setting rates for providers, receiving and analyzing data from CMS on Medicare services for this population, how to avoid any gaps in care, especially during the transition to the financial alignment demonstration, and timelines. Despite the many challenges, states are actively working to implement these initiatives.

5. Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion in the context of upcoming elections as well as potential Medicaid implications from an intense national debate about the federal budget deficit.

State policy makers are weighing the political, economic and health care consequences of their decisions related to Medicaid. With just over a year to go before the ACA health care coverage expansions go into effect in January 2014, most states are immersed in multiple planning and development efforts. States are deciding which insurance exchange model will operate in their state in 2014 and deciding how to proceed with the ACA Medicaid expansion. The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius* limited federal enforcement of the requirement to expand Medicaid giving states the ability to choose whether to implement the expansion. The vast majority of the Medicaid expansion is funded with federal dollars, so states that do not expand will forgo federal dollars and will leave many without coverage. Even without the expansion, states are still required to streamline and simplify the enrollment process for health coverage by 2014. Almost all states are moving forward with plans to take advantage of the 90/10 federal funding to upgrade or replace their Medicaid eligibility systems. States reported new opportunities to cover or improve coverage under the ACA but also highlighted challenges related to implementation timeframes, the need for additional federal guidance and additional administrative resources to implement the law.

Looking ahead, the outcome of the upcoming elections and the results of another round of federal deficit reduction negotiations are key areas of uncertainty for state Medicaid programs. While still a key priority, the singular focus on budget shortfalls and cost containment eased somewhat compared to prior years. However, decisions about moving forward with the Medicaid ACA expansion may hinge on state and national election outcomes for many states. In addition, states face some uncertainty about Medicaid changes that may be included in the upcoming federal deficit reduction debates. Despite these uncertainties, Medicaid directors and state policy makers are focused on the opportunities to improve care, enhance quality and control costs while at the same time preparing for the implementation of the ACA and its effect on Medicaid.

Introduction

After experiencing the impacts of the worst economic downturn since the Great Depression, state policy makers were finally beginning to see signs of economic recovery at the end of state fiscal year (FY) 2012 and heading into FY 2013. State revenue growth was positive and neither Medicaid spending nor enrollment was growing at the high rates seen recent years. Some states were able to avoid additional Medicaid cuts, make small restorations to cuts made in prior years or targeted program investments. However, in some states, revenues were still below pre-recession levels. A few states faced mid-year budget cuts in FY 2012 and despite improvements in the economy, most states implemented additional cost containment initiatives in FY 2013.

States now are also preparing for the new role for Medicaid in the implementation of the Patient Protection and Affordable Care Act (ACA). As passed, the ACA would expand Medicaid to nearly all adults with incomes up to 133 percent of the federal poverty level (FPL) ($14,856 per year for an individual in 2012).[1] The Congressional Budget Office (CBO) estimated that across all states the ACA changes would add 17 million new enrollees to Medicaid by 2016. Under the June 2012 Supreme Court ruling, the Secretary's authority to enforce the ACA Medicaid expansion requirement is limited and states will decide whether or when to implement the Medicaid expansion. State policy makers must therefore weigh the ideological, political, economic, and health consequences of their decisions related to Medicaid. Election year politics and looming discussions about federal deficit reduction serve as a backdrop and context for state decision making on Medicaid.

For the 12th consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a survey of Medicaid officials in all 50 states and the District of Columbia to track trends in Medicaid spending, enrollment and policy initiatives. This report also includes background on the Medicaid program and current issues such as how states are preparing for the implementation of national health reform. Findings are presented for state fiscal years (FYs) 2012 and 2013. The report provides detailed appendices with state-by-state data as well as a more in depth look through four case studies of the Medicaid budget and policy decisions in Massachusetts, Ohio, Oregon and Texas.

[1] The ACA includes an across the board five percentage point income disregard, effectively making the new eligibility floor 138% FPL.

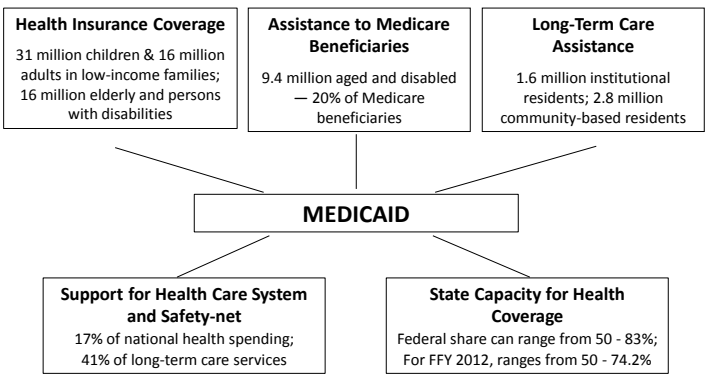
Background

1. Medicaid Today

Medicaid serves multiple roles in the health care system. Medicaid provides health and long-term care coverage to more than 62 million low-income Americans including 31 million low-income children, 16 million adults and 16 million elderly and people with disabilities.[2] The program also provides assistance for about 9 million low-income Medicare beneficiaries (dual eligible beneficiaries) who rely on Medicaid to pay Medicare premiums and cost-sharing and to cover benefits Medicare does not cover, such as long-term care. Medicaid plays a major role in our country's health care delivery system, accounting for about one-sixth of all U.S. health care spending, 41 percent of long-term care expenditures,[3] and critical funding for a range of safety-net providers. Medicaid also supports state capacity to finance health coverage. (Figure 1)

FIGURE 1

Medicaid has many roles in our health care system.

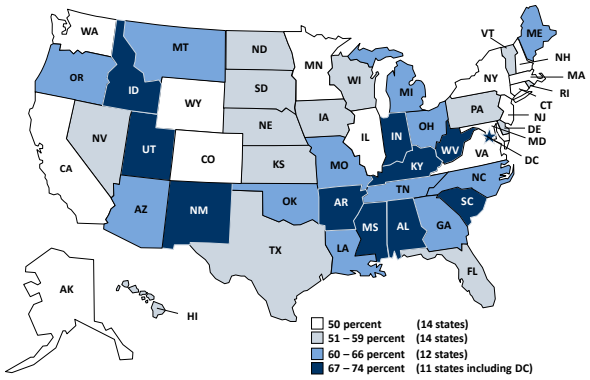


States administer Medicaid within broad federal guidelines. Within federal guidelines, states have flexibility to decide who qualifies for coverage, what benefits to cover, how much to pay Medicaid providers, how to deliver care (through managed care or another delivery system model), and how to use Medicaid to address state policy priorities such as covering uninsured children and adults.

Medicaid is financed by states and the federal government. The Medicaid program is jointly funded by states and the federal government. In federal fiscal year (FFY) 2010, total Medicaid expenditures climbed to over $389 billion.[4] 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 is lagged, so data used for FY 2013 is from the three years of 2009 to 2011. According to the statutory formula, for FFY 2013, the FMAP varies across states from a floor of 50 percent to a high of 73.43 percent.[5] (Figure 2)

FIGURE 2

Medicaid costs are shared by the states and the federal government.



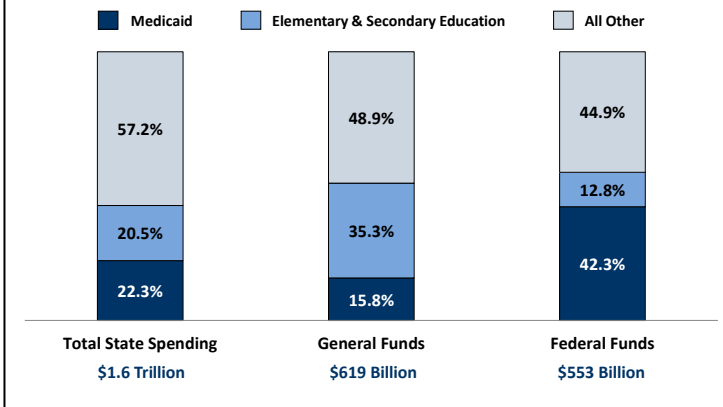
NOTE: Rates are rounded to nearest percent. These rates will be in effect Oct. 1, 2012 – Sept. 30, 2013.
SOURCE: FY2013: Federal Register, November 30, 2011 (Vol 76, No. 230), pp 74061-74063, at http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf

[2] KCMU and Urban Institute estimates based on data from FY 2009 MSIS, 2012.
[3] KCMU estimates based on CMS National Health Accounts data, 2010. Total LTC expenditures include only spending on nursing home and home health services. Some community-based services financed primarily through Medicaid home and community-based waivers and delivered in other settings are not represented here.
[4] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64) (as of 12/21/11).
[5] In FY 2013, 14 states have an FMAP at the statutory minimum of 50.0 percent: Alaska, California, Colorado, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington, and Wyoming.

Medicaid represents the largest share of federal revenues to states. Medicaid provides financing for a range of health care providers within communities across the country, supporting jobs, income and economic activity. The economic impact of Medicaid is magnified by the matching formula. At a minimum, states draw down $1 of federal money for every dollar of state funds spent on Medicaid; however, states must cut at least $2 in program spending to save $1 in state funds. Federal Medicaid dollars represent the single largest source of federal grant support to states, accounting for an estimated 42 percent of all federal grants to states in FY 2010. On average, states spent about 16 percent of their own funds on Medicaid, making it the second largest program in most states' general fund budgets following spending for elementary and secondary education, which represented 35 percent of state spending in FY 2010. (Figure 3)

FIGURE 3

Medicaid is a budget item and a revenue item in state budgets.



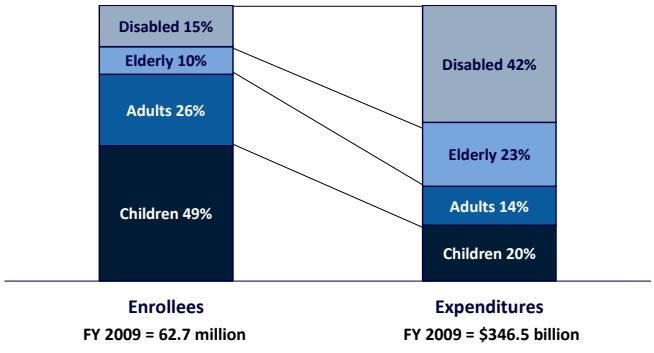
SOURCE: Actual FY 2010 data reported in: *State Expenditure* Report. NASBO, December 2011

Half of Medicaid enrollees are children, but most Medicaid spending is for the elderly and people with disabilities. About 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 about 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.[6]

Dual eligible beneficiaries account for 15 percent of Medicaid enrollees, but account for 38 percent of costs. About 9 million elderly and persons with disabilities rely on both the Medicare and Medicaid programs to obtain needed health and long-term care services. These dual eligible beneficiaries accounted for only 15 percent of Medicaid enrollment, but 38 percent of Medicaid spending in FFY 2009. (Figure 5) These same people accounted for 20 percent of Medicare enrollment and over 31 percent of Medicare spending in 2008.[7] This population relies on Medicaid to pay Medicare premiums and cost sharing, and to cover benefits not covered by Medicare, such as long-term care services. In 2006, prescription drug coverage for Duals was

FIGURE 4

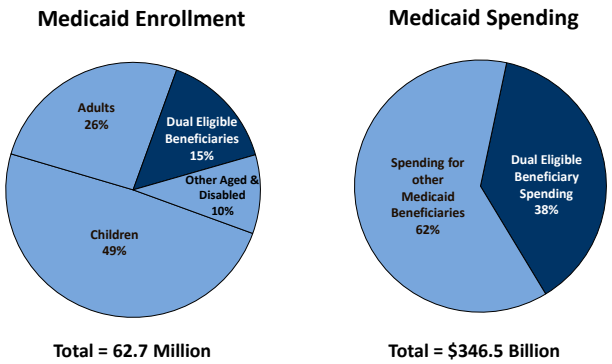
The elderly and disabled account for the majority of Medicaid spending.



NOTE: Percentages may not add up to 100 due to rounding.
SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.

FIGURE 5

Dual Eligible Beneficiaries as Percent of Medicaid Enrollment and Spending, FFY 2009



SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.

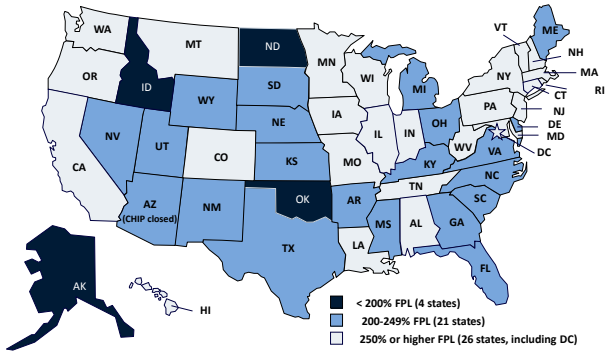
[6] KCMU and Urban Institute estimates based on 2009 MSIS and CMS 64 data.
[7] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2008.

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.

Eligibility levels vary significantly across states. To be eligible for Medicaid today, individuals must meet income and resource requirements and must also fall into one of the categories of eligible populations. The federal government sets minimum eligibility levels for coverage, and then states have the option to expand eligibility to higher incomes. As of January 2012, all but four states (Alaska, Idaho, North Dakota and Oklahoma) set Medicaid/CHIP income levels for children at or above 200 percent of the federal poverty level (FPL). (Figure 6) However, Medicaid coverage for parents is more limited with 33 states setting levels below the poverty level. (Figure 7) Median coverage for the elderly and those with disabilities is about 75 percent of the FPL (tied to the levels for Supplemental Security Income). Prior to the ACA, states could not cover childless adults under Medicaid without a federal waiver. The ACA provides states the option to expand coverage to this group up to 133 percent of the FPL without a waiver before the expansion is required in 2014.[8] Medicaid enrollees with low incomes and greater health care needs generally do not have access to employer-based or other affordable private coverage.

FIGURE 6

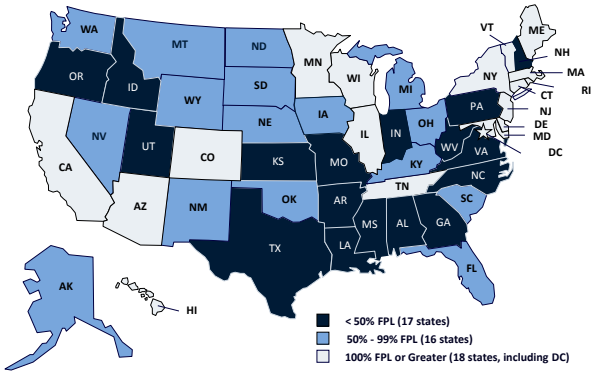
All but 4 states set Medicaid / CHIP eligibility at 200% FPL or higher. (Eligibility by Income, January 2012)



NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment. IL is waiting for approval for federal funding of its state-funded coverage between 200% and 300% FPL.
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, 2012.

FIGURE 7

Medicaid coverage for working parents is more limited. (Eligibility by Income, January 2012)



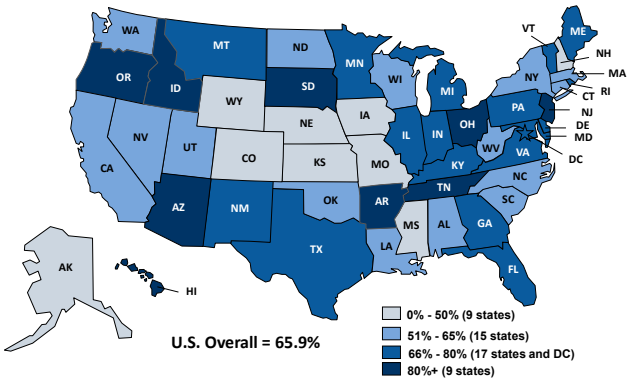
NOTE: The federal poverty line (FPL) for a family of three in 2011 is $18,530 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

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

[8] Eight states have taken up this option either through a state plan amendment or a waiver (California, Connecticut, Colorado, District of Columbia, Minnesota, Missouri, New Jersey and Washington). *Where are States Today?* Kaiser Commission on Medicaid and the Uninsured, July 2012. http://www.kff.org/medicaid/upload/7993-02.pdf.

FIGURE 8

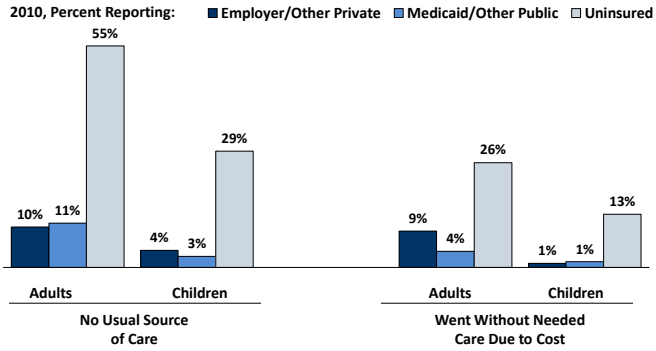
Most Medicaid enrollees receive care through private managed care.



NOTE: Includes enrollment in MCOs and PCCMs. Most data as of October 2010.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 9

Medicaid provides access to care that is comparable to private insurance and better than access for the uninsured.



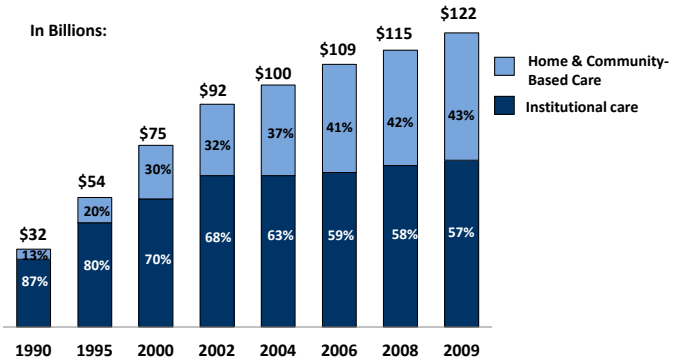
In past 12 months
Questions about dental care were analyzed for children age 2-17. All other questions were analyzed for all children under age 18. MD contact includes other health professionals. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant ($p<0.05$).
SOURCE: KCMU analysis of 2010 NHIS data.

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

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

FIGURE 10

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



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

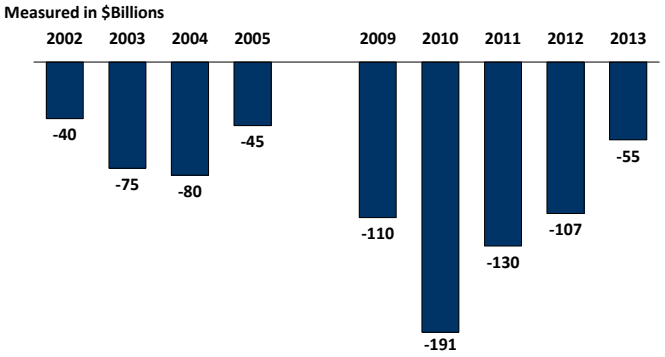
[9] Garfield, Rachel, et al. *Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY 2007-2010*. Kaiser Commission on Medicaid and the Uninsured, May 2012. http://www.kff.org/medicaid/8309.cfm.

2. Medicaid and the Economy

Headed into state fiscal year 2013, the national unemployment rate remained persistently high. While state revenues have begun to improve, they had not fully recovered from the effects of the Great Recession. State tax revenues have grown for ten consecutive quarters; however, nominal collections for the second quarter of 2012 were four percent below collections four years earlier.[10] As a result, 31 states were forced to close FY 2013 budget gaps totaling $55 billion — a smaller amount than in past years, but still high by historic standards.[11] (Figure 11) During an economic downturn individuals lose jobs and their incomes decline, more individuals qualify and enroll in Medicaid which increases program spending. At the same time, increases in unemployment have a negative impact on state tax revenues, making it even more difficult for states to pay their share of Medicaid spending increases.

FIGURE 11

State Budget Gaps, SFYs 2002-2005 and 2009-2013



NOTE: This table describes aggregate state budget shortfalls or gaps between expected revenues and the amount needed to fund current services. Data represent shortfalls prior to actions to close the shortfalls and prior to accounting for offsets from ARRA. Figures are estimates for fiscal years 2012 and 2013.
SOURCE: *States Continue to Feel Recession's Impact.* Center on Budget and Policy Priorities, June 27, 2012. Available at: http://www.cbpp.org/cms/index.cfm?fa=view&id=711.

3. Recent Legislative Action

American Recovery and Reinvestment Act (ARRA). In an effort to boost an ailing economy, Congress enacted and President Obama signed the ARRA on February 17, 2009. The overall package, estimated to cost $787 billion, included significant funding for health care and state fiscal relief. Specifically, the Act included an estimated $87 billion for a temporary increase in the federal share of Medicaid costs from October 2008 through December 2010. This was the single most significant source of fiscal relief to states in the ARRA. Similar to relief provided in 2003 during the last economic downturn, these funds were designed to help support state Medicaid programs during a time of increased demand when states were least able to afford their share of the program. The FMAP increase included a "hold-harmless" clause, a base FMAP rate increase, and additional funding for states with significant increases in unemployment. ARRA was extended through June 2011 with lower levels of federal financing, but total federal funding from the enhanced Medicaid matching rate was over $100 billion. To be eligible for these funds states could not restrict eligibility or tighten enrollment procedures to make it more difficult to obtain and retain coverage.

Budget Control Act and Federal Deficit Reduction. On August 2, 2011, President Obama signed the Budget Control Act of 2011 into law to raise the federal debt ceiling and to reduce federal spending with immediate and longer-term policies. The Act established the Joint Select Committee or "Super Committee," which was tasked with decreasing projected federal deficits by $1.5 trillion between FY 2012 and FY 2021 with broad authority to propose changes to meet its target, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the budget. The Super Committee failed to pass legislation, and as a result, an automatic reduction (or sequester) in federal spending of $1.2 trillion will go into effect in January 2013. Social Security, Medicaid, and other programs serving low-income individuals are exempt, but cuts to defense and other discretionary programs will be significant. General support exists to pass legislation after the Presidential election (in a lame duck session) to prevent the cuts from taking effect. Medicaid will likely be part of these deficit reduction discussions. Options to cut federal Medicaid vary significantly in scope and depth of the cuts. For example, the President's FY 2012 proposed budget maintains and expands Medicaid through the ACA with more targeted savings proposals. The House Republican Plan would repeal the ACA and

[10] Calculations based on data from the Census Bureau, updated for the second quarter of 2012, published September 25, 2012. http://www.census.gov/govs/qtax/.

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

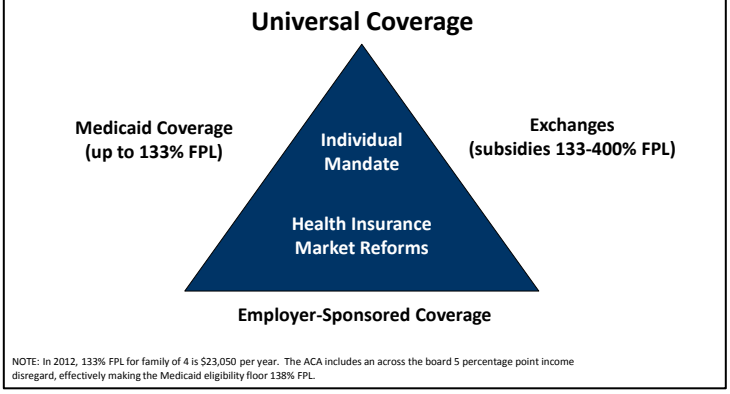
convert Medicaid from an entitlement program to a block grant which would be a fundamental change in the structure and financing of the program and result in significant reductions in federal support for Medicaid. Federal changes to Medicaid could shift costs to states, beneficiaries or providers.

4. National Health Reform and Medicaid

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA; Public Law 111-148), into law. The law expands options for affordable coverage through a Medicaid eligibility expansion and subsidies for low to moderate income individuals to purchase coverage through new Health Insurance Exchanges. 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. Health reform builds on many of Medicaid's current roles by expanding coverage with additional federal financing for the newly eligible population and by adding additional options for providing long-term care supports and for coordinating care of dual eligible beneficiaries (Figures 12 and 13).[12]

FIGURE 12

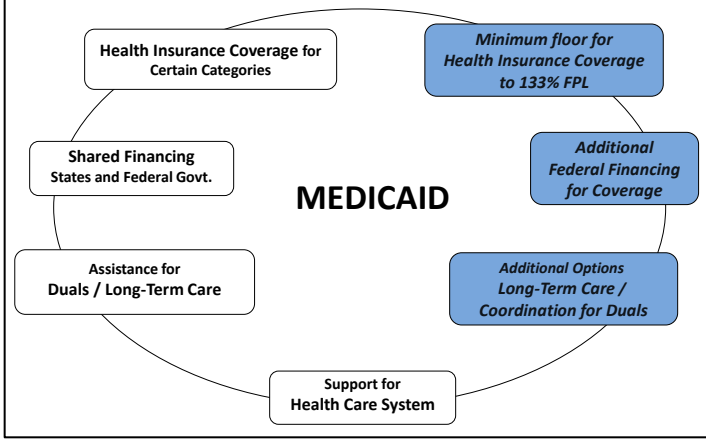
Expanding Medicaid is a Key Element in Health Reform



NOTE: In 2012, 133% FPL for family of 4 is $23,050 per year. The ACA includes an across the board 5 percentage point income disregard, effectively making the Medicaid eligibility floor 138% FPL.

FIGURE 13

Medicaid Today and *Tomorrow*



Supreme Court Decision and Coverage. By January 1, 2014, Medicaid will be expanded to provide eligibility to nearly all low-income people under age 65 with incomes below 133 percent of the federal poverty level ($14,856 for an individual or about $30,657 for a family of four in 2012).[13] For most Medicaid enrollees, income will be based on modified adjusted gross income without an assets test or resource test.[14] As a result, millions of low-income adults without dependent children who currently cannot qualify for coverage (except in a handful of states with waivers), as well as many low-income parents and, in some instances, children now covered by CHIP, will be made eligible for Medicaid. (Figure 14)

Along with changes in eligibility, the ACA requires simplified and coordinated processes to enroll in health coverage (Medicaid and Exchange coverage). Due to changes in enrollment processes, increased outreach and program awareness, the health reform law is expected to result in more people who are already eligible for Medicaid under current rules learning about and signing up for coverage. In total, Medicaid, along with CHIP, is expected to cover an additional 17 million people by 2016 if all states implement the expansion.[15]

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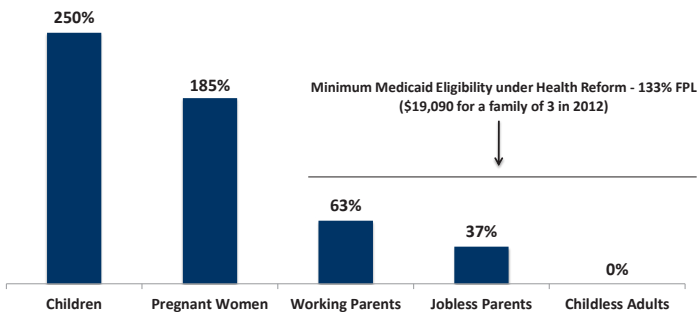
[12] *Medicaid and the Children's Health Insurance Program Provisions in the New Health Reform Law.* Kaiser Family Foundation, April 2010.
[13] As under prior law, undocumented immigrants will remain ineligible for Medicaid and CHIP, and only certain legal immigrants can secure coverage.
[14] There is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty. The legislation maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI).
[15] Congressional Budget Office Estimates, March 2012.

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. The Court's decision focuses only on the ACA's Medicaid expansion; other provisions of the law are not affected.[16]

FIGURE 14

Median Medicaid/CHIP Eligibility Threshold January 2012



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, 2012.

Financing. The new law provides full federal financing (100 percent federal) for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90 percent by 2020. States will receive their current match rates for individuals currently eligible for Medicaid. An expansion or transition matching rate is designed to provide federal funds to expansion states (those that had expanded coverage for adults to at least 100 percent of poverty prior to the enactment of health reform). These states will receive a phased-in increase in their federal match rate for childless adults so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults.[17] Prior to the Supreme Court decision, the Congressional Budget Office (CBO) estimated that the federal Medicaid/CHIP costs due to coverage related changes under health reform will be $931 billion from 2012 to 2022. The federal government is expected to finance about 93 percent of the costs of new coverage over the period.[18]

Benefits and Access. The ACA provides all newly-eligible adults with a benchmark benefit package or benchmark-equivalent package that meets the minimum essential health benefits available in the Health Insurance Exchange.[19] 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 pilot programs for medical homes and accountable care organizations.

Long-Term Care. The ACA also includes new options to provide long-term care services and supports including the Community First Choice Option in Medicaid, which allows states to provide community-based attendant supports and services to individuals with incomes up to 150 percent of poverty who require an institutional level of care through a state plan amendment (SPA) and provides states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. The ACA extends funding for Medicaid Money Follows the Person Rebalancing Demonstration Programs through 2016. The law requires the Secretary to improve coordination of care for dual eligible beneficiaries through a new office within the Centers for Medicare and Medicaid Services.[20]

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[16] *Implementing the ACA's Medicaid-Related health Reform Provisions After the Supreme Court's Decision.* Kaiser Commission on Medicaid and the Uninsured, August 2012. http://www.kff.org/healthreform/8348.cfm.

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

[18] *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act.* Congressional Budget Office, March 2012. http://www.cbo.gov/publication/43076.

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

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

Methodology

The Kaiser Commission on Medicaid and the Uninsured (KCMU) commissioned Health Management Associates (HMA) to survey Medicaid directors in all 50 states and the District of Columbia to identify trends in Medicaid spending, enrollment and policy making. This marks the twelfth annual survey conducted at the beginning of state fiscal years 2002 through 2013. In addition, seven mid-year surveys have been conducted in 2002-2004 and 2009-2012, when many states faced budget shortfalls and were forced to consider mid-year Medicaid policy changes.[21] Findings from previous surveys are referenced where possible to highlight trends.

The KCMU/HMA Medicaid survey on which this report is based was conducted in July and August 2012. The survey documents policy actions states implemented in state FY 2012 and those adopted for state FY 2013 (which began for most states on July 1, 2012.)[22] The FY 2013 Medicaid budget had been adopted by all states at the time each state survey was completed. The 2012 survey instrument captures information consistent with previous surveys, particularly for spending trends, enrollment, eligibility, provider payment rates, benefits, long-term care and managed care.[23] As with prior years, specific questions were added to reflect current issues including care coordination initiatives and health reform implementation.

Medicaid directors and other Medicaid staff provided data for this report in response to a written survey and a follow-up telephone interview. The survey was sent to each Medicaid director in June 2012. The surveys were completed and telephone interviews occurred in July and August 2012. The telephone discussions are an integral part of the survey to clarify responses, ensure complete and accurate responses and to record the complexities of state actions. For most states, the interview included the Medicaid director along with Medicaid policy or budget staff. Data is included for 50 states and the District of Columbia.[24]

Each annual survey focuses on policy changes from year to year. The survey does not attempt to catalog all current policies. This survey asked state officials to describe policy changes that occurred in FY 2012 and those adopted for FY 2013. Sometimes adopted policies are delayed or not implemented due to complex administrative or computer system changes, advance notice requirements, lack of approval from CMS or other legal, fiscal, or political considerations. 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 FY 2012 and FY 2013, average annual Medicaid spending growth was calculated using weights based on the most recent available state Medicaid expenditure data, as reported by the National Association of State Budget Officers (NASBO) *State Expenditure Report,* December 2011. Average annual Medicaid enrollment growth is calculated using weights based on state enrollment data for the month of June 2011.[25] Historic Medicaid spending data are based on estimates prepared for KCMU by the Urban Institute using data from CMS Form 64 reports, adjusted for state fiscal years.

This report also includes four state Medicaid case studies for Massachusetts, Ohio, Oregon and Texas. These state profiles provide concrete examples of state Medicaid policy changes, including program expansions, improvements and cutbacks; new initiatives as well as the fiscal and political context in these specific states in FY 2012 and FY 2013. The four state case studies are included in Appendix B of the report.

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[21] The previous annual budget survey report issued October 2011 is at: http://www.kff.org/medicaid/8248.cfm . The FY 2012 mid-year report issued February 2012 is at: http://www.kff.org/medicaid/8277.cfm

[22] State fiscal years begin on July 1 except for these states: New York on April 1; Texas on September 1; Alabama, Michigan and the District of Columbia on October 1.

[23] The 2012 survey instrument is in Appendix C of this report.

[24] In some cases, data was supplemented with additional research on state Medicaid program websites and other public sources. The Arizona survey was summarized from AHCCCS, legislative and other websites.

[25] "Medicaid Enrollment: June 2011 Data Snapshot." Kaiser Commission on Medicaid and the Uninsured, June 2011. http://www.kff.org/medicaid/upload/8050-05.pdf.

Survey Results for Fiscal Years 2012 and 2013

1. State Fiscal Conditions and the Recession

Key Section Findings:

- After experiencing the largest collapse in state tax revenues on record, state tax revenue collections across all states have grown for ten consecutive quarters. The unemployment rate has fallen but remains high, resulting in sustained demand for public programs like Medicaid.
- Total collections in states for the second quarter of calendar year (CY) 2012 grew by 1.8 percent compared to one year earlier. However, nominal collections in the second quarter of CY 2012 were four percent below collections four years earlier.
- During the height of the Great Recession, the decline in state revenues was a more significant factor than the increase in Medicaid spending on state budgets.
- The expiration of the ARRA funds at the end of FY 2011 meant a large increase in state spending to replace the loss in federal financing in FY 2012.

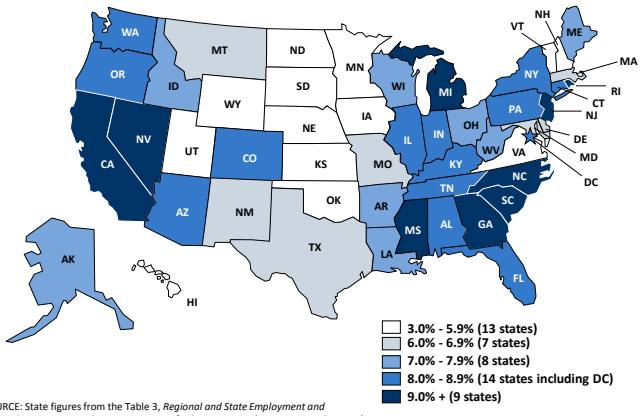
A. Current State Fiscal Conditions

States are continuing to recover from the recent recession as the fiscal outlook for states has started to improve. After experiencing the largest collapse in state tax revenues on record during the most recent recession, state tax revenues have grown for ten consecutive quarters, but remain below nominal collections four years earlier. Unemployment has fallen but still remains high, resulting in sustained demand for public programs, including Medicaid.

After remaining just above eight percent since January 2012, the unemployment rate fell to 7.8 percent in September 2012, the first time it has fallen below eight percent since January 2009. There are 4.5 million fewer jobs on non-farm payrolls since the start of the recession in December 2007. An estimated 12.1 million people are unemployed, 4.8 million of whom are long-term unemployed (those jobless for 27 weeks and over).[26] In September 2012, 9 states had unemployment rates above nine percent. (Figure 15)

FIGURE 15

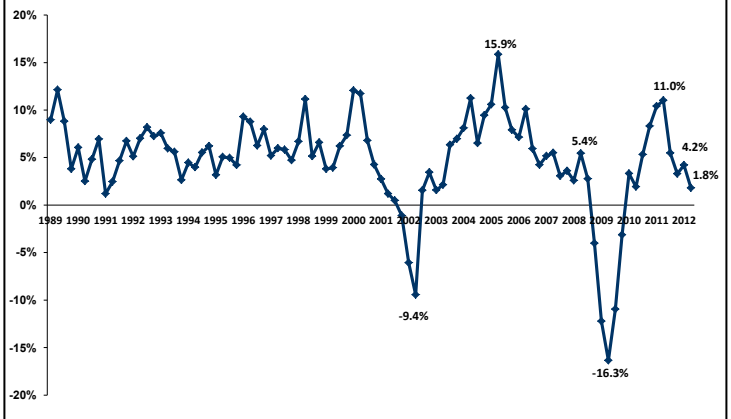
Unemployment Rates by State, September 2012



SOURCE: State figures from the Table 3, *Regional and State Employment and Unemployment: September 2012,* Bureau of Labor Statistics. (Figures are preliminary).

FIGURE 16

State Tax Revenue, 1989 – 2012



SOURCE: Percent change in quarterly state tax revenue, US Census Bureau. Updated October 2012.

[26] *The Employment Situation – September 2012.* Bureau of Labor Statistics, October 5, 2012. www.bls.gov.
"Statement by Chad Stone, Chief Economist, On September Employment Report." Center on Budget and Policy Priorities, October 5, 2012. http://www.cbpp.org/cms/index.cfm?fa=view&id=3827.

Tax revenues have been steadily increasing with ten consecutive quarters of year over year revenue growth. (Figure 16) Total collections in states for the second quarter of CY 2012 grew by 1.8 percent compared to one year earlier. However, nominal collections during the second quarter of 2012 were four percent lower than collections four years earlier in the second quarter of 2008. While a number of states saw collections above nominal levels four years earlier, collections in 21 states for this quarter were still below the same period in 2008.[27]

As they continue to recover, states have faced collective shortfalls of more than $540 billion since the start of the recession through FY 2012, with an additional $55 billion estimated for FY 2013.[28] Medicaid directors in this survey noted that while there are some positive signs of recovery, improvement remains slow in many states, with continued pressure on Medicaid and state budgets.

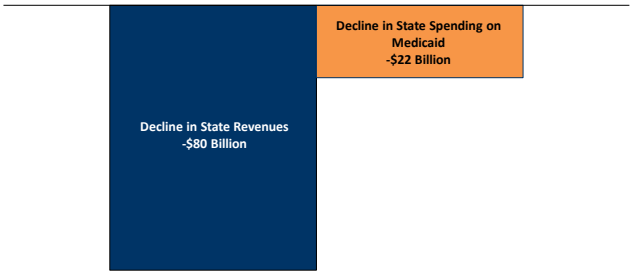
B. The Impact of the Recession

The Great Recession, which technically lasted from December 2007 to June 2009, was the worst economic downturn the country has experienced since the Great Depression of the 1930s. Recognizing that states were facing a fiscal emergency that would make it difficult to maintain essential services, Congress enacted the American Recovery and Reinvestment Act of 2009 (ARRA). The largest component of state fiscal relief was provided through a temporary increase in the FMAP for states. The ARRA enhanced Medicaid funding was used as it was intended, both to address Medicaid funding shortfalls and to address budget shortfalls across state programs. This federal support during the height of the economic downturn proved a critical source of revenue for states, resulting in the first declines in state spending on Medicaid in program history.[29]

During recessions, states are often faced with declining revenues at the same time that demand for public programs such as Medicaid are increasing. There has been some debate about the relative magnitude of factors driving state budget shortfalls during the Great Recession. Analysis shows that the decline in state revenues was a more significant factor than the increase in Medicaid spending on state budget shortfalls between FY 2008 and 2010. During this time period, state revenues declined by $80 billion while the state portion of Medicaid spending actually declined by $22 billion.[30] (Figure 17) State spending declined during this period due to the ARRA funds, but total Medicaid spending was positive.

FIGURE 17

Change in State Revenues and State Spending on Medicaid, FY 2008 - 2010



NOTES: Measures the change in state own source revenues (taxes, miscellaneous revenues, and charges) between state fiscal years 2008 and 2010 compared the change in state spending on Medicaid between state fiscal years 2008 and 2010. Medicaid spending does not include administrative costs, accounting adjustments, or the U.S. Territories.
SOURCES: 2008, 2009, and 2010 *Annual Survey of State Government Finances.* U.S. Census Bureau, 2012.
KCMU and Urban Institute estimates based on data from HCFA/CMS (Form 64), 2010.

The expiration of the ARRA funds at the end of FY 2011 meant a large increase in state spending to replace the loss in federal financing, which resulted in significant increases in the state portion of Medicaid spending. These results are discussed in the next section.

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[27] Calculations based on data published by the Census Bureau in the Quarterly Summary of State & Local Taxes. Updated with data for the second quarter of 2012, published September 25, 2012. http://www.census.gov/govs/qtax/.
[28] Elizabeth McNichol, Phil Oliff and Nicholas Johnson. "States Continue to Feel Recession's Impact." Center for Budget and Policy Priorities. June 27, 2012. Available at: http://www.cbpp.org/cms/index.cfm?fa=view&id=711.
[29] See more detail about total and state Medicaid spending trends in the next section of this report.
[30] *Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending*. Kaiser Commission on Medicaid and the Uninsured, October 2011.

2. Medicaid Spending and Enrollment Growth Rates

Key Section Findings:

- FY 2012 total Medicaid spending increased at one of the lowest annual rates on record, on average by 2.0 percent across all states. Spending growth varied across the states, with 16 states experiencing declines and 33 states experiencing increases. The only state fiscal year when total Medicaid spending growth was lower in the last 15 years was in FY 2006 when Medicare Part D assumed responsibility for pharmacy expenditures for dual eligible beneficiaries, and enrollment growth was virtually flat. For FY 2012, actual spending growth of 2.0 percent was close to the original Legislative appropriations for FY 2012 that averaged 2.2 percent. (Figure 18)

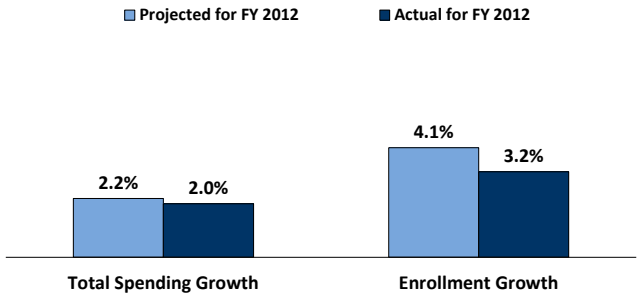
- For FY 2013, legislatures authorized total spending growth on average of 3.8 percent across all states. While higher than FY 2012, 3.8 percent is one of the three lowest rates of growth in total Medicaid spending in the past 15 years. Ten states budgeted for actual declines in Medicaid spending for FY 2013. Fewer Medicaid officials (just over one-third) reported a possible Medicaid budget shortfall compared to more than half of states at the beginning of FY 2012.

- The state share of Medicaid spending increased by 27.5 percent in FY 2012, exceptionally high growth due to the end of the enhanced FMAP on June 30, 2011. The enhanced FMAP had reduced the state cost of Medicaid for FY 2009-FY 2011. For FY 2013, the state share of Medicaid spending was appropriated to increase by 2.3 percent compared to total spending at 3.8 percent.

- Medicaid enrollment growth slowed in FY 2012 to 3.2 percent, the lowest rate of growth since 2008 at the beginning of the recent recession and below initial projections for the second year in a row. Slower growth was primarily attributed to a gradual improvement in the economy. For FY 2013, states expected enrollment to continue to grow at an even slower pace than in FY 2012, with average growth across all states projected at 2.7 percent. (Figure 19)

FIGURE 18

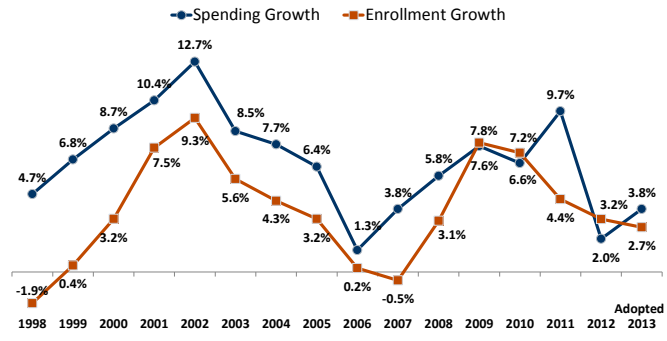
Total Medicaid Spending and Enrollment Growth: Projected and Actual for 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011 and 2012.

FIGURE 19

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2013



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

SOURCE: *Medicaid Enrollment June 2011 Data Snapshot*, KCMU, June 2012. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2012 and FY 2013 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

A. Total Medicaid Spending Growth

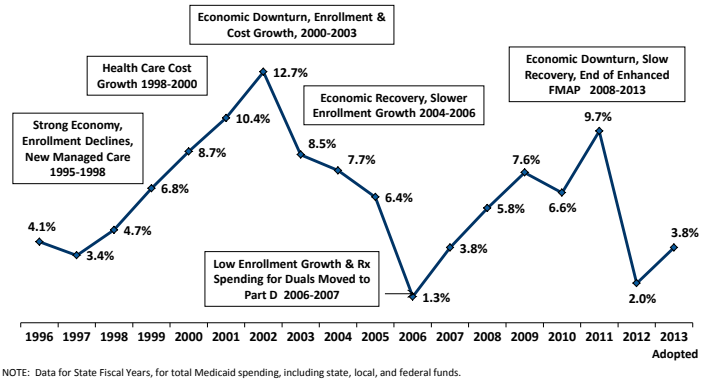
Total Medicaid spending includes all payments to Medicaid providers for Medicaid covered services provided to enrolled Medicaid beneficiaries. This definition includes "disproportionate share hospital" (DSH) payments to hospitals that serve a disproportionate share of individuals on Medicaid or who are 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 dual eligible beneficiaries.) Total Medicaid spending includes payments financed from all sources, including federal matching funds, state and local contributions.

Medicaid spending and enrollment is counter-cyclical. In an economic downturn, when people lose their jobs and incomes fall, more individuals qualify for Medicaid. During periods of economic recovery, growth in Medicaid enrollment and spending slows. Enrollment is the primary driver of Medicaid spending growth. Other important drivers of Medicaid spending are growth in health care costs in the overall health care market (private and public) and policy changes made within Medicaid programs. During the last economic downturn, Medicaid spending growth peaked in 2002 at over 12 percent. Improvement in the economy was a significant factor contributing to lower enrollment and spending growth in 2006 and 2007. In 2008, the economy slowed, causing Medicaid enrollment and spending growth to increase sharply again. The ARRA enhanced FMAP helped to support Medicaid programs during a time of declining state revenues and higher enrollment growth.

FY 2012 Total Medicaid Spending Growth. In state fiscal year 2012, total annual Medicaid spending across all states increased on average by a near-record low rate of 2.0 percent.[31] This represents a significant slowing from the 9.7 percent growth in 2011. (Figure 20) The lowest Medicaid spending growth in the last 15 years was 1.3 percent in FY 2006. In that year, enrollment growth was flat and Medicaid spending for prescription drugs for dual eligible beneficiaries was shifted to Medicare due to the implementation of Medicare Part D. Actual Medicaid spending growth for FY 2012 was slightly slower than the original appropriations of 2.2 percent.

FIGURE 20

Total Medicaid Spending Growth, FY 1996 – FY 2013



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; FY 2012 and 2013 - KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2012.

[31] FY 2012 spending levels were preliminary at the time of this survey, pending the official closing of the books for the fiscal year.

States reported that lower spending growth can be attributed to an improving economy, lower enrollment growth, policy actions and intense state efforts to mitigate the increase in state spending largely driven by the expiration of enhanced federal matching payments on June 30, 2011. In this year's survey, for FY 2012, 16 states reported negative growth in total Medicaid spending. Throughout FY 2012, the spending trend closely tracked expectations. Midway through FY 2012, a total of 36 states reported that spending growth was at or below initial appropriations.[32] In this survey, only three states reported expenditure growth above ten percent; one of these states (Minnesota) reported one of the highest rates of enrollment growth due to a significant eligibility expansion discussed in the eligibility section of this report.

FY 2013 Total Medicaid Spending Growth. For FY 2013, state legislatures appropriated growth in Medicaid spending that averaged 3.8 percent across all states. Projected Medicaid spending growth varied across states with 10 states having adopted initial budgets with negative growth and eight states adopting Medicaid budgets for FY 2013 with growth rates of ten percent or more. Medicaid budget and policy decisions for FY 2013 were made in the context of signs of economic recovery most states. Fiscal pressure remained a reality that could not be ignored, but the pressure was generally less intense, allowing some states to consider positive actions that had not been possible to consider for several years.

Compared with previous years, state officials expressed more confidence that state Medicaid budgets adopted for FY 2013 would be adequate to fully fund Medicaid spending obligations for the year. In just a third of states did Medicaid officials express concern of a possible Medicaid budget shortfall (compared to over half of states at the start of FY 2012 and almost two-thirds of states in FY 2011.) This may suggest that legislatures were able to fund Medicaid at more realistic levels for the upcoming year, compared to previous years when states were experiencing state budget shortfalls of historic proportions. State officials also pointed to improving economic conditions and associated slower rates of growth in enrollment.

B. State Spending Growth for Medicaid

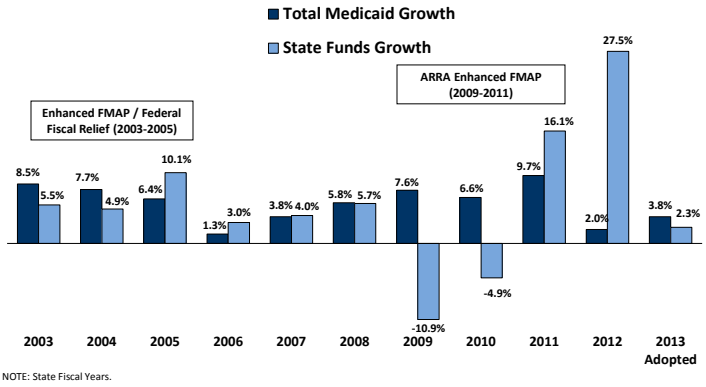
Medicaid is financed with a combination of state funds and federal matching funds. However, when state officials consider decisions about Medicaid spending, it is the cost in state general funds that is most important to state policy makers. The federal government provides matching funds to help pay for total Medicaid expenditures, but a state must be able to pay its share to obtain the federal matching funds. Historically, state and federal Medicaid spending increase at similar rates. Variation in total and state spending rates can be tied to a number of factors, such as the annual changes in the state's FMAP, changes in contributions from local governments, special financing arrangements, provider taxes or tobacco tax funding.

During each of the past two recessions, Congress enacted temporary enhancements to the FMAP to provide fiscal relief to states that affected the state cost of Medicaid. In 2003 and 2004, FMAPs were increased by 2.95 percentage points for five quarters, providing $10 billion in fiscal relief to states. The more recent recession was deeper, and the ARRA 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, across all states, while total spending increased. These declines in state spending on Medicaid are the only declines in the program's history. (Figure 21)

[32] Smith, V. et al. *A Mid-Year State Medicaid Budget Update for FY 2012 and a Look Forward to FY 2013*. Kaiser Commission on Medicaid and the Uninsured, February 2012. http://www.kff.org/medicaid/upload/8277.pdf.

FIGURE 21

Total and State Funds Medicaid Spending Growth FY 2003 – FY 2013



NOTE: State Fiscal Years.

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

The enhanced FMAP expired on June 30, 2011. As a result, states had to replace the lost enhanced federal support with increased state spending, which caused a dramatic increase (27.5 percent) in state costs relative to the previous year. Because the need to replace enhanced FMAP funding required such a high level of state funds, some states indicated that they considered policy actions for FY 2012 to mitigate the large increase in the state cost of Medicaid, and that in addition to an improving economy, this was a factor that contributed to the low overall increase in Medicaid spending of just 2.0 percent. For FY 2013, legislatures appropriated increases in the state funding for Medicaid that averaged just 2.3 percent, as overall Medicaid spending was appropriated to grow by 3.8 percent.

In some states the non-federal share of Medicaid spending includes both state and local funds.[33] The 2012 survey asked states to indicate if local contributions were mandatory to help finance Medicaid. A total of 22 states indicated that county or other local units of government were required to contribute to the non-federal share of Medicaid. In many cases, the contributions were 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 other 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.

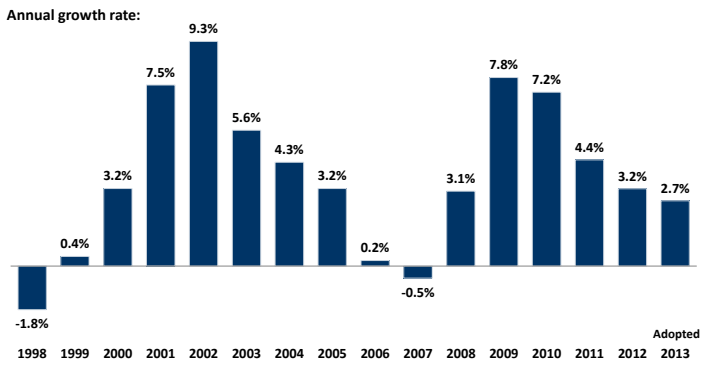
[33] For this and previous surveys, Medicaid agencies were asked to use a consistent definition of expenditures from year to year in their calculation of annual rates of growth of total Medicaid spending. The definition is determined by each state and is known to vary across states. For example, in some 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.

C. Medicaid Enrollment Growth

Historically, the pace of Medicaid enrollment growth has been directly related to the economy, with markedly larger increases occurring during an economic downturn. In FY 2012, reflecting an improving economy, Medicaid enrollment growth dropped to a pre-recession level of 3.2 percent, the lowest rate of growth since 3.1 percent recorded in 2008, and the third year in a row that growth in the number of persons on Medicaid was less than in the previous year. (Figure 22)

FIGURE 22

Change in Medicaid Enrollment, FY 1998 – FY 2013



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

SOURCE: For 1998-2011: *Medicaid Enrollment June 2011 Data Snapshot*, KCMU, June 2012 . FY 2012 and FY 2013 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2012.

The actual growth of 3.2 percent was well below the 4.1 percent projected by states at the beginning of fiscal year 2012. Just over half of all states experienced actual growth below projections made at the time the FY 2012 budget was adopted. A total of 5 states experienced an actual decline in the number of persons enrolled in Medicaid in FY 2012. The largest decline was noted by Arizona, which implemented a freeze on enrollment in its waiver program for adults without dependent children. Three states reported enrollment growth of over ten percent. Of note were Colorado and Minnesota, each of which implemented eligibility expansions to adults without dependent children (Both these expansions and the enrollment freeze for Arizona are discussed in more detail in eligibility section.)

For FY 2013, Medicaid enrollment growth is projected to slow further, on average to 2.7 percent. More than half of states projected enrollment growth in FY 2013 to be less than or the same as actual enrollment growth in FY 2012. In four states, enrollment growth was flat while two states reported enrollment growth of over ten percent. Colorado continued to experience significant growth due to eligibility expansions discussed in the eligibility section and South Carolina reported that increased enrollment for FY 2013 was in part due to implementation of Express Lane Eligibility. Across all states, however, the clear expectation was that a slowly improving economy would result in a continued slowing in the number of persons coming on to Medicaid.

The primary drivers of Medicaid enrollment growth in both FY 2012 and 2013 were the ongoing effects of the economic downturn, listed as the key factor in almost all states. The largest share of enrollment growth has been in the eligibility groups most affected by the economic downturn, primarily families with children. However, growth among persons with disabilities and the elderly was cited as a group with significant growth in 15 states. In recent years growth among the elderly and persons with disabilities, groups with relatively high per capita costs, has been steady due to demographic trends.

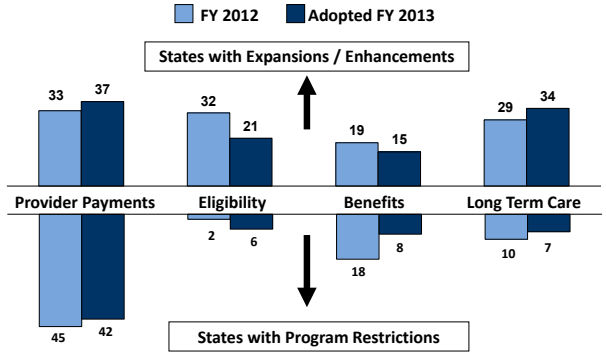
3. Medicaid Policy Initiatives for FY 2012 and FY 2013

Key Section Findings:

- In FY 2012, 48 states implemented at least one new policy to control Medicaid costs and 47 states plan to do so in FY 2013. Many states reported program reductions in multiple areas. (Figure 23)
- As in previous years, provider rate restrictions were the most commonly report cost containment strategy. A total of 45 states restricted provider rates in FY 2012 and 42 states reported plans to do so in FY 2012. A few states increased or imposed new provider taxes that mitigated provider rate cuts in some cases.
- Restrictions to Medicaid eligibility or enrollment and renewal processes are generally prohibited under the MOE requirements in the ACA. For FY 2012, 32 states made enhancements to eligibility standards or enrollment and renewal processes, and 21 states have plans to do so in FY 2013. Due to some exceptions in the ACA MOE requirements, two states reduced eligibility in FY 2012 and six states reported eligibility cuts planned for FY 2013.
- The same number of states (18) reported benefit cuts for FY 2012 as in FY 2011, while a much smaller number of states (8) reported eliminating, reducing, or restricting benefits in FY 2013.
- This year's survey shows that the 20+ year trend in most states of expanding HCBS service options continues, although a few states are taking steps to apply new service limits. In FY 2012 and FY 2013, 29 and 34 states, respectively, took actions that expanded LTC services (primarily expanding HCBS programs). Conversely, a total of 10 states in FY 2012 and seven states in FY 2013 took action to constrain LTC services.
- Notable among the many actions states are taking to refine and improve their pharmacy programs, eight states plan to adopt the "Actual Acquisition Cost" reimbursement methodology for pharmacy ingredient costs, nine states have adopted a new a "carve-in" strategy with regard to prescription drugs and capitated managed care arrangements and 11 states reported on efforts to better control behavioral health drug utilization.

FIGURE 23

State Policy Actions Implemented in FY 2012 and Adopted for FY 2013



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

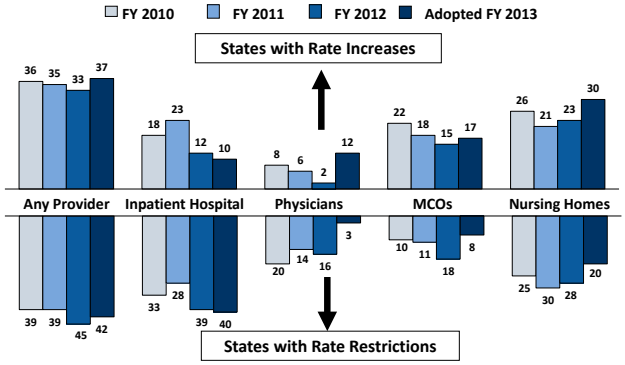
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

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. However, the maintenance of eligibility requirements in ARRA and then in the ACA, with only limited exceptions, prevented states from restricting eligibility leaving states with few levers to control spending. Since provider rates are an important determinant of provider participation and access to services for Medicaid beneficiaries, cutting Medicaid rates (which are typically lower than Medicare or commercial insurance rates) can jeopardize provider participation in the program as well as access to care for enrollees.

FIGURE 24

States with Provider Rate Changes FY 2010 – FY 2013



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

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010, October 2011, and October 2012.

While the majority of states imposed provider rate restrictions for the last several years, states reported that the enhanced funding from ARRA helped states mitigate or avoid some rate cuts in FY 2009-2011.[34] 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. For FY 2013 the picture is slightly improved with more states planning to increase rates for certain provider types including physicians, MCOs and nursing homes.[35] For the purposes of this report, provider rates restrictions include cuts to rates for physicians, dentists, and managed care organizations as well as both cuts or freezes in rates for inpatient hospitals and nursing homes. In FY 2012, 45 states reported rate restrictions for any provider type and 33 states reported rate increases for any provider. (Figure 24) For FY 2013, 42 states have planned provider rate restrictions while 37 states are planning or have implemented at least one rate increase.

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. A total of 39 states restricted hospital rates in FY 2012 (23 states froze rates and 16 states reduced rates) and a total of 40 states planned rate restrictions for hospitals in FY 2013 (34 states plan to freeze rates and 6 states are cutting rates). For nursing homes, 28 states restricted rates in FY 2012 (16 rate freezes and 12 cuts) while just 20 states plan restrictions for FY 2013, with only three states planning to actually cut any nursing home rates. Overall, states continue to restrict rates for these institutional providers, but states are implementing more freezes and fewer rate reductions compared to earlier years.

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 2012, 15 states reported MCO rate increases, 18 states reported MCO rate cuts, and 6 states reported flat MCO rates. For FY 2013, 17 states reported plans to increase MCO rates and only 8 states reported plans to cut rates, while rates will be unchanged in 12 states. (West Virginia has not yet set MCO rates that will be implemented later in FY 2013.)

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

[35] A few rates for FY 2013 had not yet been determined at the time of the survey. These include inpatient hospital rates and MCO rates in West Virginia and nursing home rates in Alabama.

In the recent recession, few states increased physician rates, and over a third of states reduced rates at least one year from FY 2010 through FY 2012. For FY 2013, only 3 states plan to cut any Medicaid physician rates and 12 states are planning rate increases.

States were asked to report separately about rate changes for primary care physicians, specialists and dentists. (Table 1) In both FY 2011 and FY 2012, primary care physicians were slightly less likely than specialists to see rate cuts. For FY 2013, ten states indicated that primary care physicians will be receiving rate increases not required by the ACA; however, most of this is explained by rate increases early in the state fiscal year since the ACA payment increase will not go into effect until January 2013. In addition, nine states are planning to increase rates for specialty care physicians. Three states reported targeted rate cuts limited to specialties or specific procedures.

Prior to the recession, many states had implemented rate increases for dentists in an effort to promote participation of dentists in the program and expand access to dental care. However, fiscal pressures resulted in 11 states with cuts to dental rates in FY 2011 and 13 states that adopted cuts to dental rates in FY 2012. Only two states report planned cuts for any dental rates for FY 2013. While cuts to dental rates are less prevalent, only three states reported increases in dental rates for FY 2012 and five states plan increases for FY 2013.

Table 1: Number of States Changing Physician or Dental Payment Rates, FY 2011, 2012 and FY 2013

Provider Type	FY 2011 Rates[36]		FY 2012 Rates		FY 2013 Rates	
	Increase	Decrease	Increase	Decrease	Increase	Decrease
Primary Care Physicians	5	11	2	12	10	0
Specialists	5	14	2	16	9	3
Dentists	4	11	3	13	5	2

The survey also provided states with an opportunity to provide information about rate changes to other categories of providers. Most states (38) reported additional rate changes, most of which were rate cuts. While the lists of providers with rate cuts were frequently long and varied significantly from state to state, the following were most often cited for rate cuts in either 2012 or 2013: laboratory and radiology, medical equipment, medical supplies and related supports, ambulance, home health, various mental health providers, outpatient hospital, chiropractors, podiatrists and other practitioners, non-emergency medical transportation, Home and Community-Based Services (HCBS) providers, and podiatrists. Some states reported rate increases, some of which occurred because the state sets Medicaid rates at a percentage of Medicare rates. A few states indicated rate increases for Federally Qualified Health Centers (FQHCs) or that certain providers were exempt from across -the-board rate cuts. Common exemptions from across-the-board rate cuts included FQHCs as well as HCBS and Hospice providers.

While the survey did not require that states indicate the magnitude of provider rate changes, several states provided a detailed response. In general the rate cuts are smaller than those indicated in recent surveys. However the number of providers affected is extensive and some states are still making deep cuts. The responses of several states are notable:

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

- **Alabama** cut rates for physician-owned lab & x-ray, independent lab & x-ray, and other licensed practitioners by ten percent effective for June through September 2012 (the last four months of that state's FY 2012.) Alabama anticipates restoring these temporary rate cuts when the new fiscal year begins in October 2012.[37]
- **California** plans to implement up to a ten percent across-the-board payment reduction retroactive to June 1, 2011. This rate cut has now been approved by the federal government but has not yet been implemented as it is has been enjoined by the federal courts.
- The **District of Columbia** reported a twenty percent across-the-board reduction for all physician rates in FY 2012. DC had increased physician rates to Medicare levels in FY 2009, so this cut puts DC rates at 80 percent of Medicare, still higher than most large state Medicaid programs. The District is also planning to cut some adult dental rates by ten percent in FY 2013.
- **Illinois** plans to cut some provider rates (including inpatient hospitals 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) is designed to save $1.6 billion. Physicians and dentists are exempted from these cuts as are safety net hospitals.
- **South Carolina** cut all provider rates (except nursing facilities, which had rates frozen) in FY 2012. Hospital rates were cut by 4 percent, primary care physician rates by 2 percent, specialty care physician rates by up to 7 percent, and dentist rates by 3 percent. These cuts were in addition to cuts implemented in FY 2011. Managed Care rates were cut briefly, but then restored and eventually increased by 8.2 percent to account for more services being carved into capitation rates.
- **South Dakota** cuts in FY 2012 included cuts of 11.48 percent to inpatient hospitals, 4.5 percent to primary care physicians, 5.1 percent to specialists, 6.4 percent to dentists, and decreases to other categories as well. Only nursing facilities were exempt; rates were frozen. South Dakota is implementing rate increases in the range of 0.5 percent to 1.8 percent in FY 2013.
- **Tennessee** had originally planned for across-the-board rate cuts of 8.5 percent in FY 2012 for providers other than inpatient hospitals and physicians which were not cut due to an increase in the hospital assessment fee. Improved revenues allowed the state to reduce those cuts to 4.25 percent. In 2012, Tennessee limited payments for emergency room physicians to a triage fee for non-emergency cases and a blended delivery rate was enacted to align rates for C-section and vaginal births. For FY 2013, improved revenues mitigated some planned rate cuts; however, the state still implemented a 2.5 percent rate cut for rates for dentists, MCOs, and nursing facilities. Rates for specialists, transportation, lab and x-ray, home health, and PACE provider rates were also reduced.
- **Texas** made significant cuts in Medicaid provider rates in FY 2012, including reductions of 8 percent for inpatient / outpatient hospitals and free-standing psychiatric facilities; 5.4 percent for MCO rates; 10.5 percent for non-state clinical laboratory services; 5 percent for renal dialysis services and ambulatory surgical centers; 2 percent for ICF-ID facilities, and other rate reductions for personal care and community based care services, durable medical equipment, prosthetics, orthotics, and supplies.

Four states (Missouri, North Dakota, Vermont, West Virginia,) reported no rate restrictions in FY 2012 or FY 2013. In addition, Alaska and Wisconsin reported no rate restrictions in FY 2012 and Kentucky, Massachusetts, Nebraska, South Dakota, and Virginia reported no rate restrictions in FY 2013.

[37] The State was able to restore these rate cuts after the passage a state Constitutional Amendment on September 18. "Reversal of Proration Cuts." Provider Alert, Alabama Medicaid Agency, October 2, 2012. http://medicaid.alabama.gov/news_detail.aspx?ID=7094.

Provider Rates and Access to Care. States were asked to discuss issues for their state related to the newly enacted federal regulations requiring a study of the adequacy of access to care before provider rates can be cut. Nineteen states indicated that they had submitted rate reduction state plans and therefore been impacted by the new requirements. Several states have successfully received CMS approval for rate cuts under these provisions, including the ten percent rate cuts in California. However, states commented that the required impact analysis was a new administrative burden and delays in approval of state plan amendments.[38]

Primary Care Rate Increase

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 two years.

States were asked about the implications of the ACA requirement and how much the estimated increase in pay will be for primary care physicians serving Medicaid patients. Forty-four states responded to this question. Three states (Alaska, Montana, and North Dakota) reported no increase because they already pay Medicare rates (or higher.) Another seven states (Delaware, Oklahoma, North Carolina, Colorado, Kansas, Mississippi, and South Dakota) estimate that physicians will see an increase of ten percent or less, while six states (California, Connecticut, Ohio, New Jersey, Washington[39] and Wisconsin, estimated increases of 80 percent or more for some or all of their primary care services. A number of states reported that the rate increases will be greater in the fee-for-service component of the Medicaid program than in Medicaid managed care because MCOs have higher payment rates to assure adequate access to care in their networks. In addition, the increases may vary across providers; for example, some states pay a higher percentage of Medicare rates for pediatric and/or obstetrical services.

Actual implementation of this policy presents significant challenges and opportunities for the states. The most significant concerns reported by states included: the lack of final rules or other detailed information from CMS; the method by which they will claim the federal funding to support this rate increase; the short timeframe for implementation; the difficulty in collecting data from MCOs and how much to include in the MCO capitation rates for this physician rate increase. As one state noted, "properly determining which providers and claims are eligible for the increased rates is an extraordinarily complex and difficult task."

Among the other concerns expressed by states were: identifying the providers eligible for the rate increase; lack of clarity about the application of the rate increase to physician extenders; ability to re-program their claims processing systems in time for implementation in January; tracking the rate differential between Medicaid and Medicare when Medicaid uses a very different structure for its physician payments; applying the rate increase to the Medicaid expansion CHIP programs (which would be funded with state funds); and providing timely notice to providers.[40] One state (Utah) indicated that it will be proposing to pay the rate differential via supplemental lump-sum payments to the providers. Use of these lump-sum payments will make the differential more easily identifiable for purposes of claiming the federal funding. States have also indicated that implementation will be costly. The provision will present some opportunities to learn how the payment increase influences provider participation and access to care.

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

[39] The state reported that the average rate increase for adult office visits would be in this range (80% or above); however, the average rate increase for child office visits and preventive visits would be much lower (i.e. these services are currently reimbursed a rate closer to Medicare.)

[40] National Association of Medicaid Directors, Comment Letter on Primary Care Physician Reimbursement Increase NPRM, June 11, 2012. http://medicaiddirectors.org/node/440.

Medicare Crossover Claims. For individuals eligible for Medicare and Medicaid (dual eligible beneficiaries), the Medicaid program is responsible for various levels of support. For individuals that meet the income threshold for full Medicaid benefits, the Medicaid program becomes a secondary payer to Medicare for all services covered by Medicare and also provides additional Medicaid benefits. For Qualified Medicare Beneficiaries (QMBs – Medicare beneficiaries with incomes below 100 percent of the FPL) Medicaid is also responsible for Medicare cost sharing.[41] In the early days of the two programs, Medicaid paid the full value of any Medicare coinsurance and deductible amounts. Largely from the 1980's forward states began to limit the amount they paid for these claims, often referred to as Medicare crossover claims. The actual Medicare payment to the provider was compared to the Medicaid fee for the same service. Many states began to limit the amount they paid providers to the difference, if any, between the amount Medicaid would have paid for the service and the amount the provider had received from Medicare. Most states have implemented this policy for inpatient hospitals services.

The survey asked states how they pay crossover claims for **physician** services for QMBs. Forty-nine states provided a response to this question, as follows:

- 11 states indicated that Medicaid always pays 100 percent of a QMB's Medicare cost-sharing amount for physician services (Arkansas, Hawaii, Iowa, Missouri, Mississippi, North Carolina, Nebraska, Oregon, South Dakota, Vermont, and Wyoming);
- 28 states indicated that Medicaid always limits reimbursement of Medicare crossover claims to the difference between the Medicaid allowable amount and the amount paid by Medicare (Alaska, California, Colorado, Connecticut, District of Columbia, Delaware, Georgia, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, North Dakota, New Jersey, New Mexico, Nevada, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, Wisconsin, and West Virginia);
- 9 states indicated that the policy differed mostly by provider type within physician services (Alabama, Idaho, Kentucky, Maryland, Maine, Michigan, Montana, New Hampshire, and Texas;
- 1 state (Florida) indicated that it had a methodology that differed from these.

Medicare Advantage Premiums. If dual Medicare/Medicaid enrollees, including full benefit dual eligibles and QMB-only duals, choose to receive their Medicare services through a Medicare Advantage plan, states have the option to cover the Medicare Advantage premium.[42] States were asked if they currently pay Medicare Advantage premiums and provided the following responses:

- 9 states said yes (Georgia, Idaho, North Carolina, Nebraska, New York, South Carolina, South Dakota, Tennessee, and Texas);
- 2 states said it varies by plan and/or premium charged (Alabama and Florida).

Thirty-five states responded that they do not cover Medicare Advantage premiums.[43] The proportion of the roughly nine million dual eligible beneficiaries receiving their Medicare services from a Medicare Advantage plan varies greatly from state to state, but is generally small. As financial alignment demonstrations are implemented for this population, this number is likely to increase. Such a change would bring more attention to this option and might create more pressure for states to assist with Medicare Advantage premiums.

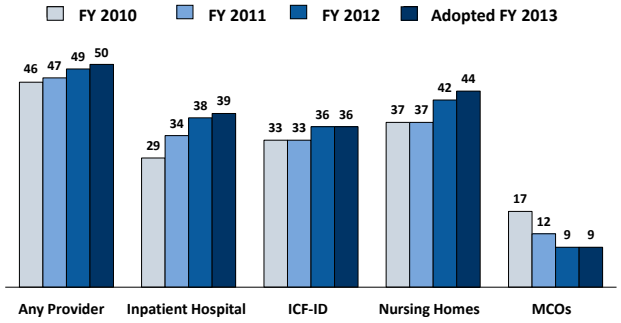
[41] Medicaid also pays the premiums for these individuals for Medicare Part B (physician services and other ambulatory care), Part D (prescription drugs), and if necessary Part A (hospitalization and limited nursing home care).
[42] States must still pay the Medicare Part B and Medicare Part D premiums for these individuals.
[43] Five states (Arizona, Connecticut, Illinois, Minnesota, and Montana) did not respond to this question.

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) have one or more provider taxes in place.[44] (Figure 25)

States often use additional revenue from provider taxes to support rate increases or to help mitigate rate reductions. However, some states use provider taxes to support the Medicaid program more broadly (e.g. to fund a coverage expansion in Colorado).

FIGURE 25

States With Medicaid Provider Taxes FY 2010 – FY 2013



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, September 2010, September 2011, and September 2012.

During FY 2012, states increased the number and size of their Medicaid provider taxes, with ten new provider taxes and increased rates for 59 existing provider taxes. For FY 2013, states indicate that they will be adding three new provider taxes and expanding 23 existing taxes. No provider taxes are being eliminated in either FY 2102 or FY 2013. Only three states (Idaho, New York, and Rhode Island) are decreasing a total of five provider taxes during either FY 2012 or FY 2013.

The most common Medicaid provider tax is still a tax on nursing facilities (44 states in FY 2013). Figure 25 shows changes in the number of provider taxes by major categories of providers. For FY 2012, Delaware, Nebraska and Washington implemented new nursing facility taxes; Arizona and Hawaii are implementing such a tax in FY 2013. The most dramatic change from FY 2010 to FY 2013 is the increased use of hospital taxes. In a prior report we found that in FY 2003 there were ten states with Medicaid hospital taxes. That increased to 23 states in FY 2009 and is now 39 states in FY 2013.[45] The number of states imposing Managed Care Organization (MCO) taxes has declined due to a change in federal law which required that MCO taxes be applied broadly to all providers (similar to the treatment of other provider taxes). A number of states that had applied taxes to a narrow set of MCOs, commonly Medicaid MCOs, subsequently dropped their taxes after the change in law. Some states already had broad based MCO taxes and others modified their MCO taxes to meet the new requirement. Other states, such as Michigan, replaced their MCO taxes with new taxes on all health care claims; however, this type of tax is not counted as a Medicaid provider tax under federal regulations and is not counted as an MCO tax for this survey.

Many states use provider taxes to fund supplemental payments to providers, particularly hospitals. In addition to provider payments related to provision of a particular Medicaid service to a particular Medicaid enrollee, most states also make supplemental payments to providers that are not tied to any particular service rendered. A recent report by the General Accountability Office (GAO-12-694) indicates that in federal fiscal year 2010 total supplemental payments other than Disproportionate Share Hospital (DSH) payments totaled $14.4 billion across 30 states reporting such payments. This represents an increase of $8 billion from the level reported by GAO for FY 2006. The GAO also reported that these payments often comprise a large share of

[44] 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.

[45] Last year's survey reported a hospital tax for Wyoming. That state reports some special financing arrangements involving intergovernmental transfers, but no Medicaid provider tax.

Medicaid payments to providers, ranging as high as 48 percent of state expenditures for inpatient hospital services, for example. The GAO reported that many of these supplemental payments are used to raise aggregate Medicaid payments for hospital services to the levels that would have been paid for the same services by Medicare. States and providers are concerned about proposals to reduce provider taxes which would limit these supplemental payments.

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 Table 2, which also reflects changes in provider taxes beyond the decisions to implement new provider taxes. (No provider taxes were eliminated in either FY 2012 or FY 2013.)

Table 2: Number of States with Changes in Provider Taxes, by Provider Type, FY 2012 and FY 2013

Provider Taxes	Tax Rate Decreases		Tax Rate Increases		Total Taxes	Taxes as a Percent of Net Patient Revenues:[46]	
						>3.5%	>5.5%
	FY 2012	FY 2013	FY 2012	FY 2013	FY 2013	FY 2013	FY 2013
Hospital	1	1	19	9	39	14	5
ICF-ID	0	1	14	7	36	31	18
Nursing Facility	0	2	23	7	44	33	17
MCO	0	0	0	0	9	2	0
Other Provider	0	0	3	0	13	6	3

States noted that a reduction in the ceiling on Medicaid provider taxes would have a significant impact on state budgets, Medicaid provider payment rates or both. Some states indicated that state finances are too weak to replace the lost revenue. Additionally, some states noted that these provider taxes help fund the Medicaid program more broadly than just payments to the category of providers that pays the tax. One state noted that "limiting provider taxes at 3.5 percent or 5.5 percent is likely to reduce provider reimbursement. . . With the current budget situation, general revenue is not likely to be a viable source to replace the lost provider tax funds." Appendix Table A-3 provides a complete listing of Medicaid provider taxes in place for FYs 2012 and 2013.

[46] 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.

Provider Taxes: Requirements and Proposed Changes[47]

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

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

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

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

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

Proposed Changes to Provider Taxes. Several proposals aimed at reducing the federal deficit have included proposals to limit states' ability to use provider tax revenue for Medicaid. The President's Budget for FY 2013 proposed to reduce the safe harbor threshold from 6 percent in 2014 to 4.5 percent in 2015, 4 percent in 2016 and 3.5 percent in 2017 and beyond. The Administration estimates that this proposal would yield $21.8 billion in federal savings over ten years.[48] As part of its recommendations for reconciliation for the FY 2013 budget, the House Energy and Commerce Committee in April 2012 proposed lowering the safe harbor threshold from 6 percent to 5.5 percent starting in 2013. The Congressional Budget Office scored this proposal as reducing direct federal spending by $11.3 billion over the 2012-2022 period.[49]

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

[48] *Fiscal Year 2013 Budget in Brief: Strengthening health and Opportunity for All Americans.* Department of Health and Human Services, http://www.hhs.gov/budget/budget-brief-fy2013.pdf.

[49] *Reconciliation Recommendation of the House Committee on Energy and Commerce Cost Estimate.* Congressional Budget Office, April 27, 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/EnergyandCommerceReconciliation.pdf.

B. Eligibility and Enrollment Process Changes

Medicaid eligibility standards determine who can qualify for the program. The enrollment and renewal procedures impact the ease with which individuals that are eligible for assistance from Medicaid can actually access the program and its services. Under the ACA Maintenance of Eligibility (MOE) requirements, states have been and continue to be prohibited from restricting eligibility standards or enrollment and renewal procedures, with limited exceptions.

Maintenance of Eligibility (MOE) Requirements

The ACA prohibits states from imposing eligibility and enrollment standards for Medicaid and CHIP that are more restrictive than those that were in place at the time the ACA was enacted (March 23, 2010). These requirements apply until 2014 for adults and until 2019 for children in Medicaid and CHIP, with some limited exceptions. The maintenance of eligibility (MOE) provisions have helped to maintain access to affordable coverage and stem the increase in the uninsured during the recent recession when demand for public programs rose and state revenues fell. Without these requirements, more states would have made coverage reductions due to budget pressures. Following the last recession, many states made eligibility restrictions and also imposed barriers to enrollment and renewal (such as adding additional documentation requirements) that resulted in significant declines in coverage. Looking ahead, these protections help to keep Medicaid and CHIP coverage stable until coverage expands under health reform. Similar MOE requirements were in place under the ARRA. Enhanced federal matching funds were contingent upon states complying with the MOE requirements.

Waivers and the MOE. In February 2011, CMS issued guidance related to the MOE and adult coverage above 133% of poverty, waivers and premiums. The guidance specified that the MOE does not require states to renew time-limited demonstration waivers, and, as such, a state can modify or terminate a demonstration waiver that was in effect on March 23, 2010 at the end of the approval period. The guidance also specified that states can increase premiums based on language in approved state plans or demonstration waivers or adopt inflation-related adjustments to premiums that were in effect as of July 1, 2008 for Medicaid and March 23, 2010 for CHIP. States can also adopt premiums for new coverage.

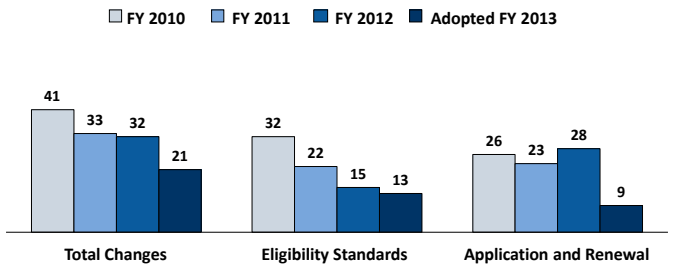
MOE Exception for Certain Adults with Incomes Above 133 Percent FPL. There is an exception to the MOE that allows states that cover adults above 133% FPL to reduce eligibility if they are facing a documented budget deficit. As of September 2012, Hawaii, Illinois, and Wisconsin have imposed restrictions under this exception. As of July 2012, nine states (CT, DC, ME, MN, NJ, NY, RI, VT, WI) provide Medicaid coverage to parents with incomes above 133% FPL, and ten states (AR, CA, ID, IN, IA, MA, NM, OK, OR, UT) provide more limited coverage to parents above this income level. Only the District of Columbia and Vermont provide Medicaid coverage to other adults with incomes above 133% FPL, and 12 states (AR, CA, IA , IN, MA, MN, NM, OK, OR, UT, VT, WI) provide more limited coverage to adults above 133% FPL.[50]

[50] "Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults," Kaiser Commission on Medicaid and the Uninsured, updated July 2012. http://www.kff.org/medicaid/7993.cfm.

While states are required to maintain existing coverage levels leading up to the expansion of Medicaid under the ACA, Figure 26 shows that many states have taken actions between 2010 and 2013 to expand Medicaid eligibility or make the enrollment and renewal processes easier despite the recent recession. In FY 2010, 41 states made positive eligibility and enrollment changes, followed by 33 states in FY 2011, and 32 states in FY 2012. In FY 2013, 21 states plan positive changes. Many of the application and renewal simplifications reported for FY 2012 and FY 2013 were designed to prepare for Medicaid expansion in January 2014 and coordination with Health Insurance Exchanges. The application simplification provisions in the ACA are required even if states do not implement the Medicaid expansion in 2014. A complete listing of all changes by state and fiscal year is provided in Appendix A-4a and Appendix A-4b.

FIGURE 26

States With Eligibility Expansions / Enhancements FY 2010 – FY 2013



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

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010, October 2011, and October 2012.

Changes to Eligibility Standards. Eligibility standards are the rules related to age, family status, immigration and residency status, disability status, income and assets that determine whether an individual or family for Medicaid coverage. As previously noted, the MOE restrict states' ability to implement eligibility cuts. Despite challenging state fiscal conditions, a number of states have implemented eligibility expansions. Table 3 lists a few of the more common eligibility changes that were implemented in FY 2012 or planned for FY 2013.

Table 3: Key Eligibility Changes

Eligibility Change	States in FY 2012	States in FY 2013
ICHIA option adopted	VT	VA
Childless adult coverage expansion	CO, MN, NM, OR	IL
New or expanded Buy-In/TWWIAA option for working disabled	CA, CO	CO, MN
Increase income and/or asset limits for long-term care or medically needy groups	FL, LA, ND, RI	FL, LA, NH, NJ
Implement or expand Family Planning coverage under a waiver or a SPA	CT, IA, MD, MT, OH	IN, MI, NY, WA

As shown in Figure 26 above, there was a peak in the number of states implementing expansions of eligibility standards in FY 2010 as a number of states took advantage of new options made available under the Children's Health Insurance Reauthorization Act (CHIPRA). As of January 2012, 25 states had implemented the CHIPRA option eliminate a five-year waiting period for coverage for children or pregnant women who are lawfully residing immigrants, including Vermont, which adopted this option in FY 2012.[51] For FY 2013, Virginia, which already adopted this option for children, plans to adopt this option for pregnant women.

Prior to the ACA, states could not cover non-disabled adults without dependent children through Medicaid unless they obtained a waiver. Effective April 2010, the ACA provided states a new option to expand Medicaid to adults to get an early start on the 2014 expansion. Funding of these initiatives is set at regular Medicaid matching rates through 2013, at which point the cost of coverage for this expansion population would change to 100 percent federal funding beginning on January 1, 2014. When adopting the early option, states may choose to expand coverage to a lower income threshold than 133 percent of FPL.

[51] 24 states had implemented this option for children while 18 states had implemented the option for pregnant women. Heberlein, Martha, et al. *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011–2012*. Kaiser Commission on Medicaid and the Uninsured, January 2012. http://www.kff.org/medicaid/8272.cfm.

Since April 2010, eight states (California, Connecticut, Colorado, the District of Columbia, Minnesota, Missouri, New Jersey, and Washington) have expanded adult coverage through the new ACA option or a waiver. Under waivers, states obtained authority as part of their expansions to impose an enrollment cap, provide more limited benefits, and cover adults with incomes above 133 percent FPL.[52] Most of these states had provided solely state- or county-funded coverage to some low-income adults. By moving these adults to Medicaid and obtaining federal financing, these states were able to maintain and, in some cases, expand coverage.

In FY 2012, two states, Colorado and New Mexico, began implementing small scale waiver initiatives to cover childless adults in Medicaid. A waiver has also been submitted to expand adult coverage in Cook County, IL.

- **Colorado** expanded coverage to adults without dependent children with incomes up to 10 percent of the FPL through an 1115 waiver in early 2012. Enrollment is capped at 10,000 and there were 7,800 enrollees as of May 2012. The expansion is funded by a hospital fee.
- **Illinois**, in collaboration with the Cook County Board and the Cook County Health and Hospital System (CCHHS), has submitted an 1115 waiver request to expand eligibility to uninsured adults with incomes at or below 133 percent FPL residing in Cook County. It is expected to cover 250,000 adults with a benefit package more limited than traditional Medicaid. Implementation was set for October 2012, but the waiver is still pending CMS approval.[53]
- **New Mexico** implemented a pilot to cover childless adults already on the waitlist for the State Coverage Initiative (SCI) program, New Mexico's waiver to cover adults without dependent children. Enrollment into the pilot program will begin in April 2012, targeting 5,000 individuals.[54]
- **Minnesota** expanded coverage to childless adults with incomes up to 75 percent of FPL in March 2011 under the ACA state plan option, providing Medicaid coverage for approximately 95,000 additional people.[55] In August 2011, the state further expanded coverage for childless adults with incomes between 75 and 275 of FPL through an 1115 waiver, expected to total 35,000 adults.[56]

A limited number of states also reported adopting or expanding family planning services to new populations either under a waiver or through a state plan option (a new option under the ACA). Specific examples include: **Ohio** implemented a new family planning waiver in January 2012 with expected enrollment of about 78,000 people and **Indiana** plans to implement a Family Planning state plan (with no prior waiver) as of January 2013, affecting an estimated 24,000 individuals. **Iowa** expanded its Family Planning Waiver eligibility, effective December 29, 2011, affecting 28,000 individuals and **Washington** plans to increase the income limit for its family planning waiver from 200 to 250 percent of FPL in FY 2013, adding about 12,000 eligible individuals.

Several states also reported expanding eligibility to individuals in need of long-term care services or those served by medically needy programs by increasing income and/or asset limits for these programs. For example, **Louisiana and New Jersey** are both seeking to apply institutional eligibility criteria to new long-term care groups and to expand eligibility to new groups with behavioral health needs. Louisiana has also applied medically needy spend down eligibility standards to new HCBS populations and plans to do so again in FY 2013. **Rhode Island**, **New Hampshire** and **North Dakota** have also expanded eligibility in this area by increasing assets limits and personal needs allowances or post-eligibility income limits.

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

[53] *Cook County Health and Hospital System's Care Coordination Enhancements and Bridge to ACA: Medicaid 1115 Waiver Proposal.* Department of Healthcare and Family Services, January 2012. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

[54] Press Release, New Mexico Human Services Department, January 2012. http://www.insurenewmexico.state.nm.us/Docs/UNM%20SCI%20Pilot%20Project%20-%20Press%20Release.pdf.

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

[56] This second eligibility expansion also transitioned adults from state-funded coverage. As of July 2012, those with incomes above 200 percent of FPL (approximately 4,000 to 7,000 individuals) were moved to a state-only "Healthy Minnesota Contribution" program.

Some states, including California, Colorado, New Hampshire, and New York[57], are transitioning their separate CHIP programs into CHIP (Title XXI) funded Medicaid expansion programs, partly in anticipation of simplified administration when the ACA expansion occurs in 2014. While in California alone 900,000 children will be moved from the Healthy Families program to Medi-Cal, this change is outside the scope of this report.[58]

Despite the maintenance of eligibility (MOE) provisions noted above, several states made major cuts or restrictions to Medicaid eligibility. Some of these changes are exempt from the MOE provision because they represent changes made when a waiver expired, were changes that did not go below eligibility standard in place in March 2010, or the change met the statutory provision for an exception to this requirement for non-pregnant, non-disabled adults with incomes that exceed 133 percent of the federal poverty level in states certifying that they project a budget shortfall. While only two states restricted eligibility in FY 2012, six states are planning to restrict eligibility in FY 2013. Among the changes states are reporting are the following:

- **Arizona**, in the process of renewing its waiver, froze enrollment in its AHCCCS Care waiver program for childless adults effective July 2011. This was estimated to affect 90,000 in the first year.
- **Connecticut** decreased the amount of spousal assets that can be retained for the long-term care population as of July 2011.[59] As of October 2012, an asset test will be added for childless adults covered under a waiver.
- **Hawaii** decreased the income limit to 133 percent of FPL for non-pregnant adults as of July 2012, affecting 5,000 individuals.
- **Illinois** implemented two eligibility restrictions as of July 2012, reducing the income limit for parents from 185 percent to 133 percent of FPL (affecting 28,000 individuals), and tightening the asset transfer limits for long-term care. Illinois also plans in November 2012 to add an income limit to its Medically Fragile Persons with Disabilities (MFPD or Katie Beckett) waiver at 500 percent of FPL. There is no current income limit and the new limit is expected to have a very limited impact.
- **Maine** plans to eliminate coverage for non-disabled young adults ages 19 to 20, reduce Medicare buy-in income eligibility, and to reduce coverage for parents from 200 percent to 100 percent of FPL, effective October 1, 2012. The state submitted state plan amendments to CMS for review in August 2012.[60] However, CMS is determining if its proposed changes are exempt from the MOE.
- **Wisconsin** made several eligibility reductions in July 2012. BadgerCare Plus is no longer available to non-pregnant non-disabled parents with incomes above 133 percent of FPL if they have access to employer-sponsored insurance and the premium contribution is not above 9.5 percent of income (affecting 7,100 people.) Retroactive eligibility was eliminated for BadgerCare Plus for non-pregnant, non-disabled parents and caretaker relatives with income between 133 percent and 150 percent of the FPL (affecting 7,600 people.) The state also imposed a 12 month restrictive re-enrollment period for BadgerCare Plus non-pregnant non-disabled adults with income above 133 percent of FPL who fail to pay a premium (estimated to affect 1,830 people.)

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[57] New York did not report this change in their survey response; however, it was noted in the following report: Heberlein, Martha et al. *Performing Under Pressure*. KCMU, January 2012. http://www.kff.org/medicaid/8272.cfm.

[58] Medicaid expansion programs are covered with Title XXI funds and therefore outside the scope of this report.

[59] Because Connecticut is not reducing the asset limit beyond what was in place on March 23, 2010, this change is not subject to the ACA MOE. *Department of Social Services section of the Connecticut State Budget for FY 2012 and 2013*, Office of Fiscal Analysis of the Connecticut General Assembly. http://www.cga.ct.gov/ofa/documents/year/BB/2012BB-20110916_FY%2012%20and%20FY%2013-Connecticut%20Budget-Part%20II.pdf.

[60] The state requested an expedited review to be completed by September 1 in order to achieve budgetary savings. When CMS indicated that such expedited review was not possible, the state filed a petition of review and a motion for injunctive relief in the US First Circuit Court of Appeals requesting the First Circuit to order CMS to approve the SPA and order CMS to pay Maine's share for coverage of these groups over and above the amounts would pay if the SPA was approved on or before October 1, 2012. The First Circuit has since denied the state's request. For more information, see: "Maine Seeks Federal Court Review of Medicaid State Plan Amendment." Press Release, Office of the Maine Attorney General, September 4, 2012. http://www.maine.gov/tools/whatsnew/index.php?topic=AGOffice_Press&id=431710&v=article10 and "Federal Court Declines to Order and Expedited Review of Maine's Medicaid State Plan Amendment." Press Release, Office of the Maine Attorney General, September 14, 2012. http://www.maine.gov/tools/whatsnew/index.php?topic=AGOffice_Press&id=436727&v=article10.

Changes to Enrollment and Renewal Processes. About half of all states made positive application and renewal changes in FY 2009 through FY 2011. For FY 2012, only 11 states reported last year that they planned to make changes that would simplify enrollment and/or renewal processes. In this year's survey, 28 states reported that they actually did make such positive changes. Only 9 states report plans to change enrollment and renewal processes during FY 2013. A significant focus of state effort related to enrollment and renewal processes is now directed to development of new coordinated, simplified and streamlined enrollment procedures across Medicaid, CHIP and the new Health Insurance Exchanges. One state commented: "In general, our efforts are focused on planning and implementing systems change in FY14 to be in compliance with the ACA."

Streamlined and simplified enrollment and renewal procedures make it easier for beneficiaries to obtain and maintain coverage. Many of these changes can also result in administrative cost savings. Many states made or are making multiple modifications to their enrollment and/or reenrollment processes in FY 2012 and FY 2013. Among the changes states reported that make the enrollment or reenrollment process easier for applicants/enrollees, Table 4 lists a few of the more common eligibility changes that were implemented in FY 2012 or planned for FY 2013.

Table 4: Enrollment Simplifications

Enrollment Simplification	FY 2012	FY 2013
Expansion or implementation of online applications or renewals	IN, KS, MN, PA, TX, UT	ND, SD, WV
Express Lane Eligibility	AL, CO, NJ, OR, SC	AL, MA, NY, SC
Administrative Renewals	AL, MA, MT, NY, NC, OR, UT	AR, NY
Telephone Renewals	CO, VT, VA	MA
Streamlined or Simplified Form	AR, LA, NY, UT	NE
Other Electronic Data Matches	CO, OR, RI	MA
Presumptive Eligibility	KS, NY, OH	
Elimination of Face-to-Face	FL, OH, WV	

No states reported enrollment restrictions in either year due to the MOE requirements.

C. Premium Changes and Buy-in Programs

While states have limited ability to require payment of a premium for an individual to enroll in Medicaid, there are certain populations for which premiums may be charged (sometimes labeled as "buy-in" programs). As of FY 2013, forty states reported that they have at least one group subject to a premium.

Working Disabled. The most common premiums allow disabled individuals receiving Medicaid to remain on the program 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 that 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-six states have some form of working disabled premium program. One state each year (MO in FY 2012 and PA in FY 2013) increased premiums in this program. Colorado added a new disabled buy-in program for working adults in FY 2012.

Waiver Populations. Some Medicaid waivers cover parents or childless adults with incomes above the limits that are typical for Medicaid programs. Thirteen states have waivers that allow them to charge premiums to these higher income populations. Iowa increased premiums in its IowaCare program in both years. As part of negotiations with CMS, Wisconsin received approval to expand premiums to two new populations – non-pregnant, non-disabled parents and caretaker relatives with incomes above 133 percent of poverty (premiums had been applied to this population with incomes above 150 percent of poverty) and extended premiums for the first time to Core Plan members (an 1115 waiver program that provides coverage to adults without

dependent children). The state also extended the lock-out period from six to twelve months for adults who lose coverage due to unpaid premiums. Each of these changes went into effect July 1, 2012.[61] Additionally in FY 2013, premiums were eliminated for parents with incomes between 150 and 200 percent of poverty in the MinnesotaCare program.

Disabled Children. The Family Opportunity Act (FOA) made it possible for families with uninsured disabled children that do not qualify for Medicaid to pay a premium for Medicaid coverage for their children. The FOA is optional for states. Only four states have chosen this option, including Colorado, which is planning to implement this option in FY 2013. Two states also have premium options for higher income families for their Medically Fragile Persons with Disabilities (MFPD or Katie Beckett) waivers.

Other. Three states have other premium initiatives. One premium for higher income parents under provisions of the Deficit Reduction Act (DRA) was eliminated (in Illinois) because the coverage group was eliminated in FY 2013. In addition, Florida submitted a waiver in April 2012 to allow those that qualify for the medically needy spend down program (whose eligibility is determined on a monthly basis) to remain eligible for six months of coverage by paying a premium that would not exceed the share of cost; this waiver is still pending with CMS.

As noted in the preceding list, there was one new premium initiative in FY 2012, three new premium initiatives in FY 2013, and one premium initiative was eliminated in FY 2013. The ACA MOE requirements affect premiums since the level of the premium charged can affect eligibility.

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

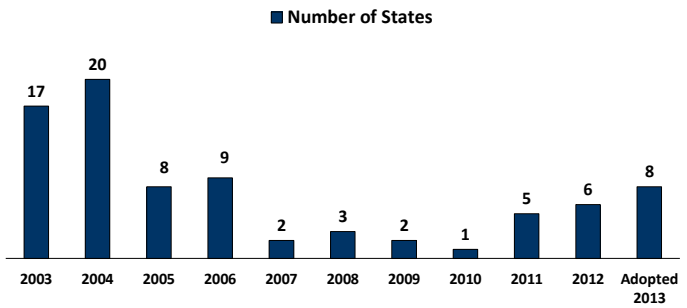
D. Copayment Requirements

Copayment requirements are used to varying degrees by most state Medicaid programs: a total of 45 states (including DC) have copayment requirements, including five states (Delaware, Louisiana, Maryland, New Hampshire and West Virginia) that impose copayments only on drugs. Only six states (Connecticut, Hawaii, Nevada, New Jersey, Rhode Island and Texas) reported having no copayment requirements at all.

In last year's survey, 14 states reported plans to raise or impose new copayment requirements in FY 2012, which was a significant increase compared to prior years. In this year's survey, only six states reported following through on those plans in FY 2012. (Figure 27) While it is not uncommon for policy actions planned at the beginning of the year to be changed or abandoned for various reasons, some of the previously planned copayment changes for FY 2012 are worth highlighting. In particular, three states (Arizona, California, and Florida) submitted waiver amendments to CMS to impose cost-sharing beyond what current federal rules allow including:

FIGURE 27

States Imposing New or Higher Copayments FY 2003 – FY 2013



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

[61] Premium changes in WI were applied to adults with incomes above 138 percent of poverty. The state could have eliminated coverage for these groups under the exception for states facing a documented budget deficit covering non-pregnant non-disabled adults above 133 percent of poverty. (See the box on Maintenance of Eligibility in the earlier section)

- Cost sharing increases for children, pregnant women, and parents that were included in the Arizona waiver proposal;
- A waiver amendment request from California to charge copayments for the vast majority of Medicaid beneficiaries (including a $50 copayment for all services received in an emergency room and $100 per day copayment for inpatient hospital services up to a maximum of $200 per admission), and
- A proposal from Florida to charge a $10 monthly premium and a $100 copayment for non-emergent use of the emergency room for most Medicaid beneficiaries.

CMS ultimately denied at least part of these waiver requests indicating that the proposed premium and cost sharing amounts were not consistent with federal rules.[62] Moreover, CMS noted that to impose higher cost sharing than was otherwise allowed, a state would need to satisfy the cost sharing waiver requirements under federal Medicaid law.[63]

Court Ruling on Arizona Cost Sharing

On August 24, 2011, the U.S. Ninth Circuit Court of Appeals ruled in *Newton-Nations et al. v. Betlach and Sebelius*, a case that involves the authority to impose heightened, mandatory copays on waiver expansions including childless adults with incomes up to 100 percent of poverty and those with high medical expenses and income below 40 percent of the 2000 poverty level once these expenses were deducted. The Secretary had approved the changes under section 1115 of the Social Security Act which allows the Secretary to approve "experimental, pilot, or demonstration" projects that are "likely to assist in promoting the objectives of the Medicaid Act."

The Court rejected the copay changes ruling that the Secretary's review did not satisfy the obligation under the Social Security Act to determine whether the proposal was likely to further the goals of the Medicaid Act and that the review did not adequately "consider the impact of the project on the" persons the Medicaid Act "was enacted to protect." The Court also questioned whether the project could have an experimental, pilot or demonstration value, expressing doubt that the copayments could "demonstrate something different than the last 35 years' worth of health policy research" (which consistently concludes that copayments cause low-income people to forego even medically necessary care). The Court further held that the Secretary must determine whether the project has value as a demonstration, experimental or pilot project, and that a project undertaken to cut benefits, that might save money, will not satisfy this requirement.

Since the court ruling, CMS has approved several Section 1115 waiver requests related to premium and cost-sharing increases in Arizona and Wisconsin in cases where coverage could have been eliminated, but requests were not approved in Arizona, California and Florida.[64]

[62] "Arizona's Section 1115 Research and Demonstration Waiver Factsheet." Arizona Health Care Cost Containment System, updated November 17, 2011. http://www.azahcccs.gov/reporting/Downloads/1115waiver/WaiverFactSheet.pdf.
CMS Letter to California Department of Health Care Services, February 6, 2012.
CMS Letter to Florida Agency for Health Care Administration, February 9, 2012.
http://www.fdhc.state.fl.us/Medicaid/statewide_mc/index.shtml#fedsubmiss

[63] Under Social Security Act Section 1916(f), a state may seek a demonstration waiver to charge cost sharing above allowable amounts if the state meets specific requirements and criteria, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years. However, to date, states have not pursued these waivers. For more information, see:
Artiga, Samantha. *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, May 2012. http://www.kff.org/medicaid/upload/8318.pdf.

[64] Artiga, Samantha. *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, May 2012. http://www.kff.org/medicaid/upload/8318.pdf.

Eight states reported plans to raise or impose new copayment requirements in FY 2013. (Figure 27) Some of these states have implemented or plan to implement multiple new copayment requirements. State changes in copayments for FY 2012 and FY 2013 are highlighted below:

- ***Pharmacy.*** Consistent with previous surveys, new or increased pharmacy copayments were the most frequently cited. Three states (Massachusetts, Minnesota and South Carolina) increased pharmacy copayments in FY 2012. Five states (California, Illinois, Maine, South Dakota and Wyoming) planned to impose or increase pharmacy copayments in FY 2013.
- ***Emergency Room.*** Four states (California, Illinois, Texas and Wyoming) planned to implement or increase copayments for non-emergency use of the emergency room in FY 2013.
- ***Waivers.*** Some states are seeking waivers to impose copayments (on exempt populations or at higher amounts) that would otherwise not be allowable under current law. In FY 2013, California is seeking waiver authority to impose enforceable copayments of $2.10 for the use of non-preferred drugs and $15 for non-emergency use of emergency departments for individuals enrolled in managed care.[65] In FY 2013, Illinois is seeking to impose new cost-sharing requirements on participants in the Medically Fragile and Technology Dependent Children's waiver.

Other common copayment changes included increases in five states (Arizona, Idaho, Illinois, Minnesota and Wyoming) on physician or clinic visits. Only one state (Vermont) reported eliminating a copayment in FY 2013 for $75 on each inpatient hospital visit.

Prior to the Deficit Reduction Act in 2005, federal law limited Medicaid copayments to nominal amounts, generally defined as $3 or less per service, and also prohibited states from applying copayments to certain services (e.g., emergency services) or certain eligibility groups (children and pregnant women). Subject to certain limits and exemptions, however, the DRA provides authority for states to charge greater than nominal cost-sharing for certain eligibility groups and most services and also permits states to vary the cost-sharing requirements by eligibility group. States may now elect to make cost-sharing enforceable – that is, allow a provider to deny rendering services if the copayment requirement is not met.

In this year's survey, only one state (Pennsylvania) reported using DRA authority to impose greater than nominal copayment requirements or to vary copayment obligations by eligibility group. Pennsylvania plans to implement DRA alternative cost-sharing (20 percent coinsurance on non-exempt services) for certain disabled children under age 18, who have household incomes above 200 percent of poverty.[66] Seven states (Arizona, Idaho, Kentucky, Mississippi, New Hampshire, Utah and Wisconsin) reported that copayment requirements were enforceable in FY 2012 for at least one eligibility group as allowed by the DRA. Another three states (California, Illinois and Maine) reported plans to take advantage of the DRA authority to make copayments enforceable in FY 2013. Additional information on FY 2012 or FY 2013 changes to copayments is reported in Appendices A-5a and A-5b.

[65] California failed to receive CMS approval of copayments previously proposed for FY 2012 including a $50 copayment for all services received in an emergency room and a $100 per day copayment for inpatient hospital services, with a maximum copayment of $200 per admission.

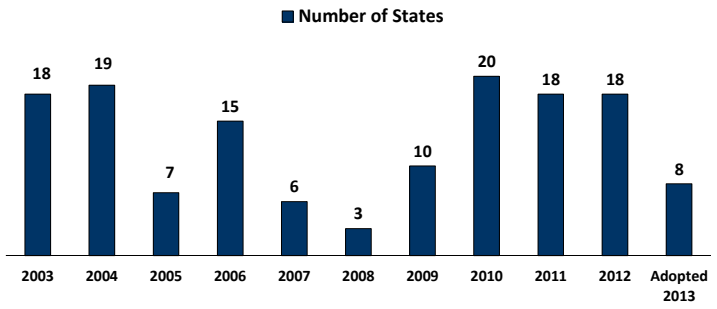
[66] The department has since indicated that it has delayed implementation of this copay for this population; the state is working with stakeholders to potentially pursue a premium for this population instead. *Department of Public Welfare Releases Statement on Co-payment Initiative.* Department of Public Welfare, October 5, 2012. http://www.dpw.state.pa.us/.

E. Benefits Changes

The same number of states (18) reported benefit cuts for FY 2012 compared to the number reporting planned cuts in last year's survey. However, significantly fewer states (8 total) reported plans to eliminate, reduce or restrict benefits in FY 2013. (Figure 28) Benefit restrictions reflect the elimination of a covered benefit or the application of utilization controls for existing benefits. Of the 18 states in FY 2012 and eight states in FY 2013 reporting cuts or eliminations, eight states in FY 2012 and three in FY 2013 reported one or more benefit eliminations as described in Table 5. Sixteen states in FY 2012 and seven in FY 2013 (including five of the FY 2012 states and two of the FY 2013 states listed in Table 5), applied more narrowly targeted limits or utilization controls to existing benefits as described in Table 6.

FIGURE 28

States Cutting or Restricting Benefits FY 2003 – FY 2013



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

Additional information on FY 2012 or FY 2013 changes to benefits is reported in Appendices A-6a and A-6b.

Table 5: Benefit Eliminations by State

State	*FY 2012*
Alabama*	• Eyeglasses.
California	• Adult Day Health.[67]
Colorado*	• Circumcision.
Idaho*	• Eyeglasses, audiology and non-emergency dental.
Indiana	• Targeted case management.
North Carolina*	• Eye exams and optical supplies.
Oregon	• 13 lines on the OHP Prioritized List of Health Services.
Washington*	• Eyeglasses and hearing aids and devices.
	FY 2013
Colorado	• Vision therapy services.
Illinois*	• Non-emergency dental and chiropractic services.
Maine*	• Ambulatory surgical center, STD screening clinic services and smoking cessation.

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

[67] After receiving CMS approval to eliminate this benefit, Medi-Cal beneficiaries receiving adult day health care services challenged the elimination of the benefit, arguing that without replacing the services, the elimination of the benefit would violate the Americans with Disabilities Act (ADA) and other laws. The parties to the lawsuit reached a settlement under which the ADHC program was phased out and replaced on April 1, 2012, with a new program called Community-Based Adult Services (CBAS). CBAS provides necessary medical and social services to those with the greatest need. It is estimated that roughly half of current ADHC participants will qualify for the new program. For the purposes of this report, the CBAS program implementation is not counted as a benefit expansion as the net effect of eliminating Adult Day Health and replacing it with CBAS is a service reduction. For more information, see: http://www.dhcs.ca.gov/services/medi-cal/pages/adhc/adhc.aspx.

Table 6: Benefit Limitations by Service Category and State

Benefits Limited[68]	*2012*	*2013*
Chiropractic services	ID	IL, ME
Dental or denture services	CO, CT, ID, IA, NC, PA, WA	IL, SD
Imaging services	CO	–
Inpatient hospital stays	AZ	IL
Outpatient hospital/ER	NH	FL
Medical supplies, DME or Orthotics	CA, NY, TX, WA	IL, TX
Mental health services	ID	IL
Occupational, physical or speech therapy	ID, NY, NC, WA	IL
Personal care services	CA, HI, MI, NM, NC	–
Physician visits	–	CA, FL
Podiatry	ID	IL
Vision services	AL, CT, ID, NC, WA	CO, IL, ME

In addition to states reducing benefits, 19 states in FY 2012 and 15 states in FY 2013 also reported expanding benefits – higher than the number of states reporting expansions in FY 2011 (13 states), and comparable to the number reporting expansions in FY 2010 and FY 2009 (15 states). These totals include five states in FY 2012 and six states in FY 2013 adding or expanding behavioral health services, four states in FY 2012 that expanded coverage for smoking cessation services[69], and one state in FY 2012 and three states in FY 2013 that are restoring or expanding dental benefits. As part of the ACA, states have also been required to cover a few new services described below.

New ACA Benefit Requirements

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

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

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

Benchmark Plans. Before the DRA, states were required to cover a set of mandatory services and could also receive federal match for covering optional services, such as prescription drugs, dental care and personal care services. Generally, states had to offer the same set of services to all individuals covered by Medicaid in their state. The DRA provision permitted states, in the case of certain groups of Medicaid beneficiaries, to substitute their traditional Medicaid benefits with "benchmark" benefits, defined as one of the following: (1) the standard Blue Cross/Blue Shield PPO option under the Federal Employees Health Benefits Program (FEHBP), (2) any plan generally available to state employees, (3) the coverage offered by the largest commercial HMO in the state, or (4) Secretary-approved coverage. States can also offer benchmark-equivalent packages. The DRA authority gives states further flexibility to vary Medicaid benefits by beneficiary group and geographic area. States can provide benchmark benefits for some children, but must cover Early Periodic Screening Diagnosis and Treatment (EPSDT) services as a wrap-around. A number of groups, such as those with disabilities, the medically frail, and low-income parents, are exempt from mandatory enrollment in benchmark plans.

[68] Policies to limit prescription drugs are discussed in the section related to prescription drugs.
[69] This count includes states that expanded coverage of smoking cessation services beyond what was required by the ACA, described in the box below.

Previous reports described the benchmark benefit plans implemented in eight states in FY 2007 and FY 2008.[70] No states reported adopting a Medicaid benchmark plan in FYs 2012 or 2013. However, the issue of benchmark benefits will become more significant, as the ACA calls for most newly eligible Medicaid enrollees to receive Medicaid benchmark or benchmark-equivalent coverage. Notably, the ACA modified the benchmark standards to require that all Medicaid benchmark and benchmark-equivalent plans cover the ten categories of "essential health benefits" (EHB) identified in the ACA. CMS guidance issued late in 2011 gave states flexibility to define their own EHB packages based on a set of commercial plan options specified in the guidance.

This year's survey did not ask states about their Medicaid benchmark benefit plans for the expansion population under the ACA. However, in a recent focus group discussion with several state Medicaid directors, a number of them commented adopting the existing Medicaid benefit package as the Medicaid benchmark plan for the newly eligible population would be the simplest – an approach that CMS has indicated states could pursue under the Secretary-approved coverage option.[71] As states prepare to implement the ACA, tracking their choices about Medicaid benchmark benefits and the EHB will be important to gauge the variation in Medicaid benefits across states and to compare benefits covered by Medicaid and exchange plans.

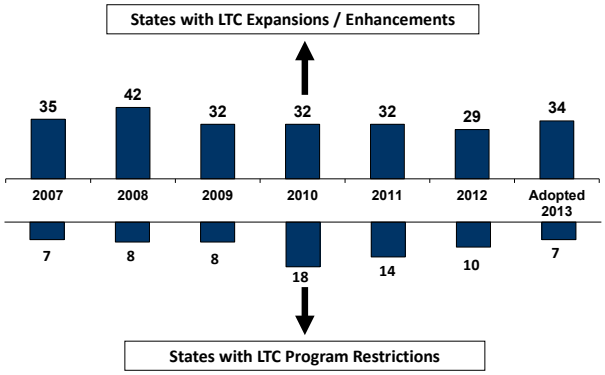
F. Long-Term Care and Home and Community–Based Services

Medicaid is the nation's primary payer for long-term care services and supports (LTC) covering a continuum of services ranging from home and community-based services (HCBS), that allow persons to live independently in their own homes or in the community, to institutional care provided in nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs-ID). LTC consumes nearly one-third of total Medicaid spending and therefore is an important focus for state policymakers. This year's survey shows that the 20+ year trend in most states of expanding HCBS continues, although a few states are applying new service limits.

States' efforts to expand HCBS options for LTC are driven by consumer demand, the United States Supreme Court's 1999 decision in *Olmstead v. L.C.* that found that the unjustified institutionalization of people with disabilities is a violation of the Americans with Disabilities Act of 1990, and an effort to control LTC costs.[72] In FY 2012 and FY 2013, 29 and 34 states, respectively, took actions that expanded LTC services (primarily expanding HCBS programs), comparable to the number of states making expansions in FY 2010 and FY 2011 (32 in both years) but less than the high of 42 states taking actions to expand LTC services in FY 2008. Conversely, a total of 10 states in FY 2012 and seven states in FY 2013 took action to constrain LTC services (compared to the high of 18 states in FY 2010.) (Figure 29) Restrictions to LTC are limited by the ACA MOE requirements described below.

FIGURE 29

Long Term Care Policy Actions FY 2007 – FY 2013



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

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

[70] Idaho, Kansas, Kentucky, South Carolina, Virginia, Washington, West Virginia, and Wisconsin.
[71] Gifford, K. et al. *A Focus Group with Medicaid Directors: As FY 2012 Ends, Looking Toward FY 2013.* KCMU, June 2012.
[72] Olmstead v. L.C., 527 U.S. 581 (1999), available at http://www.law.cornell.edu/supct/html/98-536.ZS.html.

MOE Requirements and Long-Term Care[73]

States' ability to impose certain HCBS restrictions in FY 2012 and FY 2013 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 January 1, 2014, and for children in Medicaid and CHIP until October 1, 2019. Because eligibility for Medicaid LTC services and Medicaid eligibility is linked, 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 occupied HCBS waiver capacity; or reducing or eliminating HCBS waiver slots that were funded but unoccupied as of July 1, 2008.

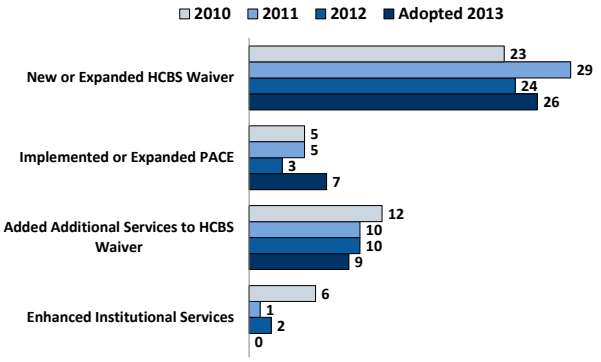
States, however, may increase the institutional LOC criteria without violating the MOE if an alternative eligibility pathway to Medicaid HCBS services is created for affected individuals. For example, a state could utilize the Section 1915(i) HCBS State Plan Option (described above) or Section 1115 demonstration waiver authority to offer different LOCs for receipt of HCBS and institutional services, ensuring that the available capacity for Medicaid eligibility remains unchanged.

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

HCBS Programs. This year's survey found that states are continuing to work on reorienting their Medicaid LTC delivery systems towards more community-based services. As in past years, the most commonly reported expansion in FY 2012 and FY 2013 was adopting new HCBS waivers or expanding existing waivers (including home and community-based services delivered through Section 1915(c) waivers as well as Section 1115 waivers or through the Section 1915(i) HCBS State Plan option). The number of states reporting this type of expansion was 24 in FY 2012 and 26 in FY 2013, comparable to the number of states reporting changes in FY 2011 (29 states) or 2010 (23 states), but fewer than in FY 2008 (38 states). Other examples of expansions include adding services to HCBS waivers and expanding PACE programs.[74] (Figure 30)

FIGURE 30

Medicaid Long-Term Care Expansions, Implemented in FY 2010 – FY 2013



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

While most states already have limits in place for their community-based services such as coverage limits, enrollment caps, and waiting lists for services, this year's survey found that seven states in FY 2012 and four states in FY 2013 imposed additional restrictions directed at HCBS programs and services (compared to seven states in FY 2011, nine states in FY 2010 and only two states in FY 2009). These reductions and restrictions are described in Table 7. Also, five states in FY 2012 made reductions to optional state plan personal care services (which are included and counted under section "E. Benefit Changes" in Table 6).

[73] See: State Medicaid Director Letter, SMD#09-005, ARRA#5, CMS, August 19, 2009 and State Medicaid Director Letter, SMDL#11-009, ACA#19. CMS, August 5, 2011.

[74] 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.

Table 7: HCBS Reductions and Restrictions

FY 2012 Reductions and Restrictions	
Arizona	Limited respite care services.
Montana	Eliminated PACE program.
Oregon	Reduced authorized hours for in-home recipients by approximately 5%.
Pennsylvania	Adopted new Long-Term Living Home and Community regulations that include new service limits.
South Carolina	Eliminated home social work visits and reduced pest control benefit slightly. Also capped PACE enrollment.
Texas	Imposed a soft cap on certain services in select waivers. Also, terminated the Consolidated Waiver Program.
Virginia	Reduced allowable hours for respite care from 720/year to 480/year and implemented a 56 hour/week cap on HCBS personal care services (with exception criteria).
FY 2013 Reductions and Restrictions	
Colorado	Make Consumer-directed care program administration adjustments.
Illinois	Subject to federal approval, will increase the minimum Determination of Need score.
New Hampshire	Add waiver service limits for transportation and respite services and for computers.
Minnesota	Subject to federal approval, tighten nursing facility level of care criteria (see discussion on ACA MOE).

Institutions. Only two states reported expansions for institutional services in FY 2012, and no state reported plans to remove restrictions or enhance institutional services in FY 2013 (compared to six states in FY 2010). In FY 2012, Alabama expanded facility coverage to include ventilator dependent residents, and Georgia revised its nursing reimbursement policy to recognize (and thereby remove a disincentive for) ventilator weaning.

Four states in FY 2012 and five states in FY 2013 implemented or planned to implement cost controls related to institutional placements (compared to 13 in FY 2010). Examples include:

- Efforts to reduce the size of or close state-owned mental health institutions or ICFs-ID (Illinois and Massachusetts);
- Reductions in payments for bed-holds (Illinois, Maryland, New Jersey, Ohio, and South Carolina);
- Subject to federal approval, plan to tighten nursing facility level of care criteria or raise Determination of Need score (Minnesota and Illinois[75]); and
- Modifying the LOC criteria to target nursing facility services to persons with higher acuity needs while simultaneously making HCBS more broadly available. (Tennessee)

Other LTC Actions. A few states also reported other LTC policy initiatives underway to improve the delivery of LTC services and increase community-based alternatives. These initiatives are not counted as institutional or community-based expansions or restrictions in this survey, but were additional LTC actions reported by the states. State policies included the implementation of residential care customer satisfaction surveys and other increased HCBS oversight and monitoring efforts; consolidation of one or more HCBS waivers; implementation of a quality incentive payment reform program for nursing facilities; modification of LTC assessment tools; conversion of certain state plan services for children with disabilities to HCBS waiver services; implementation of Money Follows the Person grant planning activities, increasing the statewide nursing facility occupancy standard for purposes of applying a moratorium (i.e. making it more difficult to receive approval for new nursing home beds); modification of the targeting criteria for an HCBS waiver to accommodate individuals with intellectual disabilities who also meet nursing facility level of care criteria (LOC); and expansion of an electronic visit verification program (telephony) to more areas. Several states reported efforts to implement or expand managed LTC programs including Delaware in FY 2012 and California, Kansas, and New York in FY 2013.

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

LTC Options in the ACA. The ACA includes a number of new LTC options that are in effect and available to states. These options are discussed below.

HCBS State Plan Option. The DRA gave states a new option to offer home and community-based services through a Medicaid State Plan Amendment rather than through a Section 1915(c) waiver. Responding to low state take-up, effective October 1, 2010, the ACA built on the DRA authority by expanding eligibility under this option to individuals with incomes up to 300 percent of the maximum SSI federal benefit rate and by making a number of other changes to address state concerns. However, the ACA 1915(i) option also eliminates the states' ability to cap enrollment, maintain a waiting list or waive the requirement for the benefit to be offered statewide. Seven states (California,[76] Colorado, Iowa, Nevada, Oregon, Washington and Wisconsin) reported having the HCBS state plan option in place prior to FY 2012.

Three states (Connecticut, Idaho and Louisiana) reported implementing the HCBS state plan option in FY 2012, two states (Delaware and Maryland) reported plans to implement in FY 2013[77], and two states (Indiana and Minnesota) reported a planned FY 2014 implementation date. In many cases, states taking up the option reported targeting services to persons with mental illness or intellectual disabilities. Also, since the ACA eliminated the ability of states to impose an enrollment cap on the HCBS State Plan option, one of the seven states that had previously implemented this option (Washington) reported eliminating it in FY 2012 and transitioning enrollees into comparable HCBS waiver services.

Balancing Incentive Program. Beginning in October 2011, the Balancing Incentive Program (BIP) makes enhanced Medicaid matching funds available to states that meet certain requirements for expanding the percentage of LTC spending for HCBS (and reducing the percentage of LTC spending for institutional services).[78] Funding is available through September 2015. To qualify, states must: 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 LTC.

In last year's survey (before CMS had released the program application and related guidance in September 2011), a large majority of states (34) reported that they did not know whether they would apply for the program. In this year's survey, four states reported having already implemented the program (Georgia, Iowa, Maryland and New Hampshire), and 10 states reported plans to implement the program in FY 2013.[79]

Community First Choice (CFC) Option. Beginning in October 2011, states electing this State Plan option to provide Medicaid-funded home and community-based attendant services and supports will receive an FMAP increase of six percentage points for CFC services. California was the only state to report implementing this option in FY 2012. Upon approval, California immediately claimed CFC funding retroactively for most in-home services provided since December 1, 2011. The state's press release announcing CMS's approval estimates that California will receive $573 million in additional federal funds during the first two years of implementation.[80] An additional six states reported definite plans to implement the CFC Option (Arkansas, Louisiana, Minnesota, Montana, New York and Oregon) in FY 2013.[81] Because the final federal rule implementing this option was not released by CMS until May 2012,[82] it is possible that more evaluation time is needed in some states before an implementation decision can be made.

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[76] California reported that it was still awaiting CMS approval of its SPA (submitted in FY 2011) but had requested a retroactive effective date.
[77] Montana reported plans to implement a 1915(i) state plan option to provide HCBS services for children with serious emotional disturbances which will include current 1915c services plus additional services. This change was reported in the benefit section – see Appendix A-6b for more details.
[78] BIP is only available to states that spent less than 50% of Medicaid funds on non-institutional LTC in FY2009.
[79] Indiana, Mississippi, Missouri, and Texas reported plans to implement this option in FY 2013 and have applications approved by CMS, which can be viewed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html. Additionally, Alabama, Arkansas, Connecticut, Illinois, New Jersey, and Rhode Island reported plans to implement this option in FY 2013.
[80] "CALIFORNIA RECEIVES FIRST-IN-THE-NATION APPROVAL OF NEW COMMUNITY-BASED CARE OPTION FOR AT-RISK SENIORS AND PERSONS WITH DISABILITIES." State of California Health and Human Services Agency, September 4, 2012. http://www.cdss.ca.gov/cdssweb/default.htm.
[81] Maryland also reported plans to implement the Community First Choice option in FY 2014.
[82] 77 *Fed. Reg*. 26828 (May 7, 2012).

G. Prescription Drug Utilization and Cost Control Initiatives

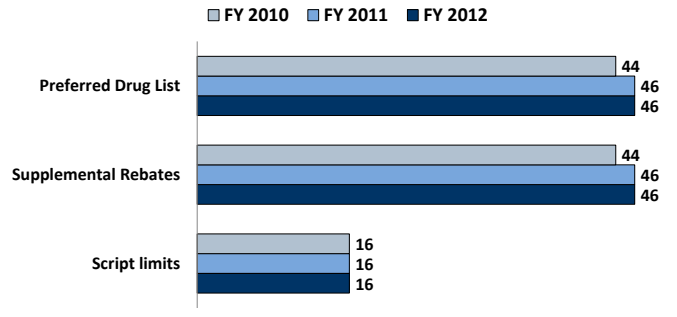
Almost all state Medicaid programs employ a sophisticated array of pharmacy management tools including preferred drug lists (PDLs), supplemental rebate programs, prior authorization programs, state maximum allowable cost ("state MAC") programs, generic incentives and other utilization management controls. This year's survey finds that a majority of states continue to take steps to refine their pharmacy programs. Of particular note are the growing number of states with plans to adopt the "Actual Acquisition Cost" reimbursement methodology for ingredient costs, the decreasing number of states choosing to "carve-out" prescription drugs from their capitated managed care arrangements and the significant number of states reporting on efforts to better control behavioral health drug utilization. Also of note, despite the ongoing rapid growth in specialty pharmacy expenditures, fewer states reported a cost containment action focused on specialty drugs compared to last year's survey.

Pharmacy Management Policies in Place. In FY 2012, 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. Of the remaining five states that have not adopted a PDL or implemented a supplemental rebate program, three (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 also remained the same at 16 states in FY 2012. (Figure 31)

Summary of FY 2012 and FY 2013 Pharmacy Policy Changes and Cost Containment Efforts. Thirty-three states in FY 2012 and 29 in FY 2013 implemented cost-containment initiatives in the area of prescription drugs, comparable to number of states taking such actions in FY 2011 (31 states), but fewer than the number in FY 2010 (38 states). As PDL and related supplemental rebate programs have matured in most states, the number of states reporting PDL or supplemental rebate changes (e.g., adding new PDL drug classes or joining a multi-state rebate pool) appears to have stabilized at a lower level (10 to 13 states) compared to FY 2009 when 28 states reported expanding or enhancing a PDL and 24 states reported new or enhanced supplemental rebate efforts. (Figure 32) A smaller number of states in FY 2013 also reported plans to reduce ingredient cost reimbursement (8 states), reduce dispensing fees (1 state) or impose limits of the number of prescriptions (1 state) compared to FY 2012.

FIGURE 31

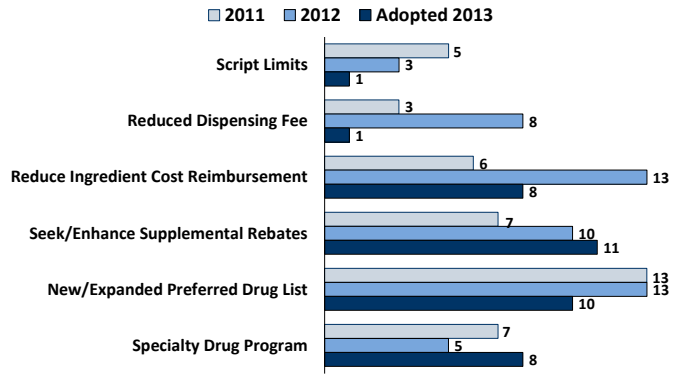
Medicaid Pharmacy Policy Measures in Place at the beginning of FYs 2010, 2011 and 2012



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

FIGURE 32

Medicaid Prescription Drug Policy Changes FY 2011 – FY 2013



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011, 2012

AWP Ingredient Cost Pricing. State Medicaid programs reimburse pharmacies for the "ingredient cost" of each prescription, plus a dispensing fee.[83] For many years, a majority of states used the "Average Wholesaler Price" (AWP) benchmark in their pharmacy reimbursement policies for ingredient costs. In recent years, however, the validity of this methodology has been questioned including a court challenge that resulted in one AWP publishing firm (First Databank) discontinuing its AWP publishing after September 2011.[84] 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. CMS is now in the process of developing a database of National Average Drug Acquisition Costs (NADACs) and is encouraging states to move to an AAC methodology when the NADAC data becomes available. To that end, in June 2012 CMS launched its outpatient drug acquisition cost survey of retail community pharmacies.[85]

In this year's survey, a number of states reported transitioning or planning to transition to an alternative ingredient cost reimbursement benchmark:

- Eleven states reported moving from AWP to the Wholesale Acquisition Cost (WAC) benchmark and two states reported keeping AWP but adding WAC as an alternative benchmark (i.e., using the lower of AWP or WAC or using WAC when AWP is not available).
- One state reported adopting both the WAC benchmark and the "Suggested Wholesale Price" (SWP) benchmark, when available.
- Eight states reported plans to move to the Average Acquisition Cost (AAC) benchmark.

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

Specialty Drugs. While the overall trend in drug spending across all health care sectors (including Medicaid) slowed to 2.7 percent in 2011, spending on specialty drugs continued to grow at a much higher rate – 17.1 percent – and is predicted to grow by approximately 20 percent per year through 2014.[86] In fact, one state Medicaid director commented in this year's survey that specialty drugs accounted for all of the pharmacy spending growth in that state and that the pharmacy spending trend on a per member per month basis would have decreased if specialty drug spending were excluded. This year's survey again asked states about specific cost containment efforts focused on specialty drugs. Despite increasing cost pressure in this area, only five states in FY 2012 and eight states in FY 2013 reported implementing or plans to implement a new cost containment action focused on specialty drugs, down from the 19 states that indicated planned FY 2012 actions in last year's survey. (Table 8) An additional six states commented, however, that specialty drug policies were under consideration or were likely to be the focus of Medicaid pharmacy policy development in the future.

[83] In accordance with federal and state law, states pay the lower of (a) the ingredient cost rate plus a dispensing fee; (b) the Federal Upper Limit (FUL) or State Maximum Allowable Cost rate, if applicable, plus a dispensing fee; or (c) the pharmacy's Usual and Customary Charge.
[84] Medi-Span, Gold Standard, and Micromedex, unlike First DataBank, will continue to publish AWP.
[85] CMCS Informational Bulletin, "Medicaid Pharmacy – Survey of Retail Prices," May 31, 2012.
[86] *Express Scripts 2011 Drug Trend Report*, April 2011, accessed at http://www.drugtrendreport.com/drug-trend-downloads.

Table 8: Specialty Drug Cost Containment Approaches by Type and State

Cost Containment Approach	*FY 2012*	*FY 2013*
Selective contracting with specialty drug providers	VT	KS, NV
Revisions to the reimbursement methodology for specialty drugs	VT, WI, WY	GA, IL
Implementation of specialty drug case management efforts	MI	CO, IL, NV
Other	TX	CO, IL, IN, NC, NV, WA

"Other" actions reported included allowing MCOs to separately contract for specialty pharmacy services (Texas), changing the responsibility for management of injectables (Colorado), requiring entities that dispense clotting factor to have signed a "Standards of Care Agreement" (Illinois), implementation of a specialty pharmacy call center with evidence-based authorization criteria (Indiana), educating pharmacies to incentivize better performance (North Carolina), and limiting the distribution of hemophilia product for routine use to comprehensive hemophilia treatment centers (Washington).

Managed Care Carve-outs. Prior to the passage of the ACA, states were unable to collect rebates on prescriptions purchased for Medicaid recipients by managed care organizations (MCOs) operating under capitated arrangements. As a result, states sometimes "carved-out" the pharmacy benefit from MCO contracts to maximize state rebate collections. The ACA now allows states to 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, as of July 2012, nine states reported a full carve-out (compared to 13 states in 2011[87]), six states reported a partial carve-out (compared to 8 in 2011) and Illinois reported that different policies applied to different MCO programs (drugs are carved out of the voluntary MCO program and carved in to the mandatory MCO program). States moving from a full or partial carve-out policy to a carve-in policy include New Jersey, New York, Ohio, and Texas in FY 2012 and Louisiana, Utah, and West Virginia in FY 2013. Also, two states reported electing to use a carve-in approach when implementing a new MCO program: Illinois in FY 2012 and New Hampshire in 2013. Seven of these nine states reported that the new ACA authority to collect rebates on MCO prescriptions did factor into the state's decision to change to a carve-in model.

Other Pharmacy Policy Changes. Nineteen states in FY 2012 and 13 in FY 2013 reported on a wide range of other pharmacy cost containment measures including:

- Initiatives focused on better controlling behavioral health drug utilization (Alabama, Alaska, District of Columbia, Indiana, Maryland, Michigan, and South Dakota). The Maryland initiative is discussed below. Four other states (Arkansas, Mississippi, Virginia and Wisconsin) also reported actions to better control the utilization of antipsychotic medications in children, but described those actions as having a fiscally neutral effect;
- Increasing other prior authorization requirements (Alaska, Indiana, New Mexico, South Dakota, Virginia, Washington, and Wisconsin);
- Enhancing or improving a State Maximum Allowable Cost (SMAC) programs (Colorado);
- Limiting optional or over the counter drugs (California, Indiana, Iowa, Tennessee, and Vermont);
- Imposing additional dosage or quantity limits (Alaska, Georgia, Indiana, Maine, New York, Tennessee, and Vermont);and
- Implementing a medical pharmacy management, or medication therapy management program (Maine, Minnesota and Wisconsin).

[87] One of the 13 states reporting a full carve-out in last year's survey (Connecticut) ended its MCO program at the end of CY 2011.

Maryland Peer Review Program for Mental Health Medications

Maryland's Peer Review Program was designed to address the increasing use of antipsychotic agents in children and adolescents despite the lack of sufficient evidence concerning the long-term efficacy and safety of these agents in the pediatric population. The program works in partnership with the Mental Hygiene Administration and the University of Maryland Division of Child and Adolescent Psychiatry and School of Pharmacy, to ensure optimal treatment for children in concert with appropriate non-pharmacologic measures in the safest manner possible. Effective July 31, 2012, the program expanded from the previous age five limit to encompass children under age of ten.

In addition, two states (Vermont and Wyoming) reported increasing third party liability collection efforts; two states (Indiana and Maine) reported implementing e-prescribing services or support; two states (California and Oklahoma) reported changes to prior authorization or pricing of physician administered drugs; two states (Arizona and Missouri) implemented a 340B initiative; the District of Columbia reported accessing a Department of Defense contract to purchase HIV/AIDS drugs at a lower price; Washington reported plans to implement a formulary that would be in addition to its existing PDL, and Virginia reported the elimination of a $5 fee previously paid to long-term care "unit dose" providers (now covered by Medicare).

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

- Eight states increased **dispensing fees** in FY 2012 (Alaska, Iowa, Idaho, Illinois, Maine, Montana, North Carolina and Vermont) and five states planned to increase dispensing fees in FY 2013 (Colorado, Delaware, Hawaii, Iowa, and Louisiana). In five of these states (Colorado, Delaware, Idaho, Iowa and, Louisiana), dispensing fee increases were intended to partially offset reimbursement decreases resulting from the adoption of the AAC ingredient cost reimbursement methodology. Two other states transitioning to AAC (New York and Wyoming) indicated that future dispensing fee changes related to the AAC change were possible.
- One state increased **ingredient cost reimbursement** for rural pharmacies in FY 2012 (Minnesota) and two states (Connecticut and South Dakota) reported plans to increase ingredient cost reimbursement in FY 2013 (but only for independent pharmacies in Connecticut).
- Two states increased their **monthly prescription cap**: Alabama restored the four brand limit that had been reduced to one brand in FY 2012 and Mississippi increased its two brand limit to three if the brand is less expensive than the generic equivalent. Mississippi also removed the two brand limit for children.

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

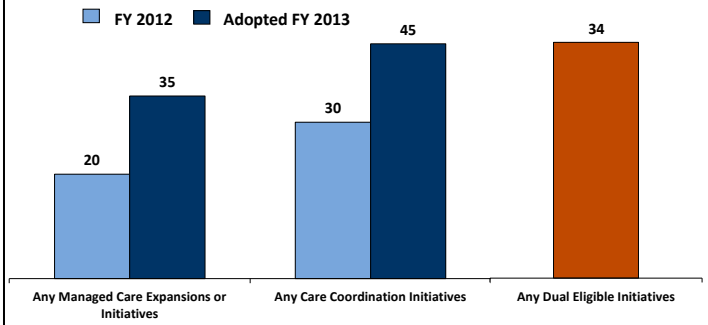
4. Delivery System and Quality Initiatives and Waivers

Key Section Findings:

- Twenty states in FY 2012 and over two-thirds of states in FY 2013 reported expanded use of managed care, primarily by adding eligibility groups, expanding managed care into new geographic areas or by implementing new managed LTC initiatives. A total of 40 states reported adopting managed care policies in FY 2012 or FY 2013. Improvement in health plan performance and health care quality and outcomes are key objectives of Medicaid managed care. In FY 2012, a total of 14 states adopted new quality improvement strategies, and for FY 2013, a total of 23 states indicated new strategies will be implemented. (Figure 33)
- States are implementing a range of other initiatives to coordinate and integrate care, many of which are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high care. Specific initiatives include health homes, patient-centered medical homes, and Accountable Care Organizations, as well as other efforts to coordinate physical and behavioral health, and long-term care and acute care services. New care coordination efforts are underway in all but six states in FY 2012 and FY 2013.
- New initiatives related to the development of systems of integrated, coordinated care to serve dual eligible beneficiaries remain a top priority for FY 2012 and FY 2013. Ultimately 25 states are actively working with CMS to develop financial alignment demonstrations (including 15 states that received $1 million planning contracts), and nine other states are working on additional strategies related to services for this population. To date, only Massachusetts has finalized a MOU with CMS to implement its financial alignment demonstration starting in April 2013.
- Many states apply for and obtain section 1115 research and demonstration waivers to operate their Medicaid programs in ways that would otherwise not be allowed under federal law. These initiatives often involve mandatory managed care. A total of 19 states indicated that they plan to implement a comprehensive Section 1115 waiver initiative in FY 2013. Most frequently, these states reported that these initiatives involve delivery system and provider payment reforms for individuals with disabilities and special health care needs.

FIGURE 33

States With Managed Care, Care Coordination and Dual Eligible Initiatives, FY 2012 – FY 2013



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 more groups from voluntary to mandatory participation in managed care and as well as the 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, as well as initiatives to coordinate physical and behavioral health, long term care and acute care services, 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 the 25 states participating in the financial alignment model through CMMO as well as nine other states (AR, DE, FL, IN, KS, LA, NH, NJ, and NM).
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012.

A. Managed Care Policy Changes and Initiatives

States continue to increase their reliance on managed care in Medicaid. In FY 2012, all states except Alaska New Hampshire and Wyoming operated comprehensive managed care programs. Of the 48 states (including DC) with comprehensive managed care, a total of 38 states had MCOs and 26 states operated PCCM programs; 20 had capitated managed care only, 10 operated PCCM programs only, and 18 states had both MCOs and PCCM programs. Connecticut, which previously had both MCOs and a PCCM, ended both these forms of managed care in FY 2012 and is implementing its own "managed fee-for-service" program in the last half of FY 2012. New Hampshire is scheduled to newly implement a comprehensive risk-based managed care program in January 2013. A total of 23 states, all of which had either MCOs or PCCM programs, or both, also reported having risk-based PHP arrangements or other "limited benefit plans" for specific services such as behavioral health, dental care or non-emergency medical transportation.

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.[88]

Types of Medicaid Managed Care Arrangements

Capitated 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 care and performance on a contractually specified set of quality metrics. Federal rules require that Medicaid capitation payment rates be "actuarially sound."[89] 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 high-quality, 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 specialist referrals when needed. The state generally pays PCPs a small per-member-per-month case management fee in addition to payments for services on a regular fee-for-service basis. Some states have an "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, non-emergency medical transportation, long-term care, or dental care. Federal regulations recognize two types of PHPs: those that include any inpatient hospital service are Prepaid Inpatient Health Plans (PIHPs), and those that do not include any inpatient hospital service 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.

Behavioral Health Organizations (BHOs).[90] BHOs are specialty managed care organizations that provide mental health and substance abuse treatment services to individuals. State Medicaid agencies may contract directly with BHOs to provide and manage behavioral health services to Medicaid beneficiaries, or Medicaid managed care organizations may subcontract with a BHO. In either contracting arrangement, the BHO maintains a distinct provider network, coverage rules, administrative services, and other insurance functions.

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

[89] 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.

[90] Decoding Medicaid Care Delivery and Financing Models: A Glossary of Widely Used Terms, KCMU, May 2012. http://www.kff.org/medicaid/8313.cfm.

Looking back over the past two decades, the share of Medicaid beneficiaries enrolled in either MCOs or PCCM programs has increased dramatically. In 1991, nine percent of all enrollees were in managed care, increasing to 51 percent in 2000,[91] and the proportion of Medicaid beneficiaries in managed care arrangements for any of their care now is over two-thirds, including over half of beneficiaries who are in comprehensive MCOs, and about one sixth who are enrolled in PCCM programs.[92]

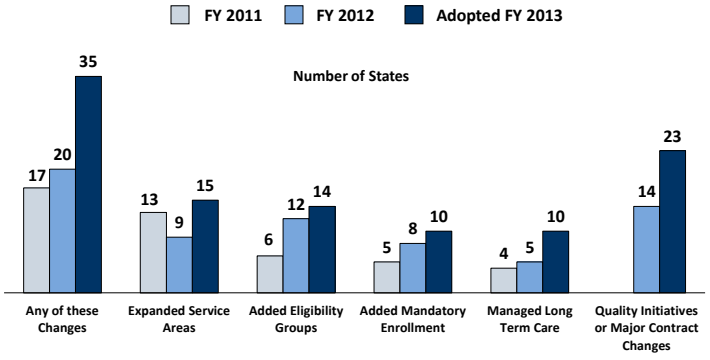
Based on information provided for this survey, a clear recent trend is that Medicaid programs are increasingly reliant on MCOs, and in some cases, phasing down their PCCM programs. For example, the Medicaid PCCM program in Nebraska ended in FY 2011, and those in Georgia, Kentucky, Texas, and Virginia ended in FY 2012; both Kansas and Pennsylvania PCCM programs are targeted to end in FY 2013. New York and Florida indicated that they are discussing plans to phase down their PCCM programs in the future as they move to rely more on capitated, risk-based MCOs.

A few states, including Connecticut and Oregon, are moving away from traditional capitated managed care models. The new managed fee-for-service model in Connecticut incorporates features of care coordination and management, quality metrics and reimbursement approaches designed to achieve improvement in patient care and outcomes. The state has assumed administrative responsibility and financial risk for the new system, using the services of a contracted Administrative Services Organization. Oregon is moving to a system of Coordinated Care Organizations (CCOs). Oregon expects to eliminate MCO contracts eventually, as the CCO structure is fully implemented by 2014. The Oregon CCOs are described more in the next section on care coordination and in a case study describing the Oregon initiative found in Appendix B.

Changes in Managed Care. In FY 2012 and FY 2013, significant managed care initiatives occurred or will occur in over two-thirds of the states, increasing the prevalence of managed care in Medicaid. These initiatives include expansions of managed care into new geographic regions, enrollment of new eligibility groups into managed care, a shift from a voluntary to a mandatory enrollment model for specific populations, and new or expanded use of managed long-term care. Altogether, a total of 40 states adopted one or more of these policies in either FY 2012 or FY 2013, including 20 states in FY 2012 and 35 states in FY 2013 (see Figure 34 and Table 9).

FIGURE 34

Medicaid Managed Care Changes
FY 2011 – FY 2013



NOTE: States were asked to report new initiatives or expansions in these areas; this does not reflect ongoing state efforts in these areas. While states have reported managed care quality initiatives in the past, there was not a comparable count available for FY 2011.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011 and 2012.

[91] *2000 Medicaid Managed Care Enrollment Report*. CMS, 2001.
[92] Kathleen Gifford, Vernon Smith, Dyke Snipes and Julia Paradise, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September 2011. http://www.kff.org/medicaid/8220.cfm.

Managed Care Expansions. Geographic coverage expansions of managed care occurred in nine states in FY 2012, and are slated to take place in 15 states in FY 2013. Most often, geographic expansions refer to the extension of managed care to additional counties in a state, usually into more rural counties. Such expansions resulted in statewide Medicaid managed care in some states – for example, Louisiana and Kentucky in FY 2012, and Nebraska in FY 2013. New eligibility groups were added into managed care in 12 states in FY 2012, and 14 states in FY 2013. Most frequently, the new eligibility groups were seniors and persons with disabilities, including dual eligibles, and children in foster care or on SSI. Eight states made a shift from voluntary to mandatory enrollment in managed care in FY 2012 and ten states intend to make this change in FY 2013. The move to mandatory enrollment typically applies to groups such as foster care children. The number of states implementing or expanding managed long-term care totaled five in FY 2012, and ten states plan such activities in FY 2013. Other states are preparing for managed long-term care; for example, Florida issued an ITN (Invitation to Negotiate) in June 2012 for managed long-term care with implementation targeted for FY 2014.

Managed Care Quality Initiatives. A total of 27 states listed new or enhanced quality strategies related to managed care for FY 2012 or FY 2013. In an open-ended question, states were asked to list only strategies that were new or enhanced, rather than all strategies in place. States listed a wide variety of strategies that met this criterion, including new provisions in managed care contracts and new policies specifically designed to improve care and health care outcomes. Examples of FY 2012 and FY 2013 initiatives include:

- Strengthening quality measures in MCO contracts, by adding new quality measures and new data reporting requirements.
- Increasing the percentage of the monthly capitation payments that is withheld and at-risk, or adding specific quality measures for MCO performance.
- Implementing quality-based incentives or algorithms for auto-enrollment that favor higher-performing health plans.
- Following up with Medicaid patients after discharge from a mental health inpatient stay.

Specific state examples of state managed care quality initiatives are listed on the following page.

Table 9: Key Managed Care Changes

Managed Care Change	States in FY 2012	States in FY 2013
Expanded Service Areas	AL, CA, CO, KY, LA, NY, TX, VA, WI	CA, FL, IA, ID, IL, LA, MS, NC, NE, NH, NV, NY, PA, VA, WI
Added Eligibility Groups	AL, CO, DE, KY, LA, MI, NC, NJ, NY, OR, TX, VA	AR, CO, GA, IL, MI, NE, NJ, NY, OH, OR, RI, VT, WA, WV
Added Mandatory Enrollment	CA, CO, KY, LA, MN, NJ, NY, OR	CA, GA, KS, MI, MS, NJ, NY, OR, PA, WA
Long-Term Care Managed Care	AL, DE, NY, SC, TX	CA, CO, IL, KS, MA, NJ, NY, OH, RI, TN
Quality Initiatives or Major Contract Changes	CA, CO, LA, MA, MN, MO, NJ, NY, OH, OR, TX, UT, VA, WI	AR, CA, CO, DC, GA, IL, IN, KS, LA, MD, MA, MN, NV, NH, NJ, OR, PA, RI, SC, TX, VA, WV, WI

A listing of states reporting either managed care expansions or quality initiatives and major contract changes is provided in Appendix A-8. More details on quality initiatives and major contract changes are in Appendix A-9.

Examples of State Managed Care Quality Initiatives

California has a comprehensive strategy that includes: (1) identifying and using new 2013 and 2014 HEDIS© performance measures, including specific measures for seniors and persons with disabilities, (2) using certain measures to award more default enrollments to higher performing plans, (3) implementing the All-Cause Readmissions statewide collaborative, baseline data stage in 2012, and intervention stage in 2013, (4) requiring of plan quality improvement projects based on HEDIS© scores, (5) ensuring that all beneficiaries in managed care have access to a medical home, including expanding managed care to currently fee-for-service only counties, (6) establishing a process for plans to contact beneficiaries for care coordination when a service is denied.

The **District of Columbia** changed its pay-for-performance program to include new measures, including reduction in preventable hospital admissions and low-acuity emergency room visits, and modified its P4P reimbursement structure, eliminating the withhold and instituting a bonus payments based on performance.

Massachusetts is implementing a comprehensive array of quality strategies both in its PCCM program, known as the Primary Care Clinician (PCC) program, and in its contracts with MCOs. In FY 2012, the Massachusetts PCC contract included pay-for-performance (P4P) provisions designed to improve outcomes for enrolled Medicaid patients. A P4P program for MCOs is being developed for implementation in 2013-2014. The behavioral health contractor that serves PCC patients completed three performance improvement projects, including one that provided incentives to community mental health centers to improve care of members in their community. A new care management program is to begin in October 2012 that will enroll up to 4,000 PCC Plan members in three tiers of care management. The contractor will receive a fixed payment per enrollee per month and be able to receive incentive payments based on the outcomes for participants in the program. A $4 million P4P pool is established, based on measures of performance, including three HEDIS© behavioral health measures and one measure for improving primary care for clients of the Department of Mental Health. The contractor risk will be increased from a 50% share in FY 2013 to 100% in FY 2015.

Ohio also changed its pay-for-performance reimbursement method from an at-risk withhold to a pure bonus, as it aligned its P4P to a new Medicaid quality strategy.

South Carolina is requiring all MCOs in FY 2013 to work on ten quality programs from those listed on a performance report card. One area will be mandatory and health plans choose the other nine. Payments will be made in 2014 based on performance improvement from an incentive pool created from a 1 percent reduction in the administrative fee and a withhold of 1.5 percent from MCO rates.

Texas made major changes in the new Uniform Managed Care Contract in March 2012. The new contract includes a Performance-Based Capitation Rate and a Quality Challenge Award. The performance-based capitation rate includes a 5 percent withhold, placing each health and dental plan at risk for up to 5 percent of the capitation payment, based on the plan's performance on pre-determined quality measures. Payments are to be made from the 5 percent withhold pool in January 2013. Any funds not awarded from this pool will be awarded to plans through the Quality Challenge Award, based on their performance relative to each other on a second set of metrics.

Virginia revised its Managed Care Quality Strategy to include MCO involvement and public comment periods. The five year quality strategy now includes both Medicaid and CHIP. Virginia also added new Medicaid performance measures for comprehensive well child visits for adolescents, and for follow up after discharge from a mental health hospital stay.

Managed Care and Behavioral Health. Under different state models, the financial and clinical responsibilities for behavioral health services are "carved in" or "carved out" of the MCO benefit package. In some states, most behavioral health services may be carved in to MCOs, with more specialized services being carved out. For example, services for individuals with severe mental illness (SMI) might be administered by a state or county mental health authority, or delivered through a separate behavioral health organization (BHO). For FY 2013, in 16 of the 38 state Medicaid programs that contract with MCOs, behavioral health services are always carved out of the MCO contract and, in five states, behavioral health is always carved in. In the remaining states, some benefits are included in and other benefits are excluded from MCO contractual responsibilities. A total of 13 of the 38 states with MCOs indicated that the agency contracts separately with a BHO for some or all of these services. To better coordinate care, states are including new requirements for BHOs (in Hawaii and Louisiana) and new requirements for care coordination in managed care contracts. Pennsylvania initiated performance improvement projects with two MCOs to reduce behavioral health admissions for members with severe mental illness through improved care coordination.

B. Care Coordination Initiatives

States are implementing a range of initiatives to coordinate and integrate care. Many of these initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for the delivery of high-quality care. In addition to initiatives for dual eligible beneficiaries discussed in the next section, Medicaid care coordination strategies in FY 2012 and FY 2013 include: health homes, patient-centered medical homes, and Accountable Care Organizations, and well as initiatives to coordinate physical and behavioral health, and initiatives to coordinate long-term care and acute care services.

Models of Care Coordination Strategies

Health Homes. Section 2703 of the ACA provides a state plan option for Medicaid programs to establish "health homes" that meet specific standards and are focused on the coordination and integration of care for persons with chronic conditions and disabilities. A state can implement health homes by securing CMS approval of a state plan amendment (SPA), under which the state establishes a medical home that coordinates all primary, acute, mental and behavioral health, and long-term services and supports for individuals who have (or are at risk for) at least two chronic conditions, or who have a serious and persistent mental health condition. States can use health homes to serve dual eligible beneficiaries. States with an approved SPA receive 90 percent federal funding for qualifying expenditures for the first eight quarters of their project. Health home services, defined in the ACA, 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 HIT to link services.[93]

Patient-Centered Medicaid Homes (PCMH). The PCMH model has evolved in recent years from the early definition of the 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) is one of a small number of organizations that has issued specific standards that the PCMHs must meet to receive its accreditation.[94]

Accountable Care Organizations (ACOs). There is currently no uniform federal definition of an ACO and the concept continues to evolve. Generally, an ACO is a group of health care providers that agree to share responsibility for the delivery of health care to and the health outcomes of a defined group of people. The organizational structure of ACOs may vary but, in concept, all ACOs would include primary and specialty care physicians and at least one hospital. Individual 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 the savings among the 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 developed key infrastructure (e.g., electronic medical records) necessary to facilitate coordination among ACO providers. States may also use different terminology in their Medicaid ACO initiatives, such as Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado.[95]

Thirty states reported implementing or expanding care coordination activities in FY 2012 while 45 states reported such actions in FY 2013. (Figure 35) Some states are implementing multiple strategies concurrently. This survey does not capture all care coordination efforts underway in the states, as Medicaid officials were asked only to describe new initiatives beginning in FY 2012 and FY 2013. These counts are not mutually exclusive as some initiatives are applicable to more than one category (i.e. states commonly reported health home initiatives for those with severe and persistent mental illness both as a health homes initiative and as a an initiative to better coordinate physical and behavioral health services.)

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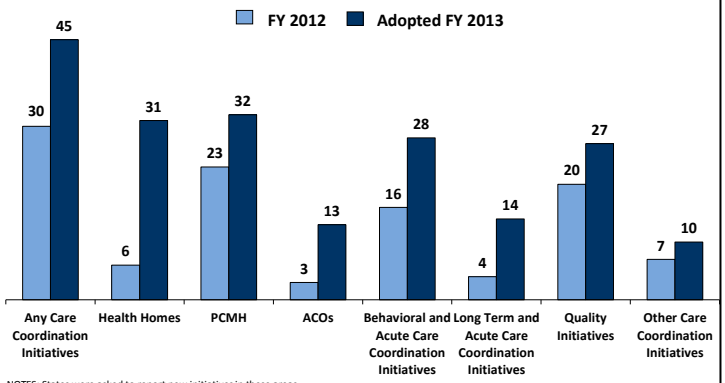
[93] Paradise, J. *Health Homes for Medicaid Beneficiaries with Chronic Conditions*. KCMU, August 2012. http://www.kff.org/medicaid/8340.cfm.
[94] Decoding Medicaid Care Delivery and Financing Models: A Glossary of Widely Used Terms, KCMU, May 2012. http://www.kff.org/medicaid/8313.cfm.
[95] *Ibid*

Health Homes. State health home initiatives often were part of overall efforts to improve care for Medicaid populations with complex health needs, and were seen as particularly important in efforts to coordinate and improve care for persons with mental health and substance abuse treatment needs. As of September 2012, seven states had approved SPAs including Missouri and Rhode Island (two SPAs each), Iowa, New York, North Carolina, Ohio and Oregon. Three states have SPAs under consideration at CMS (Alabama, Wisconsin and a second one for New York). In addition to these states that have approved SPAs or SPAs under consideration, a total of 16 states had received planning grants and were at various stages of planning, including several that had drafted a SPA that was under initial review at CMS.[96] In this survey, a total of 31 states indicated they implementing or expanding initiatives around health homes in FY 2013.[97]

FIGURE 35

States With Care Coordination and Managed Care Changes FY 2012 – FY 2013



NOTES: States were asked to report new initiatives in these areas.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010, September 2011, and September 2012.

Patient-Centered Medical Home (PCMH) Initiatives. The principles of a PCMH are being incorporated into many Medicaid initiatives. According to the National Academy for State Health Policy, since 2006 at least 41 states have undertaken initiatives, adopted policies or taken steps to advance the development and use of medical homes for Medicaid beneficiaries.[98] The CMS Innovations Center is implementing the Comprehensive Primary Care Initiative, a set of demonstrations designed to foster effective organization and delivery of primary care across payers including Medicare and Medicaid. Seven awards were made in August 2012, for statewide initiatives in Arkansas, Colorado, New Jersey and Oregon, and for three regional projects in New York Hudson Valley, Cincinnati-Dayton, Ohio and Tulsa, Oklahoma. For example, the Arkansas project will pilot the transformation of 75 selected primary care practices into PCMHs through the payment of a per-member fee for Medicaid, Arkansas Blue Cross Blue Shield and other payers. The goal is to help practices deliver high-quality, coordinated, and patient-centered care while lowering costs. For patients with more complex needs or chronic conditions, an enhanced PCMH will provide more intense care coordination and supports. Those needing more specialized care (i.e. persons with developmental disabilities or severe and persistent mental illness) will receive care through a health home.

In FY 2012, almost half of states (23) reported they were implementing a PCMH initiative, and 32 states said they have plans to implement a PCMH initiative in FY 2013. Medicaid initiatives included stand-alone PCMH pilots as well as PCMH requirements incorporated into MCO contracts or PCCM arrangements. Other new Medicaid PCMH initiatives involve programs focused on the highest-risk populations (Vermont), or include episode-based payment (Arkansas). Some Medicaid programs indicated a PCMH was part of their health home initiative (Iowa and Wisconsin). Other Medicaid programs are participating in multi-payer projects to foster PCMH statewide (e.g., Arkansas, Ohio, Washington and West Virginia).

PCMH models can be implemented in less populated states as well as those with large urban centers. For example, Alaska and Wyoming, the only two states with no traditional Medicaid managed care arrangements, both reported that they were developing PCMH pilot projects in FY 2013. Another rural state, South Carolina, adopted an initiative that rewards primary care providers as they reach PCMH levels 1, 2 and 3.

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[96] CMS, Integrated Care Resource Center, August 2012.
[97] This count does not include four states that have received planning grants (AZ, DC, IL, and VA). These states did not indicate plans for FY 2012 or 2013 related to health homes. This could indicate that the state is still evaluating whether to pursue this option or planning to implement in FY 2014.
[98] See description of medical home initiatives and support of states by the National Academy for State Health Policy at: http://www.nashp.org/med-home-map . Additional information about the Patient-Centered Primary Care Collaborative is at: http://www.pcpcc.net/content/nashp-1

Accountable Care Organizations (ACOs). A limited number of states are pursuing ACO initiatives, either through Medicaid alone or in collaboration with other payers. In FY 2012, three states indicated they were implementing an ACO initiative. For FY 2013, the number increased to 13 states. Two states (California and Ohio) are developing pediatric ACO demonstration projects pursuant to Section 2706 of the ACA, for implementation as early as the end of FY 2013. These ACOs would meet specific standards and be able to share in savings they achieve for Medicaid. The Minnesota ACO is part of the Health Care Delivery Systems demonstration, and New Jersey, after planning and developing regulations in FY 2012, is planning to implement an ACO initiative in designated regions of the state in FY 2013. Utah is planning to implement in January 2013, and Massachusetts in March 2013, where ACO providers will be required to be certified as PCMHs. Hawaii is actively encouraging MCOs to forge contracts with hospitals that involve shared risk as an ACO. Texas is planning to engage stakeholders to determine the feasibility of an ACO, and possibly to begin development in September 2013. Some states are developing their own approaches based on an ACO construct like Connecticut, Massachusetts and Oregon.

Oregon Coordinated Care Organization (CCO) Delivery System

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 waiver amendment includes a global budget payment system for CCOs based on a hybrid of capitated and non-capitated payments. 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 for 300 community health workers by 2015 and a loan repayment program for primary care physicians who agree to work in rural or underserved communities. The waiver requires savings in the state's cost growth trend on an annual basis, starting in year 2 of the waiver. Savings may not be realized by withholding needed care, degrading quality or cutting payment rates.

Initiatives to coordinate physical health and behavioral health. Medicaid is the largest single source of funding for public mental health services[99] and the primary payer for anti-psychotic medications.[100] In addition, over one-quarter of inpatient hospital days paid for by Medicaid are for behavioral health-related conditions. While there is variation across states, the behavioral health and physical health systems have frequently been described as "silos" of care that are not well-coordinated. Poor coordination can result in high cost and poor outcomes. Data show that persons with severe mental illness die 25 years earlier than their peers,[101] and a high proportion of these premature deaths can be attributed to avoidable or treatable conditions.[102]

The majority of states have ongoing strategies and new initiatives focused specifically on improving the coordination and delivery of behavioral health services. In FY 2012, new initiatives were underway in 16 states, and 28 states have plans to implement a new initiative in FY 2013. Efforts to coordinate behavioral and physical health are also covered under a health home project (in Alabama, Missouri, Mississippi, North Carolina and New York) and in the projects for dual eligible beneficiaries (in California, Colorado, Indiana and Michigan).

Initiatives to coordinate long-term care and acute care services. As with behavioral and physical health services, Medicaid programs have long been characterized by "silos" for the delivery of acute and long-term care. However, the recent focus on improving care for patients with the most complex and costly needs has led to new efforts to integrate and coordinate the medical and long-term care delivery systems. Many of these

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[99] Frank, R., Conti, R and Goldman, H., *Mental Health Policy and Psychotropic Drugs*. The Milbank Quarterly, Vol. 83, No. 2, 2005 (pp. 271-298).
[100] Centers for Medicare and Medicaid Services, Overview of Mental Health Services, http://www.cms.hhs.gov/MHS/
[101] Parks, J., et al. *Morbidity and Mortality in People with Serious Mental Illness*. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council Technical Report, October 2006.
[102] *Making the Ohio Medicaid Business Case for Integrated Physical and Behavioral Health Care.* The Best Practices in Schizophrenia Treatment Center of the Northeastern Ohio Medical University, 2012. http://www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare.

efforts are incorporated into other initiatives including health homes, PCMHs and dual eligible beneficiary initiatives. Separate from these efforts, four states indicated that they had a project being implemented in FY 2012 focused specifically on coordinating acute and long- term care. These projects included: a comprehensive care coordination initiative in Arkansas, a new waiver in Colorado that increases coordination of waiver and acute mental health services, an expansion of STAR-PLUS in Texas, and Wyoming's first PACE program.

For FY 2013, 14 states had plans to implement initiatives including integrated long-term care including coordinated care initiatives for duals in California, Massachusetts, Minnesota, New Jersey and Vermont; new coordination in the Accountable Care Collaboratives in Colorado; implementation of the Balancing Incentives Payment Program in Iowa; new managed long-term care in New Jersey and in the new managed care program in New Hampshire; new contract language in managed LTC contracts to incorporate the PCMH model in New Mexico; and in Washington, a redesign of Medicaid managed care to include enhanced care coordination for physical, behavioral, chemical dependency and long-term care services for Medicaid-only clients.

Quality Initiatives. A number of states noted either new or expanded quality initiatives related to care coordination in FYs 2012 and 2013 (20 states and 27 states, respectively). Many of these initiatives are related to other care coordination initiatives, such as states requiring the tracking of quality measures specifically related to care coordination in new programs or as part of managed care expansions mentioned earlier. A few states also noted the creation or expansion of agency positions focused on care coordination. In addition:

- Connecticut's new ASO contract incorporates care management and intensive case management requirements along with analytics to profile provider performance.
- Initiatives targeting specific conditions and services (such as the creation of an oncology home in North Carolina and a care management program targeting infant mortality in Oklahoma.)
- Texas is using their CAHPS survey to target patient education on access to care coordination services.
- Vermont is implementing public health registries and health briefs to identify gaps in care with primary care and specialty providers as well as community patterns of high risk utilization.
- Wyoming developed a Total Health Record that provides clinical data for Medicaid clients; the state is working with its utilization management vendor to identify and assist those outside of care standards.

Other Care Coordination Initiatives. Other initiatives reported were: participation in the CMS dental initiative (Pennsylvania), the Medicaid Emergency Psychiatric demonstration (DC), initiatives focused on foster children (Virginia), Section 1115 comprehensive waiver programs to be implemented that include specific care coordination provisions (in Kansas and Texas), participation in the National Academy for State Health Policy Medicaid Safety Net Learning Collaborative (Texas), and the Strong Start and Striving to Quit initiatives (Wisconsin). In July 2012, Arkansas launched a multi-payer initiative that is based on an "episode of payment" model. The model aims to address both cost and quality of care by aligning incentives to reduce variation in quality and to increase cost-efficient practices.

C. Initiatives for Dual Eligible Beneficiaries.

Few initiatives are commanding higher priority for Medicaid in FY 2012 and 2013 than those relating to the development of new systems of integrated financing and coordinated care to serve dual eligible beneficiaries (individuals enrolled in both Medicaid and Medicare). The ACA established the Medicare-Medicaid Coordination Office (MMCO) to improve the integration of benefits for dual eligible beneficiaries and the Center for Medicare and Medicaid Innovation, which has new demonstration authority to test payment and service delivery models that fully integrate care for dual eligible beneficiaries.[103] Together, these offices are working with states to develop new approaches to improve care for this population. The nine million dual eligible beneficiaries account for 15 percent of all Medicaid beneficiaries, but 38 percent of all Medicaid expenditures.

In July 2011, CMS invited any interested state to test its proposed financial alignment models for dual eligible beneficiaries. CMS's guidance to states describes two models, a capitated approach and a managed fee-for-service approach, to integrate care and align financing for dual eligible beneficiaries. Twenty-six states submitted financial alignment demonstration proposals, although one (New Mexico) was subsequently withdrawn.[104] Of the 25 active proposals, 17 propose testing the capitated model, five propose testing the managed fee-for-service model, and three propose testing both models.[105]

Thirty-four states indicated in this survey that they will be developing new payment or delivery system options for dual eligible beneficiaries. This includes the 25 states actively working with MMCO, plus New Mexico, and eight other states (Arkansas, Delaware, Florida, Indiana, Kansas, Louisiana, New Hampshire and New Jersey) that are developing initiatives outside the financial alignment demonstrations to coordinate care for some or all dual eligible beneficiaries in their states, including coordination of acute care services. Dual eligible beneficiaries have the option to receive their Medicare services from Medicare Advantage plans, including Duals Special Needs Plans (D-SNPs). States are increasingly seeking to enroll dual eligible beneficiaries in these same Medicare Advantage plans to manage their Medicaid acute care services so that one MCO is responsible for both Medicaid and Medicare acute care services. Additionally, some states mentioned initiatives to better coordinate Medicaid-only services for dual eligible beneficiaries, including the use of managed long-term care.

The states that are seeking to integrate care outside of the financial alignment demonstrations are using varied approaches. In most cases, states are developing new models to integrate Medicaid services for dual eligible individuals across components of the Medicaid program. Among the initiatives reported are the following:

- Delaware moved dual eligible beneficiaries into managed long-term care in FY 2012 and is now implementing a Program of All-Inclusive Care for the Elderly (PACE) model in FY 2013. The PACE program is a fully integrated Medicare/Medicaid initiative for frail elders that need long-term care. Delaware is also interested in a financial integration model in the future if there is such an opportunity.
- Florida is expanding its Medicaid managed care program to include long-term care services and will be including dual eligible beneficiaries in this initiative. The scope of benefits also includes dental services and disease management.

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[103] *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries*. Kaiser Commission on Medicaid and the Uninsured, October 2012, http://www.kff.org/Medicaid/8368.cfm.

[104] Fifteen states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin) were awarded design contracts in April, 2011 under the ACA to develop integrated care models for dual eligible beneficiaries. Thirty-eight states (including the 15 states receiving design contracts and DC) submitted letters of intent to test CMS's proposed financial alignment models. Of these, 26 states submitted demonstration proposals to CMS in spring 2012.

[105] Copies of the 25 active proposals submitted by the states, comments received by CMS on these proposals and other information on the financial alignment initiative is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html. See also: *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS*. Kaiser Commission on Medicaid and the Uninsured, October 2012), http://www.kff.org/Medicaid/8369.cfm.

- Louisiana is conducting research and reviewing the results of the financial alignment demonstrations. They also indicate that their greatest challenge is data as well as a lack of cooperation and ease of coordination between Medicare and Medicaid, even with the leadership from the MMCO. Louisiana indicates that they are getting ready, moving deliberately, and waiting to review results of others.
- New Hampshire will be including their dual eligible beneficiaries in managed care with an option to opt-out, building on an initiative that is already in place in several other states.
- New Jersey indicates that a primary feature of the state's pending Section 1115 Comprehensive Waiver request is the implementation of Managed Long Term Services and Supports (MLTSS). According to the NJ Medicaid Director, dual eligible beneficiaries will be included in the managed long-term care program, but the state is not participating in the CMS Dual Eligible Financial Alignment Initiative and will therefore not be permitted to take advantage of the Medicare shared savings and passive enrollment options that are part of that demonstration. Instead, the state will seek to better integrate services for dual eligible beneficiaries by contracting with Medicare Advantage D-SNPs.

A few states that are not currently working with MMCO mentioned that they were still potentially interested in participating in a future financial alignment demonstration.

To date only one state, Massachusetts, has finalized a Memorandum of Understanding (MOU) with CMS to implement its capitated financial alignment demonstration. The effective coverage date for enrollees is April 1, 2013. This initiative targets dual eligible beneficiaries ages 21 to 64 and will provide nearly all Medicare and Medicaid benefits and supplemental benefits through Integrated Care Organizations (ICOs) that will offer patient-centered medical homes, care coordination, and clinical care management. Long-term services and supports (LTSS) will be overseen by Independent Living-LTSS coordinators from community-based organizations independent of ICOs.[106]

Many of the other 24 states working on financial alignment models have proposed later effective dates than originally envisioned by CMS. Thirteen states have proposed implementing their demonstrations in January 2014, and based on reports in the survey[107], more states are expected to delay implementation as the development of the initiative is taking longer than originally anticipated. This survey asked states to identify their biggest challenges or issues in coordinating care for dual eligible beneficiaries, whether or not they are pursuing a financial alignment demonstration. State officials listed many issues and challenges including:

- Complexities and unknowns in both the financing of the initiative and rate setting for service providers. This issue includes concerns about how Medicare savings will be shared with states in both the capitated and managed fee-for-service models.
- Receiving and analyzing data from CMS on Medicare services for dual eligible beneficiaries.
- Differences in the regulations and procedures between Medicare and Medicaid including differences in grievance and appeal processes.
- Questions about how to coordinate and integrate care and avoid any gaps in care, especially during the transition to the financial alignment demonstration. This is further complicated by differences in provider networks between the two programs.
- Differences in benefits (for services that at a high level might appear to be the same) and in IT systems.
- Timelines and schedule for rollout, especially when states are busy preparing for so many other aspects of ACA implementation, most notably Medicaid expansion and Exchanges.

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[106] Ibid. *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries.* KCMU, October 2012.

[107] Proposals posted by CMS list the following states as having implementation dates of January 2014: AZ, HI, ID, OR, RI, SC, TN, TX, VT, and VA. In addition, NY and WA reported in this survey implementation dates of January 2014 – New York indicated that their initiative would be implemented in phases, one part of which would be January 2014. Washington's posted proposal also indicates that implementation will be phased-in. Indiana, which is not participating in the financial alignment demonstration, also indicated a January 2014 implementation. It is important to note that activity in this area is ever changing; implementation dates reported here may have changed.

Despite these and many other challenges, states clearly indicated in this survey and elsewhere that they are committed to efforts to better coordinate and integrate care for dual eligible beneficiaries, citing the potential improvements in care and cost savings for both Medicare and Medicaid. As with other reforms, federal and state partners will learn more about what works best, and the delivery models will evolve to reflect this knowledge. Two state Medicaid directors testified in July 2012 testimony before the U.S. Special Senate Committee on Aging.

Views from the States: Testimony before the US Special Senate Aging Committee – July 18, 2012[108]

Tom Betlach, Arizona Medicaid Director: "It is frustrating to hear others dismiss Medicaid managed care as an option for duals and suggest that states are either ill-intentioned or incapable of achieving success for this population. This is not about achieving a budget target. States like Arizona want to move the system forward, improve care for our citizens and be responsible with the taxpayers' dollars….States have managed these issues for duals and it is the states that understand their local communities best….Equally disconcerting is this notion that states are moving too fast and the demonstrations are too big. We have had 45 years of fragmentation. We have decades of comparison data that show the shortcomings of the existing system. We don't need control groups in these duals demonstrations. We know what is not working for the people we serve and the taxpayers who are footing the bill. The current system is indefensible and unsustainable; we should not wait any longer to build upon a proven model."

Jason Helgerson, New York Medicaid Director: "New York is well positioned to partner with the federal government around duals integration. Duals are among the most fragile people living in New York, and the fact that Medicare and Medicaid have not worked well together has meant poor patient outcomes and high costs. New York's approach to duals integration is multifaceted. First, the state will utilize Health Homes to provide care management for duals that don't require long-term care services. This initiative will be deployed in January 2013 and will benefit 126,000 Medicaid members. Next the state will expand on its highly successful Managed Long-term care program, which currently manages the long-term care needs of 50,000 duals. This program, now mandatory in the state, will grow to more than 120,000 by January 2014. In that same year, the state will add the Medicare services to the existing benefit package, so as to "convert in place" these duals into a fully integrated managed care product. New York will also be working to expand this successful model to 10,000 duals who are developmentally disabled."

D. State Waivers

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive certain Medicaid requirements in the Act and to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. This authority is discretionary and is to be used for experimental, pilot, or demonstration projects that the Secretary believes 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 services.

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 renew or amend the waiver to continue operations. As of May 2012, 33 states and the District of Columbia operated one or more comprehensive Section 1115 Medicaid waivers.[109] In addition, according to the Office of Management and Budget, federal funds flowing through Section 1115 waivers will account for a third of total federal Medicaid expenditures in 2012.[110]

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[108] Testimony from Hearing on Examining Medicare and Medicaid Coordination for Dual-Eligibles, US Senate Special Committee on Aging, held July 18, 2012, http://aging.senate.gov/hearing_detail.cfm?id=337279&, accessed on September 27, 2012.

[109] *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity.* Kaiser Commission on Medicaid and the Uninsured, May 2012. http://www.kff.org/medicaid/8318.cfm.

[110] Ibid., citing Office of Management and Budget, Table 27-5: "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," Analytical Perspectives, Budget of the United States Government, Fiscal Year 2013, http://www.whitehouse.gov/omb/budget/Analytical_Perspectives.

In this year's survey, State Medicaid officials were asked if they were planning to implement a comprehensive Section 1115 waiver or waiver amendment in FY 2013 (other than a dual eligible demonstration or family planning waiver). A total of 19 states indicated plans to do so. The approval process for waivers can be lengthy and involves negotiations between the state and CMS. States usually develop a plan, and then submit a concept paper to CMS prior to a formal application. Ideas in the concept paper, however, may not be included in a final waiver approval. At the time of the survey, these waivers were in various stages. The majority were either still in development or had been submitted to CMS awaiting approval. States are pursuing a number of different types of program changes through waivers, with some states proposing to make multiple types of broad program changes.[111] In this survey:

- Eight states (California, Florida, Kansas, New Jersey, Nevada, New York, Oregon and Washington) reported using Section 1115 waiver authority to implement or expand managed care including managed long-term care in three states (Kansas, New Jersey and New York).
- Five states (Minnesota, New York, Oregon, Vermont and Washington) reported plans to use 1115 waiver authority to implement significant delivery system and/or provider payment reforms.
- Five states (California, Louisiana, Minnesota, New Jersey and New York) reported 1115 initiatives to make federal matching funds available to support safety-net delivery systems.
- Several states reported waivers or waiver amendments to implement cost containment measures including increased cost sharing[112] (California); benefit changes (Connecticut and Nevada), and enrollment caps or eligibility cuts (Connecticut and Iowa).
- Three states with existing 1115 waivers providing coverage to persons above 133 percent of the FPL (Indiana, Oklahoma, and Vermont) reported plans to renew and/or amend their existing waivers to make various eligibility, enrollment, benefit and/or other changes in anticipation of health care reform implementation in 2014.[113]
- Three states (Minnesota, New Jersey, and Ohio) reported plans to use waiver authority to simplify the enrollment process for LTC or for the aged and disabled.
- Two states (Minnesota and New Jersey) plan to use waivers to reduce reliance on institutional LTC.
- Two states (Illinois and Missouri[114]) reported plans to use 1115 waiver authority to expand eligibility to childless adults who would otherwise become eligible for Medicaid in 2014 under the ACA.

[111] As of September 2012, CMS reported pending waivers in 14 states (AR, AZ, CA, CT, FL, IN, IL, KS, MN, NV, NM, NJ, NY and OH) http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/public-comments.html. New Jersey received CMS approval of its Comprehensive waiver proposal on October 2, 2012. http://www.state.nj.us/humanservices/dmahs/home/CMW_approval_letter.pdf.

[112] New Mexico is also preparing an 1115 waiver that will make a number of changes, including changes to cost-sharing. However, this waiver is planned for FY 2014 implementation and therefore outside of the scope of this survey. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

[113] On July 31, 2012, CMS notified the State of Indiana that it would renew the Healthy Indiana Plan (HIP) 1115 waiver for only one year through December 31, 2013. Indiana had sought a multi-year renewal and had also requested that the HIP benefit package be used as the Essential Health Benefit package for the Medicaid expansion in Indiana under health reform.

[114] Review of waiver documentation at CMS indicates that the authority to expand eligibility in St. Louis County was approved in 2010, there was a recent amendment to "continue to support a critical primary care and specialty care network for low-income individuals in the St. Louis while implementing a new performance and incentive structure to help promote better health outcomes for individuals served through the Demonstration." Factsheet on Missouri's Gateway to Better Health Waiver, updated July 10, 2012. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

5. Medicaid Administration and Program Integrity Initiatives

Medicaid Administration. FY 2012 and FY 2013 have proven to be years of extraordinary activity and innovation for Medicaid programs, with numerous initiatives placing great demands on limited administrative resources. The accomplishment of complex Medicaid initiatives, which could affect the expenditure of hundreds of millions of state dollars and the health coverage of thousands of state citizens, requires appropriate skill sets and a sufficient level of administrative capacity. However, the budget pressures that affected virtually all states in recent years resulted in hiring freezes and administrative restrictions across state governments, and these restrictions affected Medicaid programs along with other programs administered by state workers. As a result, even though its workloads and programmatic requirements were increasing, and major tasks are required to prepare for Medicaid's role in the implementation of the ACA, Medicaid has had to bear its share of the burden as all of state government worked "to do more with less."

This survey captured changes in FY 2012 and FY 2013, after several years of cutbacks in administrative resources in many states. In FY 2012, Medicaid administrative capacity was reduced in one-third of states (17 states), while capacity remained the same in 22 states, and increased in 12 states. In FY 2013, Medicaid administrative capacity was reduced in 15 states (including 10 states with consecutive years of decreases in FY 2012 and FY 2013); remained the same in 20 states, and increased in 16 states (including 7 states with consecutive increases in FY 2012 and FY 2013.) Many states observed that their resources were stretched thin as they worked to implement significant initiatives, including preparation for health reform in 2014.

Program Integrity. Medicaid has always had a primary focus on program integrity and prevention of fraud and abuse, but budget pressures, spending increases as well as Congressional oversight has intensified the focus in this area.[115] 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. States continue to invest in these new approaches to address what one state called "the ever-changing fraud schemes" that target Medicaid. These efforts include identification and evaluation of risks to the program, expansion of anti-fraud data mining and audit tools, and proactive front-end integrity efforts such as using procedures in the provider enrollment process to prevent providers that pose a risk from enrolling in the program, thus avoiding program costs that might be inappropriately incurred. New MMIS systems include the capability to systematically validate and revalidate provider credentials upon enrollment and on an ongoing basis.

In FY 2012 and FY 2013 many states implemented the federally required Recovery Audit Contractor (RAC) program that involves targeted audits of providers. In a recent letter, the National Association of Medicaid Directors called for new collaboration with CMS around program integrity efforts.[116] States listed a broad range of program integrity actions and strategies. A key focus has been to shift the emphasis from recovery of payments to prevention of payment for inappropriate claims. Specific examples include the following:

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[115] *Program Integrity in Medicaid: A Primer*. Kaiser Commission on Medicaid and the Uninsured, July 2012. http://www.kff.org/medicaid/8337.cfm.
[116] Letter from NAMD to Marilyn Tavener, Acting Administrator, CMS, October 5, 2012. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_cms_pi_efforts_121005.pdf

Efforts to Review Provider Participation: Enhanced provider screening, use of various data bases for electronic verification, provider site visits; enhanced ability to verify provider licenses; pre-enrollment screening for high and moderate risk providers

Efforts to Review Data, Claims and Audits: Detailed utilization review of paid claims; use of predictive modeling tools to detect fraud in Medicaid claims; access to Medicare Provider Enrollment, Chain, and Ownership System (PECOS) and the Social Security Administration (SSA) death index, increased targeted field audits; launched the RAC program; implemented Medi-Medi (Medicaid – Medicare data sharing program) and increased efforts with Medicaid Integrity Contractor (MIC) auditors; developed analytics and methodologies to identify and fix managed care program vulnerabilities to detect, recover and prevent inappropriate provider billings; new software for tracking of fraud and abuse audits; developed a systematic scoring tool for program integrity, allowing review of more providers under the credible allegation of fraud rules; developed new rules and processes for payment suspension

Efforts To Increase / Develop Staff and Collaborative Across State Agencies and with CMS: Staff participate in training at the CMS – sponsored Medicaid Training Institute; increased internal collaboration with management, general counsel and program staff, and increased external collaboration with CMS Medicaid Integrity Group; Added staff to investigate and determine available third party resources for cost avoidance or recovery; added nurses and contracted consultants to perform medical records reviews; increased referrals to the Attorney General's Medicaid Fraud Control Unit; established a new Office of Inspector General for Medicaid Services; increased presence in provider community through provider education programs.

In FY 2012, Medicaid program integrity efforts were increased in over two-thirds of states (35 of 49 states responding to this question), while capacity remained the same in one state. In FY 2013, Medicaid program integrity resources increased in 33 of 49 states responding to this question; remained the same in 13 states, and decreased in 2 states. In one of the states with a decrease, the state indicated that the program integrity vendor contract had been restructured after the vendor had exceeded contractual annual performance requirements for cost savings through both recoveries and cost avoidance.

6. Key Issues in Implementing Health Reform

With just over a year to go before implementation of the ACA health care coverage expansions in January 2014 through Medicaid and the new state insurance exchanges, most states are immersed in multiple planning and development efforts. This year's survey asked states about the impact of the recent Supreme Court decision regarding the constitutionality of the ACA and also which insurance exchange model (State-based, State Partnership or Federally Facilitated) would operate in their state. States were asked about the state budget impact of the ACA and whether their state planned to take advantage of the enhanced federal funding to build or upgrade an eligibility system. Finally, states were asked to comment on the challenges and opportunities presented by health care reform implementation. State responses are summarized below.

Impact of the U.S. Supreme Court Decision. In its long-awaited landmark ruling in *National Federation of Independent Business v. Sebelius*[117], the United States Supreme Court, in June 2012, upheld the constitutionality of the ACA's individual mandate, but in a move few expected, found that the Medicaid expansion was unconstitutionally coercive of states, because the HHS Secretary could potentially withhold all of a state's existing federal Medicaid funds for non-compliance. The Court remedied the unconstitutionality, however, by circumscribing the Secretary's enforcement authority leaving the Medicaid expansion in tact but essentially making it optional for states.[118] One director said, "The Supreme Court decision interjected uncertainty – new options that we did not know we had."

States were asked in the survey whether their plans around ACA implementation had been affected by the Supreme Court decision. Sixteen states responded "no" with several commenting that they were still moving ahead with implementation efforts. Thirty states responded "yes." Of these, only a handful of states said their state planned not to expand Medicaid, based on state discussions in the weeks following the Supreme Court decision. The remainder indicated that the ultimate decision was uncertain, the Medicaid expansion was being studied or was otherwise under consideration. A number of states highlighted that the Supreme Court decision had created a legislative issue that had not existed before, and that a decision would be deferred until after the November election. Additionally, states commented on the new political challenge created by the court decision and on the need to spend more time justifying the expansion.

State Decisions on Insurance Exchange Model. The ACA provides that in 2014, insurance exchanges (Exchanges) in each state will provide individuals and small business employees with access to health insurance coverage. The Exchanges will offer competitive marketplaces that enable individuals and small employers to compare and purchase private Qualified Health Plans on the basis of price, quality, and other factors. Exchanges will also provide consumers with information about their eligibility for premium tax credits and states are required to coordinate eligibility for Medicaid with that for premium subsidies with a single application form, on-line applications, and integrated screening and enrollment requirements.

Exchanges will operate either as State-based Exchanges or Federally-facilitated Exchanges (in cases where a state chooses not to operate its own exchange). A State may also operate in partnership with Department of Health and Human Services (HHS) as a "State Partnership Exchange," which allows States to administer Exchange activities associated with plan management activities, some consumer assistance activities, or both. States seeking HHS approval to operate a State-based Exchange or a State Partnership Exchange must submit an "Exchange Blueprint" that documents how its Exchange meets or will meet all legal and operational requirements by November 16, 2012 (for plan year 2014).[119]

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[117] 567 U.S. ___ (2012). The case was heard together with *Florida v. Department of Health and Human Services.*

[118] MaryBeth Musumeci, *A Guide to the Supreme Court's Affordable Care Act Decision,* Kaiser Family Foundation, July 20, 2012. http://www.kff.org/healthreform/8332.cfm.

[119] Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, HHS Center for Consumer Information and Insurance Oversight, August 14, 2012, accessed at http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.

Exchange Models and Flexibility Within Models

State-based Exchange. State operates all Exchange activities; however, State may use Federal Government services for the following activities: premium tax credit and cost sharing reduction determination; exemptions; risk adjustment program, and reinsurance programs.

State Partnership Exchange. State operated activities for: plan management, consumer assistance or both. State may elect to perform or can use Federal government services for the following activities: reinsurance program, Medicaid and CHIP eligibility; assessment or determination (coordinated with CMS).

Federally Facilitated Exchange. HHS operates; however, State may elect to perform or can use Federal government services for the following activities: reinsurance program and Medicaid and CHIP eligibility; assessment or determination (coordinated with CMS).

This year's survey asked each state to indicate whether the state intends to operate a State-based Exchange, a State Partnership Exchange or a Federally Facilitated Exchange (or whether a decision on the Exchange model is yet to be made). States that have selected a model were also asked to indicate the Exchange's role in Medicaid and CHIP assessments or determinations (or whether that role remains undetermined). State responses are summarized in Table 10 below which shows that half of all states (25) reported that the state Exchange model had not yet been decided.

Table 10: State Exchange Model

Model Option	# of States	States
State-based Exchange	17	CA, CO, CT, DC, HI, KY, MA, MD, MN, MS,[120] NM,[121] NV, NY, OR, RI, VT, WA
State Partnership Exchange	1	AR
Federally Facilitated Exchange	8	AK, DE[122], IL[123], LA, MT, ND, SC, TX
Undetermined	25	AL, AZ, FL, GA, IA, ID, IN, KS, ME, MI, MO, NC, NE, NH, NJ, OH, OK, PA, SD, TN, UT, VA, WI, WV, WY

One state noted that a Federally Facilitated Exchange would be used for start-up but that the state hoped to migrate to a State-based Exchange later. Some states also commented that additional legislative authority would be needed to adopt a State-based Exchange model, which likely could not be accomplished by the November 16, 2012 deadline for submitting an Exchange Blueprint for the 2014 plan year.

Even if a state had decided on the Exchange model, many were undecided about the Exchange's role in Medicaid eligibility determinations. For the 17 states planning to implement a State-based Exchange, seven would use the Exchange to make all Medicaid/CHIP eligibility determinations that are based on the Modified Adjusted Gross Income ("MAGI") standard; four would use the Exchange to make all MAGI and non-MAGI-based Medicaid/CHIP eligibility determinations, two would have the Exchange make only assessments of Medicaid/CHIP eligibility, one would use another agency to make determinations for Medicaid, CHIP and to calculate premium tax credits, and three were undetermined.

[120] While other reports have noted work moving toward a state-based exchange occurring in the state, it is not clear if the Governor has made an official public announcement that the state will be pursing this exchange model.

[121] While other reports have noted work moving toward a state-based exchange occurring in the state, it is not clear if the Governor has made an official public announcement that the state will be pursing this exchange model.

[122] Shortly after conducting the interview with individuals in the Delaware Medicaid agency, the Governor indicated plans for the state to begin planning for a state partnership model. *State Exchange Profiles: Delaware*. Kaiser Family Foundation, updated August 1, 2012. http://healthreform.kff.org/state-exchange-profiles/delaware.aspx.

[123] The state noted that the federally facilitated exchange would be for start-up only; the state hopes to migrate to a state-based exchange at a later date. This conflicts with earlier reports from the Governor that the state was moving in the direction of a state partnership exchange. *State Exchange Profiles: Illinois*. Kaiser Family Foundation, updated September 20, 2012. http://healthreform.kff.org/state-exchange-profiles/illinois.aspx.

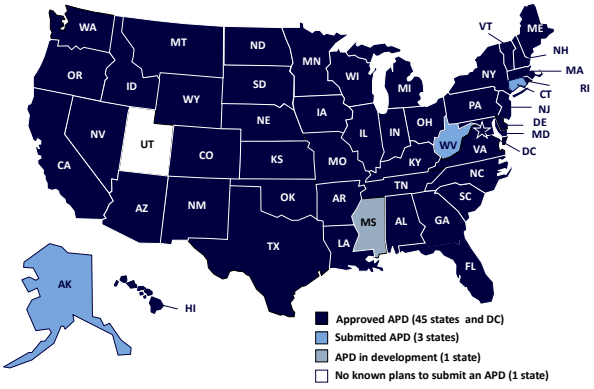
ACA Fiscal Impact. For states that choose to expand Medicaid eligibility in 2014 under ACA authority, 100 percent of the cost of those "newly eligible" will be federally financed through 2016. Thereafter, the federal contribution phases down to 90 percent by 2020. States will continue to receive their regular federal Medicaid match rate for those currently eligible for Medicaid who enroll as a result of the individual mandate or ACA-related outreach. Some states are projecting increased state costs from the ACA, largely from increased participation among those currently eligible and the state cost of covering the "newly eligible" under Medicaid after 2016. Others are expecting some state savings from reductions in non-Medicaid state indigent care costs.

About half of the states reported that they had prepared a fiscal analysis of the ACA on their state's budget and the majority of these states showed higher state costs related to increased enrollment among those eligible but not enrolled, the loss of DSH funds under the ACA, "crowd-out" (Medicaid enrollment increases resulting from losses of employer-sponsored coverage) and new or higher administrative costs. States citing a positive fiscal impact often reported reductions in state uncompensated care costs or the ability to transition current waiver expansion groups to full Medicaid coverage at the enhanced federal match rate. One state also cited savings from increased pharmacy rebates from the new ACA authority to collect rebates in MCOs.

Eligibility Systems and 90/10 Enhanced Medicaid Match. When the ACA passed in 2010, Medicaid eligibility systems in many states were technologically outdated and not able to meet the ACA 2014 requirements to expand Medicaid eligibility, implement the new Medicaid income eligibility standard based on MAGI, conduct streamlined real-time determinations utilizing electronic data matching, and interface with new health insurance exchanges. To help states implement the system upgrades needed to meet the new system requirements, CMS approved a temporary funding opportunity in November 2010 (through December 2015) allowing states to receive a 90 percent federal match for the design, development, and implementation of major upgrades or new Medicaid eligibility systems, up from the regular 50 percent administrative match rate. Under the final rule adopted in April 2011[124] (referred to as the "90/10" rule), states may also receive a 75 percent federal match rate for maintenance and operations of these upgraded systems.

Figure 36

Status of Major Medicaid Eligibility System Upgrades, July 2012



NOTE: "APD" refers to an Expedited Advanced Planning Document.
SOURCE: Centers for Medicare and Medicaid Services, Medicaid Eligibility and Enrollment System Activity, July 27, 2012.

According to CMS, 50 states have submitted Advance Planning Documents (APDs)[125] requesting enhanced funding for eligibility/enrollment systems and 46 states have received approval for enhanced funding.[126] CMS has approved $1.6 billion in systems funding of which $1.5 billion is at the 90 percent match rate. (Figure 36)

States with approved APDs reported varying degrees of progress toward completion of their planned projects. At the time of the survey, at least 12 states were still engaged in a procurement process to bring on needed contractors – some still at the beginning (developing an RFP) and others nearer the end (evaluating proposals). Another five states reported that contractors had been selected and project work had begun. A small number of states specifically reported that their projects were at an advanced stage or were expected to be completed

[124] Federal Register, April 19, 2011 (Vol. 76, No. 75), pp 21950 - 21975, at http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf.
[125] The purpose of the APD process is to: describe broadly the state's plan to manage the design, development, implementation, and operation of a system that efficiently, comprehensively, and cost-effectively meets federal, state, and user needs; set system performance goals in terms of projected costs and benefits; obtain federal financial participation. "State Systems APD Guide," ACF & CMS, Oct. 2010, http://www.acf.hhs.gov/programs/cse/stsys/apd/
[126] In this survey, MO and WI reported that they would not use the 90/10 funding although they have approved ADPs from CMS. In MO, there was concern that the legislature would not appropriate the state funds to be able to spend the money available from CMS.

prior to 2014. For example, Montana reported that its eligibility system was relatively new (implemented in October 2009) and that its planned upgrades would be completed by October 2012. New Mexico reported that its new "Aspen" system (under development since September 2011) would be completed and ready to go live for pilot testing in July 2013. Kansas reported that its system was on target for implementation in October 2013. Finally, one state Medicaid director commented that while her state had just selected a contractor, they planned to "reuse" or "borrow" already developed solutions from more advanced states (e.g., MAGI rules) and reconfigure them as necessary.

Key Challenges and Opportunities in Implementing the ACA. States were asked to identify the biggest challenges and opportunities in implementing health reform. Many states identified multiple implementation challenges. By far, the most commonly cited related to the need for additional federal guidance on various topics such as the conversion to MAGI standards, eligibility rules, and essential health benefits, the limited time available given the scope of work remaining and the fiscal challenges and administrative resource needs associated with implementation. A number of states commented on political challenges and the uncertainty that remained at both the federal and state levels around key decisions that could be affected by the outcome of the November elections. Other challenges mentioned by more than one state include building the Exchange and/or a new eligibility system and developing the needed interfaces between them, lack of state flexibility, juggling competing state priorities and potential impacts on health care access.

Some states commented on positive opportunities arising from health care reform implementation including the ability to cover or improve the health of the uninsured, simplifying and improving the Medicaid enrollment process, opportunities for state savings, potential to bend the cost curve, the availability of various ACA demonstration and grant opportunities.

7. Looking Ahead: Perspectives of Medicaid Directors

The focus of Medicaid officials made a significant turn in FY 2012 and into FY 2013, toward program improvement, preparation for implementation of major care coordination initiatives for seniors and persons with disabilities, development of new eligibility systems, and preparation for Medicaid's new role under health reform. Fiscal issues remain a concern, but the singular focus on budget shortfalls and cost containment eased somewhat compared to prior years. Medicaid administrators at the beginning of FY 2013 were focused on strategies to make Medicaid better, more accountable and more effective. When asked to identify the top issues and challenges for FY 2013 and beyond, Medicaid directors listed the following:

- Making decisions about the ACA Medicaid expansion and preparing for the expansion in Medicaid coverage in 2014.
- Development of new information technology systems related to eligibility (designed to move to MAGI income rules, to streamline and simplify enrollment and to coordinate enrollment with new insurance Exchanges), MMIS, payment reform, quality strategies, and other health information technologies to support new program initiatives.
- Development of new strategies to improve care, quality and outcomes, including new requirements for MCOs, patient-centered medical homes, health homes, managed long-term care, coordination and integration of physical health and behavioral health care, and new quality improvement strategies integrated with reimbursement methodologies.
- Development of new systems of care and reimbursement for seniors and persons with disabilities, including managed care and coordinated systems for dual eligible beneficiaries. These initiatives are designed to better serve high need populations but are complex and difficult to design and implement.

While pushing forward, it is also a time of considerable uncertainty for Medicaid. The Supreme Court decision on health reform gave states the choice of whether or how they move forward with the Medicaid expansion in the ACA. In many states, Medicaid directors see this important decision for their state legislature that will be debated as part of the state budget for FY 2014. Medicaid directors also expressed uncertainty and concern about how federal Medicaid rules might change in the future as debate about federal deficit reduction intensifies. The future of the ACA and Medicaid's role in the U.S. health system will hinge on the outcome of the elections in November 2012 and the federal budget debate that will follow.

In the meantime, Medicaid directors are still grappling with the lingering effects of the recession, including budget pressures and limited administrative staff and program resources. Despite these constraints, Medicaid directors are focused on the significant opportunities to make changes in their programs that are designed to improve the cost-effectiveness, quality and value in Medicaid through higher standards of performance and new systems of care that provide better health outcomes for Medicaid beneficiaries. In some cases, these will be changes that redesign the program in significant or even transformative ways, while other changes build in small steps on successful past initiatives.

When asked what they were most proud of about their program, Medicaid directors spoke about significant accomplishments in a time of extreme budget challenges. Many pointed to specific major initiatives that posed challenges in development and implementation while others pointed to broader cost containment actions that averted cuts that would have harmed beneficiaries. Some states pointed to implementation of new systems for eligibility, claims processing or the certification of a new MMIS system. Many directors said they were most proud of the state Medicaid program staff. One director said, "there are fewer staff now than three years ago but they have moved the program forward in transformative ways."

Conclusion

Headed into FY 2013, state fiscal pressures remain a concern, but improvements in state revenues and near-historic low rates of growth in Medicaid spending are signs that the economy is improving. While cost containment is still a major focus, Medicaid directors are also working on initiatives to improve health care and health outcomes, particularly for the most frail and vulnerable of Medicaid beneficiaries, whose care is often fragmented and costly.

Medicaid spending growth has moderated from the rates exceeding 7 percent in state fiscal years 2009, 2010 and 2011. In FY 2012, overall Medicaid spending increased on average across the states by only 2.0 percent, the one of the lowest rates of growth on record. Slow growth is expected to continue into FY 2013, for which legislatures authorized Medicaid spending growth averaging just 3.8 percent. This relatively low spending growth is due in part to an improving economy and slowing growth in the number of persons enrolled in Medicaid. Medicaid enrollment grew on average by 3.2 percent in FY 2012, and is projected to grow by just 2.7 percent on average in FY 2013. Slow spending growth is also due to actions of Medicaid programs to contain costs. Nearly all states implemented or plan to implement policies to cut costs in FY 2012 and FY 2013. The most common action was to restrict provider payment levels. With the improving economy, states were also able to make some program investments including some restorations or increases to provider rates. In addition, payment rates for primary care services will increase in 2013 and 2014 with federal financing due to the ACA requirement to pay for these services at Medicare fee levels. States are also continuing to expand long-term care services in the home and community, to shift care away from institutions and to look for ways to coordinate acute, primary and long-term care.

One of the most important priorities across Medicaid programs now is focus on care coordination to better serve current enrollees in the program, especially those with chronic and complex conditions, including dual Medicare – Medicaid enrollees. Two-thirds of states are developing such initiatives using health homes, patient-centered medical homes, accountable care organizations, and other state-specific approaches designed to coordinate and integrate physical health, behavioral health and long-term care. Central to these approaches is the alignment of reimbursement methodologies that are tied to performance. Many Medicaid directors believe these initiatives have the potential to improve care and reduce costs, particularly in the way they serve populations with high health care needs.

At the same time, state Medicaid agencies are preparing for their role under health reform and the potential to provide coverage for millions of new enrollees. Even if states do not implement the ACA Medicaid expansion, they will be responsible for enrollment simplifications that will involve upgrades to Medicaid eligibility systems and alignment of systems with Health Insurance Exchanges. ACA related changes to Medicaid will continue to be a major focus of Medicaid administrators over the next year.

Medicaid programs have faced daunting challenges over the past few years and more challenges lie ahead as state economies continue to recover but slowly, states implement the ACA and face questions about federal changes to Medicaid in the federal deficit reduction debate. Despite challenges and uncertainty, Medicaid directors indicated that they will continue in their efforts to improve the program, improve care for the Medicaid population, hold down costs and at the same time prepare for decisions and implementation of health reform.

Appendix A: State Survey Responses

Appendix A-1
Positive Policy Actions Taken in the 50 States and the District of Columbia
FY 2012-2013

States	Provider Payment Increases		Benefit Expansions		Eligibility Expansions		Simplification to Application/ Renewal		Decreased or Eliminated Copayments		Long Term Care Expansions	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Alabama	x	x					x	x			x	x
Alaska	x	x					x				x	x
Arizona			x									
Arkansas	x	x	x				x				x	x
California	x	x			x							x
Colorado			x	x	x	x	x				x	x
Connecticut	x	x	x	x	x		x				x	x
Delaware	x	x									x	x
District of Columbia	x	x	x								x	
Florida	x	x		x	x	x	x				x	x
Georgia	x	x					x	x			x	
Hawaii		x		x		x						
Idaho				x							x	x
Illinois	x					x					x	x
Indiana	x	x	x			x	x				x	
Iowa	x	x	x		x		x				x	x
Kansas	x			x			x				x	
Kentucky	x	x									x	x
Louisiana	x	x	x		x	x	x				x	x
Maine												
Maryland	x	x			x						x	x
Massachusetts	x	x		x			x	x			x	x
Michigan	x	x	x	x		x					x	x
Minnesota		x			x	x	x				x	x
Mississippi	x	x		x								x
Missouri	x	x										x
Montana		x		x	x		x					x
Nebraska		x					x	x				x
Nevada	x	x										
New Hampshire	x		x			x						
New Jersey	x	x				x	x					x
New Mexico		x		x	x							x
New York	x	x	x	x		x	x	x				x
North Carolina			x				x				x	x
North Dakota	x	x	x		x			x			x	
Ohio[1]		x	x		x		x				x	
Oklahoma		x										x
Oregon	x		x		x		x					
Pennsylvania	x						x					x
Rhode Island		x	x	x	x		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	x	x			x		x			x	x	x
Virginia		x				x	x				x	x
Washington	x	x	x	x		x					x	
West Virginia	x	x					x	x			x	
Wisconsin	x	x										x
Wyoming												x
Total	**33**	**37**	**19**	**15**	**15**	**13**	**28**	**9**	**0**	**1**	**29**	**34**

[1] The increase in provider payments noted here for FY 2013 is due to higher nursing facility payments resulting from case-mix acuity adjustments; nursing facility rates were not increased.

Appendix A-2
Cost Containment Actions Taken in the 50 States and the District of Columbia
FY 2012-2013

States	Provider Payments		Pharmacy Controls		Benefit Reductions		Eligibility Cuts		Changes to Application and Renewal		New or Increased Copay Requirements		LTC	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Alabama	x	x	x		x									
Alaska		x	x	x										
Arizona	x	x	x		x		x				x		x	
Arkansas	x	x	x	x										
California	x	x	x		x	x						x		
Colorado	x	x	x	x	x	x								x
Connecticut	x	x	x	x	x		x	x						
Delaware	x	x												
District of Columbia	x	x	x	x										
Florida	x	x				x								
Georgia	x	x		x										
Hawaii	x	x		x	x			x						
Idaho	x	x	x		x						x			
Illinois	x	x	x	x		x		x				x		x
Indiana	x	x	x	x	x									
Iowa	x	x	x	x	x									
Kansas	x	x	x	x										
Kentucky	x													
Louisiana	x	x		x										
Maine	x	x	x	x		x		x				x		
Maryland	x	x	x	x										x
Massachusetts	x										x		x	x
Michigan	x	x	x		x									
Minnesota	x	x	x					x			x			x
Mississippi	x	x	x	x										
Missouri				x										
Montana	x	x											x	
Nebraska	x													
Nevada	x	x		x										
New Hampshire	x	x			x									x
New Jersey	x	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														
Ohio	x	x	x										x	
Oklahoma	x	x		x										
Oregon	x	x			x								x	
Pennsylvania	x	x	x		x						x	x	x	
Rhode Island	x	x												
South Carolina	x	x	x	x							x		x	
South Dakota	x		x	x		x						x		
Tennessee	x	x	x											x
Texas	x	x	x	x	x	x						x	x	
Utah	x	x	x	x										
Vermont			x	x								x		
Virginia	x		x	x									x	
Washington	x	x	x	x	x									
West Virginia														
Wisconsin		x	x	x				x						
Wyoming	x	x	x	x								x		
Total	**45**	**42**	**33**	**29**	**18**	**8**	**2**	**6**	**0**	**0**	**6**	**8**	**10**	**7**

Appendix A-3
Provider Taxes in Place in the 50 States and the District of Columbia
FY 2012-2013

States	Hospitals		ICF-ID		Nursing Facilities		Managed Care Organizations		Other****		Any Provider Tax	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Alabama	x	x*			x	x**			x	x	x	x
Alaska												
Arizona												
Arkansas	x	x	x	x**	x	x**					x	x
California	x	x**	x	x**	x	x**					x	x
Colorado	x	x*			x	x*					x	x
Connecticut	x	x*	x	x**	x	x*					x	x
Delaware						x						x
District of Columbia	x	x***	x	x**	x	x*	x	x			x	x
Florida	x	x	x	x**	x	x**					x	x
Georgia	x	x	x	x**	x	x**					x	x
Hawaii		x				x						x
Idaho	x	x	x	x*	x	x**					x	x
Illinois	x	x	x	x**	x	x					x	x
Indiana	x	x**	x	x**	x	x**					x	x
Iowa	x	x	x	x*	x	x					x	x
Kansas	x	x			x	x					x	x
Kentucky	x	x	x	x**	x	x			x	x	x	x
Louisiana			x	x	x	x			x	x	x	x
Maine	x	x*	x	x*	x	x*			x	x	x	x
Maryland	x	x*	x	x**	x	x**	x	x			x	x
Massachusetts	x	x			x	x*					x	x
Michigan	x	x			x	x*					x	x
Minnesota	x	x	x	x*	x	x*	x	x	x	x	x	x
Mississippi	x	x	x	x**	x	x**			x	x**	x	x
Missouri	x	x**	x	x**	x	x**			x	x*	x	x
Montana	x	x	x	x	x	x*					x	x
Nebraska			x	x**	x	x					x	x
Nevada					x	x**					x	x
New Hampshire	x	x**			x	x					x	x
New Jersey	x	x	x	x**	x	x*	x	x	x	x	x	x
New Mexico							x	x*			x	x
New York	x	x*	x	x*	x	x*			x	x	x	x
North Carolina	x	x	x	x*	x	x**					x	x
North Dakota			x	x**							x	x
Ohio[1]	x	x	x	x*	x	x*					x	x
Oklahoma	x	x	x	x**	x	x**					x	x
Oregon	x	x*			x	x**					x	x
Pennsylvania	x	x	x	x**	x	x**			x	x*	x	x
Rhode Island	x	x*			x	x*	x	x			x	x
South Carolina	x	x	x	x							x	x
South Dakota			x	x***							x	x
Tennessee	x	x*	x	x*	x	x*	x	x*			x	x
Texas			x	x*			x	x			x	x
Utah	x	x	x	x*	x	x*					x	x
Vermont	x	x**	x	x**	x	x**			x	x**	x	x
Virginia			x	x*							x	x
Washington	x	x	x	x	x	x*					x	x
West Virginia	x	x	x	x*	x	x*			x	x*	x	x
Wisconsin	x	x	x	x*	x	x					x	x
Wyoming					x	x**					x	x
Total	**38**	**39**	**36**	**36**	**41**	**43**	**8**	**8**	**12**	**12**	**47**	**49**

[1] The state does not have traditional provider taxes but does have franchise fees. For purposes of this report, the franchise fees in this state were included in the counts here.

*States reported that these taxes would be impacted were the safe harbor threshold to be dropped to 3.5%.

** States reported that these taxes would be impacted were the safe harbor threshold to be dropped to 5.5%.

***States reported that they did not know at the time of the survey if these taxes would be impacted were the safe harbor threshold to be dropped to 3.5%.

****States reporting multiple "other" provider taxes were Minnesota, Missouri, New York, Vermont and West Virginia in both 2012 and 2013.

Appendix A-4a: Eligibility and Application Renewal Process Related Actions Taken in the 50 States and the District of Columbia, FY 2012[127]

State	Eligibility and Application Changes in FY 2012
Alabama	**Application & Renewal (+):** Use of Express Lane Eligibility for Plan First applications and renewals.
Alaska	**Aged & Disabled (nc):** Increased Personal Needs Allowance for Nursing Home residents from $75 to $200/month. The state does not except an increase in enrollment from this policy change. (affects 260, 7/1/2011) **Application & Renewal (+):** Alaska added opt out language to applications and renewals. Any application or renewal for any program is now treated as an application for Medicaid unless the individual opts out. **Application & Renewal (nc):** Voter registration information has been added to every application and renewal.
Arizona	**Adults without Dependent Children (-):** AHCCCS Care enrollment frozen for this group. (estimated to affect 90,000 out of 230,000 in first year, effective July 2011)
Arkansas	**Application & Renewal (+):** Implemented a streamlined renewal form (pre-populated) and process for Medicaid and CHIP children, including telephone and ex parte renewals.
California	**Disabled (+):** Working Disabled Program (WDP) that covers up to 250% FPL will be modified with the following changes: continuous eligibility through 26 weeks of employment; exemption of Social Security disability income that converts to Social Security retirement income, and two expansion of assets that are exempt. (5,860, 8-1-11) **Application & Renewal (nc):** As a result of litigation and compliance with a court order, CA is refining the Health-e-App for purposes of screening children who submit an application through the Single Point of Entry that processes Healthy Families Program applications and screens children to Medi-Cal. The application changes will include questions to screen for the 1931(b) program in addition to the current poverty level programs for children.
Colorado	**Childless Adults (+):** Colorado submitted a waiver to expand Medicaid coverage to adults without dependent children with incomes below 10% FPL. Program will initially be capped at 10,000 with a waiting list. (7,800, May 2012 **Disabled Adults (+):** Implemented Disabled Buy-in program for working adults (TWWIIA). (240, March 2012) **Application & Renewal (+):** Implement interfaces to eliminate paper for citizenship, identity and income. **Application & Renewal (+):** Implement Express Lane Eligibility using criteria from other agencies. **Application & Renewal (+):** Changed rules to permit passive and telephone redeterminations.
Connecticut	**Adults (+):** Tuberculosis waiver. (11/2011) **Aged & Disabled (+):** Increasing the amount of income disregards for the Medicare Savings Program. (7/2011) **Aged & Disabled (-):** Decreasing the amount of spousal assets retained for long-term care population. (7/2011) **Adults (+):** Implemented new family planning state plan. (11/2011) **Application & Renewal (+):** Increased staff, modernized systems, hired external contractor to calculate spend-down. All of these actions reduce wait times for applicants.
Delaware	
District of Columbia	
Florida	**All Categories (+):** Removed a requirement for individuals absent from the US for 30 days or more to reside in the US for 30 days upon returning before qualifying or re-qualifying for Medicaid. (unknown, 9/6/2011) **Aged & Disabled (+):** 1) Increased the average private pay nursing home rate divisor from $5000 to $6880 for determining transfer of assets penalty periods. 2) Increase in the minimum monthly maintenance needs allowance and the excess shelter standard for "at home" spouses of institutionalized individuals. **Application & Renewal (+):** Change waives a disability interview when sufficient information is provided on paper Disability Report forms. **Application & Renewal (+):** Change in the requirement of what disability-related information is mandatory for completing a referral to Division of Disability Determinations. **Application & Renewal (+):** Individuals who turn in requested documentation/verification information within 60 days of their date of application will have their eligibility determined without having to file a new application for Medicaid.
Georgia	**Application & Renewal (+):** Simplification of the application process for the Katie Beckett waiver. **Application & Renewal (+):** Simplification the application process for the Family Planning Waiver (Planning for Health Babies).

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

State	Eligibility and Application Changes in FY 2012
Hawaii	
Idaho	
Illinois	**Application & Renewal (nc):** Began to change passive renewal process for children. Review of exparte data used to identify known changes.
Indiana	**Application & Renewal (+):** Finished roll-out of technology to allow online applications statewide. **Application & Renewal (+):** Elimination of individual execution of medical rights assignment; now operational by state law.
Iowa	**Adults (+):** Expand eligibility for Family Planning Waiver. (28,000, 12/29/2011) **Adults (nc):** Suspend Medicaid eligibility for inmates. (Unknown, 1/1/12) **Application & Renewal (+):** Child support referrals are no longer required for fathers in the home when paternity has not been established. **Application & Renewal (nc):** Allow interviews to be scheduled by telephone call as well as by written notice.
Kansas	**Application & Renewal (+):** Presumptive Eligibility for Pregnant Women. (200, 11/1/11) **Application & Renewal (+):** New online application system.
Kentucky	
Louisiana	**Disabled Children (+):** Under the Coordinated System of Care (CSOC), the following expansions occurred, together affecting 2400 (effective 3/1/2012): (1) 1915c HCBS waiver for Mentally Ill and Seriously Emotionally Disturbed Youth with income up to 300% of the SSI Federal Benefit Rate (FBR) or eligible with Medically Needy Program. (2) 1915(b)(3) waiver to provide psychosocial services to children meeting a level of need but not NF/hospital level of care. **Medically Needy (+):** Applied institutional spousal income disregards to those meeting the 1915(i) level of need; must spend down to 150% of poverty to qualify for the program. Provides behavioral health services only. (23, 3/1/12) **Medically Needy (+):** Spend down eligibility for New Opportunities HCBS Waiver (allow individuals to spend down to the 300% of FBR waiver eligibility level). (20, 6/27/2012) **Application & Renewal (+):** Streamlined on-line renewal form (to increase retention).
Maine	
Maryland	**Adults (+):** Family Planning Waiver expansion. (3,000, 1/1/2012) **Application & Renewal (nc):** New LTC application and redetermination forms. (7/1/2011)
Massachusetts	**Application & Renewal (+):** Administrative Renewal Process was expanded (Dec. 2011) to include additional populations, community residents who receive social security as their sole source of income. **Application & Renewal (nc**): The Medical Benefit Request (MBR), the Senior Medical Benefit Request (SMBR), and other related forms have been revised to: - clarify policy and capture applicant information to determine whether individuals who are applying for benefits are residents of Massachusetts and if they intend to remain in the state; - remove all references to the Fishing Partnership Health Plan (FPHP); - expand data collection under Native American Indian section of the application to identify all Native American/Alaskan Native (adults and children) who are exempt from cost sharing.
Michigan	
Minnesota	**Childless Adults (+):** Childless adults with incomes from 75 percent to 275 percent FPL moved to Medicaid (35,000, 8/1/11) **Application & Renewal (+):** Implemented on-line application portal 1/1/12.
Mississippi	
Missouri	
Montana	**Adults (+):** 1115 Family Planning Expansion for women ages 19-44 with incomes up to 200% FPL. (6/1/12) **Application & Renewal (+):** Administrative Redeterminations were added, effective 4/1/12.
Nebraska	**Application & Renewal (+):** Full implementation of ACCESSNebraska customer service centers and universal case management.
Nevada	
New Hampshire	
New Jersey	**Application & Renewal (+):** Expand Express Lane Application State-wide - National School Lunch Program (NSLP).
New Mexico	**Childless Adults (+):** State Coverage Initiative-University of New Mexico pilot project started in April 2012 with a target of enrolling 5,000 individuals under an approved waiver. (5,000, April 2012)
New York	**Application & Renewal (+):** Automate administrative renewals for Medicare Savings Program participants with fixed incomes. **Application & Renewal (+):** Implement presumptive eligibility under the Family Planning State Plan Option.

State	Eligibility and Application Changes in FY 2012
	Application & Renewal (+): Revise (simplify) renewal form.
North Carolina	**Application & Renewal (+):** Medicaid for Infants & Children and SCHIP reenrollment process change to an ex-parte process.
North Dakota	**Aged & Disabled (+):** Expand personal needs allowance for persons in Long-term care to allow payment of taxes from rental property. (<100, 8/1/2011)
Ohio	**Adults (+):** Implement Family Planning State Plan option. (78,000, 1/8/2012) **Children (+):** Removed resource requirement for 19 and 20 year old "Ribicoff Kids." (5,500, 10/1/2011) **Application & Renewal (+):** Removed face-to-face requirement for Aged, Blind & Disabled. (effective 1/9/12) **Application & Renewal (+):** Presumptive eligibility for children and pregnant women, adding hospitals, FQHCs and FQHC look-a-likes. (effective 4/1/12)
Oklahoma	
Oregon	**Adults (+):** OHP Standard randomized drawings from reservation list were increased to reach an average monthly enrollment of 60,000. **Young Adults (+):** Full time students at a higher education institute were no longer required to meet eligibility requirements for Pell eligibility or 'expected family contributions.' (Very few, 1/1/12) **Application & Renewal (+):** Medicaid will be suspended rather than terminated for clients who are incarcerated as long as their stay is expected to be a year or less (in a county jail vs. prison); medical assistance will be restored upon their release from custody. (Effective October 2011, affecting several hundred individuals). **Application & Renewal (+):** The OHP application was revised to eliminate the need to request proof of citizenship/identity for medical applicants who claim to be US citizens. In almost all cases, workers have been able to get the verification through a match with SSA; it was no longer necessary to ask applicants to provide this verification with their application. **Application & Renewal (+):** Oregon had already implemented an automatic redetermination process for medical only clients. Effective July 1, 2011, OHA began an automatic redetermination process for clients who were on medical and SNAP; they were given an automatic renewal pending letter for the medical redetermination. The computer system began adding an automatic date of request and bypass-end-date coding, allowing clients to respond to additional information requests by written form or by phone. **Application & Renewal (+):** Express Lane Eligibility for children was piloted in the National School Lunch Program; for the participating school districts, children in the school lunch program with income below 163% FPL could receive Medicaid without completing an application. (Close to 100 enrolled, 11/14/11)
Pennsylvania	**Application & Renewal (+):** Enhancement to on-line application (COMPASS) - scanning and imaging of verification documentation. **Application & Renewal (nc):** More rigorous application of existing eligibility policies.
Rhode Island	**Long-term care (+):** Increased the amount of allowable home equity interest for individuals seeking eligibility for Medical Assistance nursing facility services or other long-term care services from $500,000 to $525,000. In addition, rules further reflect an increase in the amount of the equity value of the life estate of an institutionalized individual that can be considered an excluded resource from $500,000 to $525,000. (Unknown, 4/1/12) **Medically Needy (+):** Medically Needy Income limits were increased. (Unknown, 1/1/12) **Application & Renewal (+):** In November 2011, RI adopted the CHIPRA option (section 211) which allowed states to use SSA information to verify the citizenship and identity of each applicant electronically through a State Verification and Exchange System (SVES). If the match is successful (i.e., no discrepancy with name, SSN, DOB), a code is automatically entered into our eligibility system, InRhodes, to signify that the citizenship and identity has been verified. By implementing this change, the state eliminated the need for most applicants to provide original documentation of citizenship and identity. (Clients whose information cannot be verified will be sent a request for original documentation.) Application and recertification forms were changed to reflect this new process.
South Carolina	**Application & Renewal (+):** Implemented Express Lane Eligibility for Children for Redeterminations.
South Dakota	
Tennessee	
Texas	**Application & Renewal (+):** HHSC is enhancing online self-service options. In FY 2012, HHSC will add online self-service options for submitting renewal applications and reporting additional changes.
Utah	**Application & Renewal (+):** Presumptive eligibility for all children in a foster care family (<100, 4/1/12) **Application & Renewal (+):** Matched CHIP/Medicaid review forms - single application. **Application & Renewal (+):** Use of ex-parte data (administrative renewals) for most of Medicaid population. (qualified for CHIPRA 5 of 8 bonus) **Application & Renewal (+):** Beneficiaries can report changes (such as address) online. **Application & Renewal (+):** Beneficiaries can choose to receive notices electronically.
Vermont	**Children & Pregnant Women (+):** CHIPRA ICHIA option to allow Medicaid eligibility for legally residing pregnant women and children. (20 per year, 7/1/2011) **Children (+):** Adopted a premium grace period for children. (240 per month, 7/1/2012)

State	Eligibility and Application Changes in FY 2012
	Application & Renewal (+): Implemented "cold calling" clients to obtain missing application information for eligibility determination.
Virginia	**Adults (nc):** Family planning waiver converted to a state plan option. (10/1/2011) **Application & Renewal (+):** Added option for telephone renewals.
Washington	
West Virginia	**Application & Renewal (+):** The application change was completed that a face to face interview is not required for any type of Medicaid. The option of e-signature is also available.
Wisconsin	**Application & Renewal (nc):** Converted to a regional service delivery model that streamlined application processing and change/call centers statewide.
Wyoming	

Appendix A-4b: Eligibility and Application Renewal Process Related Actions Taken in the 50 States and the District of Columbia, FY 2013[128]

State	Eligibility and Application Changes in FY 2013
Alabama	**Application & Renewal (+):** Automated ELE renewals for Plan First (family planning) and children. **Application & Renewal (+):** Automated Ex-parte renewals for children living with guardians other than parents.
Alaska	
Arizona	
Arkansas	
California	
Colorado	**Disabled Children (+):** Adding Disabled Buy-In for Children (FOA). (1,000, 7/1/12)
Connecticut	**Childless Adults (-):** Add an asset test for childless adults under 1115 waiver. (10/1/12)
Delaware	
District of Columbia	
Florida	**Aged & Disabled (+):** Increased the average private pay nursing home rate divisor from $6880 to $7362 for determining transfer of assets penalty periods. (Unknown, 9/1/12)
Georgia	**Application & Renewal (+):** Better Coordination between Medicaid and CHIP Application Processes.
Hawaii	**Adults (-):** Reduce income limit to 133% for non-pregnant adults. (5,000, 7/1/12) **Adults (+):** Expand asset limit for non-pregnant adults (E.g. $5000 for household of 1). (10,000, 7/1/12)
Idaho	
Illinois	**Adults (+):** Expand eligibility through 1115 waiver to adults with incomes at or below 133% FPL that reside in Cook County. (estimated to impact 250,000 adults; implementation targeted for October 1, 2012 though waiver still listed as pending)[129] **Parents (-):** Income limit for parents reduced from 185% to 133% of FPL. (28,000, 7/1/12) **Disabled Children (-):** Katie Beckett (MFTD) waiver - family income limit of 500% FPL added. (few, 11/1/12) **Aged & Disabled (-):** Asset transfer limit for long-term care (unknown, 7/1/12) **Application & Renewal (nc):** Eligibility verification by an outside vendor - only affects beneficiaries if there are discrepancies in data. **Application & Renewal (nc):** Passive renewal changed to exparte renewals. When exparte data indicates no change in income, family is notified of renewal based on exparte data.
Indiana	**Adults (+):** Family Planning services only to uninsured up to 133% FPL. (24,000, Jan. 2013)
Iowa	
Kansas	
Kentucky	
Louisiana	**Adults needing Behavioral Health Services (+):** Non categorically eligible individuals (age 18 or older) not otherwise eligible under the State Plan, but determined eligible(under 150% FPL) using institutional rules (non-application of spousal and parental deeming of income and resources) eligible only for Specialty Behavioral Health services. (30,000, date contingent on CMS approval) **Medically Needy (+):** Create spend down eligibility for Supports and Residential Options HCBS Waivers (allow individuals to spend down to the 300% of FBR waiver eligibility level). (15, date contingent on CMS approval).
Maine	**Young Adults (-):** Eliminate Coverage for 19-20 year olds (10/1/12,pending CMS approval of SPA) **Parents (-):** Reduce coverage for parents from 200% to 100% FPL (10/1/12, pending CMS approval of SPA) **Aged & Disabled (-):** Reduce Medicare buy-in income eligibility by 10% per category (10/1/12, pending CMS approval of SPA)
Maryland	

[128] 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).

[129] *Cook County Health and Hospital System's Care Coordination Enhancements and Bridge to ACA: Medicaid 1115 Waiver Proposal.* Illinois Department of Healthcare and Family Services and Cook County Health and Hospitals System, January 6, 2012. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-new-demo-request-pa.pdf.

State	Eligibility and Application Changes in FY 2013
Massachusetts	**Application & Renewal (+):** Plan to implement a new electronic data match with MA Department of Revenue Quarterly Wage data. This process will identify households with DOR reported income over 310% FPL and send the Job Update form. The form will only be required to be returned by the household if the reported income is not accurate or no longer valid. **Application & Renewal (+):** Implement Express Lane Eligibility in FY 2013 with SNAP caseload as basis for family renewal of MassHealth Insurance benefits. **Application & Renewal (+):** Launch a limited Telephonic Renewal Pilot in one of four Enrollment Centers in FY 2013 to explore the viability of a potential statewide rollout.
Michigan	**All (+):** Convert Plan First! Family Planning waiver into SPA which includes adding coverage for men and eliminating age restrictions.
Minnesota	**Childless Adults (-):** Move childless adults between 200% -250% of FPL to state-only "Healthy Minnesota Contribution" program. (4,000 to 7,000, 7/1/12) **Elderly Disabled (+):** Expand Medicaid for Employed Persons with Disabilities (buy-in) to allow persons aged 65+ to stay on.
Mississippi	
Missouri	
Montana	
Nebraska	**Application & Renewal (+):** Develop prepopulated on-line review application.
Nevada	
New Hampshire	**Aged & Disabled (+):** Changed post eligibility treatment of income for HCBS-ABD eligibles living independently or with family; such individuals are now able to retain up to 300% SSI. (Unknown, 11/1/12) **Adults (+):** Adopt new Family Planning State Plan Option. (no current SPA or waiver)
New Jersey	**Aged & Disabled (+):** Under the state's Comprehensive Waiver proposal, NJ will utilize 1915(c) and 1915(i)-like authorities under the 1115 to cover children: 1) meeting level of need criteria for severe emotional disturbance (SED) / acute stabilization who will be eligible up to 150% of the FPL using institutional eligibility criteria; 2) Children meeting a hospital level of care with incomes up 300% of the federal benefit rate using institutional eligibility criteria. Also under the waiver, the state plans to use a 1915(i)-like state plan to implement an expansion to the Medication Assisted Treatment Initiative (MATI) services for opiate dependent State residents with incomes up to 150% of the FPL and clinical criteria. (5,000, TBD upon approval by CMS.)
New Mexico	
New York	**Adults (+):** Adopt new Family Planning State Plan Option. (Currently under a waiver.) (Unknown, 11/1/12) **Application & Renewal (+):** Automate enrollment in Medicare Savings Program under MIPPA (NYC and Upstate). **Application & Renewal (+):** Expand automated administrative renewals for aged, blind and disabled recipients receiving pensions; including cases with a spend-down. **Application & Renewal (+):** Implemented Express Lane Eligibility for children moving from CHPlus to Medicaid.[130] (May 2012)
North Carolina	
North Dakota	**Application & Renewal (+):** Implement new online system for renewal of eligibility.
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	
South Carolina	**Application & Renewal (+):** Implement Express Lane Eligibility for Children on new applications.
South Dakota	**Application & Renewal (+):** Implement online eligibility application process.
Tennessee	
Texas	**Children & Pregnant Women (nc):** Provide Medicaid coverage to children under 19 years of age and pregnant women who are inmates and become a patient of a medical institution. (160, Jan. 2013)
Utah	
Vermont	**Application & Renewal (nc):** Eliminate 2nd verification request.

[130] Administrative Directive: Transmittal 12 OHIP/ADM-2: Transitioning Children from Child Health Plus to Medicaid Using Express Land Eligibility, New York State Department of Health, May 14, 2012. http://www.health.ny.gov/health_care/medicaid/publications/docs/adm/12adm-2.pdf.

State	Eligibility and Application Changes in FY 2013
Virginia	**Children & Pregnant (+):** Adopt the CHIPRA option to allow Medicaid eligibility for legally resident pregnant women (unknown, 7/1/12)
Washington	**Adults (+):** Increase income limit on Family Planning Waiver from 200 percent to 250 percent FPL. (12,000, 7/1/12)
West Virginia	**Application & Renewal (+):** Plan to include adult Medicaid groups on our web-based application process called inROADS.
Wisconsin	**Adults (-):** Implement a 12 month restrictive re-enrollment period for BadgerCare Plus non-pregnant, non-disabled adults with household income above 133% of the FPL who fail to pay a premium. (1,830, 7/1/12) **Adults (-):** Restrict BadgerCare Plus eligibility for non-pregnant, non-disabled BadgerCare Plus parents and caretaker relatives with income above 133% of the FPL who have current or past access to employer sponsored health insurance where the required premium contribution does not exceed 9.5% of household income for the employee only plan (7,100, 7/1/12) **Adults (-):** Eliminate retroactive eligibility for BadgerCare Plus non-pregnant, non-disabled parents and caretaker relatives with household income between 133-150% of the FPL (7,600, 7/1/12) **Application & Renewals (nc):** Require Core Plan members (Childless adults eligible under an 1115 waiver) to report and verify changes in income. These changes will not affect eligibility but do affect premium levels**.**
Wyoming	

Appendix A-5a: Premium and Copayment Related Actions Taken in the 50 States and the District of Columbia, FY 2012[131]

State	Premium and Copayment Changes in FY 2012
Alabama	
Alaska	
Arizona	**Copayments (New):** $2 copays for non-emergency medical transportation (NEMT) for adults without dependent children in Maricopa and Pima Counties. (April 1, 2012) **Copayments (Increased):** Providers are now permitted to charge a fee to adults without dependent children and TANF parents who reside outside of Maricopa and Pima counties who miss appointments. Providers must have a written plan approved by AHCCCS before they can charge members for missed appointments. (January 1, 2012)
Arkansas	
California	
Colorado	**Premiums (NEW):** Medicaid Buy-in Program for Working Adults with Disabilities (TWWIIA)
Connecticut	
Delaware	
District of Columbia	
Florida	
Georgia	
Hawaii	
Idaho	**Copayments (New):** New copayment requirements for imposed for Podiatry, Optometry and Chiropractor services (effective November 1, 2011) and on Physician, occupational, physical, and speech therapy services (effective January 1, 2012). Limited currently to the Katie Beckett group.
Illinois	
Indiana	
Iowa	**Premiums (Increased):** 1115 Waiver (Iowa Care) has annual inflationary premium increases.
Kansas	
Kentucky	
Louisiana	
Maine	
Maryland	
Massachusetts	**Copayments (Increased):** For all non-exempt groups, increased pharmacy copays from $3 to $3.65 except for antihyperglycemics, antihypertensives, and antihyperlipidemics, which remain at $1. For CommCare members below 100% FPL, copays increased to be in line with MassHealth copays, per statute. (October 1, 2011).
Michigan	
Minnesota	**Copayments (Increased):** Increased the monthly maximum pharmacy copayment amount from $7 to $12 for all non-exempt groups. (October 1, 2011) **Copayments (New):** Imposed a $3 copayment on all non-exempt groups for non-preventive office visits. (October 1, 2011).
Mississippi	
Missouri	**Premiums (Increased):** Ticket to Work Health Assurance Program premiums increased as they are indexed to the Federal Poverty Level (FPL).
Montana	
Nebraska	
Nevada	
New Hampshire	

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

State	Premium and Copayment Changes in FY 2012
New Jersey	
New Mexico	
New York	
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Oregon	
Pennsylvania	**Copayments (Increased):** Increased nominal scale copayment amounts to reflect changes in the medical care component of the consumer price index. (May 15, 2012)
Rhode Island	
South Carolina	**Copayments (Increased):** Increased copayment requirements for adult members and expanded to include Medical Home Network members. (July 1, 2011) Existing copays for prescriptions were increased from $3 to $3.40.
South Dakota	
Tennessee	
Texas	
Utah	
Vermont	
Virginia	
Washington	
West Virginia	
Wisconsin	
Wyoming	

Appendix A-5b: Premium and Copayment Related Actions Taken in the 50 States and the District of Columbia, FY 2013[132]

State	Premium and Copayment Changes in FY 2013
Alabama	
Alaska	
Arizona	
Arkansas	
California	**Copayments (New):** Propose to implement the following new enforceable copayments for individuals enrolled in managed care: $3.10 for the use of non-preferred drugs for individuals enrolled in managed care and $15 for non-emergency use of the emergency department.
Colorado	**Premiums (NEW):** Medicaid Buy-in Program for Children with Disabilities (FOA)
Connecticut	
Delaware	
District of Columbia	
Florida	**Premiums (NEW):** An amendment to the 1115 MEDS AD Waiver has been submitted to allow qualifying individuals who meet the share of cost for 1 month to remain eligible for up to 6 months by paying a premium not to exceed the share of cost. (Effective upon CMS approval for Medically Needy)
Georgia	
Hawaii	
Idaho	
Illinois	**Premiums (Eliminated):** The coverage group under 1902(a)(10)(A)(ii) of parents from 150% to 185% FPL was eliminated. **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 to $3.65 and increased drug copays (on all members) for brands (from $3 to $3.65), generics (0 to $2) and OTCs (0 to $2). (July 1, 2012) **Copayments (New):** Plan to impose new cost-sharing requirements on participants in the Medically Fragile and Technology Dependent Children's HCBS waiver. (November 2012)
Indiana	
Iowa	**Premiums (Increase):** 1115 Waiver (Iowa Care) has annual premium increases.
Kansas	
Kentucky	
Louisiana	
Maine	**Copayments (Increased):** Plan to make pharmacy copayments enforceable for those above 100 percent FPL.
Maryland	
Massachusetts	
Michigan	
Minnesota	**Premiums (Eliminated):** MinnesotaCare premiums were eliminated for parents covered under Medicaid with incomes between 150 and 200 percent FPL.
Mississippi	
Missouri	
Montana	
Nebraska	
Nevada	
New Hampshire	
New Jersey	
New Mexico	

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

State	Premium and Copayment Changes in FY 2013
New York	
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Oregon	
Pennsylvania	**Premiums (Increase):** Medical Assistance for Workers with Disabilities (MAWD) premium will be increased from 5% to 6% pending CMS approval. **Copayments (New):** Plan to implement DRA alternative cost-sharing (20 percent coinsurance on non-exempt services) for certain disabled children under age 18, who have household incomes above 200 percent FPL.[133] (October 1, 2012)
Rhode Island	
South Carolina	
South Dakota	**Copayments (Increased):** For all non-exempt groups, increased pharmacy copayments on brands (from $3 to $3.65). (July 1, 2011) **Copayments (New):** For all non-exempt groups, imposed new pharmacy copayments on generics ($1). (July 1, 2011)
Tennessee	
Texas	**Copayments (New):** Planning to implement copayments on non-emergent use of the emergency department. Copayments on other services under consideration as well.
Utah	
Vermont	**Copayments (Eliminated):** Eliminated $75 copay per inpatient hospital visit. (August 1, 2012) **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.) (August 1, 2012)
Virginia	
Washington	
West Virginia	
Wisconsin	**Premiums (NEW):** As of July 1, 2012, Core Plan members (Childless adults covered under a 1115 waiver) are subject to premiums. **Premiums (Expanded):** As of July 1, 2012, non-pregnant, non-disabled parents and caretaker relatives with incomes above 133% FPL are subject to premiums. (Previously only those above 150% FPL were subject to premiums.)
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). (August 1, 2012)

[133] The department has since indicated that it has delayed implementation of this copay for this population; the state is working with stakeholders to potentially pursue a premium for this population instead. *Department of Public Welfare Releases Statement on Co-payment Initiative.* Department of Public Welfare, October 5, 2012. http://www.dpw.state.pa.us/.

Appendix A-6a: Benefit Related Actions Taken in the 50 States and the District of Columbia, FY 2012[134]

State	Benefit Changes in FY 2012
Alabama	**All Adults (-):** Reduced in coverage of routine eye exams and work-up for refractive error to once every three years from once every two years. Also ended coverage of eyeglasses. (June 1, 2012)
Alaska	
Arizona	**Adult (+):** Reduced adult hospice services restored. (July 2011) **All (-):** Imposed a 25-day annual inpatient hospital limit. (October 2011)
Arkansas	**All Adults: (+):** Added coverage of four additional days of inpatient psychiatric care (from 21 to 25 days) (May 1, 2012)
California	**Non-institutionalized Adults (-):** Capped hearing aid benefits at $1,510 per year including repairs, ear molds and hearing aids. (July 1, 2012) **Adults (-):** Eliminated Adult Day Health benefit and replaced with the more limited Community-based Adults Services Program. (March 31, 2012/April 1, 2012) **Adults (-):** Limited enteral nutrition. (September 1, 2011) **Children (nc):** Added coverage for concurrent hospice and curative care treatment (ACA required). (March 2, 2012)
Colorado	**Adults (+):** Added Hospice services. (May 2012) **Pregnant Women (+):** Added coverage for tobacco cessation counseling for pregnant women and women in the early postpartum period (up to 60 days postpartum) with certain limitations. (January 2012) **All (-):** Limited coverage for fluoride application and dental prophylaxis. (July 2011) **All (-):** Added prior authorization for certain radiology services. (April 2012) **All (-):** Eliminated coverage of circumcisions.(July 2011)
Connecticut	**Adults (+):** Restored adult podiatry services. (October 1, 2011) **Adults (+):** Expanded coverage for tobacco cessation services. (January 1, 2012) **Adults (-):** Limited coverage of dental services. (July 1, 2011) **Adults (-):** Limited coverage of eyeglasses. (July 1, 2011)
Delaware	
District of Columbia	**Adults (+):** Added coverage for substance abuse and rehabilitative services. **Adults (+):** Began Medicaid Emergency Psychiatric Demonstration. (July 2, 2012) **Children (+):** Added coverage of palliative and hospice services for children.
Florida	
Georgia	
Hawaii	**Aged and Disabled Adults (-):** Reduced coverage for chore services from 20 to 10 hours per week. (July 1, 2011)
Idaho	**Adults (-):** Reduced chiropractic coverage from 24 visits per year to 6. **Non-pregnant Adults (-):** Limited dental benefits for non-pregnant adults aged 21 and over to emergency dental care only. Emergency dental treatment may include medically necessary oral surgery, extractions, exams, anesthesia, and x-rays to support those services. Some palliative care will also be covered. **Adults (-):** Reduced Psycho Social Rehabilitation (PSR) coverage for adults from 5 to 4 hours/week for those over 21 years old. **Adults (-):** Aligned Medicaid therapy coverage policy with Medicare by capping physical and speech therapy for adults at $1,870 per year. Occupational therapy for adults capped separately at the same amount. **Adults (-):** Limited podiatry coverage for adults based on chronic care criteria. **Adults (-):** Eliminated coverage for eyeglasses. **Adults (-):** Limited vision coverage for adults based on chronic care criteria. **Adults (-):** Eliminated coverage for audiology services.
Illinois	
Indiana	**All (-):** Eliminated targeted case management services. (July 1, 2011) **Aged and Disabled (+):** Added coverage for bridge appointments after psychiatric hospital stay. (December 1, 2011) **Adults (nc):** Added coverage for Free-standing Birthing Centers (an ACA requirement). (January 1, 2012)
Iowa	**Adults (+):** Added coverage for additional family planning services. (December 29, 2011) **All (-):** Increased prior authorization requirements for orthodontia related to certain medical conditions. (July 1, 2011) **Aged and Disabled (nc):** Transitioned remedial services to managed care. (July 1, 2011)
Kansas	

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

State	Benefit Changes in FY 2012
Kentucky	
Louisiana	**Children (+):** Added coverage for services provided by Medical Psychologists, Licensed Psychologists, Licensed clinical social workers, Licensed professional counselors, licensed marriage and family therapists, licensed addiction counselors, Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialist In Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice). Also, added coverage for Rehabilitation Services (Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, Crisis Intervention, Therapeutic Group Home) and for Psychiatric Residential Treatment Facilities. (March 1, 2012) **Adults (+):** Using 1915(i) authority, added coverage for mental health related rehabilitation services (Treatment by a licensed mental health practitioner; Community Psychiatric Support and Treatment; Psychosocial Rehabilitation; and Crisis Intervention) for adults with incomes up to 150% FPL who meet criteria (Acute Stabilization Needs, Serious Mental Illness &/or Major Mental Disorder.) (March 1, 2012)
Maine	
Maryland	
Massachusetts	
Michigan	**Children (+):** Added coverage for Cochlear Implants. (April 1, 2012) **Children (+):** Added coverage for Polycarbonate Lenses. (January 1, 2012) **Adults (+):** Reinstated coverage of adult chiropractic services. (June 1, 2012) **All (-):** Increased the threshold for ADL needs required to obtain Home Help Services (personal care services).
Minnesota	
Mississippi	
Missouri	
Montana	
Nebraska	**Adults (nc):** Added coverage for Free-standing Birthing Centers (an ACA requirement). (July 1, 2011)
Nevada	**All (nc):** Align all coverage policies for preventative services with US Preventative Services Task Force guidelines. (April 2012)
New Hampshire	**All (-):** Limited non-emergency visits to hospital emergency room to 4 per year. (March 1, 2012) **All (+):** Removed 12 visit limit on physician services. (November 1, 2011)
New Jersey	**All (nc):** Several services carved in to managed care arrangements including home health, medical day care, prescription Rx, rehabilitation services and personal care assistant. (July 1, 2011)
New Mexico	**Adults (-):** Applied limits to Personal Care Option (PCO) benefit and reduced PCO benefit categories from 10 to 6. (September 15, 2011) **Adults (nc):** Added coverage of smoking cessation services for select eligibility groups as required by the ACA. (January 1, 2012)
New York	**All (+):** Added coverage of substance abuse screening (SBIRT) provided by office-based primary care practitioners. (Coverage previously limited to hospital outpatient departments, free-standing clinics, and emergency room settings.) (September 1, 2011) **All (+):** Expanded coverage of smoking cessation counseling for all recipients. (Coverage was previously limited to pregnant women and persons under age 21.) (April 11, 2011) **Adults (-):** Limited physical, occupational and speech therapy to 20 visits (each) per 12-month period. (Persons with developmental disabilities or traumatic brain injuries will not be subject to the limits.) (October 1, 2011) **All Adults (-):** Limited enteral formula coverage. (May 1, 2011) **All Adults (-):** Limited orthopedic footwear coverage. (April 1, 2011) **Non-Pregnant Adults (-):** Limited Compression stocking coverage. (April 1, 2011)
North Carolina	**All (-):** Revised functional requirements for personal care services to assure comparability of assessment standard across all service settings (necessary to comply with a CMS audit finding). (April 2012) **All (-):** Applied new limits to denture coverage and coverage for dental scaling and root planning (deep cleaning). (October 1, 2011) **Children (-):** Applied new utilization controls on orthodontic services. (August 1, 2011) **Adults (-):** Limited occupational therapy, physical therapy and speech therapy to 3 visits per year. (January 1, 2012) **All Adults (+):** Restored coverage for bariatric procedures with new standards and limits. (January 1, 2012) **Adults (-):** Eliminated coverage of eye exams and optical supplies. (October 2011)
North Dakota	**All (+):** Added coverage for home health telemonitoring services. (July 1, 2011)
Ohio	**Pregnant women and children (nc):** Expanded coverage for smoking cessation services (ACA required for pregnant women). (Jan. 1, 2012) **Pregnant women (nc):** Added coverage for Free-standing birth clinics (an ACA requirement) (Jan. 1, 2012) **All (+):** Added coverage for obesity screening. (Jan. 1, 2012) **Pregnant women (+):** Added medical nutritional therapy. (Jan. 1, 2012)
Oklahoma	

State	Benefit Changes in FY 2012
Oregon	**Expansion Adults (+):** Increased OHP Standard hospital benefit. (January 1, 2012) **All (-):** Eliminated coverage of 13 lines on the OHP Prioritized List of Health Services.[135] (January 1, 2012)
Pennsylvania	**Adults (-):** Reduced dental services by eliminating endodontic services, limiting dentures to 1 per lifetime and limiting cleanings to 2 per year. (September 30, 2011)
Rhode Island	**All (+):** Added coverage for a limited set of complementary alternative pain management services for the treatment of chronic pain for Communities of Care enrollees in RIte Care or Rhody Health Partners who meet established criteria. The complementary alternative services may include limited Chiropractic care, Acupuncture and Therapeutic Massage in accordance with CMS authority. (April 1, 2012)
South Carolina	
South Dakota	
Tennessee	**Non-pregnant Adults (+):** Added coverage for medically necessary smoking cessation products (previously available only to pregnant women and enrollees under the age of 21). (July 1, 2011)
Texas	**All (-):** Added requirement for a Qualified Rehabilitation Professional assessment to be conducted for fitting and receipt of wheeled mobility devices. (September 1, 2011) **All (+):** Added coverage of non-routine end stage renal disease (ESRD) services in ER. (January 1, 2012) **Children (-):** Restricted coverage for cranial molding orthosis to non-positional plagiocephaly (flattened skull). (February 1, 2012)
Utah	
Vermont	
Virginia	
Washington	**Pregnant women and LTC beneficiaries (+):** Restored comprehensive dental care for pregnant women and clients living in LTC facilities or served in HCBS waivers administered by the Aging and Disability Services Administration. (July 1, 2011) **Adults (-):** Limited dental coverage to emergency dental only for adults with intellectual disabilities who are not living in a LTC facility or served in HCBS waivers administered by the Aging and Disability Services Administration (making dental benefit the same as other non-institutionalized adults). (October 1, 2011) **Adults (-):** Eliminated coverage for hearing aids and devices. (July 1, 2011) **Adults (-):** Imposed a 12 visit per year limit on occupational therapy, physical therapy, and speech therapy. (July 1, 2011) **Adults (-):** Eliminated coverage for eyeglasses. (July 1, 2011) **Children (nc):** Added coverage of concurrent care for children in hospice. (May 1, 2012) (ACA requirement)
West Virginia	
Wisconsin	**All (nc):** Transferred administration of non-emergency transportation services from counties to the state. (July 1, 2011)
Wyoming	

[135] For more details on the specific services eliminated, see: http://www.oregon.gov/OHA/healthplan/meetings/hs-prioritized-list.pdf?ga=t.

Appendix A-6b: Benefit Related Actions Taken in the 50 States and the District of Columbia, FY 2013[136]

State	Benefit Changes in FY 2013
Alabama	
Alaska	
Arizona	
Arkansas	
California	**Adults (-):** Will limit physician and clinic visits to 7 (using a soft cap). Additional visits will require a physician certification. (January 1, 2013)
Colorado	**Adults (+):** Augment coverage for communication devices. (August 2012). **Adults (-):** Eliminate coverage for vision therapy services. (August 1, 2012)
Connecticut	**Adults (+):** Expand coverage for pharmacy assistance technology (medical equipment). (October 1, 2012)
Delaware	
District of Columbia	**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	**Non-Pregnant Adults (-):** Reduce the number of primary care physician visits covered per recipient from unlimited to 2 per month. (August 1, 2012) **Non-Pregnant Adults (-):** Reduce the number of hospital emergency department visits covered per recipient from unlimited to 6 per year. (August 1, 2012) **All (+):** Increase the maximum number of visits to FQHCs per recipient per day from 1 regardless of reason to 1 each per day for medical, dental and mental health. (August 1, 2012)
Georgia	
Hawaii	**Expansion Adults (+):** Expand benefits of QUEST-ACE and QUEST-Net to equal those for adults in QUEST. (July 1, 2012)
Idaho	**Aged and Disabled (+):** Restore dental benefits for A&D and DD HCBS waiver enrollees. (July 1, 2012) **Aged and Disabled (+):** Restore psycho social rehabilitation cuts for dually diagnosed individuals.(July 1, 2012)
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. (July 1, 2012) **Adults (-):** Limit eyeglasses to one pair every 2 years. (July 1, 2012) **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. (July 1, 2012) **Adults (-):** Inpatient detoxification admission stays will not be approved for reimbursement if there has been a previous inpatient detoxification stay within the last 60 days. (July 1, 2012) **Adults (-):** Apply stricter quantity limits for incontinence supplies. (July 1, 2012) **Adults (-):** Subject Cesarean Section codes to prepayment review (payment to be reduced to vaginal rate if not medically necessary). (September 1, 2012) **Adults (-):** Eliminate non-emergency dental and chiropractic coverage. (July 1, 2012) **Adults (-):** Limit podiatry coverage to only adults with diabetes. (July 1, 2012)
Indiana	
Iowa	
Kansas	**All (+):** Add coverage for bariatric surgery. (January 1, 2013) **Adults (+):** Add basic dental coverage for adults. (January 1, 2013)
Kentucky	
Louisiana	
Maine	**Adults (-):** Impose a limit on chiropractor visits. (September 1, 2012) **Adults (-):** Reduce vision exams from once every 2 years to once every 3 years. (September 1, 2012) **Adults (-):** Eliminate coverage for ambulatory surgical centers. (September 1, 2012) **Adults (-):** Eliminate coverage for STD Screening clinic services. (September 1, 2012) **Non-Pregnant Adults (-):** Eliminate smoking cessation products and services**.** (September 1, 2012)
Maryland	
Massachusetts	**Adults (+):** Add a hospice benefit to members in MassHealth Basic and Essential. **Adults (+):** Restore coverage for composite fillings for front teeth for adults.
Michigan	**Children (+):** Add coverage for Autism Therapy. (January 1, 2013) **All (+):** Expand coverage for full vision services. (October 1, 2012)

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

State	Benefit Changes in FY 2013
Minnesota	
Mississippi	**Children (+):** Remove 6 visit limit on Emergency Department services. (September 1, 2012) **Adults (+):** Remove 30 day limit on adult inpatient services. (October 1, 2012)
Missouri	
Montana	**Children (+):** Implement 1915i HCBS services for Seriously Emotional Disturbed (SED) children to include current 1915c waiver services plus 4 new services: peer to peer, co-occurring, crisis intervention, and specialized evaluation services. (October 1, 2012)
Nebraska	
Nevada	**Adults (nc):** Add coverage for Free-standing Birthing Centers (an ACA requirement). (August 2012)
New Hampshire	
New Jersey	
New Mexico	**Adults (+):** Add coverage for methadone clinic services. (September 1, 2012)
New York	**All Adults (+):** Expand coverage of podiatry services, to include private office-based podiatrists, for adults age 21 and older with diabetes mellitus. (June 1, 2012) **All (+):** Add coverage of obesity counseling, home lead investigations, and environmental asthma investigations. **All (+):** Add coverage of medical language interpretation. (September 1, 2012) **Pregnant women (+):** Add coverage for lactation counseling for eligible pregnant women and expanding coverage of Nurse Family Partnership home visits for pregnant women and new mothers. **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. (June 1, 2012)
North Carolina	
North Dakota	**Pregnant women (nc):** Expand coverage for smoking cessation services (ACA requirement for pregnant women). (July 1, 2012)
Ohio	
Oklahoma	
Oregon	
Pennsylvania	
Rhode Island	**Aged and Disabled (+):** Add Behavioral Health benefit for PCCM Connect Care Choice (CCC) Members to see mid-level practitioners who are co-located in CCC Primary Care practice sites. (August 1, 2012) **Aged and Disabled (+):** Add coverage for nutrition services (pending approval). **Aged and Disabled (+):** Add coverage for Group Education services (pending approval).
South Carolina	
South Dakota	**Adults (-):** Impose a $1,000 annual limit on adult dental services. (July 1, 2012)
Tennessee	
Texas	**Adults (-):** Remove coverage of binaural hearing aids and related services. (October 1, 2012) **All (+):** Add axis changes as criteria for replacement lenses for vision services. **All (+):** Add coverage of new indications for Onabotulinum (Botox).
Utah	
Vermont	
Virginia	
Washington	**Children (+):** Add coverage of Applied Behavioral Analysis for children with autism. (January 1, 2013). **Pregnant Women (nc):** Expand coverage for smoking cessation services (ACA required for pregnant women).
West Virginia	
Wisconsin	
Wyoming	

Appendix A-7a
Pharmacy Cost Containment Actions in Place in the 50 States and the District of Columbia
FY 2012

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	
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	
Masschusetts	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	
Rhode Island	x	x	
South Carolina	x	x	x
South Dakota			
Tennesee	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	
Total	**46**	**46**	**16**

Appendix A-7b
Pharmacy Cost Containment Actions Taken in the 50 States and the District of Columbia
FY 2012-2013

States	Impose Script Limits		Reduce Disp Fee		Reduce Ingredient Cost		Preferred Drug List		Suplemental Rebates		Specialty Drug		Other Actions	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Alabama	x												x	
Alaska					x								x	x
Arizona													x	
Arkansas							x	x	x	x				
California													x	
Colorado					x	x	x	x	x	x		x		
Connecticut			x		x		x		x	x				
Delaware														
District of Columbia					x		x	x						x
Florida														
Georgia								x		x		x		x
Hawaii						x								
Idaho					x									
Illinois		x		x	x	x						x		
Indiana			x									x	x	x
Iowa						x							x	
Kansas							x			x		x		
Kentucky														
Louisiana						x								
Maine	x				x								x	x
Maryland			x											x
Massachusetts														
Michigan							x				x		x	
Minnesota					x								x	
Mississippi							x	x	x	x				
Missouri														x
Montana														
Nebraska														
Nevada												x		
New Hampshire														
New Jersey													x	
New Mexico													x	
New York			x		x		x	x	x	x			x	
North Carolina						x						x		
North Dakota														
Ohio													x	
Oklahoma														x
Oregon														
Pennsylvania	x		x											
Rhode Island														
South Carolina			x		x		x	x	x	x				
South Dakota			x		x									x
Tennessee													x	
Texas			x			x	x		x		x		x	
Utah							x	x	x	x				
Vermont							x	x	x	x	x		x	x
Virginia					x		x	x	x	x			x	
Washington												x	x	x
West Virginia														
Wisconsin					x						x		x	x
Wyoming						x					x			x
Total	**3**	**1**	**8**	**1**	**13**	**8**	**13**	**10**	**10**	**11**	**5**	**8**	**19**	**13**

Appendix A-8
Managed Care Actions in the 50 States and the District of Columbia
FY 2012 - FY 2013

States	Geographic Expansions		Add Eligibility Groups		New Mandatory Enrollment		Managed Long Term Care		Quality Initiative and Major Contract Changes		Any of these Actions	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Alabama	x		x				x				x	
Alaska												
Arizona												
Arkansas				x						x		x
California	x	x			x	x		x	x	x	x	x
Colorado	x		x	x	x			x	x	x	x	x
Connecticut												
Delaware			x				x				x	
District of Columbia										x		x
Florida		x										x
Georgia				x		x				x		x
Hawaii												
Idaho		x										x
Illinois		x		x				x		x		x
Indiana										x		x
Iowa		x										x
Kansas						x		x		x		x
Kentucky	x		x		x						x	
Louisiana	x	x	x		x				x	x	x	x
Maine												
Maryland										x		x
Massachusetts								x	x	x	x	x
Michigan			x	x		x					x	x
Minnesota					x				x	x	x	x
Mississippi		x				x						x
Missouri									x		x	
Montana												
Nebraska		x		x								x
Nevada		x								x		x
New Hampshire		x								x		x
New Jersey			x	x	x	x		x	x	x	x	x
New Mexico												
New York	x	x	x	x	x	x	x	x	x		x	x
North Carolina		x	x								x	x
North Dakota												
Ohio				x				x	x		x	x
Oklahoma												
Oregon			x	x	x	x			x	x	x	x
Pennsylvania		x				x				x		x
Rhode Island				x				x		x		x
South Carolina							x			x	x	x
South Dakota												
Tennessee								x				x
Texas	x		x				x		x	x	x	x
Utah									x		x	
Vermont				x								x
Virginia	x	x	x						x	x	x	x
Washington				x		x						x
West Virginia				x						x		x
Wisconsin	x	x							x	x	x	x
Wyoming												
Total	**9**	**15**	**12**	**14**	**8**	**10**	**5**	**10**	**14**	**23**	**20**	**35**

Appendix A-9: Managed Care Quality Initiatives and Contract Changes, FY 2012 and FY 2013

State	Fiscal Year	Description of Managed Care Quality Initiative or Contract Change
Arkansas	2013	Included quality measures as part of the Arkansas Health Care Payment Improvement Initiative.
California	2012	- Identified new 2013 HEDIS Performance Measures, including stratifying specific measures for SPDs. - Implemented the new Statewide Collaborative on Reducing Hospital Readmissions - baseline data stage. - Required individual plan Quality Improvement Projects based on HEDIS scores. - Developed measures for monitoring Patient Centered Medical Home. - Required plans to report on SPD related quality activities.
	2013	- Identify new 2014 HEDIS Performance Measures. - Implement an All Cause Readmissions (ACR) statewide collaborative - intervention stage. - Ensure all beneficiaries enrolled in Medi-Cal managed care have access to a medical home. - Increase access to medical homes through managed care expansion into currently FFS-only counties. - Establish process for plans to contact beneficiaries for care coordination when a medical exemption request (MER) is denied.
Colorado	2012	Included incentive payments in Accountable Care Collaboratives.
	2013	Implement gain-sharing with FQHC/RHCs.
District of Columbia	2013	Modified pay-for-performance program to include new measures (reducing preventable hospital admissions and low-acuity emergency room visits), and modified P4P reimbursement structure (eliminating withhold in favor of bonus payment)
Georgia	2013	Renegotiated 2013 CMO contracts to reflect value-based purchasing approach. Per renegotiated contracts, will track improvement on 32 measures; contracts contain added quality measures and P4P to reflect enhanced emphasis of certain measures. Providers will have incentives to move toward state's goals.
Illinois	2013	Implement P4P for HMOs and possibly Coordinated Care Entities (CCEs).
Indiana	2013	Tighten contract language and increase quality outcome requirements within managed care contracts.
Kansas	2013	Develop new quality measures and a new P4P.
Louisiana	2012	Implemented a new MCO/PCCM Shared Savings program.
	2013	Add dental and pharmacy benefits to existing MCO contract and new PAHP for FFS dental.
Maryland	2013	Increase the withhold percent of capitation used for P4P from 0.5% to 1.0%.
Massachusetts	2012	--The PCC-BH Contractor completed three performance improvement projects, one of which provided incentives to community mental health centers to improve the community tenure of their members and unaffiliated members in their community.
	2013	Finalizing improvement initiatives for FY13, baseline year will be CY 2011, measurement period CY 2012. --Completing negotiations for a Care Management program for PCC Plan members to begin on October 1, 2012. The contractor will enroll up to 4,000 members in three tiers of Care Management. The contractor will receive a per participant per month allotment for members in the program and also be eligible for incentives for improving health outcomes participants in the program. --In addition, the contractor will have a pool of $4 million for Pay for Performance measures: three are HEDIS behavioral health measures; one if for improving primary care for members who are clients of the state Department of Mental Health. --The new contract also includes a section on Care Integration to measure the bi-directional activity between behavioral health providers and primary care clinicians. --The new PCC-BH contract will expand the risk for the contractor from a 50% share in 2013 to full risk in FY 2015. --Pursue payment reform initiatives that will reward effective and efficient care and decrease fee for service payment based system.
Minnesota	2012	Conducted competitive MCO bidding for 7-county Minneapolis/St Paul region (for childless adults and low-income families and children).
	2013	Expand competitive bidding to other regions.
Missouri	2012	- Established rates to increase budget predictability. - Enhanced service delivery by restricting number of health plans to up to three per region. - Enhanced fraud and abuse, liquidated damages and oversight provisions. - Required health plans to provide incentive payments for meaningful use of EHR. - Implemented behavioral and medical health homes.

State	Fiscal Year	Description of Managed Care Quality Initiative or Contract Change
Nevada	2013	Add new quality measures in managed FFS program.
New Hampshire	2013	Include 5% quality withhold in new MCO contracts.
New Jersey	2013	Develop new quality strategy plan under Comprehensive Waiver (waiver implementation TBD.)[137]
New York	2012	- Added some long-term care services and orthodontia to managed care contracts. - Require coverage of dental in contracts. - Carved out transportation services. - Revised statutory changes to external appeal requirements. - Implement requirement of annual reporting of care management data. Data used for evaluation of quality of care management programs and outcomes for members involved in care management services.
Ohio	2012	- Launched Medicaid quality strategy. - Aligned P4P to new Medicaid quality strategy and funding method went from at-risk to a pure bonus.
Oregon	2012	Developed baseline for quality metrics as part of Community Care Organizations (CCO) implementation.
	2013	Implement a 1% withhold for timely and accurate data related to quality metrics in year 2 of CCOs. CCOs will be required to meet quality metrics to obtain a financial incentive that includes the 1% withhold.
Pennsylvania	2013	Transition from contract compliance monitoring of managed care contracts to quality improvement monitoring.
Rhode Island	2013	Included long-term care services in new contract.
South Carolina	2013	- Reduced administrative fee by 1% and moved to incentive program (7/1/2012). Will retrospectively apply the withhold in April 2013. - Remove withhold of 1.5% from managed care rates and put into a pool that will be dispensed in the fall of 2014. (3/1/2013 - 12/31/2013) - Require plans to work on 10 quality programs from those listed on the report card and show a 1% increase in improvement. One item will be mandatory and plans can choose the other nine. Outcome of the plans improvement on the quality item will affect withhold incentives.
Texas	2012	- Implemented the Performance-Based Capitation Rate (5% at-risk), & Quality Challenge Award in contracts. The 5 Percent at Risk and Quality Challenge Program for Health and Dental Plans place each plan at risk for up to 5% of their capitation payment, depending on the outcome of performance measures. Any funds that are recouped are awarded to plans based on their performance, relative to each other, on a second set of quality metrics. - The Uniform Managed Care Contract (UMCC) was reprocured in March 2012.
	2013	Pay for quality measures from 5% withhold pool as of January 2013.
Utah	2012	- Changed all health plans to capitated full risk MCOs. - Capitated substance abuse services.
	2013	- Add pharmacy benefit to capitated plans.
Virginia	2012	- Revised Managed Care Quality Strategy to include MCO involvement and public comment periods. It is a five year strategy and it includes both Medicaid and CHIP, whereas the previous version was for Medicaid only.
	2013	- Add comprehensive well child visits for adolescents as well as follow-up with Medicaid/CHIP members after discharge from a mental health hospital stay.
West Virginia	2013	Include Pay for performance.
Wisconsin	2012	- Carve out non-emergency medical transportation (NEMT) in 6 counties with implementation of NEMT vendor. - Expanded P4P program for HMOs, prepared for Striving to Quit initiative
	2013	Implement Striving to Quit and Strong Start initiatives

[137] New Jersey received CMS approval of its Comprehensive waiver proposal on October 2, 2012. http://www.state.nj.us/humanservices/dmahs/home/CMW_approval_letter.pdf.

Appendix A-10
Medicaid Care Coordination Initiatives
FY 2012-2013

States	Behavioral / Acute Care		PCMH		Health Home		LTC & Acute Care		ACOs		Quality		Other Actions	
	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Alabama		x	x			x					x			
Alaska				x										
Arizona														
Arkansas	x	x	x	x	x	x	x	x			x	x	x	x
California		x				x		x		x		x		
Colorado	x	x	x	x			x	x	x	x	x	x		
Connecticut	x		x			x				x	x	x		
Delaware				x		x								
District of Columbia											x	x	x	
Florida														
Georgia				x								x		
Hawaii		x		x		x				x		x		
Idaho		x		x		x						x		
Illinois		x		x				x				x		
Indiana		x		x		x		x				x		
Iowa		x		x		x		x						
Kansas		x		x		x		x		x		x		x
Kentucky														
Louisiana	x		x	x							x			
Maine		x		x		x				x		x		
Maryland	x	x	x			x								
Massachusetts	x	x	x	x		x		x		x	x	x		
Michigan		x	x											
Minnesota			x	x		x		x	x	x		x		
Mississippi		x		x		x						x		
Missouri	x		x		x	x			x		x			x
Montana														
Nebraska			x	x								x		
Nevada		x		x		x						x		
New Hampshire		x		x		x		x			x	x		
New Jersey	x	x	x	x		x		x		x	x	x		
New Mexico			x	x		x		x				x		
New York	x	x	x	x	x	x					x	x		
North Carolina		x				x					x	x		
North Dakota													x	
Ohio			x			x				x				
Oklahoma						x				x	x			x
Oregon	x	x	x	x	x	x				x	x	x		
Pennsylvania	x	x	x	x									x	
Rhode Island	x		x	x	x	x					x			
South Carolina	x			x							x			
South Dakota														
Tennessee			x	x										
Texas			x				x				x		x	x
Utah		x								x				
Vermont	x	x	x	x		x		x			x	x	x	x
Virginia		x		x							x	x	x	x
Washington		x		x		x		x				x		x
West Virginia						x								x
Wisconsin	x	x	x	x	x	x						x		x
Wyoming	x	x	x	x		x	x				x			
Total	**16**	**28**	**23**	**32**	**6**	**31**	**4**	**14**	**3**	**13**	**20**	**27**	**7**	**10**

Appendix B: Profiles of Selected States:

- **Massachusetts**
- **Ohio**
- **Oregon**
- **Texas**

1. Massachusetts Case Study

State Budget

Massachusetts, like most states, has faced tremendous fiscal challenges resulting from the Great Recession that began in 2007. While state revenues have continued to improve since 2009, lawmakers nevertheless faced a projected $1.3 billion shortfall as they met in 2012 to write the FY 2013 budget.[138] On July 8, 2012 – eight days into the new fiscal year – Governor Deval Patrick signed into law the FY 2013 state budget which was balanced through cuts, savings measures, small revenue initiatives and the use of $615 million in one-time funds including rainy days fund and other dedicated fund transfers.[139] The largest sources of savings are MassHealth savings initiatives. Overall, the FY 2013 budget grew by approximately 4 percent with modest increases for K-12 education.[140]

The FY 2013 budget for MassHealth (the state's Medicaid program) grew by 5.3 percent – a substantially lower increase than originally projected. To achieve the lower expenditure growth rate, the budget requires $478 million in net savings through payment reforms, long-term care changes and a combination of program integrity activities and cash management strategies. The budget makes a few new MassHealth investments including improvements to enrollment and redetermination processes, health reform implementation funding, infrastructure and capacity building grants for certain hospitals and community health centers, restoration of limited adult dental services, supplemental rate payments for pediatric hospitals and higher rates for Personal Care Attendants providing in-home services.[141] The FY 2013 budget also includes the following health care-related provisions:

- *Delivery System Transformation Initiatives Trust (DSTI) Fund and Grants:* A transfer of $186.9 million to the DSTI Fund will be used for incentive payments to seven safety net hospitals for activities to improve health delivery and payment systems.
- *Prescription Advantage.* The budget decreases funding for the Prescription Advantage program reflecting reduced utilization expected as a result of expanded Medicare coverage for drug costs.
- *Academic Detailing.* Funding is increased by $500,000 to promote cost-efficient drug prescribing practices among providers that serve a high number of MassHealth members.[142]

Health Care Cost Containment

Due to state health reforms passed in 2006 that include an individual mandate and subsidized coverage of uninsured low-income residents, Massachusetts has the lowest uninsured rate in the country: over 98 percent of non-elderly residents have health insurance and nearly 100 percent of children are covered.[143] A decision was made to address access issues in the 2006 reforms and to address cost issues in subsequent legislation. Like all states, the cost of health coverage to the state budget is significant. In FY 2013, total spending on MassHealth accounts for $11 billion of the $32.5 billion budget. Most of the recent growth in the MassHealth budget has been driven by increased enrollment as a result of the economic downturn. However, comprehensive health care cost containment that benefits public payers, employers, and families has been an

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[138] Noah Berger, *"FY 2013 Budget Preview,"* Massachusetts Budget and Policy Center, January 18, 2012; accessed at http://www.massbudget.org/report_window.php?loc=fy13_budget_preview.html.
[139] *"Budget Monitor: The FY 2013 Budget,"* Massachusetts Budget and Policy Center, September 17, 2012; accessed at http://www.massbudget.org/report_window.php?loc=budget_monitor_gaa_fy13.php.
[140] *"Governor Patrick Signs FY 13 Budget,"* Office of Governor Deval Patrick Press Release, July 8, 2012, accessed at http://www.mass.gov/governor/pressoffice/pressreleases/2012/20120708-fy13-budget.html.
[141] *"MassHealth and Health Reform Funding in the FY 2013 General Appropriations Act,"* Massachusetts Medicaid Policy Institute Budget Brief, August 2012; accessed at: http://www.massmedicaid.org/~/media/MMPI/Files/FY2013GAAFINAL.pdf.
[142] Ibid.
[143] Division of Health Care Finance and Policy, Commonwealth of Massachusetts; *Key Indicators; Quarterly Enrollment Update, June 2011 Edition;* February 2012; Accessed August 2012 at: http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf.

area of focus for Massachusetts since the beginning of the Patrick administration. Six years after enacting near-universal health care coverage legislation, Massachusetts once again passed groundbreaking legislation aimed at reducing health care cost growth by $200 billion over 15 years. The new law enacted August 6, 2012, limits health care spending growth to no more than the gross state product (GSP)[144] through 2017, and no more than a half-percentage point below GSP for five years starting in 2018.[145] The law prescribes a number of mechanisms to help achieve the target expenditure savings while improving quality, including the following:[146]

- *Payment Restructuring:* Medicaid and other state-funded health care programs must transition to new payment methodologies that incentivize delivery of quality care that is coordinated, efficient and effective while reducing waste, fraud and abuse.
- *Accountable Care Organizations Certification*: The law includes certification standards for ACOs and provides for preferential consideration of certified ACOs for state-funded health care programs.
- *Wellness Investments*: A wellness tax credit of up to $10,000 per employer is available for companies that implement workplace wellness programs, and health insurance companies must provide a premium adjustment for small businesses that adopt such programs. The law also dedicates $60 million over four years to community-based public health initiatives to reduce rates of chronic conditions such as obesity, diabetes, and asthma.
- *Health System Supports*: A dedicated $135 million over 4 years supports community hospitals' transition to new payment methodologies and care delivery models; $30 million assists providers to adopt interoperable electronic health records; and $20 million goes to the Health Care Workforce Transformation Trust Fund to support health care workforce training.
- *Access to Services*: The law expands the role of physician assistants and nurse practitioners to that of primary care providers; expands a workforce loan forgiveness program for behavioral health providers; and establishes a new primary care residency program.
- *Transparency and Accountability*: Reporting requirements for all health care provider systems, and a new "Cost and Market Impact Review" to assess the impact of policy and reimbursement changes on cost, quality, and market competiveness are established. The law also establishes a process to monitor price variation among providers. The Attorney General is charged with monitoring and investigating market trends that affect patient access and quality.
- *Consumer Transparency:* A consumer health information website with prices and other online tools to support price and quality comparisons is authorized.
- *Malpractice Reform*: The law includes measures to promote the negotiated early settlement of medical malpractice cases. Also, providers or facilities that admit a mistake or error are protected from having the statement used as admission of guilt in court, unless a provider lies under oath about the error or mistake.
- *Pharmaceutical Purchasing*: State agencies responsible for purchasing prescription drugs are required to form a uniform procurement unit for bulk purchasing, and a commission responsible for determining other methods to reduce drug costs is created.

[144] GSP is a state's economic output, a measurement similar to the nation's gross domestic product (GDP).
[145] In June, Massachusetts' annualized 2012 GSP was 4%. UMass Donahue Institute Economic and Public Policy Research unit; Current and leading indices, June 2012; accessed August 2012 at: http://www.massbenchmarks.org/indices/indices.htm.
[146] Health Care for All Massachusetts; http://hcfama.org/_data/n_0001/resources/live/Conference-%20Next%20Phase%20of%20HCR%20Final%20Summary.pdf.

Dual Eligible Integration Initiative

On August 23, 2012 CMS announced Massachusetts as the first state to partner with CMS under the Financial Alignment Demonstration initiative to improve care coordination and financing for dual eligibles. Massachusetts entered into a Memorandum of Understanding (MOU) with CMS to contract with Integrated Care Organizations (ICOs) responsible for managing and coordinating the care of duals. Approximately 110,000 of the state's 270,000 duals would be eligible to participate in the program.[147, 148] Enrollment into the program begins April 1, 2013. The state released a Request for Responses (RFR) to procure ICOs for the program in June.

Technology Improvements

In anticipation of ACA implementation in January 2014, Massachusetts leveraged a number of federal funding opportunities[149] to develop the web portal, eligibility and enrollment systems needed for the one-stop shopping experience that will be available through the state Health Insurance Exchange called the Health Connector. Noting it as one of the Commonwealth's top priorities, the state is taking an integrative approach to develop a "best-in-class system" to determine eligibility for the full range of health coverage programs in the state and for premium tax credits and cost sharing subsidies.[150] The Integrated Eligibility System (IES) will use a web-based application to determine eligibility for Medicaid or CHIP, and to enroll in those programs real-time. The system will also determine eligibility for tax credits for employers or employees shopping for health insurance through the Exchange. In the future, the state plans to expand the IES to include eligibility for other public assistance programs including the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance to Needy Families (TANF).

In addition to the policy initiatives discussed above, Massachusetts made, or is planning a number of Medicaid policy changes summarized below.

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[147] Centers for Medicare & Medicaid Services Office of Public Affairs; press release August 23, 2012; accessed August 2012 at: http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4436&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

[148] Memorandum of Understanding between CMS and the Commonwealth of Massachusetts Regarding a Federal State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees; Accessed August 2012 at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf.

[149] Massachusetts received an Early Innovator grant from CMS to lead a consortium of states – the *New England States Collaborative for Insurance Exchange Systems (NESCIES)* project. Participating states include Connecticut, Maine, New Hampshire, Rhode Island and Vermont. See: *Massachusetts Application for the Cooperative Agreement to Support Innovative Exchange Information Technology Systems*; December 22, 2010; Accessed August 2012 at: http://www.nescies.org/sites/www.nescies.org/files/NewEnglandCollaboration.pdf. The state also received CMS approval of its APD for the 90/10 federal match for developing the system, an Exchange Planning Grant, and a Level 1 Exchange Establishment grant.

[150] MassHealth Roadmap to 2014, Affordable Care Act Transition Plan (Draft), July 1, 2012; accessed August 2012 at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/120701-masshealth-roadmap-to-2014.pdf.

Provider Rates

- In FY 2012, increased provider rates for inpatient hospital and nursing homes and decreased rates for MCOs.
- In FY 2013, increasing provider rates for inpatient hospitals, primary care physicians, specialty physicians, MCOs, nursing homes and outpatient behavioral health providers. Physician rate increases are in addition to the ACA required increases for primary care services beginning January 1, 2013.

Eligibility and Enrollment Changes

In FY 2012:

- The administrative renewal process was expanded to include community residents who receive social security as a sole income source.

In FY 2013:

- Implement new electronic data match with MA Department of Revenue Quarterly Wage data to identify households with income over 310% FPL to send a form for updated job information.
- Implement ExpressLane Eligibility with SNAP caseload as basis for family renewal of MassHealth benefits.
- Launch telephonic renewal pilot in 1 of 4 enrollment centers to explore viability of potential statewide rollout.

Cost Sharing

In FY 2012:

- Increased pharmacy co-pays for generic and brand name drugs from $3.00 to $3.65 with some exceptions.
- Increased Commonwealth Care (state's program for low-income uninsured adults) co-pays for members below 100% FPL to align with MassHealth co-pays.

Benefit Changes

In FY 2013:

- Adding a hospice benefit to members in MassHealth Basic and MassHealth Essential, subject to CMS approval of an amendment to Massachusetts' 1115 Demonstration Project.
- Restoring coverage for composite fillings for front teeth of adults.

Long-term Care

In both FY 2012 and FY 2013:

- Continued downsizing of state MR institutions.
- Continued transition of ID/DD individuals from SNFs to community-based settings.
- Continued transition of other SNF residents to community-based settings (using Money Follows the Person Demonstration and various HCBS waivers).

Managed Care

In FY 2012:

- Implemented significant enhancements to quality initiatives for all managed care products.

In FY 2013:

- Implementing a dual eligible demonstration (see narrative above).
- New behavioral health managed care contract will include:
  - Pay-for-performance tied to meeting HEDIS behavioral health measures and for improving primary care for members who are clients of the state Department of Mental Health.
  - Measures to assess bi-directional integration activity between behavioral health providers and primary care clinicians.
  - An expanded risk arrangement: contractor assumes 50% in 2013 and 100% in 2015.

Other

In FY 2012:

- MassHealth increased targeted field audits to enhance program integrity.

In FY 2013:

- Launching payment reform initiatives to improve access, quality, patient experience, and to better integrate and coordinate physical health and behavioral health services.
- Incorporating pre-payment screening of Medicaid claims.
- Using SAVE (Systematic Alien Verification for Entitlement) program to verify immigration status.

2. Ohio Case Study

State Budget Overview

When Governor John Kasich took office in January 2011, he faced a budget deficit of $7.7 billion and a state rainy day fund balance of just 89 cents.[151] While improved state revenue collections helped to partially close the gap, Ohio lawmakers addressed the remaining shortfall by adopting a two-year state budget in June 2011 that cut funding to local governments and schools over the two-year period by more than a billion dollars each compared to the previous biennium.[152] Other non-Medicaid state spending was also reduced by nearly $700 million and authority was provided to the Governor to sell six prisons and to pursue a long-term lease of the Ohio Turnpike to a private operator.[153] At the same time, lawmakers eliminated the state's estate tax starting in 2013, reduced the scope of the state's prevailing wage law and transferred control of the state's wholesale liquor business (through a 25-year lease) to the state's privately run job creation agency, JobsOhio.[154] One year later, the state ended FY 2012 with a $482 million rainy day fund balance resulting from higher than anticipated tax revenues and lower than expected spending, particularly in Medicaid.[155]

Medicaid Reform

Three days after taking office, Governor Kasich signed Executive Order 2011-02K creating the Governor's Office of Health Transformation (OHT) charged with reforming the state's Medicaid program, streamlining state health and human services programs and working with private sector partners to improve overall health system performance in Ohio.[156] In his State of the State Address two months later, the Governor reiterated his call for dramatic government reform, especially reform of the state's Medicaid program.[157] As a result, the 2011-2013 state budget included a number of measures intended to modernize the Medicaid program to both improve quality and stabilize Medicaid program spending by rewarding value instead of volume. Chief among these reforms was completing the transition of the nursing facility reimbursement system from a "cost-based" system to a "price-based" system that rewards efficiency. The budget also reduced FY 2012 nursing facility rates, on average, by 5.8 percent, saving the state $360 million over two years. At the same time, funding for Medicaid home and community-based services was expanded, making it possible to serve an additional 12,890 Ohioans in community settings. Other reforms included:

- Authorizing the creation of a new Integrated Care Delivery System (ICDS) for dual eligibles and persons with severe and persistent mental illness;
- Investing $47.25 million over the biennium to create health homes for individuals with severe and/or multiple chronic illnesses;
- Expanding Medicaid presumptive eligibility for pregnant women and children;
- Integrating Medicaid alcohol and drug treatment and mental health carve-out benefits (previously administered separately by the Departments of Mental Health and Alcohol & Drug Addiction Services) into the overall Medicaid program, improving coordination of these services, and

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[151] Director Timothy S. Keen, "Reduce, Reform, Revitalize: *The 3 Rs of Governor Kasich's Mid-Biennium Review,"* Ohio Office of Budget and Management, June 21, 2012; accessed at http://obm.ohio.gov.

[152] Wendy Patton, *"We Deserve a Better Business Plan,"* Policy Matters Ohio, Issue Brief, August 1, 2011; Wendy Patton, *"A Thousand Blows: State Budget Slashes Funding for a Broad Swath of Local Government Services,"* Policy Matters Ohio, Issue Brief, August 31, 2011.

[153] "An Overview of the State of Ohio FY 2012-12 Budget," Office of Budget and Management; accessed at http://obm.ohio.gov/SectionPages/Budget/OperatingBudget.aspx.

[154] Ibid.

[155] Aaron Marshall, "Gov. John Kasich: Rainy day fund to see boost to $482 million, but price tag from health care looms," Cleveland Plain Dealer, July 3, 2012.

[156] Governor John Kasich, Executive Order 2011-02K, Creating the Governor's Office of Health Transformation, January 13, 2011; accessed at http://www.governor.ohio.gov/Portals/0/pdf/executiveOrders/EO2011-02.pdf.

[157] Mark Naymik, "Gov. John Kasich warns of dramatic operational and political change ahead," Cleveland Plain Dealer, March 8, 2011.

- Transitioning the financial responsibility for the non-federal share of Medicaid matching funds for alcohol and drug treatment and mental health carve-out benefits from community behavioral health boards to the state.[158]

Additional Medicaid reform legislation was enacted during the 2012 legislative session as a part of the Governor's "Mid-Biennium Review" (MBR) process that challenged cabinet agencies to undertake a top to bottom review of operations and programs to identify opportunities to reduce the cost of government and revitalize Ohio's ability to attract and retain jobs. Among the numerous reforms and improvements impacting the various health and human services agencies were the following Medicaid-related measures:

- Amendments to the state's privacy laws to make them consistent with federal HIPAA rules, thereby promoting adoption of electronic health information exchange;
- Elevation of the Medicaid Director to a cabinet-level position appointed by the Governor;
- Investment of $3 million in additional community mental health funding on local "hot spots" using innovative approaches to care for high-cost and difficult-to-serve populations;
- Creation of a Medicaid quality incentive payment initiative, and
- Direction of additional funds to ensure access to nursing facilities with low vacancy rates and high Medicaid utilization in poor communities that are federally designated empowerment zones.[159]

Medicaid Eligibility Modernization Project

Driven in part by the Medicaid enrollment simplifications required by the ACA, the OHT released a proposed Section 1115 Demonstration Waiver request in June 2012 that would build upon, but go beyond, the ACA requirements to dramatically transform Ohio's Medicaid eligibility determination process. Specifically, Ohio's proposed "Medicaid Eligibility Modernization Project" waiver would:

- Simplify the Medicaid eligibility categories, from the current 150+ categories to three eligibility groups;
- Procure and implement a new eligibility and enrollment system, replacing the 30-year old system; and
- Streamline state and local responsibility for eligibility determinations.

The proposal, intended to be implemented at the same time as the ACA (January 1, 2014), would further collapse the simplified ACA categories and also fold some non-institutionalized adults in the Aged, Blind, and Disabled category into the new simplified "Community Adults" category. There would be no asset test for this category and Express Lane Eligibility data matching options would be used as well. The Health Policy Institute of Ohio recently commented: "According to national experts who track waiver proposals, this is precedent setting, and if approved, Ohio would set a national benchmark for simplification:"[160]

Following the release of the proposed waiver, the Supreme Court of the United States ruled in *National Federation of Independent Business v. Sebelius*[161] that the ACA's Medicaid expansion is essentially optional for states, throwing in doubt some aspects of the future of the proposed waiver (i.e. whether adult Medicaid eligibility will extend to 100 or 138 percent of the FPL). At the time of the survey, the state had not yet decided whether to expand Medicaid citing concerns over the potential fiscal impact to the state.

In this year's survey, Ohio reported the following Medicaid policy changes for FYs 2012 and 2013.

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[158] "Final Report on Medicaid Transformation in HB 153: *Creating better health, better care and cost savings through improvement,*" Governor's Office of Health Transformation; accessed at: http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=pKA95cQm_CM%3d&tabid=102.
[159] "Final Report on Health and Human Services Reforms in the Mid-Biennium Review: *Transforming Health Care and Creating a Healthy and Productive Workforce,"* Governor's Office of Health Transformation; accessed at: http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=UpReqSPByaE%3d&tabid=134.
[160] "Modernizing Medicaid Eligibility," Health Policy Institute of Ohio, June 2012.
[161] 567 U.S. ___ (2012). The case was heard together with *Florida v. Department of Health and Human Services.*

Provider Rates and Provider Taxes/Assessments
In FY 2012: • Rate decreases imposed on nursing facilities, physicians, nursing and home aids. • Inpatient hospital outlier policy change resulted in reimbursement reduction. • Rate increase granted to ICFs. • Implemented DME selective contracting. • Reduced MCO rates by 3.7% to 3.8%. • Increased provider franchise fees for hospitals, ICFs/MR-DD, and nursing facilities. In FY 2013: • No rates are being increased except nursing facility rates (current rate formula will generate higher average rates due to case mix acuity increases; the state did not enact an increase in rates.) • Increased provider franchise fees for ICFs/MR-DD.
Eligibility, Application and Renewal Changes
In FY 2012: • Implemented Family Planning waiver expansion (78,000 persons affected). (January 8, 2012) • Removed resource requirement for 19 and 20 year old "Ribicoff Kids." (5,500, 10/1/2011) • Removed face-to-face interview requirement for Aged, Blind & Disabled eligibility determinations (January 9, 2012) • Allowed hospitals, FQHCs and FQHC look-alikes to determine presumptive for children and pregnant women. (April 1, 2012)
Benefit/Service Changes
In FY 2012: • Expanded coverage for smoking cessation services for pregnant women (ACA required) and children. (January 1, 2012) • Added coverage for free-standing birth clinics (an ACA requirement). (January 1, 2012) • Added coverage for obesity screening. (January 1, 2012) • Added coverage for medical nutritional therapy for pregnant women. (January 1, 2012)
Pharmacy
• In FY 2012, carved the pharmacy benefit into MCO contracts.
Long-Term Care
In FY 2012: • Implemented the SELF waiver for persons with DD/ID. (January 1, 2012) • Reduced covered nursing facility leave days from 30 to 15 and changed reimbursement percentage from 50% to 25%. (January 1, 2012) In FY 2013: • Implementing Quality Incentive Payment Reform program for nursing facilities. (July 1, 2012)
Managed Care and Care Coordination
In FY 2012: • MCO P4P measures were aligned to new Medicaid quality strategy and funding method went from at-risk to a pure bonus. • Medicaid working with Department of Health to support statewide promotion of patient-centered medical homes. In FY 2013: • Implementing Integrated Care Delivery System dual eligible demonstration. (April 2013) • Implementing Health Homes for persons with severe and persistent mental illness. (October 1, 2012)

3. Oregon Case Study

State Budget Overview

Oregon has a biennial budget, but the legislature meets annually so that both executive and legislative changes are possible during a biennium. The Executive Recommendation for the 2011-13 biennium assumed a continuation of weak revenues experienced during the 2009-11 biennium. The Governor therefore recommended reductions in State support for higher education, corrections and human services programs and assumed savings through state agency consolidations and other efficiencies. Absent cuts to the baseline spending, Oregon would have faced an estimated $3.5 billion General Fund hole for FY 2011-2013.[162]

The enacted budget relied upon across the board reductions including continuation of cuts used to bring the FY 2009-2011 appropriation into balance and caps on inflationary adjustments. To shield against unanticipated State revenue shortfalls, the Legislature established a 3.5% "hold back" across all appropriations. These funds would only be available to agencies if the state's economy stabilized over the biennium.

During the 2012 legislative session, the 2011-2013 appropriation was marginally increased as revenues improved. The final budget that was passed with the 2012 changes totaled $58.8 billion Gross / $14.8 billion General Fund, which represents an increase of General Fund spending of about $1.18 billion, but a 5.5% decrease in total spending from the $62.2 billion for the prior biennium. The primary reason for the decrease is the reduced federal funding (by nearly 16%) as a result of the end of the economic stimulus funding and unemployment benefit extension programs. [163]

Medicaid Budget and Policy Actions

As noted above, Oregon would have faced a severe funding deficit for the 2011-2013 biennium if current services were continued. The Medicaid budget was affected by the loss of enhanced federal funding (the ARRA stimulus FMAP) and increased demand for Medicaid services (due in part due to increasing Medicaid enrollment resulting from the recession). The enacted legislation included a number of measures intended to reduce expenditures in Oregon's Medicaid program.

Medicaid Provider Rate Cuts. The Oregon legislature passed the 2011-2013 biannual budget with 11.2% provider rate reductions in both managed care and fee-for-service delivery systems starting in the first year of the biennium. Rate cuts were applied to specialty care physicians and other professionals[164], dentists, in addition to a number of other providers and services.[165] The only providers excluded from the rate reductions were primary care physicians (rates were held flat), hospitals (rates were increased, funded by an increase in the hospital tax rate) and nursing homes (rates were increased). Due to improved revenue projections and an increase in the provider taxes, these cuts are less severe than the 19% across-the-board rate reductions originally proposed by the Governor.

For the second year of the biennium there were additional rate cuts for Managed Care Organizations (MCOs), physician RVU-based rates except for primary care, and ambulance providers, as well as some reductions to hospital rates.

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[162] Legislative Fiscal Office, *Analysis of the 2011-13 Legislatively Adopted Budget*, September 21, 2011 at: http://www.leg.state.or.us/comm/lfo/2011-13%20LAB.pdf.

[163] Legislative Fiscal Office, *Budget Highlights: Updated 2011- 13 Legislatively Approved Budget Based on February 1- March 3, 2012 Session Actions,* March 2012 at: http://www.leg.state.or.us/comm/lfo/2011-13/2011-13%20Budget%20Highlights%20Update.pdf.

[164] Other professionals include nurse practitioners, podiatrists, chiropractors, radiologists, anesthesiologists, and therapists among others.

[165] These include clinical lab, durable medical equipment, prosthetic devices, home health, maternity case management, pharmacy dispensing fees, ambulance, alcohol and drug treatment, mental health, and transportation brokerages

Priority List Change: The Oregon Health Plan Prioritized List of Services is a unique tool used in Oregon to align spending on conditions/treatments to available funding using a prioritization process. The Governor's original Medicaid budget recommendation for the 2011-2013 biennium assumed program savings through elimination of the 38 lowest priority conditions/treatments that had been covered in the 2009-2011 biennium. The final action was to eliminate only 13 conditions/treatment combinations (lines 499 through 511).[166]

Efficiency Improvement and Increased Program integrity: The budget proposal assumes savings through reductions in inefficient provider practices. These are identified as unnecessary overutilization of hospital services (with specific focus upon one-day hospital stays and usage of ICU services), inefficient use of extenders and medical errors. There were also savings identified from increases in program integrity efforts such as the newly required Recovery Audit Contracts (RACs).

Oregon Health System Transformation

Oregon gained CMS approval on July 5, 2012, for a Medicaid 1115 waiver demonstration to implement the *Oregon Health System Transformation*, a major healthcare reform plan passed by the state legislature and signed by the Governor in June 2011. This initiative had been in development for several years with input from multiple stakeholders. The waiver is designed to deal with an unsustainable budget situation while increasing the efficiency, effectiveness and quality of Medicaid services. Under the plan, Oregon began on August 1, 2012, to transition Medicaid beneficiaries from traditional MCOs (or from fee-for-service coverage) to community-based Coordinated Care Organizations (CCOs).

Oregon already had a robust managed care program with 84 percent of eligible Medicaid, CHIP and Oregon Health Plan members receiving services from fully capitated plans. The CCO initiative is designed to move away from traditional budget balancing through reductions in rates, services and eligibility to a regional model that saves money through better coordination and integration of care, use of non-traditional providers and care models and promotes alternative payment methodologies.

A key difference between CCOs and either current Oregon health plans or ACOs is that the CCOs are created locally and have local governance which is designed to give local flexibility and create local accountability for health and budgets. While the initial CCOs represent collaboration between existing MCOs and mental health organizations, other models are possible as long as the entity is able to assume risk and meet all CCO certification requirements. The CCOs can develop new patient-centered models of care that better coordinate services, focus on prevention and management of chronic illness, and are more flexible in the use of non-traditional care givers. CCOs will be accountable for care management and provision of integrated and coordinated health care for enrolled Medicaid beneficiaries for both mental health and physical health care which will be managed within a fixed global budget.[167]

At this point, long-term care services are excluded from the CCO model. CCOs are expected to rely on alternative payment methodologies that focus on prevention and patient-centered primary care homes, alignment of incentives to support the Triple Aim (better health, better care, lower costs), evidenced-based practices and health information technology to improve health and to reduce health disparities.[168]

CCO implementation began on August 1, 2012, with eight CCOs serving all or part of 18 counties. By November 1, 2012, all counties in Oregon should be fully covered by CCOs.

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[166] For more details on the specific services eliminated, see: http://www.oregon.gov/OHA/healthplan/meetings/hs-prioritized-list.pdf?ga=t.
[167] *Transition to Coordinated Care Organizations, FAQ.* Oregon Health Authority, http://www.oregon.gov/oha/OHPB/healthreform/docs/cco-organization-faq-120906.pdf, accessed 9-14-2012.
[168] *Better Health, better care, lower costs: Transforming the Oregon Health Plan*. Presentation by Jeanene Smith, Administrator of the Office for Oregon Health Policy and Research, http://www.academyhealth.org/files/JeaneneSmithpresentation.pdf, accessed on September 14, 2012.

Federal fiscal relief. Facing a severe state budget crisis, Oregon also negotiated approval for a financing mechanism under the 1115 waiver demonstration that will allow the State to claim up to $704 million in new federal funds over five years. Under the waiver, Oregon may claim federal matching payments for selected designated state health programs (DSHP) that are ineligible for federal reimbursement under the regular Medicaid program.[169] This increase in federal funds will allow Oregon to reinvest state funds in Medicaid program to support the Oregon Health System Transformation. This is expected to yield another $1.2 billion in federal funds (based on the state's FMAP rate of 63%), bringing the total new federal contribution up to $1.9 billion over five years.

The waiver agreement ties DSHP funding directly to Oregon's goal to reduce Medicaid spending growth. The savings target is a 2-percentage point reduction in Medicaid per capita spending (as defined by all costs included in the CCO global budget) to be achieved over the initial two-year period and sustained in subsequent years.[170] If Oregon does not achieve a target, then CMS shall reduce the DSHP FFP limit in the following year. In addition, the goal of the waiver demonstration is to improve access to care and quality of care for Medicaid beneficiaries over the same 5-year waiver period.

The waiver documents state that the demonstration will use the following 5 levers to drive savings and quality:

- Lever 1: Improved care management experienced by beneficiaries in CCOs
- Lever 2: Administrative efficiencies in CCOs
- Lever 3: Integration of physical and behavioral health for beneficiaries in CCOs
- Lever 4: Improved care coordination experienced by beneficiaries aligned with patient centered primary care homes (PCPCH)
- Lever 5: Use of flexible services

Duals Financial Alignment Initiative

Oregon is pursuing a CMS Financial Alignment Demonstration and was one of fifteen states that received planning funds to develop this model. In the short term, Oregon's legislature has excluded long-term care (LTC) services from Medicaid managed care, including CCO global budgets. However, OHA has established mechanisms to hold CCOs and the LTC system jointly accountable for quality, outcomes, and costs for the individuals served by LTC and CCOs. In the future, OHA hopes to integrate all Medicare and Medicaid services in the new CCOs under the Financial Alignment Initiative capitated model, beginning in January 2014. However, OHA has concerns that the rate methodology under the Financial Alignment Demonstration may not produce a workable rate for Oregon due to Oregon's low Medicare FFS costs, high Medicare Advantage penetration, and other factors.

In addition to the policy initiatives discussed above, Oregon made, or is planning a number of Medicaid policy changes summarized in the following table.

[169] CMS is using Section 1115(a) "cost not otherwise matchable" waiver authority to provide FFP for these state program expenditures.
[170] The baseline trend rate off of which the reduction target is measured is 5.4 percent per year. The 5.4 percent is based on the President's Budget Medicaid per capita spending trend rate.

Provider Rates
In FY 2012: • Hospital rates were increased due to an increase in hospital provider taxes. Nursing home rates were also increased. • Managed care rates and most fee-for-service rates (other than hospital & nursing home) were cut by 11.2% with exclusions for primary care providers as well as inpatient hospital and nursing home rates mentioned above. In FY 2013: • No rates are being increased. • Fee-for-service rate reductions are implemented or planned for hospitals, specialty care physicians, durable medical equipment and ambulance. • MCO rate reductions are supplanted by savings from the CCO initiative.
Eligibility, Application and Renewal Changes
In FY 2012: • OHP Standard randomized drawings from the reservation list were increased to reach an average monthly enrollment of 60,000 for the biennium. (10,000, FY 2011-2013) • Full time students at a higher education institute were no longer required to meet eligibility requirements for Pell eligibility or 'expected family contributions'.(Fewer than 20, 1/1/12) • Medicaid will be suspended rather than terminated for clients who are incarcerated as long as their stay is expected to be a year or less (in a county jail vs. prison); medical assistance will be restored upon their release from custody. (Effective October 2011, affecting several hundred individuals). • The OHP application was revised to eliminate the need to request proof of citizenship/identity for medical applicants who claim to be US citizens. In almost all cases, workers have been able to get the verification through a match with SSA; it was no longer necessary to ask applicants to provide this verification. • Oregon had already implemented an automatic redetermination process for medical only clients. Effective July 1, 2011, OHA began an automatic redetermination process for clients who were on medical and SNAP; they were given an automatic renewal pend letter for the medical redetermination. The computer system began adding an automatic date of request and bypass-end-date coding to these clients, allowing the client to respond to a request for additional information by written form or by phone., • Express Lane Eligibility for children was piloted in the National School Lunch Program; for the participating school districts, children in the school lunch program with income below 163% FPL could receive Medicaid without completing an application. 11/14/11 (About 100 enrolled)
Benefit/Service Changes
In FY 2012: • The OHP Standard (Oregon's expansion group of adults up to 100% FPL) program was expanded to include an inpatient hospital benefit. (January 1, 2012) • As of January 1, 2012, coverage of 13 lines on the OHP Prioritized List of Health Services was eliminated.
Long-Term Care
In FY 2012: • Oregon reduced authorized hours for in-home recipients by approximately 5% (January 1, 2012).
Managed Care
In FY 2013. • As part of the CCO initiative, Oregon is implementing a 1% withhold for timely and accurate encounter data reporting. Oregon also will be developing further quality and access metrics for use in future years as part of an incentive pool.

4. Texas Case Study

State Budget Actions

Texas operates on a biennial budget cycle with the legislature meeting every two years. The last legislative session was held during the spring of 2011. Heading into the FY 2012-2013 session, Texas legislators faced a $3.5 billion budget shortfall in the FY 2010-2011 budget as well as a budget shortfall of at least $9 billion for the upcoming biannual budget period (FY 2012-2013).[171] In part this was due to a 2.9 percent decline in the amount of general revenues available for FY 2012-2013 compared to FY 2010-2011 attributed to the recession.[172] After a long and contentious session that extended into a special session, the state passed a budget for FY 2012-2013 that did not raise taxes, preserved $6 billion in the state's Rainy Day Fund, and made significant cuts to government spending, estimated at $15 billion at the time of passage.[173]

The largest decreases in funding measured from the prior biennial budget (all funds) were in the areas of Health and Human Services (15.3% drop from the previous biennium) and Education (4.6% drop from the previous biennium).[174] The cuts to Health and Human Services Funding included $2.03 billion in general revenue funds to Medicaid, which included cuts to provider payment rates ($805 million), an expansion of managed care ($386 million in general revenue savings), and other benefit and spending cuts ($843 million), as well as intentional underfunding of the Medicaid budget by $4.8 billion in general revenue that legislators will have to address in the coming legislative session.[175] The legislature also included an additional $238 million in general revenues generated from increased health insurance premium tax collections due to the Medicaid managed care expansion.[176]

Recent revenue forecasts have shown stronger growth than originally projected; state sales tax collections grew by 9.4 percent over the previous year along with increases in motor vehicle sales taxes and increased severance tax revenues due in part to higher oil prices.[177]

Medicaid Policy Actions

The state included a number of cost containment initiatives, including a number of provider rate cuts, some benefit changes (particularly in long-term care) as well as other initiatives that produced savings relatively quickly. However, Medicaid policy actions in the state of Texas were primarily driven by the approval of a section 1115 waiver that expanded managed care, ended the former Upper Payment Limit payment methodology, and created two funding pools to help offset uncompensated care costs and to encourage delivery system reform. The waiver, approved in December 2011, will run for five years through September 30, 2016.[178]

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[171] Oliff, Phil et al. "States Continue To Feel Recession's Impact." Center on Budget and Policy Priorities, June 27, 2012. http://www.cbpp.org/files/2-8-08sfp.pdf.
[172] Combs, Susan. *Biennial Revenue Estimate, 2012-2013 Biennium*. Texas Comptroller of Public Accounts, January 2011. http://www.window.state.tx.us/taxbud/bre2012/96-402_BRE_2012-13.pdf.
[173] "Gov. Perry: Our Budget Positions Texas for Continued Job Creation and Prosperity." Press Release, Office of the Governor. July 26, 2011. http://governor.state.tx.us/news/press-release/16423/.
[174] *Texas Fact Book*. Legislative Budget Board, 2012. http://www.lbb.state.tx.us/Fact_Book/Fact%20Book%202012.pdf.
[175] Ibid.
[176] "Major Medicaid-CHIP 2012-2013 State Budget Decisions: A Mix of Cuts, IOUs, "Efficiencies" and Gray Areas." Center for Public Policy Priorities, July 21, 2011. www.cppp.org.
[177] Combs, Susan. *2012-2013 Certification Revenue Estimate*. Texas Comptroller of Public Accounts, December 2011. http://www.window.state.tx.us/taxbud/bre2012/96-402_BRE_2012-13.pdf.
[178] Texas Demonstration Fact Sheet. Centers for Medicare and Medicaid, December 12, 2011. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthcare-transformation-fs.pdf.

Managed Care Expansion. Under the waiver, the State expanded its existing Medicaid managed care programs, STAR and STAR+PLUS. About 940,000 beneficiaries were transitioned to capitated managed care in March 2012.[179] With the expansion of managed care, the state ended its primary care case management program. STAR is the primary managed care program that serves low-income families, children, pregnant women, and newborns; under the waiver, the STAR program was expanded statewide as of March 2012.[180] STAR+PLUS is a capitated health maintenance organization (HMO) model for Medicaid clients with disabilities and dual eligible clients. As of March 2012, STAR+PLUS expanded to all areas of the state except for the Medicaid Rural Service Area (Medicaid RSA). The Medicaid RSA consists of 164 rural counties; Medicaid beneficiaries residing in the Medicaid RSA who require home and community-based services (HCBS) are no longer excluded from STAR [181] and will receive HCBS through a1915(c) waiver. Managed care enrollees have unlimited monthly access to medically necessary prescription drugs; this benefit will now be managed by the MCOs, a decision made in part due to the availability of rebates on MCO prescriptions made available under the Affordable Care Act.

The state also instituted performance-based capitation rates in MCO contracts as well as Quality Challenge Awards. Health and dental capitated plans will have five percent of their capitation payment at-risk. At the end of each fiscal year, the plan may be subject to a five percent recoupment of capitation paid based on how well they do in meeting defined performance measures. Any of the funds that are recouped from lower-performing plans will be funneled into the Quality Challenge Awards. These funds will be awarded to higher performing plans based on their performance relative to each other – meaning the highest performing plan will receive the largest share of the funds, followed by second-best performing plan, etc.

Uncompensated Care Pools and Delivery System Incentive Reform Payments. The Texas waiver also allows the state to pool trended funds from its former supplemental payment (Upper Payment Limit) programs and additional savings from managed care to create two pools. The first pool reimburses hospitals and certain other providers for uncompensated care costs.[182] The state is currently in process of revising the forms used to determine payments under this pool; advanced uncompensated care payments will be made in the meantime to avoid financial hardship from the delay.[183]

The second pool of funds is the Delivery System Reform Incentive Payment Pool (DSRIP). Similar to the program established under California's Bridge to Reform waiver, the funds in this pool will be used to support efforts at the provider level to enhance access to care and the health of the patients and families they serve. The DSRIP program will be used to make incentive payments to encourage delivery system reform in four broad areas - infrastructure development, program innovation and redesign, quality improvements, and population-focused improvement. Reform activities will be conducted by Regional Healthcare Partnerships (RHPs) that are financially anchored by a public hospital or local governmental entity; RHPs will collaborate with a variety of healthcare providers to evaluate current challenges in the delivery system and propose a course of action to address those challenges.[184] The state received federal approval of the Program Funding and Mechanisms protocol August 31, 2012, and of the RHP Planning Protocol September 26, 2012.[185]

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[179] *California and Texas: Section 1115 Medicaid Demonstration Waivers Compared*. Kaiser Commission on Medicaid and the Uninsured, December 2011. http://www.kff.org/medicaid/8266.cfm. The state notes that in total over 3 million individuals are now served in managed care in the state. Presentation for the House Human Services Committee Interim Committee Hearing by Executive Commissioner Kyle Janek and Chief Deputy Commissioner Chris Traylor, September 17, 2012. http://www.hhsc.state.tx.us/news/presentations/2012/091712-presentation.pdf

[180] Populations excluded from the waiver are individuals whose only Medicaid coverage consists of payment for Medicare premiums, medically needy, foster care children, women covered under Breast and Cervical Cancer Program, residents in Intermediate Care Facilities for Persons with Mental Retardation or those residing in a nursing facility for four months or more, those only eligible for emergency medical services.

[181] SSI adults residing in the MRSA area are required to enroll in the STAR program; SSI children in these areas can voluntarily enroll.

[182] "Overview of the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver." Texas Health and Human Services Commission, August 2011. http://www.hhsc.state.tx.us/1115-Waiver-Resources.shtml.

[183] These advanced payments will likely be process in October and will be subject to reconciliation. http://www.hhsc.state.tx.us/rad/hospital-svcs/1115-waiver.shtml.

[184] Texas Demonstration Fact Sheet. Centers for Medicare and Medicaid, December 12, 2011. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthcare-transformation-fs.pdf.

[185] Tools and Guidelines for Regional Healthcare Partnership Participation website - http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml.

Duals Financial Alignment Initiative. Texas submitted an application in May 2012 for the financial alignment initiative offered by the Medicare-Medicaid Coordination Office within CMS. The state has proposed to utilize the capitated model offered by CMS by leveraging its existing managed long-term care system (STAR+PLUS). The state will focus on adult duals, those that are eligible for full benefits from both Medicare and Medicaid, residing in areas of the state where STAR+PLUS currently operates. [186] The goal of the demonstration will be to provide all Medicare and Medicaid services through a single managed care organization; therefore, participating managed care organizations (MCOs) will be responsible for delivering Medicaid benefits under its STAR+PLUS agreement with the state and Medicare benefits through its Medicare Advantage agreement. Participating duals will be passively enrolled into a Medicare Managed Care Plan (MA/SNP) that corresponds with their STAR+PLUS health plan.[187] The target implementation date is January of 2014; as of September 10th, Texas was awaiting formal feedback on the application from CMS. Approximately 214,000 individuals, the full dual eligible adult population enrolled in STAR+PLUS, will be eligible for the initiative.

Women's Health Program. Texas submitted to CMS a request for renewal of its Medicaid demonstration waiver for the Women's Health Program, which provided family planning services to 130,000 low-income women who would not otherwise qualify for Medicaid coverage. Consistent with new state legislation, the renewal request also contained additional waiver amendments that would waive federal requirements that allow Medicaid beneficiaries freedom of choice among participating qualified providers.[188] In March 2011, CMS denied the state's request to renew the waiver due to the enforcement of the state's law limiting participation of family planning providers in the Women's Health Program.[189]

Effective November 1, 2012, Texas will transition the Women's Health Program to a state funded program, despite the fact that Texas was receiving $9 from the federal government for every $1 spent on the program under the waiver. Planned Parenthood filed suit in April 2012 to block enforcement of the state law. The district court enjoined the state from enforcing the law. In August, the US Fifth Circuit Court of Appeals vacated the injunction and remanded the case back to the district court.[190]

The Affordable Care Act (ACA)

Texas was one of the 26 states party to a lawsuit, *National Federation of Independent Business (NFIB) v. Sebelius*, which challenged the constitutionality of the ACA. In response to the Supreme Court ruling, the Governor of Texas has stated that the state "has no intention of implementing a state insurance exchange or expanding Medicaid."[191] The legislature will not be able to weigh in officially until it comes back into session in January 2013. Some counties, such as Bexar County which includes San Antonio, are exploring the option of expanding Medicaid coverage in their jurisdictions despite the Governor's position.[192]

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[186] Excluded are those residing in institutional settings; certain 1915(c) waiver program participants; "Partial" Duals (QMBs, SLIMBs, etc.) *Texas Dual Eligibles Integrated Care Demonstration Project Application*. Texas Health and Human Services Commission, May 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/TXProposal.pdf.

[187] Beneficiaries will be given the option to opt out of the MA/SNP on a monthly basis but not the Medicaid Managed Care plan.

[188] Texas legislators recently renewed a state law that prohibited the use of Women's Health Program funds "to perform or promote elective abortions or to contract with an entity that performs or promotes elective abortions or that affiliates with entities that perform or promote elective abortions." Proposed Rules, posted July 6, 2012. http://www.dshs.state.tx.us/DynamicContent.aspx?id=8589970162.

[189] CMS Letter, dated March 15, 2012. http://www.lonestarproject.net/files/TX_Letter_3-15-12.pdf

[190] *Planned Parenthood Association of Hidalgo County, et al. V. Suehs*, US Fifth Circuit Court of Appeals, filed Aug 2012. https://docs.google.com/gview?url=http://docs.justia.com/cases/federal/appellate-courts/ca5/12-50377/12-50377-2012-08-21.pdf&chrome=true.

[191] "Texas Will Not Expand Medicaid or Implement Health Benefit Exchange." Governor's Office. July 9, 2012. http://governor.state.tx.us/news/press-release/17408/.

[192] Aizenman, N.C. "Texas Counties Consider going it alone on Medicaid expansion." *Washington Post*, August 26, 2012. http://www.washingtonpost.com/national/health-science/texas-counties-consider-going-it-alone-on-medicaid-expansion/2012/08/26/f35686dc-e322-11e1-98e7-89d659f9c106_story.html.

Provider Rates

In FY 2012:

- Inpatient and Outpatient Hospital and non-state Freestanding Psychiatric Facility rates were cut by 8%.
- Managed Care rates were cut overall by 6.8%.
- Rates for HCBS providers were cut; cuts for these providers ranged from 1% to 42% while ICF-ID rates were cut by 2%.
- Rates for non-state clinical laboratory services were cut by 10.5%.
- Rates were cut by 5% for Renal Dialysis Services and Ambulatory Surgical Centers.
- Rates for Community Based Alternatives Personal Assistance Services were cut by 3.95%.

In FY 2013: Provider rates are by and large unchanged, with a small cut MCO rates (.1%)

Eligibility, Application and Renewal Changes

- In FY 2012, the state added online self-service options for submitting renewal applications and reporting additional changes.
- Beginning January 2013, the state will provide Medicaid coverage to children under age 19 and pregnant women who are inmates and become a patient of a medical institution (provided they meet existing eligibility criteria).
- Beginning Nov 2012, Women's Health Program will transition from a Medicaid demo to a state-funded program.

Benefit/Service Changes

In FY 2012:

- Expanded coverage of non-routine end stage renal disease services in ER to all groups.
- Restricted cranial molding orthotics to non-positional plagiocephaly (flattened skull).

In FY 2013:

- Plan to eliminate coverage of binaural hearing aids and related services for those over age 21 in Oct 2012.
- Plan to add coverage of replacement lenses for axis changes in early 2013.
- Plan to add coverage of new indications for Onabotulinum (Botox) in early 2013.
- Plan to add coverage of licensed midwives in birthing centers in January 2013.

Pharmacy

- Carved in pharmacy services into managed care contracts. MCOs are prohibited from instituting monthly prescription caps.
- Added 4 new drug classes to the PDL. MCOs must follow the state's PDL.
- In FY 2012, decreased dispensing fees. In FY 2013, the state plans to cut ingredient cost reimbursement.

Long-Term Care

In FY 2012: Imposed a soft cap on certain services in select 1915(c) waivers.

In FY 2013:

- Adding 1915(i) day activity and health services to the Medicaid state plan. (Early 2013)
- Adding consumer direction to employment services in the Deaf Blind with Multiple Disabilities Waivers. (Apr 2013)
- Adding consumer directed services option to employment services in select waivers.
- Plan to implement the State Balancing Incentive Payment Program.

Managed Care

- Implemented STAR statewide in March 2012. The state also eliminated its PCCM program.
- Expanded STAR+PLUS to more geographic areas; mandatory enrollment for SSI adults, voluntary for SSI children.
- Instituted Performance-Based Capitation rates (5% at risk) and Quality Challenge Awards in MCO contracts.
- Selected to participate in the Center for Health Care Strategies Advanced ACOs in Medicaid Learning Collaborative.
- In March 2012, selected to participate in NASHP's Medicaid Safety-Net Learning Collaborative.

Appendix C: Survey Instrument

MEDICAID BUDGET SURVEY
FOR STATE FISCAL YEARS 2012 AND 2013

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

Return Completed Survey to: Vsmith@healthmanagement.com

State _____ **Name** _____

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

1. The State Economic/Budget Situation

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

_____

b. Is your state projecting an overall state budget shortfall for FY 2013? Select One...

c. Has your legislature enacted the Medicaid budget for FY 2013? Select One...

2. Medicaid Expenditure Growth: State Fiscal Years 2011, 2012 and 2013

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

Fiscal Year (generally, July 1 to June 30)	Percent Change for Each Fund Source			
	State	Local or Other	Federal	All Fund Sources
FY ending in 2011 (FY 2011) a. Percentage change: FY 2011 over FY 2010	%	%	%	%
FY ending in 2012 (FY 2012) b. Est. Percentage Change: FY 2012 over FY 2011	%	%	%	%
FY ending in 2013 (FY 2013) c. Est. Percentage Change: FY 2013 over FY 2012	%	%	%	%

Comments: _____

d. Are local or county governments *required* to contribute to the non-federal share of Medicaid financing through IGTs, CPEs or some other funding mechanism (excluding DSH payments)? Select One...

   A. If "yes," is local or county government financing for Medicaid increasing, decreasing or staying the same relative to state funding? Select One...

d. Looking now at the FY 2013 Medicaid appropriation (or the expected appropriation), how likely is a FY 2013 Medicaid budget shortfall in your opinion? ***(Check one)***

☐ Almost certain no shortfall ☐ Not likely ☐ Possible ☐ Likely ☐ Almost certain to be a shortfall

3. Factors Driving Expenditure Changes

What would you consider the most significant factors that were upward and downward pressures on your total Medicaid spending in FY 2012, and that will be in FY 2013 (e.g., enrollment, healthcare inflation, rate changes, utilization, specific policy changes, etc.)?

		FY 2012	FY 2013
a. ***Upward*** Pressures	A. Most significant factor?		
	B. Other significant factors?		
b. ***Downward*** Pressures	A. Most significant factor?		
	B. Other significant factors?		

4. Medicaid Enrollment

2012 over 2011	2013 over 2012 (proj.)
A. %	B. %

a. Overall % enrollment growth/decline (+/–):

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

c. Please describe what you believe were the *key factors that were upward and downward pressures* on enrollment in FY 2012, and will be in FY 2013.

In FY 2012:	
In FY 2013:	

Comments : _____

5. Provider Payment Rates

Compared to the prior year, please indicate by provider type any rate increases or decreases implemented in FY 2012 or to be implemented in FY 2013. Include COLA or inflationary changes as increases.

Optional: if available, please indicate actual percentage change as well.

Provider Type	FY 2012	FY 2013
a. Inpatient hospital		
b. Doctors – primary care physicians		
c. Doctors – specialists		
d. Dentists		
e. Managed care organizations		
f. Nursing homes		

g. Please list any other provider rates subject to reimbursement increases or reductions:
   A. For FY 2012. _____
   B. For FY 2013. _____

Comments (e.g., rate changes that were court-ordered or limited by legal action, etc. — use 5(i) below to comment on ACA mandated increases for primary care): _____

h. **Rate Reduction SPAs.** Since July 1, 2011, has your state been impacted by CMS' new processes related to Medicaid State Plan Amendments that reduce provider reimbursement? Select One...
   A. If "yes," briefly describe the impact: _____

i. **ACA Required Payment Increases for Primary Care Services.** The ACA requires that primary care physician rates be increased to Medicare levels on January 1, 2013, with federal reimbursement for the increases based on state Medicaid rates as of July 1, 2009.
   A. Are any of your July 2012 payment rates below July 1, 2009 rates? Select One...
   B. What will be the approximate percentage increase in primary care rates in 2013? _____ %
   C. Comments on implementation challenges and issues: _____

j. **Medicare Crossover Claim Reimbursement:** Medicaid is required to pay Medicare cost-sharing amounts (co-insurance, deductibles and copayments) for Qualified Medicare Beneficiaries (QMBs), usually referred to as "crossover claims." Please select the statement below that best reflects your state's crossover claim reimbursement policy **for physicians** ***(select one)***:
   A. ☐ Medicaid always pays 100 percent of a QMB's Medicare cost sharing amounts.
   B. ☐ Medicaid always limits reimbursement of Medicare crossover claims to the difference between the Medicaid allowable amount and the amount paid by Medicare.
   C. ☐ Medicaid sometimes limits crossover claim reimbursement to the difference between the Medicaid allowable amount and the amount paid by Medicare, based on provider type.
   D. ☐ Other: _____
   Comments: _____

k. **Medicare Advantage Premiums:** States may, but are not required to, cover Medicare Advantage plan premiums for enrolled QMBs. Does your state cover the cost of Medicare Advantage premiums for QMBs? Select One...

6. Provider Taxes/Assessments

Please use the drop down boxes in the table below to indicate provider taxes in place in FY 2011, and new taxes and or changes for FY 2012 and FY 2013. In the far right columns, indicate whether proposed federal 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 2011 (Yes, No)	Provider Tax Changes (New, Increased, Decreased, Eliminated, No Change or N/A) in:		FY 2012 increase due to federal cap increase? (Yes, No, N/A)	Does tax exceed either 3.5% or 5.5% of Net Patient Revenues (and therefore affected by proposals to limit taxes to that level)?	
		FY 2012	FY 2013		Exceeds 3.5%	Exceeds 5.5%
a. Hospitals						
b. ICF/MR-DD						
c. Nursing Facilities						
d. MCOs						
e. Other: _____						
f. Other: _____						

Comments: _____

7. Medicaid Eligibility Standards

Describe changes in Medicaid eligibility standards* implemented in FY 2012 or planned for FY 2013. Under "Nature of Impact," use the drop down boxes to indicate if the change is an "Expansion," a "Restriction," or a change with a "Neutral" effect from the perspective of the beneficiary. If there are no eligibility changes to report, please check the box on line "c." (Please exclude changes in CHIP-funded programs.)

Year	Nature of Eligibility Change and Affected Eligibility Groups	Effective Date	Est. Number of People Affected	Nature of Impact	By Waiver Authority
a. FY 2012	A.				☐
	B.				☐
	C.				☐
b. FY 2013	A.				☐
	B.				☐
	C.				☐
c. ☐ **No changes in either FY 2012 or FY 2013**					

* "Eligibility standards" include income standards, asset tests, retroactivity, continuous eligibility, treatment of asset transfer or income, enrollment caps or buy-in options (including Ticket to Work and Work Incentive Improvement Act or the DRA Family Opportunity Act). If applicable, include early expansion state plan option to cover childless adults.

d. **Family Planning State Plan Amendment (SPA).** Does your state provide coverage/enrollment that is limited to only Family Planning services under a SPA or a waiver? Select one...

   A. If your state adopted the Family Planning SPA, were family planning services extended to new populations (e.g., men or persons under age 18)? Select one...

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

Comments: _____

8. Application/ Renewal Process

Describe any changes to the Medicaid application or renewal process.* Under "Nature of Impact," use the drop down boxes to indicate if the change is a "Simplification," a "Restriction" or a change with a "Neutral Effect" from the perspective of the beneficiary. If there are no changes to report, check the box on line "c".

Year	Application or Renewal Process Change	Nature of Impact:
a. FY 2012	A.	
	B.	
b. FY 2013	A.	
	B.	
c. ☐ **No changes in either FY 2012 or FY 2013**		

*Application changes include changes in forms, verification, frequency of redeterminations/renewals, new online systems, etc.)

Comments (e.g., if the changes are motivated by the CHIPRA bonus, etc.): _____

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 2012 or planned for FY 2013. **(Do not include premiums for CHIP-funded programs.)** If there are no Medicaid premiums in your state, please check the box on line "c".

Eligibility Group Subject to a Premium Requirement	In Place in FY 2011?	Changes in:		By Waiver Authority?
		FY '12?	FY '13?	
a.	☐			☐
b.	☐			☐
c. ☐ **No Medicaid premiums**				

Comments: _____

10. Benefits

Describe below any change in benefits *implemented* during FY 2012 or planned for FY 2013. Under "Nature of Impact," use the drop down boxes to indicate if the change is an "Expansion," a new or increased benefit, "Limitation," a benefit "Elimination" or a benefit change with a "Neutral Effect" from the perspective of the beneficiary. If there are no benefit changes to report for either year, please check the box on line "c".

Year	Benefit Change	Effective Date	Eligibility Groups Affected	Nature of Impact	By DRA Authority	By Waiver Authority
a. FY 2012	A.				☐	☐
	B.				☐	☐
	C.				☐	☐
b. FY 2013	A.				☐	☐
	B.				☐	☐
	C.				☐	☐
c. ☐ **No changes in either FY 2012 or FY 2013**						

Comments: _____

11. Long Term Care Policy

Briefly identify LTC actions[1] taken during FY 2012 or planned for FY 2013. Under "Community or Institutional Action," use the drop down boxes to indicate if the action impacts "Community-based" services, "Institutional" services or "Both." Under "Nature of Impact," use the drop down boxes to indicate if the action is an "Expansion," a new or more restrictive service "Limitation" or "Elimination", or change with a "Neutral Effect." If there are no actions to report for either year, check the box on line "c." (Exclude rate, tax or benefit changes already reported in questions 5, 6 or 10).

Year	Long Term Care Policy Action	Community or Institutional Action?	Effective Date	Nature of Impact
a. FY 2012	A.			
	B.			
	C.			
b. FY 2013	A.			
	B.			
	C.			
c. ☐ **No changes in either FY 2012 or FY 2013**				

DRA and ACA LTC State Options	In Place in 2011	New in FY 2012	Plan to implement in FY 2013	No Plans to Implement	Don't Know
d. HCBS **State Plan** Option (**not HCBS waiver**)	☐	☐	☐	☐	☐
e. State Balancing Incentive Payment Program		☐	☐	☐	☐
f. Community First Choice Option		☐	☐	☐	☐

Comments: _____

12. Cost Sharing

a. Does your state require Medicaid copays? Select one...

b. Are Medicaid copayments enforceable[2] in your state for any eligibility group? Select one...

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

Changes in Cost Sharing: In the table below, please describe any Medicaid cost sharing policy changes in FY 2012 or planned for FY 2013. Under "Nature of Impact," use the drop down boxes to indicate if the action was a "New" requirement, an "Increase" to, "Decrease" to, or "Elimination" of an existing requirement, or an action with a "Neutral Effect."

If there are no cost sharing changes to report for either year, check the box on line "f."

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

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

Year	Cost Sharing Action	Effective Date	Eligibility Groups Affected	Nature of Impact	By Waiver Authority?
d. FY 2012	A.				☐
	B.				☐
	C.				☐
e. FY 2013	A.				☐
	B.				☐
	C.				☐
f. ☐ No changes in either FY 2012 or FY 2013					

Comments : _____

13. 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,

A. In FY 2012? Select one... B. In FY 2013? Select one...

C. 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,

A. In FY 2012? Select one... B. In FY 2013? Select one...

C. 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 program management tools listed in the table below, please indicate changes implemented in FY 2012 or planned for FY 2013. 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 end of FY 2011?	Fiscal Year	Program Change in Fiscal Year	Fiscal Impact
c. Preferred Drug List (PDL)	☐	2012		
		2013		
d. Supplemental rebates	☐	2012		
		2013		
e. Prescription cap[3]	☐	2012		
		2013		
f. ☐ **No changes in these pharmacy management tools either FY 2012 or FY 2013**				

MCO Rebates. For states with capitated MCO contracts for comprehensive benefits as of July 1, 2012:

g. Is the pharmacy benefit "carved in" or "carved out" of the capitation rate? Select one...

Comments (e.g., if differs by program): _____

h. If pharmacy benefits were previously fully or partially carved-out of the MCO rate, did the availability of rebates on MCO prescriptions factor into a decision to change to a carve-in? Select one...

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

Specialty Drug Cost Containment. Using the check boxes in the table below, please indicate if any specialty drug cost containment actions were implemented in FY 2012 or are planned for FY 2013. If there are no changes to report for either year, please check the box on line "m."

Specialty Drug Cost Containment Action	FY 2012	FY 2013	Description (if applicable)
i. Implement selective contracting with specialty drug providers	☐	☐	
j. Revise the reimbursement methodology	☐	☐	
k. Implement specialty drug case management	☐	☐	
l. Other action: _____	☐	☐	
m. ☐ No changes in either FY 2012 or FY 2013			

Other Pharmacy Program Changes. In the table below, please indicate any other pharmacy program changes implemented in FY 2012 or planned for FY 2013, (including those related to mental health). Under "Fiscal Impact," please indicate if the change will "generate savings", "increase costs", or be "fiscally neutral". Use the check box on line "q" if there are no changes to report for either year.

Pharmacy Program Changes	Fiscal Impact	FY 2012 or FY 2013?
n.		
o.		
p.		
q. ☐ **No changes in either FY 2012 or FY 2013**		

Other comments on pharmacy policy changes: _____

14. Medicaid Managed Care

a. What managed care programs are used by Medicaid in FY 2013: (*Check all that apply):*
   - ☐ Capitated comprehensive health plans
   - ☐ PCCM
   - ☐ Non-comprehensive plans (e.g., behavioral health, dental, non-emergency transportation, etc.)
   - ☐ Other _____
   - ☐ None

b. What managed care program or policy actions were *implemented* during FY 2012, or will be implemented in FY 2013? Please briefly describe those that apply.

Managed Care Program or Policy Actions	Actions Implemented FY 2012	Actions To Be Implemented FY 2013
A. Expand/ PCCM or MCO geographic service areas		
B. Enroll new eligibility groups (please specify)		
C. Change from voluntary to mandatory enrollment (specify by eligibility category)		
D. Implement/expand long term care managed care		
E. Restrict or eliminate the use of managed care		
F. Major contract changes (e.g., withhold percentage, P4P, etc.)		
G. New or enhanced managed care quality initiative		

c. **Behavioral Health Delivery System**

A. Are behavioral health services in, or carved out fully or partially from, capitated managed care arrangements in your state? Select one...

B. Does your state contract with a Behavioral Health Organization to manage and deliver behavioral health services? Select one...

C. Please briefly describe any physical health/behavioral health integration issues in your state: _____

Comments: _____

15. Care Coordination Initiatives.

Please identify and briefly describe new Medicaid care coordination initiatives implemented or planned to be implemented in FY 2012 or 2013 in your state:

	Care Coordination Initiatives	Actions Implemented FY 2012	Actions To Be Implemented FY 2013
a.	Implement an initiative to **coordinate physical health and behavioral health care**		
b.	Implement or expand a **"patient-centered medical home"** initiative		
c.	Implement new ACA State Plan option to establish **Health Homes** for persons with chronic conditions		
d.	Implement an initiative to **coordinate long term care and acute care** services		
e.	Implement or expand **Accountable Care Organization** initiative		
f.	Implement new or expand **quality** efforts relating to care coordination		
g.	Other actions (including initiatives with the Center for Medicare and Medicaid Innovations other than those focused on Duals)		

Comments: _____

16. Dual Eligibles Initiatives

a. Is your state developing new payment or delivery system programs for dual eligibles? Select one...

b. If yes, what is your targeted implementation date? _____

c. What are your biggest challenges or issues in coordinating care for the duals (whether or not your state is pursuing a CMS demonstration)? _____

Other comments: _____

17. Section 1115 Waivers

a. Is your state currently planning to implement a comprehensive Section 1115 Medicaid waiver or waiver amendment, other than a dual eligibles initiative or Family Planning Waiver, in FY 2013? Select one...

b. If yes, what is the status of the waiver? Select one...

c. If yes, please indicate the types of changes you are seeking. (*Check and describe all that apply):*

A. ☐ Early expansion of Medicaid eligibility for adults _____

B. ☐ Enrollment simplification _____

C. ☐ Eligibility reduction _____

D. ☐ Benefit restriction/elimination _____

E. ☐ Increase in cost-sharing _____

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

G. ☐ Safety-net delivery system improvement initiatives _____

H. ☐ Other delivery/payment system reforms (e.g. ACO, payments for episodes of care, etc.) _____
I. ☐ Other: _____

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

Comments: _____

18. Federal Health Reform Implementation Issues:

a. Have your state's plans around ACA implementation been affected by the Supreme Court Decision? Select one...
   A. If "yes," please briefly describe how your state's plans have been affected. _____

In the table below please indicate by checking the applicable box whether your state intends to operate a State-based Exchange, a State Partnership Exchange or a Federally Facilitated Exchange, or if the state decision is yet to be made. Also, for the option checked, please indicate the appropriate state option reflecting the Exchange's role in Medicaid/CHIP assessments or determinations.

b. ☐ **State-based Exchange:** State operates all Exchange activities but may use Federal government services for Premium tax credit and cost sharing reduction determination, Exemptions, Risk adjustment and Reinsurance program.	
State Exchange will *(check one):*	A. ☐ Make **assessments** of Medicaid/CHIP eligibility based on MAGI B. ☐ Make Medicaid/CHIP eligibility **determinations** based on MAGI C. ☐ Make *all* Medicaid/CHIP eligibility **determinations** (MAGI and Non-MAGI) D. ☐ Undetermined
c. ☐ **State Partnership Exchange:** State performs Plan Management, Consumer Assistance or both. State performs or uses Federal government services for Reinsurance program and Medicaid and CHIP eligibility: assessment or determination model	
Check one:	A. ☐ Federal services will be used for MAGI-based **assessments** of Medicaid/CHIP eligibility B. ☐ Federal services will be used for MAGI-based Medicaid/CHIP eligibility **determinations** C. ☐ State will perform all assessments/determinations (MAGI and Non-MAGI) D. ☐ Undetermined
d. ☐ **Federally Facilitated Exchange**: HHS operates but State may elect to perform or use Federal government services for Reinsurance program and Medicaid and CHIP eligibility: assessment or determination model	
Check one:	A. ☐ Federal services will be used for MAGI-based **assessments** of Medicaid/CHIP eligibility B. ☐ Federal services will be used for MAGI-based Medicaid/CHIP eligibility **determinations** C. ☐ State will perform all assessments/determinations (MAGI and Non-MAGI) D. ☐ Undetermined
e. ☐ **Undetermined, state decision is yet to be made.**	

f. Has there been an analysis of the full fiscal impact of the ACA on your state's budget? Select one...
   A. If yes, indicate if the impact is: Select one...
   B. If yes, please describe the most significant savings and costs to the state in the short run and longer term. _____
g. Will your state be seeking or has your state secured federal 90/10 funding from CMS for a new Medicaid eligibility system? Select one...
h. If applicable, at what stage is your state in the process of building a new eligibility system? _____

i. What are the biggest challenges and opportunities you see in implementing health reform? _____

_____

19. Medicaid Administration

a. Please indicate below whether your agency has experienced reductions or increases in administrative capacity for FY 2012 or FY 2013.

   A. For FY 2012: Select one...

      A. Please briefly describe the nature of reductions or increases, if any: _____

      _____

   B. For FY 2013: Select one...

      A. Please briefly describe the nature of reductions or increases, if any: _____

      _____

b. **Program Integrity:** Please indicate below whether your agency is making any significant new investments or changes to your program to enhance program integrity in FY 2012 or FY 2013.

   A. For FY 2012: Select one...

      A. If "yes," please briefly describe: _____

   B. For FY 2013: Select one...

      A. If "yes," please briefly describe: _____

   Comments: _____

20. 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?_____

This completes the survey. Thank you very much.

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

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