



State Policy Report #22

UPDATE: Medicaid §1115 Waiver and Post Deficit Reduction Act (DRA) State Plan Amendments:
Proposed or Adopted Changes

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Introduction

Below is a matrix that provides a snapshot of the components of various Section 1115 Medicaid waivers, 1115 waiver renewals and state plan amendments (SPAs) submitted and/or approved since the enactment of the Deficit Reduction Act of 2005. The matrix is followed by more detailed summaries of the individual waivers or SPAs with a focus on eligibility, benefits, and cost-sharing. Many states have attempted, or are considering, major redesigns of the Medicaid program which are outlined in the summaries along with changes in financing. Any changes that specifically address health centers have also been highlighted. Some of these waivers have been approved while others are pending or even still in the concept development phase.

The status of waivers and SPAs changes frequently and NACHC works to keep the information as current as possible. Since the matrix was last updated in December 2007, Rhode Island and Texas, have submitted or received approval for 1115 waivers, and the status of Indiana and West Virginia's waivers have been updated. In addition, Maine, Missouri and Wisconsin have submitted SPAs.

State	Eligibility ^a	Benefits & cost sharing ^b	Altering Medicaid's fundamental structure and design ^c	FQHC-specific changes ^d	Payment and financial performance incentives ^e	Intergovernmental transfers (IGTs) and Disproportionate Share Hospital (DSH) payments ^f
Arkansas	X	X		X		
California	X	X	X		X	X
Florida	X	X	X	X		X

^a Denotes changes that would either increase or decrease the categories and groups of individuals eligible for coverage under the state program

^b Denotes changes that would add or reduce benefits, alter the definition of medical necessity, or impose or reduce any form of patient financial responsibility (premiums, deductibles, coinsurance or other financial obligations)

^c Denotes changes that would either expand or replace Medicaid's basic structure as a public insurer with an alternative form of coverage such as vouchers to buy various forms of privately marketed health insurance such as high-deductible plans coupled with personal savings accounts.

^d Denotes any change that may fall into one of the other categories shown on the table and that *specifically* references FQHCs in any way (e.g., waiving FQHC wraparound payment rules as part of a reform plan to replace Medicaid with market vouchers)

^e Denotes changes designed to affirmatively or negatively incentivize certain types of provider services such as disease management programs, substitution of urgent care for hospital emergency department services, or reduction in payments for certain services and procedures

^f Denotes changes in disproportionate share payment rules or current state practices involving the generation of federal financial participation via the use of "intergovernmental transfer" (IGT) arrangements. States commonly provide financial support for their Medicaid programs through a combination of appropriated revenues and accounting practices that treat as a state Medicaid expenditure certain expenditures under other state public programs. An example of a commonly used IGT arrangement would be state and local expenditures for health services furnished to disabled children in school. State and local payments for such services may be counted as State Medicaid expenditures in the case of children who are Medicaid-enrolled, where the service is a covered service, and the provider furnishing the service participates in Medicaid (e.g., a school health clinic operated by a local school system).

State	Eligibility	Benefits & cost sharing	Altering Medicaid's fundamental structure & design	FQHC-specific changes	Payment & financial performance incentives	Intergovernmental Transfers (IGTs) and Disproportionate Share Hospital (DSH) payments
Georgia	X	X	X		X	
Hawaii	X	X	X	X		X
Idaho		X	X			
Indiana	X	X			X	X
Iowa	X	X			X	X
Kansas	X	X				
Kentucky 1	X	X		X		
Kentucky 2		X	X			
Louisiana	X	X	X	X		X
Maine		X				
Massachusetts	X	X	X	X		X
Michigan 1	X	X			X	
Michigan 2	X	X	X			X
Missouri	X	X	X	X	X	
Montana	X	X	X			
Nebraska	X	X	X	X		X
Nevada	X	X	X			
New Hampshire	X	X	X		X	
New York			X	X		
Oklahoma	X	X		X		
Oregon	X	X		X		X
Rhode Island	X	X	X	X	X	
South Carolina	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X
Texas	X	X	X	X	X	X
Vermont	X	X	X		X	
Virginia	X	X		X		
Washington	X	X		X		
West Virginia	X	X	X			
Wisconsin	X	X				

Please note: All supporting documents are available at www.nachc.com

Arkansas

Status- Arkansas received approved by CMS in March 2006 for an 1115 Health Insurance Flexibility and Accountability (HIFA) waiver for the expansion of Medicaid as well as a partial SCHIP expansion.

Eligibility- Expands eligibility to uninsured working adults and their spouses, between the ages of 19 to 64 (both parents and childless under 200% FPL). The demonstration will be available only to employers who have not offered group health insurance in the past 12 months. Eligible employers (under 500 employees) will voluntarily elect to participate or not. Once the employer has elected to participate, employees' whose family income is equal to or below 200% FPL will be eligible for the limited benefits, those employees whose income is over 200% will be eligible for identical benefits but no state or federal funds will be used. Each employer will be required to achieve 100 percent employee health insurance coverage regardless of family income.

Benefits and Cost Sharing-

- 6 physicians visits per year
- 2 outpatient hospital visits per year
- 2 prescriptions per month
- 7 days inpatient coverage per year
- Lab and X-ray when associated with one of the visits above.

The State will require enrollee cost sharing as follows without regard to family income:

- A. \$100 Deductible
- B. 15% coinsurance
- C. \$1000 out of pocket maximum.

The participating employers would have to contribute \$100 a month for each employee with income less than twice the poverty level and \$15 a month for higher income workers.

FQHC specific changes- In the waiver application, language states that FQHC services is not listed as a benefit, and additionally states that FQHC providers may be eligible for negotiated rates with Managed Care Organizations (MCOs).

There is no specific request to waive FQHC covered services in the approval, so presumably the state will pay FQHCs PPS for the childless adults covered under Medicaid. It is unclear whether FQHCs will receive PPS for parents covered by SCHIP within the SCHIP expansion under the overall waiver.

California

Status- In August of 2006 the State of California submitted a request to amend their prior approved MediCal Hospital/Uninsured 1115 demonstration waiver, intended to stabilize the financing of the states safety-net hospitals and implement comprehensive Medicaid reform. The amendment was requested in large part due to unmet program goals established for the first and second years of the original waiver. In October 2007, CMS approved the requested amendment targeting coverage expansions for eligible low-income children and uninsured adults through various programs within a “Coverage Initiative” (CI) to be established at the county level and approved through August 2010. Specifically, CMS approved annual funding of \$180 million to be used to expand coverage options to the uninsured through multiple county designed expansion programs established to link the uninsured with safety-net systems/providers already in place. Through the CI programs, counties and providers were given the following objectives; to increase the number of Californians with health care coverage, to strengthen and expand the local safety-net system, to improve access to high quality care and improved health outcomes, and to derive savings to the system through improved efficiency in the delivery of care and services.

While each county demonstration within the CI varies depending on the needs and demographics of the region, the majority of programs seek to cover individuals/adults at or below 200% of Federal Poverty Level (FPL), LA County being the singular exception choosing to target individuals at 133.3% FPL. County programs provide coverage and care through a range of coverage mechanisms, from medical home models of care, to disease management and chronic care models, to primary and preventive care models, to small employer based programs. In particular, the State was explicit in establishing the CI and county programs not as entitlement programs, but as separate, targeted expansions to coverage options.

The fundamentals of the original MediCal waiver demonstration have essentially remained consistent with programmatic requirements, eligibility, and benefits, the exception being the financing component of the program. California’s Safety Net Care Pool (SNCP) relies heavily on funding derived from disproportionate share hospital (DSH) payments and certified public expenditures (CPEs). In order to comply with recent federal regulations on distribution and leverage of federal financing, the structure for financing evolved to coincide with new requirements. Of the \$766 million allocation to the SNCP, \$188 million is designated specifically to finance the CI.

Eligibility- While specific eligibility requirements vary from county to county; the CI does set fundamental eligibility standards. Individuals aged 19 to 64 who are at or below 200% FPL, and who are not eligible for Medicaid/SCHIP are eligible for coverage through various CI programs. Additionally, individuals with incomes at or above 101% FPL who also meet prior established requirements and have not been insured in the previous months (unless through employer sponsored insurance that was discontinued for specific state approved reasons) will be eligible for coverage under the CI and associated

programs. Worth noting, language within the approved waiver amendment states that ‘due to fluctuating funding’, the State maintains the option to freeze or limit enrollment at any time based on funds available.

Benefits and Cost Sharing- There are several components to the CI cost sharing requirements. Enrollment fees may not exceed \$250/individual or \$300/family. Premiums range from zero cost for enrollees at 0-100% FPL, to \$25 for 101-200% FPL, but may not exceed \$25 for any category of eligibility. **FQHC** benefits are covered under the CI with a generic co-pay of \$20. The Counties have some flexibility in how they establish benefits, but generally speaking CI benefits are rather comprehensive, including but not limited to; in and out patient hospital services, clinic services (**FQHC, RHC, FQHC Look-A-Like**, County, Specialty Clinics and State Licensed Free Clinics), physician services and some home health services. Specific to FQHC covered services: optometry, psychology, podiatry, physical therapy, occupational therapy, audiology, radiology and lab services are all covered. The CI covers some prescription and over the counter drugs with co-pays ranging from \$5 for prescriptions under \$50, \$15 for prescriptions between \$50-200, 20% of the cost of prescriptions costing over \$200, and an overall maximum of \$100/prescription.

Altering Medicaid’s Fundamental Structure- The most significant real expansion of enrollment will now occur in the last three years of the demonstration, at which point \$180 million of the \$766 million annual Safety Net Pool Allocation is diverted to expand coverage. Ten counties in California (Alameda, Contra Costa, Kern, LA, Orange, San Diego, San Francisco, San Mateo, Santa Clara, Ventura) have been contracted by the California DCHS to provide expanded services under the CI. Plans use a variety of methods and targets within programs to accomplish the goals established for the CI. For example, Alameda County Excellence (ACE) program will offer expanded benefits to eligible and enrolled Alameda County residents with incomes at or below 200% FPL. ACE focuses on chronic care and disease management through preventive and primary care at a designated medical home – targeting chronically ill populations. In contrast, San Diego County has developed a public-private partnership built upon the local health care safety-net system. The San Diego program targets enrollment to eligible uninsured and underserved, again emphasizing chronic disease management and addressing misuse of hospital emergency departments. Finally, in still another county model, Santa Clara County will provide comprehensive primary and preventive health care from a choice of primary care providers. The program will cover all county residents that meet DRA/FPL standards. However, the Santa Clara program will target self-employed and low-wage workers, developing a shared responsibility model distributing health coverage cost between employer, employee, and community. Lastly, in regard to coverage for undocumented immigrants, the Safety Net Care Pool will make deductions at a rate of 17.9% for each billing, to occur during each year of the waiver, to cover the cost of providing care to the undocumented population.

FQHC Specific Changes- California’s approved amendment language does not explicitly change or target changes with respect to FQHCs. However, because the structure of the CI varies from county to county, the implications of the initiative will also vary

significantly for health centers dependant upon the preexisting relationship or disposition of the county in which the health center is located. Currently, some counties already exist as strong partners with their region health centers, while in other cases health centers have been shut out of the process entirely. Further review and advocacy will likely be necessary in order to ensure positive collaborations between California's counties and CHCs.

Intergovernmental Transfers & DSH Payments- Safety Net Care Pool funds may be accessed only by the State, counties, or cities and designated providers for uncompensated costs of medical services provided to uninsured individuals, as agreed upon by CMS and the State.

- Private hospitals will have "look-alike" funding that uses General Fund support to match federal funds. Public hospitals that previously received these supplemental federal funds will utilize the SNCP and DSH funding. The Public hospital will utilize Certified Public Expenditures (CPEs) and IGTs to draw federal match. The State is permitted to finance Medicaid payments and DSH payments to these providers using CPEs.
- During the term of the demonstration, the State will not impose a provider tax, fee, or assessment on inpatient hospital services, outpatient hospital services, or physician services.
- DSH payments cover those expenses incurred by hospitals covering unqualified aliens for non-emergencies.
- Government operated hospitals will also receive DSH payments from federal funds of 175% of the uncompensated care costs for Medicaid patients. IGTs will be made to cover uncompensated costs of government operated hospitals over 100% from non-Federal share.
- In compliance with federal regulations, financing cannot be redistributed or given back to government entities, funds must remain with the hospital.

Source: CMS Special Terms and Conditions MediCal Hospital/Uninsured Care Demonstration Amendment documents – October 5, 2007. CMS website www.cms.gov

Florida

Status- Waiver was approved by CMS and legislature passed implementing bill in December 2005.

Eligibility- Florida began enrolling two eligibility groups into Empowered Care during the first half of 2006: section 1931 eligibles and related group (called the “TANF and TANF-related eligibility group”) [low-income parents and children] and the Aged and Disabled (those receiving SSI cash assistance, those eligible under Medicaid Expansion Designated by SOBRA-Aged and Disabled assistance group). The following individuals eligible under the above groups will be excluded from participation during the initial phase: institutionalized individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility for the Developmentally Disabled (ICF-DD), and individuals with Medicare coverage. These individuals may voluntarily participate in Empowered Care. The state will start with Broward and Duval Counties and plans (with legislative approval) to serve a vast majority of Medicaid recipients by 2010, including those residing in nursing homes and other institutionalized settings, the developmentally disabled, recipients receiving hospice service, sub-acute and dual-eligibles.

Benefits and Cost Sharing- “Empowered Care,” a proposal for changing Florida Medicaid, will provide a risk-adjusted premium for individuals eligible for Medicaid with three components (comprehensive care, catastrophic care, and an enhanced benefit account). The premium will be divided into three components and be actuarially comparable to all services currently covered under the Florida Medicaid program. There will be an option for individuals to use their premiums to “opt out” of Medicaid and purchase employer sponsored insurance. If the premium for employer-sponsored insurance is greater than the Medicaid premium, the recipient will be responsible to pay the additional amount. Individuals must earn eligibility to access the enhanced benefits by exercising personal responsibility and participating in established healthy practices (the state will create a list of activities that an individual may participate in to generate contributions to the account—a flexible spending account—which can be used for qualified medical expenditures and services not generally available to the Medicaid recipients). These enhanced benefits will be available to the individuals even after Medicaid eligibility has ended, however the funds will only be able to be used to purchase insurance, and if the individual does not use these funds after three years, the funds will be returned to the state. Under this proposal, cost-sharing requirements consistent with the current levels in the State Plan may be imposed for mandatory populations. However, the state may seek authority to increase cost-sharing for the optional eligibility categories.

Altering Medicaid’s fundamental structure and design- Under “Empowered Care,” the role of the state will change so that it is largely a purchaser of care. The proposed model is expected to become the primary delivery system statewide after full implementation. The state is seeking to increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service

program. Specifically, many individuals currently in a fee-for-service program would move to a plan that is responsible for managing all of their care. The state wants to use multiple vendors, or care networks, to provide services. These will include: Managed Care Organizations (HMOs and EPOs); Licensed Insurers (PPOs and POS); Provider Sponsored Networks; Minority Physician Networks; and Rural Health Care Networks.

FQHC specific changes- The state will require plans to “make a good faith effort” to include FQHCs, rural health clinics, and county health departments in their network. If a plan can demonstrate to the state and CMS that adequate capacity and appropriate range of services for vulnerable populations exist to serve the expected enrollment without contracting with FQHCs, RHCs, and CHDs then the plan can be relieved of this requirement.

Intergovernmental transfers and DSH payments- The waiver replaces the state’s current upper payment limit financing with a \$1 billion annual “low income pool” for which hospitals are currently the only eligible entities.

Source: CMS Special Terms and Conditions October 2005 and HB 3B.

Georgia

Status- The original author of Georgia's Medicaid reform concept paper has since left his position within the state. The reform process as it applies to the concept paper has been put on hold until indefinitely while the State considers existing and alternative options for reform.

Eligibility- Georgia's Medicaid Reform Model outlined in the 2005 concept paper proposes to convert nursing home services from an entitlement to an optional service, available only after it is determined that there is no suitable community placement for an individual.

Benefits and Cost Sharing- The Georgia proposal would institute beneficiary co-payments and expand sliding scale premiums for mandatory eligibles and services. Under the proposed Medicaid waiver, the requirement to provide any medically necessary service for eligible children could be limited to a prescribed set of services shown to promote children's health instead of the periodic screening, vision, dental, and hearing services now mandatory in the state under the EPSDT requirements. The proposal wants to eliminate current law requiring that for the elderly and disabled to be eligible for community-based services they must first be determined eligible for nursing home level of care. The Georgia proposal would institute higher co-payments for optional populations and services, particularly pharmacy services, and would institute flexible health spending accounts to be used for the costs of sharing obligations or optional benefits. The proposal also urges capped funding for optional services other than PeachCare (which already receives capped funding).

Altering Medicaid's fundamental structure and Design- Georgia's waiver proposal would capitate federal spending for all Medicaid services, initiatives, and administrative costs for 3 to 5 years. Federal funding would be based on a mutually agreed upon base year expenditure and projected growth trends. The proposal states that benefits and funding would be tailored to each consumer's individual needs through the use of MCOs, transparent pricing and quality measures and incentives, flexible health savings accounts, and cost sharing programs. The proposal involves moving away from an entitlement to a waiver for Medicaid, allegedly giving the state more flexibility to manage mandatory eligibles and services.

Payment and Financial Performance Incentives- Flexible health spending accounts would be used to encourage and reward consumers for making healthy choices and participating in prevention programs under the Georgia proposal. Consumers will have the responsibility to select providers and health care services based upon cost and quality of service. If they choose health care that is cost effective and high quality, they will reduce their obligation for cost sharing. Georgia would also like to use marketplace transparency in the pharmacy benefit plan as a tool to place downward pressure on the cost of prescription drugs. The state would set specific cost and dispensing fees for each drug category. Consumers choosing to purchase drugs at the cost and dispensing fee set by the state would not share in the cost of the drug, however, if consumers choose drugs

above the state set cost and dispensing fee, they would pay the difference between the state rates and the actual charge from the pharmacy.

Source: Concept paper draft 5/20/05

Hawaii

Status- Waiver renewal approved Jan. 31, 2006.

Eligibility- The State of Hawaii has proposed a Section 1115 waiver amendment to its QUEST program. All current QUEST eligibility groups will continue to be covered under the demonstration, and additional populations will be covered under QUEST Expanded (QEx): 9,000 kids between 200 and 300% FPL with SCHIP funds; 20,000 adults under 100% FPL (TANF parents, childless adults on general assistance, childless adults that meet asset limits).

Benefits and Cost Sharing- The current state plan benefits will be provided to kids via mandatory managed care (except blind/disabled). \$500 per person/per year dental benefit for all adult recipients will be added to the primary and acute health care benefit package under QEx. The benefits provided to adults via mandatory managed care are: emergency visits, 10 inpatient hospital days, 12 outpatient visits (associated diagnostic tests), 6 mental health outpatient visits, 3 ambulatory surgeries, immunizations (diphtheria and tetanus), family planning, limited prescription drugs, and language/interpreter services. Premiums: 50% of cost person/month for self-employed expansion adults (except pregnant, general assistance, TANF); \$60/month for expansion adults with incomes above 100% FPL; \$30/month for expansion adults below 100% FPL; up to \$60/month for kids between 250-300% FPL (limited to 5% family income).

FQHC Specific Changes- Hawaii received a waiver regarding FQHC contracting. Specifically, if an MCO can demonstrate to CMS and the state that both adequate capacity and appropriate range of services for vulnerable populations exist without contracting with FQHCs the plan can do so with approval.

Source: January 31, 2006 Special Terms & Conditions

Idaho

Status- after initially pursuing an 1115 Waiver, Gov. Kempthorne announced May 25 that their state plan amendment (SPA) had been approved on May 19, 2006 to implement value-based Medicaid reforms. Thirteen (13) reform requests have received federal approval to date. Federal approval pending: 1) premium assistance requirement changes; 2) moving Healthy Connections into state plan; and 3) combining two home & community-based waivers. State rules will be reviewed by the 2007 Legislature.

Benefits/Cost-sharing- Does not add new eligibles to the Medicaid program but merely expands benefits for current beneficiaries. They will offer 3 alternative benefit packages aimed at specific beneficiary groups including low-income children & working-age adults, individuals with disabilities/special needs, and Medicaid/Medicare dually eligible adults.

- a) The Benchmark Basic Plan will serve healthy low-income children and adults with the traditional Medicaid benefits excluding long-term care, organ transplants, and intensive mental healthcare. This plan does cover preventative and nutritional services. This plan becomes available July 1, 2006.
- b) The Enhanced Benchmark Plan will cater to disabled/special needs and elderly beneficiaries and will include long-term or institutional care. This plan becomes available July 1, 2006.
- c) The Coordinated Benchmark Plan will enroll dual eligibles in both Medicare Part B (outpatient coverage) and Part D (drug benefit) plans. This plan becomes available October 1, 2006.

Other-Through a long-term care partnership program, they will encourage the private purchase of long-term care insurance. Implementation was intended as early as 2006, but has been put on hold based on other state initiatives and competing priorities.

The state will award grants to schools to deliver **preventative** services to low-income students. This is consistent with a general emphasis on prevention with this SPA – all of the above described packages include preventative services.

Indiana

Status- In December 2007 CMS approved an amended version of Indiana's Affordable Choices 1115 waiver demonstration plan, emphasizing expanded health care coverage options to the uninsured parents of Medicaid and SCHIP covered children as well as uninsured childless adults. Specifically, language within the waiver lays out coverage plans using federal match/DSH dollars, HSA plans, and coverage expansions. To coincide with the recently approved waiver language, during the 2007 legislative session the Indiana legislature passed the 'Healthy Indiana Plan', a comprehensive health care reform bill providing health care coverage to all uninsured Hoosiers (Indiana residents), increased access to childhood immunizations and reduction of smoking rates.

Eligibility-The Healthy Indiana Plan covers Indiana's uninsured (120,000 individuals) ages 18-65, that have been uninsured for past six months, are under 200% FPL, are not eligible for any other Medicaid product, and are without access to employer sponsored health insurance. Additionally, individuals who are under 200% FPL, must be without any other form of health insurance, and maintain at least twelve months of Indiana residency to be eligible for coverage. Other coverage expansions include; uninsured parents of Medicaid and SCHIP children with income between 23% and 200% FPL who are not otherwise eligible under any existing Medicaid category, and pregnant women from 150% to 200% FPL. Also, the plan provides for presumptive eligibility for pregnant women and extends SCHIP coverage to 300% FPL.

Benefits/Cost Sharing- Under the Healthy Indiana Plan, the state will provide free preventative care up to \$500 annually, including, mammograms, colorectal screenings, smoking cessation classes and smoking patches. Additionally, enrollees will be allotted \$1100 per adult in a HSA "Personal Wellness Responsibility Account" (POWER Account), that can be used to cover initial medical costs. Contributions to the POWER account is shared by enrollees and the state (contributions are not always tax-free), dependent on the beneficiaries ability to pay, with a maximum contribution of 4.5% of gross family income. The account will be controlled by the beneficiary. After the account has been depleted, expenses are covered by the state at up to \$300,000 annual insurance and up to \$1million lifetime. Also, unused funds will be rolled over to cover the member contribution for the next year. Additionally, participants have a choice to purchase dental and vision plan coverage. Participants are required to pay 50% of the premium cost, the state covering the remaining 50%. These optional purchasing plans will be on top of the POWER Accounts contributions.

Payment and Financial Performance Incentives- Small employers can qualify for tax credits, called "125 Plans," if they provide qualified wellness programs. The employer may receive the tax credit for making health benefits plans available to employees for the first two taxable years the plan is available.

Intergovernmental Transfers and DSH Payments- In an effort to improve the health of Indiana residents and reduce smoking rates, Healthy Indiana Plan is funded by a \$.44 cent increase in tobacco price. Additional funding will come from DSH payments. Reform

language changes funding for hospital care for the indigent program, municipal DSH program, and Medicaid indigent care trust fund. Presumably, as an increasing number of uninsured become covered under the Healthy Indiana Plan, DSH money can and will be used to support expansion efforts.

Source: Healthy Indiana Plan, Issue 1, Judy Monroe, M.D., State Health Commissioner (February 2007); State Health Plan Summary Presentation, Healthy Indiana Plan website, state of Indiana Government (April 2007)

Update:

The state began enrolling people in the Healthy Indiana Plan (HIP) starting in January, 2008. In order to win approval from CMS to operate the plan under an 1115 waiver, the state can't expand beyond the current Medicaid eligibility of 200% of the poverty level and had to remove some dental and vision-care components from the plan.

According to a report by the Kaiser Family Foundation as of June 2008, over 53,000 adults had applied for HIP, but 40% of applications were denied. Data shows that half of denials were due to enrollees already having coverage or having access to coverage. A third of denials were a result of lack of information needed to establish eligibility or income requirements. The rest of the denials were due to exceeding income levels and other reasons. However, as of June 2008, 12,986 adults were enrolled in HIP. 69% of these beneficiaries were below 100% of the poverty level and 89% had incomes below 150% of the poverty level. 65% of HIP enrollees were women and 59% were adults without dependent children.

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Iowa

Status- Waiver approval by CMS July 2005

Eligibility- Iowa's IowaCare Demonstration eligible population includes: individuals ages 19-64 with family incomes between 0-200% FPL who do not meet eligibility requirements of the Medicaid State Plan or any other waiver (with the exception of beneficiaries eligible for the Family Planning waiver); parents whose incomes between 0-200% FPL is considered in determining the eligibility of a child found eligible under either Title XIX or Title XXI, who are not otherwise Medicaid eligible; newborns and pregnant women with income at or below 300% FPL who have incurred medical expenses of all family members that reduce available family income to 200% FPL; children from birth until 18 with serious emotional disabilities who would be eligible for State Plan services if they were in a medical institution and need home and community-based services in order to remain in the community, and who have income at or below 300% of the SSI Federal benefit or a net family income at or below 250% FPL. Iowa also reserves the right to limit the demonstration population. Additionally, Iowa's family planning waiver will cover women ages 13-44 with income at or below 200% FPL, whose covered population will coincide with the Iowa Care Demonstration.

Benefits and Cost Sharing- Under the Iowa proposal, benefits and coverage for the expansion population (not including the emotionally disabled children) will be limited to inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies and transportation services to the extent covered by the Medicaid State plan. The expansion population will also be charged monthly premiums. Co-payments will also be required of the expansion population. For those children with serious emotional disabilities, case management, respite care, environmental modifications and adaptive devices, in-home family therapy, and family and community support services will be part of the benefit package in addition to all the benefits offered under the Medicaid State plan. All expansion members will be entitled to and will be required to utilize a "medical home" and a "dental home" will be found for each Medicaid-eligible child.

Payment and Financial Performance- If participation in wellness programs result in cost savings, consideration will be given to sharing a portion of cost savings with members possibly through reduction in monthly premiums or reduction of co-pay obligations. Iowa is considering the Maine Primary Care Physician Incentive Program (compensating physicians who rank above the 20th percentile when compared to others in the primary care specialty).

Intergovernmental transfers and DSH payments- Iowa will continue to provide disproportionate share hospital payments through the graduate medical education and disproportionate share fund program, but the supplemental DSH program will be discontinued and a new DSH program will be developed to allocate the State's remaining DSH allotment to the expansion population network.

Source: Approval letter dated July 1, 2005; Iowa Care draft dated 4/18/2005.

Kansas

Status- In September 2006, CMS approved the Kansas state plan amendment (SPA) application for an alternative benefits package, which was submitted in August 2006 and implemented starting in January 2007. The SPA, which was authorized under section 1937 of the Social Security Act as added by the Deficit Reduction Act of 2005, establishes an optional benchmark benefit for its existing Working Healthy Ticket to Work Medicaid Buy-In program, which focuses on allowing people with disabilities to regain or maintain employment and to reduce their dependency on cash assistance.

Eligibility-Individuals categorically eligible in the State's Ticket to Work and Work Incentives Improvement Act (TWWIIA) Basic Medicaid buy-in program with developmental disabilities, physical disabilities, and traumatic brain injuries, who require Personal Assistance Services and related services in order to live and work in the community, are also eligible for the new benchmark program.

This optional Medicaid buy-in eligibility group is comprised of working individuals between the ages of 15 and 65 years old who, except for their income and resource levels, are eligible to receive SSI. These individuals will be given the opportunity to voluntarily opt out of traditional Medicaid coverage and into benchmark coverage. This option will be available Statewide.

Participants must:

1. Have a developmental disability, physical disability, or traumatic brain injury;
2. Be 16 to 64 years of age;
3. Be determined disabled by the Social Security Administration;
4. Have earned income verified by FICA/SECA payments;
5. Have countable net income no higher than 300% of the FPL; and
6. Have assets no higher than \$15,000.

Enrollment will be dependent on available employment opportunities throughout the State.

Benefits and Cost Sharing- In addition to the traditional State plan services, individuals enrolled in this program will receive additional benefits tailored to specific health needs, including:

- Person-centered assessments
- Personal Assistance Services such as assistance with any Activity of Daily Living (ADL), Instrumental Activity of Daily Living (IADL), and health-maintenance activities that are permitted under State law;
- Independent Living Counseling such as information, training and assistance necessary for individuals to direct and manage their personal assistance and related services and service budgets
- Assistive Services such as items or equipment that will improve independence, employment and/or health and safety

The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

FQHC specific changes- The same limitations of federally qualified health centers under the traditional Medicaid state plan are also in effect under the Benchmark Benefits/Secretary-approved coverage.

Also, in their application, Kansas assured CMS that “individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2),” and that “payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).”

Kentucky- Partnership Healthplan

Status- Partnership renewal approved July 2005 which only applies to 16 counties.

Eligibility- Kentucky received approval to modify its Partnership program to guarantee managed care program members, regardless of the type of health plan, that they will be eligible for all Medicaid benefits for a six month period from the date of their initial eligibility (instead of the date of enrollment). Kentucky will eliminate retroactive eligibility and restrict each individual eligible for medical assistance to a single health care partnership in the network.

Benefits and Cost Sharing- Kentucky will modify the program to include behavioral health services, including pharmacy benefits, within the services offered under this waiver.

FQHC Specific Changes- Kentucky received a waiver from the mandatory payment of prospective payment system and supplemental payments to FQHCs and rural health clinics. Plans may, with CMS approval, receive an exemption to the requirement to contract with FQHCs if they can demonstrate that they can provide adequate capacity and appropriate range of services for vulnerable populations without contracting with FQHCs.

Source: Draft renewal document dated 2/4/05; approval letter dated July 1, 2005 (with Special Terms and Conditions)

Kentucky-KY Health Choices

Status- On May 3, 2006, the Kentucky Health Choices program was approved under DRA, to be implemented May 15, 2006. This makes Kentucky the first state to implement comprehensive Medicaid reform through the Deficit Reduction Act. The plan allows low-income, disabled, and elderly beneficiaries to have benefits catered to their specific needs. While previously applying for an 1115 Waiver, the DRA State Plan Amendment allows KY to more easily modify their plan and avoid the requirement for “budget neutrality.” They are still working on an 1115 waiver for the full Optimum Choices package.

Benefits and Cost-Sharing- KY established four benchmark packages tailored to specific groups of enrollees:

- a. Global Choices is the normal plan covering adults – pregnant women and parents. This is the “regular State Medicaid Plan coverage.” This plan also covers disabled and elderly populations (who chose not to opt into one of the more tailored options), foster children, and medically fragile children. Includes increased cost sharing and new benefit limits compared to the previous benefit package. For example, there is a \$50 co-pay for inpatient services, \$3-6 for physician services, and \$1 for generic drugs. There is a \$225 annual out-of-pocket maximum for both prescription drugs and medical services. There are no co-pays for preventative services and pregnant women are exempt for co-pays. Benefits include basic medical services excluding long-term care.
- b. Family Choices will cover the most children including SCHIP children and ensures nominal cost-sharing under the plan amendment through a Secretary-approved Benchmark. The state is mandating enrollment for healthy children. Coverage is 200% of the FPL for SCHIP, 185% FPL for infants, and 150% FPL for other children up to 19. Has no prescription drug limits and a higher vision care maximum. Children are exempt from cost sharing.
- c. Comprehensive Choices is a voluntary plan for elderly individuals in need of nursing facility care. Provides lower co-payments for physician, vision, dental, hearing, and chiropractic services through a Secretary-approved Benchmark. Benefits include the services of Global Choices plus waivers for basic level home care and high intensity institutional care.
- d. Optimum Choices is a voluntary plan for mentally retarded and developmentally disabled individuals needing special care. Provides the same nature of lower co-pays as for the Comprehensive plan through a Secretary-approved Benchmark. The benefits include Global Choices plus three levels of long-term care: high intensity, targeted, and basic.

Other- None of these have been implemented.

- Disease Management programs that target specific diagnoses (Diabetes, COPD, pediatric obesity, cardiac failure, and asthma) have voluntary participation.

- Premium-assistance option to encourage employer-sponsored insurance (**ESI**) take-up. If Medicaid beneficiaries opt-in (voluntarily) to their employer-sponsored insurance, KyHealth Choices will pay the premium.
- Limited Get Healthy Benefits, including limited dental and vision services, for beneficiaries that participate in Disease Management Programs for diabetes, asthma, pediatric obesity, and cardiac failure.

Sources- Commonwealth of Kentucky Press Release, May 3, 2006 “Kentucky, CMS Launch Governor’s Medicaid Transformation Initiative”; Kentucky Medicaid Reform Fact Sheet – KyHealth Choices; The Kaiser Commission on Medicaid Facts: “KyHealth choices Medicaid Reform: Key Program Changes and Questions” July 2006.

Louisiana

Status- Very little tangible progress seems to have been made since the state submitted its concept paper to CMS on Oct. 20, 2006. When CMS was criticized by members of the Energy and Commerce Subcommittee on Oversight and Investigations for its lack of communication and timely action on this issue, Secretary Leavitt responded by stating that discussions between CMS and LA are ongoing and that feedback had indeed been provided. Specifically, he wrote in a letter dated March 21, 2007, that “I supported the reform concepts in their proposal. Following this submission, [CMS] worked with the State to develop a financial model to facilitate the State’s submission of a Medicaid demonstration application that accomplishes the goals of the [Louisiana Health Care Redesign] Collaborative [received by LA January 30, 2006].” “Further,” he went on to write, “some concepts endorsed by the Collaborative could be implemented without a waiver or demonstration submission and the State has the option of submitting a State Plan Amendment immediately to provide additional coverage.”

Nevertheless, there remains a puzzling impasse. No waiver or state plan amendment proposal from the state has been submitted, and, in fact, state officials have called the accuracy of the financial model CMS provided into question, claiming that CMS’s program cost estimates are misguided and could lead to dangerous financial liabilities for the state. A February letter to Collaborative members and stakeholders from the state attempts to explain CMS’s shortcomings: “We believe these discrepancies [between state and federal cost estimates] resulted in the HHS model containing the following: incorrect cost projections; omission of high cost populations; unrealistic managed care assumptions; and overestimation of enrollment rate.”

Furthermore, a recent study conducted by the Center on Budget and Policy Priorities has concluded that “if Louisiana embraced the health care redesign model suggested by the U.S. Department of Health and Human Services [as defined by the “Affordable Choices Initiative”], many Louisiana residents would be left without insurance, others who obtain insurance would get inadequate coverage and the state’s safety-net providers would be left without the necessary support to provide care to those who remain uninsured.”

Eligibility-

Statewide expansions:

- Uninsured children with incomes up to 300% of the FPL
- Uninsured pregnant women with incomes up to 200% of the FPL; and
- Individuals with serious mental illnesses (SMI) and addictive disorders with incomes up to 200% of the FPL.

Region I (Orleans, Jefferson, Plaquemines and St. Bernard parishes) expansion

- Uninsured parents with incomes up to 200% of the FPL; and
- Uninsured childless adults with incomes up to 200% of the FPL.

Benefits and Cost Sharing- In serving the “low income uninsured and Medicaid-enrolled populations” eligible residents (except high-risk categories) would be provided a

“financial credit sufficient to apply either to the purchase of an individual comprehensive health insurance policy, or to the employee cost of participation in a qualified employer-sponsored health plan.” “The foundation of the benefit coverage used to establish the amount of this financial credit will be the Louisiana Benchmark Health Plan”—for adults that would be the LaChoice plan but with reduced co-pays and deductibles and LaCHIP (state’s SCHIP program) would be the benchmark plan for children....” “The Benchmark plan will be an option for the current fee-for-service Medicaid program.” See pages 14-15 of Concept Paper

Altering Medicaid’s Fundamental Structure and Design-Delivery of Services – The preferred vehicle for expansion to the uninsured will be through private insurance, either through an existing employer-sponsored plan or through a “medical home plan” that will be accessed through a new health insurance connector. The concept paper presents the medical home model as the foundation for coverage of the uninsured as well as for the transformation of the way care is provided in the Medicaid program. The basic medical home would have all patients seeing a primary care provider who could refer as medically necessary to specialists, hospitals, and other health care providers as well as referring to a specialized medical home those individuals with complex chronic diseases.

The Health Insurance Connector, as described in the concept paper, would be “an administrative entity” that would connect “any individual needing health insurance to the affordable options for insurance coverage that are available to them.” For Medicaid recipients “or the low-income uninsured” to be covered through the expansion, “the connector would make premium subsidies available on a sliding scale according to income.”

Payment to Providers-Reimbursement systems would be established “to support a moderately managed care system”

FQHC Specific Changes- DHH also calls for “[f]ederal resources to establish new and increase capacity of existing community health centers and flexibility of administrative and funding requirements for CHCs in light of hurricane recovery needs and circumstances. DSHH states that “Louisiana will request 10 new federally qualified health center sites for Region 1.” See pages 8 and 20 of Concept Paper.

Intergovernmental transfers and DSH payments- Budget neutrality for the Louisiana proposed waiver is partially based on redirection of DSH for non-categorical populations (childless adults in the LaChoice and LHP programs). DHH proposes to allocate up to \$60 million of the State’s current DSH allotment to a Graduate Medical Education pool.

Sources -“Louisiana Health Care Redesign Collaborative: Concept Paper For A Redesigned Health Care System for Region 1” For CMS Submittal, October 20, 2006.

“Affordable, Accessible, and Flexible Health Coverage – Affordable Choices Initiative” <<http://www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html>>

Solomon, Judith. "President's 'Affordable Choices' Initiative Provides Little Support for State Efforts to Expand Health Coverage" Center on Budget and Policy Priorities, 3 April 2007 <<http://www.cbpp.org/4-3-07health2.htm>>

"Collaborative Member and Stakeholders in the Louisiana Health Care Redesign Collaborative process:" February 2007

Maine

Maine Katie Beckett SPA

Background

The Katie Beckett coverage option is available to children with serious health conditions. Eligibility requirements include; children aged 18 or younger, beneficiaries must not be eligible for other MaineCare coverage or groups, individuals must be qualified as *disabled* as defined by the Department of Social Security. Individuals covered under the Katie Beckett program cannot be living in a hospital, nursing facility, psychiatric hospital, or intermediate care facility for individuals with mental retardation – but can require the level of care provided by these types of facilities. Furthermore, in accordance with state and federal law, the cost of providing care outside of these institutions cannot exceed the annual cost of institutional care needed by the child.

Maine State Plan Amendment 07-012

The Katie Beckett SPA was submitted by the State of Maine in December of 2007, was quickly approved by CMS in January, 2008 and implemented thereafter on April 1, 2008. The primary function of the SPA is to establish a cost sharing mechanism, in accordance with the federal Deficit Reduction Act, in order to implement premium payments for the Katie Beckett population.

Cost Sharing

Under the SPA alternate premiums to the Katie Beckett population will be imposed on families with incomes over 150% of the Federal Poverty Level (FPL). The State will use a sliding fee scale to determine monthly premiums. The sliding fee scale is based on income and cost of premiums will not exceed the aggregate cap of 5% of gross income. Under the Maine Katie Beckett SPA premiums will range from .005 to 2.5% of gross income.

Sources: MaineCare Services web site – Bureau of Medical Services:

<http://maine.gov/bms/memberfiles/katiebeckett.htm>

CMS website – Deficit Reduction Act/SPA section

http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp

Massachusetts

Status- MassHealth Medicaid Section 1115 Demonstration approved on July 26, 2006, effective July 28, 2006 for the demonstration extension period of July 1, 2005 through June 30, 2008

Eligibility- Family Assistance/Mass Health - - includes persons who are HIV-positive, as long as they are under 65 and have income that is less than or equal to 200% FPL and who would not otherwise be eligible for Medicaid; and non-disabled children who have income that is less than or equal to 200 percent of the FPL and who would otherwise not be eligible for Medicaid due to family income. Expands kids to 300% FPL.

Breast and Cervical Cancer Treatment Program - - uninsured women with breast or cervical cancer who are not otherwise eligible for Medicaid and who have income less than or equal to 250% of the FPL and who have been screened by CDC/State Dept. of Public Health to receive MassHealth coverage

Insurance Partnership - - employer-based health insurance program in which employer makes a certain level of contributions and permits expenditures for an employer subsidy expands to 300% FPL.

Basic - - demonstration allows the State to make expenditures for medical coverage provided to long-term unemployed childless adults age 19 through 64 with income at or below 100% FPL who are receiving Emergency Aid to Elders, Disabled and Children or services from the Department of Mental Health

Essential - - demonstration allows the State to make expenditures for medical coverage provided to long-term unemployed childless adults ages 19 through 64 with income at or below 100% FPL who are not eligible under Basic

Medical Security Plan - - provides medical coverage for those receiving unemployment benefits from the Division of Unemployment Assistance with incomes at or below 400% FPL

CommonHealth - - provides medical coverage to working adult individuals with a disability and children with a disability with income above 133 % of the FPL, who are not eligible for Standard

Commonwealth Care Health Insurance Program - - provision of premium assistance for the purchase of private health insurance products for individuals at or below 300% of the FPL who are not otherwise eligible under the State plan or the demonstration

Increases in Enrollment Caps under the demonstration for: Beneficiaries with HIV receiving coverage under the Family Assistance Program; Long-term and chronically unemployed beneficiaries receiving services under the Essential program (from 40,000 to

60,000); Enrollment Cap removed for working disabled adults covered under the CommonHealth program.

Intergovernmental Transfers and DSH Payments-MCO supplemental payments will be capped along with DSH funds; No IGT funding but CPEs are allowed; Federal government will match state spending for a new Safety Net care Pool to provide health care services to the uninsured and to cover “Unreimbursed Medicaid Cost”

Altering Medicaid’s Fundamental Structure and Design- Expands Insurance Partnership (IP) program which provides small businesses with partial subsidies for group health insurance purchased for low-income employees and their families and provides premium assistance for employees by expanding income eligibility to 300% of FPL and limiting the value of the employee subsidy paid under the IP program to the value that would be paid to individuals receiving an insurance subsidy under the Commonwealth Care Health Insurance Program.

Premium assistance payments from the Commonwealth Care Health Insurance program to managed care organizations that have contracted with the Commonwealth as of 7-1-06 (Boston HealthNet, Cambridge Network Health, Fallon Community Health Plan, and Neighborhood Health Plan).

Safety Net Care Pool (SNCP) –funds will be used for the provision of premium assistance to low income individuals not otherwise eligible under the State plan or this demonstration; payments to providers for the costs of health care for the uninsured and payments to safety net providers

FQHC specific changes-funding for health centers in FY 2007 with apparently no major changes to pool structure until 9/30/07; Establishing the current FQHC Medicare Rate as the pool reimbursement “rate” for freestanding community health centers; Community health centers will be paid the base rate and add payments for additional services including but not limited to, ESPDT services, 340B pharmacy, urgent care, and emergency room diversion services; Reimbursement for CHC bad debt.

As of October 2007 all Uncompensated Care Pool balances will be transferred to a newly created Health Safety Net Trust Fund which will:

- Set rate for hospitals and health centers and reimburse hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents of the commonwealth,
- Limit medical necessary services to those mandated under Medicaid,
- Support demonstration projects including disease management services for patients in community health centers and community mental health centers and through coordination between these centers and acute hospitals.

Michigan-“Modernizing Michigan Medicaid”

Status- Waiver proposal submitted to CMS in June 2005-currently on hold.

Eligibility- The Modernizing Michigan Medicaid proposal would effect a change in coverage for only two groups of adults currently receiving Medicaid coverage through optional categories of eligibility: caretaker relatives and individuals who are 19 and 20 years of age. These individuals have countable income that is less than 133% of AFDC level (about 50%FPL). The proposal seeks authority for the state to freeze enrollment for enrollees who are 19 and 20 years of age, and also requests a waiver of the statutory requirement for three-months retroactive enrollment.

Benefits and Cost Sharing- Michigan’s proposal would provide a reduced scope of benefits to individuals covered by the waiver compared to the benefits offered under the State Plan to other Medicaid beneficiaries. The modified benefit package for these two groups (non-pregnant, non-disabled 19 and 20 year olds and caretaker relatives) will NOT include the following: hearing services, vision services, speech therapy, physical therapy, and occupational therapy. The state will impose limitations on some of the State Plan benefits it currently offers, as well as introduce a co-payment for emergency department services. The proposed benefit changes and co-payments are: inpatient hospitalization limited to 20 days/year; prescription drug coverage limited to four prescriptions per month per beneficiary; and all emergency room visits will require a \$10 co-payment.

Payment and Financial Performance Incentives- Michigan co-payments for emergency department services will be used to encourage appropriate utilization of the ER.

Source: Demonstration Application dated June 1, 2005.

Michigan-“Michigan First Healthcare Plan”

Status- In 2006 Governor Granholm announced a plan to cover an additional 500,000 uninsured Michigan residents. As recently as February 2007 she was in talks with Secretary Leavitt about the plan, but no proposal has been formally submitted to date.

Eligibility- Uninsured below 200% FPL will be eligible.

Benefits and Cost Sharing- State will establish guidelines for benefits and cost-sharing. At a minimum benefits will include: preventive and primary care, hospital care, emergency room care, mental health services and prescription drugs. Uninsured below 100% FPL will pay minimal out of pocket costs and those between 100-200% FPL will pay more based on a sliding scale.

Altering Medicaid’s Fundamental Structure & Design- Private market will create products based on minimum requirements laid out by state which uninsured can choose from to meet their health and income needs. Managed care will be used. The state also plans to improve health IT and promote healthy lifestyles.

Intergovernmental Transfers and DSH Payments-The state plans to finance the waiver using certified public expenditures and “costs not otherwise matchable”. The state will request federal funds for programs that are currently state only and for savings the state has achieved through Medicaid efficiencies.

Source: Department of Community Health PowerPoint presentation February 1, 2006.

Missouri

Status- In April, 1998, Missouri was first granted an 1115 waiver for its Managed Care Plus (MC+) program. This statewide program, which provided managed care to all eligible adults and children in the state with gross income up to 300% FPL, was coupled with the state's 1915(b) waiver and expired in March, 2007.

In 2006, prompted by a severe budget shortfall, the state cut 100,000 people off of Medicaid and cut services for another 300,000. Also, the state legislature set an end date for the entire program: June 30, 2008. In anticipation of this date, Missouri's state government put together a Medicaid Reform Commission Report, which proposed what is called the MO HealthNet, a managed care program that focuses on wellness, prevention, individual responsibility, and technology, among other things, to replace the current Medicaid system. A bill (SB 577) recently passed in the Missouri legislature seeks to officially establish the MO HealthNet, giving the state department of social services wide latitude in receiving federal approval (either through a waiver or a state plan amendment) and in implementing the details of the law. The relevant changes included in that bill are outlined below.

Eligibility- Creates Ticket to Work program which extends eligibility to working disabled below 250% FPL (premiums for those between 100-250% FPL). Extends services for foster care children to age 21. Limits Health Insurance for Uninsured Children Program to those without access to affordable employer sponsored insurance. Adds women above 18 years of age and below 185% FPL to Uninsured Women's Health Program.

Benefits and Cost Sharing- Hospice was restored as a benefit. Medically necessary dental and optometry will be covered subject to appropriations.

As of July 1, 2008, all participants will have to pay co-pays for all services except personal care, mental health and CHIP.

Requires premiums for those enrolled in the Health Insurance for Uninsured Children Program as follows:

- 150-185% FPL, 3% of 150% FPL
- 185-225% FPL, 4% of 185% FPL
- 225-300% FPL, 5% of 225% FPL

Altering Medicaid's Fundamental Structure & Design-All MO HealthNet participants will be placed in one of three "Health Improvement Plans": managed care, coordinated fee for service, or Administrative Service Organization (ASO).

Payment and Financial Performance Incentives-Creates a committee to develop pay for performance program.

FQHC specific changes- While there was no mention of FQHCs in the 1115 waiver, the new proposal for the MO HealthNet makes explicit reference to health centers, ensuring that there will be some oversight of the process.

“The department of social services may apply to the federal Department of Health and Human Services for a Medicaid/MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional Medicaid/MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(1)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the oversight committee created in section 208.955.”

Sources-Senate Bill No. 577, 94th General Assembly, First Regular Session, State of Missouri.

“The Transformation of Missouri Medicaid to MO HealthNet,” Departments of Social Services, Health and Senior Services and Mental Health, State of Missouri, December 7, 2006.

“State Watch | Missouri Senate Votes To Move Medicaid Beneficiaries Into Managed Care Programs,” Daily Health Policy Report, Kaiser Family Foundation, April 13, 2007, <http://www.kaisernet.org/daily_reports/rep_index.cfm?DR_ID=44239>.

“Using Blunt Force On Missouri’s Most Vulnerable Population,” Families USA, March 2007, <<http://www.familiesusa.org/assets/pdfs/missouri-blunt-force.PDF>>.

Missouri - State Plan Amendment Update

Insure Missouri - Phase 1, Benchmark Plan

Background

In October of 2007 Missouri submitted their most recent State Plan Amendment (SPA), phase one of three phases, in the form of a mandatory benchmark plan targeted to parents and caretaker relatives aged 19 and older. The benchmark plan expands eligibility for individuals covered under section 1931 of the Social Security Act covering certain low income families. The SPA adds an earned income disregard up to 100% of Federal poverty level (FPL) as well as an alternative benchmark benefit package, as permitted under section 1937 of the SSA, mandating enrollment of parents and caretaker relatives aged 19 and older. Mandatory enrollment is imposed on those who either become eligible as a result of the income disregard or who are eligible under section 1925 of the SSA. The benchmark plan is offered through private health insurance carriers and is equivalent

to the Federal Employees Health Benefits Program Blue Cross/Blue Shield Standard Option PPO.

The SPA and described expansion is the first of three planned phases contained within the broad 'Insure Missouri' plan, the second and third phases require approval of a separate 1115 waiver and are scheduled for implementation in 2008 and 2009. Through the benchmark plan the state intends to provide beneficiaries greater opportunity to participate in mainstream health insurance and reduce inappropriate use of health care services. The Insure Missouri SPA was approved in January 2008 with a planned implementation of March 14, 2008.

Eligibility

The Insure Missouri benchmark plan is mandatory to parents and care taker relatives aged 19 and older with a net income less than or equal to 100% FPL. Beneficiaries are eligible through the 1931 group under the SSA, as well as parents and caregivers of equal age eligible for transitional coverage under section 1925, SSA. Furthermore, the benchmark plan uses an earned income disregard in all budget tests for the 1931 eligibility group.

Benefits

In general, the benchmark plan is equivalent to the Federal Employees Health Benefits Program Blue Cross/Blue Shield Option PPO, and is provided statewide. More specifically, the package of covered services includes: in and out patient hospital and ambulatory surgical services, physician and advanced practice nurse services, FQHC and RHC services, emergency services, lab, x-ray, and other diagnostic services, prescription drugs, mental health and substance abuse services, family planning, personal care, emergency transportation, hospice, transplant related services, and local/public health agency services.

Cost Sharing

Although specific costs are not provided, contained within the 'Insure Missouri' SPA is language outlining 'nominal cost sharing' as well as language specifying that the services in the benefit package are to be furnished on a per member per month basis. It is unclear to what extent cost sharing provisions could be both unmanageable to beneficiaries and potentially taxing to health centers which may or may not be expected to absorb fees not paid by beneficiaries.

Sources:

[CMS Website-DRA/SPA Section](#)

[Social Security Act Website](#)

Montana

Status- Section 1115 (HIFA) Demonstration Waiver submitted to CMS in summer of 2006, currently pending. Estimated implementation date of July 1, 2007.

Eligibility-

- (1) Will use Medicaid funds to finance a portion of the state-funded Mental Health Services Plan (MHSP), essentially establishing Medicaid eligibility
- (2) Up to 1500 uninsured children with family incomes at or below 150% of FPL
- (3) Up to 300 seriously emotionally disturbed (SED) children ages 18-20 with family incomes at or below 150% of poverty;
- (4) Up to 600 working parents with incomes at or below 200% of poverty at the end of Transitional Medical Assistance.

Benefits and Cost-Sharing- MHSP participants who do not have health insurance can choose among three limited physical health care benefit options, including:

- Assistance with the cost of the monthly premium of employer-based insurance;
- Payment of monthly premium payment for a private insurance plan; or
- Medicaid fee-for-service benefits that average \$2000 per person per year.
- For uninsured children—a Medicaid-funded health care benefit identical to the one provided under Montana’s SCHIP program.
- For SED youths, up to three years of Medicaid-funded health care benefits identical to SCHIP and specialized transitional behavioral health services to meet the needs of this group.
- For working parents, one of the same three health care options described above for MHSP participants.

Provides Medicaid funding for portion of Montana Comprehensive Health Authority Premium Assistance program, covering people with incomes at or below 150% of poverty with serious medical conditions who cannot get private insurance. Also provides for a system of monthly employer premium incentives and employee premium assistance payments for small businesses to offer employee health insurance through small business purchasing pool. Services for expansion groups” will be limited and capped to a specific benefit regardless of medical necessity”. Child populations receive SCHIP-like benefit package; waives EPSDT. Cost-sharing dependent on which package the individual chooses.

Altering Medicaid’s Fundamental Structure and Design- Moves from defined benefit to defined contribution for adult expansion populations via premium assistance programs. State can cap enrollment, disenroll, and reduce or eliminate services due to budget constraints. Benefits are limited regardless of medical necessity.

FQHC specific changes—there is no mention of FQHC services or reimbursement in the Montana 1115 waiver application, nor is there a request to waive FQHC statutory requirements. The waiver is silent as to the role FQHCs would play with regard to the

provision of employer-based insurance or private insurance plan options for certain optional and expansion groups nor does it specify whether FQHC services would be part of or SCHIP-type services for these groups.

Source: “A Proposal to Provide Health Care Services to Uninsured Low-Income Montanans Through an 1115 Medicaid Waiver” Montana Dept. of Public Health and Human Services (final document--June 27, 2006).

Nebraska

Status- Concept paper developed December 2005.

Eligibility- State wants to study documentation of eligibility to determine if there is abuse. State will change to partial month eligibility for the first month.

Benefits and Cost Sharing- Create separate SCHIP program for kids and pregnant women between 150-185% FPL including a different benefit package and increased cost-sharing. State will implement cost-sharing (capped at 10% of family income) for families over 150% FPL with kids receiving specialized services (i.e. Katie Beckett, etc). State will establish premiums, co-pays and deductibles, limit amount, duration, and scope, place limits on optional services similar to commercial insurance and require disease management. Expansion of home and community-based services (HCBS) options for persons with disabilities.

Altering Medicaid's Fundamental Structure and Design- State will study shifting from a defined benefit to a defined contribution program. Create a Public/private partnership with small employers to offer Insurance coverage to employees.

FQHC specific changes-Community Health Centers- establish a technical assistance committee to work with local health providers, elected officials, and other community leaders to establish community health centers, satellites of existing centers and, where possible, to help them qualify as Federally Qualified Health Centers. Expand the use of the drug discount programs (e.g., the federal 340B program) so that all eligible organizations can purchase prescription drugs at lower costs.

Nevada

Status- HIFA waiver approved by CMS November 2, 2006. Planned implementation date December 1, 2006.

Eligibility- Expands Medicaid coverage to pregnant women between 133 and 185% FPL and employer sponsored insurance to parents, caretaker relatives, and legal guardians of Medicaid or SCHIP eligible children below 200% FPL.

Benefits and Cost Sharing- Pregnant women will receive the same Medicaid benefit package and will have no cost-sharing requirements. Parents et al will receive the benefit package provided by their employer sponsored insurance and related cost-sharing. The employer benefit packages must meet a minimum standard which includes inpatient and outpatient hospitalization, emergency room services, physician, nurse-midwife, nurse practitioner and physician assistant services, prescription drugs, medical dental services, acupuncture, marriage and family therapy, mental health and substance services, lab, home health, hospice, physical, occupational and speech therapy, chiropractic, optician and optometrist services. No wrap-around services will be provided.

Altering Medicaid's Fundamental Structure and Design-For premium assistance program, employees and spouses will be eligible. The employer must contribute at least 50% of the cost of insurance and the state will provide up to \$100 per adult member per month.

New Hampshire

Status- Waiver proposal was submitted to CMS for approval.

Eligibility- New Hampshire's proposal will not really expand or collapse the eligibility of Medicaid beneficiaries; however it proposes that the Medicaid financial eligibility rules be changed by closing legal loopholes that enable individuals to divest themselves of assets and resources in order to become eligible for Medicaid.

Benefits and Cost Sharing- New Hampshire wants to encourage personal responsibility for the costs of long-term care and Medicaid through appropriate cost sharing and incentivizing the purchase of long-term care insurance.

Altering Medicaid's Fundamental Structure and Design- The three main changes included in the waiver are: increasing the look-back period for asset transfers to 60 months, changing the penalty period for asset transfers, and incentivizing the purchase of long term care insurance. Much more extensive reforms were initially proposed, but are currently on hold, these include:

- A Primary Care Case Management, including disease management, for all federally qualified individuals enrolled in the Medicaid program;
- A program of catastrophic coverage (a catastrophic pool paying for hospitalization and emergency care), plus fee-for-service payments for certain specific services and a new Health Services Account for optional services for those individuals with incomes above 133% FPL;
- Resource centers to serve as single points of entry for the developmentally disabled, those with behavioral health issues and the elderly enrolled in waiver programs (centrally managed care organization);
- Medical Report Cards to provide all Medicaid consumers with up-to-date information on the cost and quality of health care providers and services
- And nursing home pre-admission screening and counseling to make sure only those unable to remain in the community are accepted into nursing facilities. The GraniteCare proposal will also encourage TANF recipients to pursue careers in the healthcare field by providing an educational incentive in return for community based care.

Payment and Financial Performance Incentives- New Hampshire proposed to incentivize the use of long-term care insurance by exempting individuals who purchase coverage from resource limits and estate recovery if they exhaust their policy. The initial proposal included Health Savings Accounts (HSAs), but these were not included in the pending waiver. The concept contemplated was those who fulfill their prevention requirements and meet other health and wellness targets set by their primary physician would be given monetary vouchers for wellness related activities, child care, housing, transportation, and/or education. For those who did not utilize all their non-emergency account and meet prevention goals, a portion of the remaining funds would be given to the consumer in the form of vouchers to be used for wellness related activities, summer camp for a child, or other activity. Just as consumers would be rewarded for meeting their

preventive care requirements, providers would also be rewarded for delivering preventive services. Providers who met the required level of preventive care would qualify for incentives such as enhanced reimbursement. The proposal also discussed using pay-for-performance programs to encourage improved quality of care by providers.

Source: New Hampshire's GraniteCare: Recommendations to Modernize Medicaid (NH Dept of Health and Human Services; November 10, 2004) and final waiver application 9/26/05.

New York

Status- “Federal-State Healthcare Reform Partnership (“FSHRP”) Medicaid section 1115 demonstration program waiver proposal was approved September 29, 2006 for the period 10/1/2006 through 9/30/2011

Altering Medicaid’s Fundamental Structure and Design- Demonstration is intended to accomplish the following: transfer of authority to enroll the aged and disabled populations into mandatory managed care from the Partnership Plan demonstration to this demonstration; expansion of mandatory managed care enrollment to 14 counties where there is managed care capacity; implementation of a significant number of Medicaid program efficiencies including: a preferred drug list, employer sponsored insurance program, and rigorous fraud and abuse recovery efforts.

Major components of restructure:

(1) reduction of excess capacity in the acute care hospital industry/rightsizing acute care infrastructure; development of management programs to assist in effectively managing patients outside of acute care setting including efforts toward: *Data collection* - To begin to capture data on services provided outside institutional settings, funding will be used to establish appropriate data measures and analytic tools and to assist providers in implementation of data reporting systems. *Ambulatory/Primary Care Management* - Funding will be used to assist in the implementation of disease management programs focused on monitoring and patient compliance for individuals with chronic conditions. Focus on efforts to avoid hospitalization of nursing home residents through improved primary care management of these patients in the nursing homes.

(2) shift emphasis in long-term health care services from institutional to community-based settings; reduction in nursing home excess capacity and worker retraining; by 4/1/08, the State must have implemented, subject to CMS approval, a program to create a single point of entry for Medicaid recipients needing long-term care in at least one region of the State

(3) investing in health information technology initiatives

(4) reorienting away from inpatient facilities to primary care focused delivery systems

FQHC Specific Changes– In the context of delivery systems, there is acknowledgement that existing contracts with FQHCs shall continue in force.

Oklahoma

Status- On December 21, 2006, Oklahoma's SoonerCare program (managed by the Oklahoma Health Care Authority) was approved for a three-year extension which will not expire until December 31, 2009. This is not a state plan amendment but rather an extension of the SoonerCare Section 1115(a) Research and Demonstration Waiver (#11-W-00048/6). This is the third extension the SoonerCare program has been granted. Oklahoma is in the process of researching 1115 capabilities vs. DRA opportunities with an SPA.

Eligibility-

The Demonstration Populations Include:

- 1 TANF (Temporary Assistance for Needy Families) - Rural and Urban groups
- 2 Pregnant Women & Children - Rural and Urban groups
- 3 Aged, Blind, & Disabled - Rural and Urban groups
- 4 Children - Rural and Urban groups
- 5 *SoonerCare* population – “other”
- 6 TEFRA Children
- 7 a O-EPIC population: Non-disabled Low Income Workers & Spouses
- 7 b O-EPIC population: Working disabled

Benefits/Cost-Sharing-With the exception of the O-EPIC members enrolled in Qualified Health Plans, all SoonerCare beneficiaries enroll with a Primary Care Provider/Case Manager (PCP/CM) who is responsible for furnishing primary and preventive services and making referrals. These PCP/CMs receive a monthly capitation payment for each enrolled member.

With the exception of the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) members (see below), benefits are similar for all groups & include (with minimal cost-sharing for adults but no co-payments for children, pregnant women, emergency, or family planning services):

- Ambulance & Ambulatory Services
- Behavioral Health & Case Management
- EPSDT for children
- Dental
- Family Planning
- **FQHC - \$1 co-pay per service**
- Home health & hospice
- Inpatient, Lab & x-ray
- Outpatient
- PCP/Clinic visits

The first O-EPIC demonstration population—low-income non-disabled workers and their spouses—are eligible to receive premium assistance (**\$10 per visit to FQHCs**) if they are employed by a qualifying small employer, are self-employed or unemployed, and meet

other eligibility criteria. The State will also offer an Individual Plan that certain O-EPIC members—including certain working disabled adults--can enroll in.

FQHC Specific Changes- According to CMS’s Special Terms and Conditions for the SoonerCare renewal, “Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force” (pg. 14, Delivery Systems).

Sources-Centers for Medicare & Medicaid Services Special Terms and Conditions, SoonerCare, Oklahoma Health Care Authority, January 1, 2007

Oregon

Status- Waiver approval by CMS January 2002

Eligibility- Oregon's demonstration, "Oregon Health Plan 2," provides for an expansion of coverage of targeted low-income children, parents of children eligible for Medicaid and SCHIP, pregnant women, and childless adults. The State can base financial eligibility solely on gross income and the 3-month retroactive coverage does not apply in Oregon.

Benefits and Cost Sharing- Oregon received a waiver to enable the State to replace its current Medically Needy program with different eligibility rules, including raising the income eligibility level to 100% FPL for demonstration eligibles, and to waive the requirement that a Medically Needy program be available to pregnant women and children if it is available to other populations.

FQHC Specific Changes- Oregon received a waiver enabling the State to only provide FQHC and RHC services through managed care providers.

Intergovernmental transfers and DSH payments- Oregon received a waiver allowing the State to not provide DSH payments when health plans are responsible for reimbursing hospitals.

Source: OHP letter award for OHP 2 dated Jan 22, 2002.

Rhode Island

Status- Rhode Island submitted its Section 1115 Consumer Choice Global Compact Waiver to CMS on August 8, 2008. The state is seeking to make significant changes to Medicaid, by operating its entire Medicaid program under a single waiver demonstration and altering the payment structure to create a federal block grant.

Eligibility- Under the proposal, Section 1115 RItE Care and RItE Share programs for children and families, the 1915(b) Dental Waiver, State Plan services and various Section 1915(c) Home and Community Based Services waivers will become part of the global waiver. Rhode Island states that it is their intention to maintain all coverage groups now eligible under the State Plan and has committed to maintaining mandatory Medicaid populations; however during the demonstration the state reserves the right to revise eligibility for optional populations. Also, the state seeks to add three new populations under the Global Compact: parents pursuing behavioral health treatment while their children are temporarily in state custody; children who would otherwise be voluntarily placed in state custody; and elders at risk for long-term care and in need of home and community-based services.

Benefits/Cost Sharing- The Global Waiver seeks to raise RItE Care premium rates to 5% of income for families at 150% of the Federal Poverty Level (FPL) and 3% for families 133-150% of FPL. The waiver also seeks the authority to charge the following co-pays for families below 133% FPL: \$3 per Emergency Department (ED) visit for all children and parents 0-150% FPL; \$25 per ED visit for all children and parents above 150% FPL; prescription co-pays; \$0 for generic drugs regardless of FPL; \$3 for brand name drugs regardless of FPL.

In addition, the state seeks to align benefits for parents above 100% FPL currently enrolled in RItE Care with those offered by commercial health insurance groups. In order to do this, the state says it may eliminate certain health benefits including dental, over the counter drugs, and podiatry.

Altering Medicaid's Fundamental Structure and Design- The Global Waiver would introduce a fixed allotment or capped pool of federal dollars to spend during the demonstration, while Rhode Island would restrict Medicaid spending to a "maintenance of effort" requirement equaling 23% of the overall state budget, which would allow administrative flexibility to the State to manage Medicaid costs within the federal capped allotment.

Also, the state will establish an interagency long-term care Assessment and Coordination Organization (ACO) to ensure beneficiaries served under the Global Waiver have access to appropriate services in the appropriate setting. ACO will streamline the intake and assessment processes and provide beneficiaries with clear, concise and accurate information about their care options.

FQHC Specific Changes- There is no specific mention of FQHC services or reimbursement in the Rhode Island Global Waiver application, nor is there a request to waive FQHC statutory requirements. FQHCs are listed under the mandatory Medicaid services, which the state has declared they are committed to maintain. However, it is still unclear exactly how this 1115 waiver will directly affect FQHCs.

Payment and Financial Performance- The waiver application seeks to reward quality assurance/improvement and cost-effectiveness by reimbursing providers through Medicaid purchasing and payment methods. Payments will be tied to quality performance measures including patient satisfaction, access to care, and clinical outcome measures that are tracked through a provider's quality improvement plan. To help oversee and ensure providers are rewarded through performance-based contracting, the state will develop partnerships between the Waiver Quality Director, Quality Team and other agencies.

Sources: Rhode Island Global Consumer Choice Compact Waiver application (July, 2008)

South Carolina

Status- While the State had submitted a broad 1115 waiver proposal to CMS prior to the passage of the Deficit Reduction Act of 2005 (DRA), South Carolina subsequently submitted a concept paper to CMS entitled “South Carolina Healthy Connections—Medicaid Transformation Plan”. The concept paper was submitted as a state plan amendment (SPA) to CMS in March 2007, and approved with an effective date of April 1, 2007. The SPA incorporates many of the concepts of the original waiver which can now be carried out through a State Plan Amendment per the flexibility provided under the DRA. Upon approval, South Carolina created two pilot plans; the Flexible Benefit Plan and Health Opportunity Accounts (HOAs), both initially serving as demonstration projects. The first of the two plans is to be modeled after the State Employees Health Savings Plan, the second incorporating HOAs for a limited contingent of the Medicaid population based in Richland county. According to the South Carolina Department of Health/Medicaid the proposal will identify and “study the behaviors of the Medicaid population with respect to how each constituency chooses to utilize benefits in a private plan scenario”. Specifically, the state hopes to assess behaviors related to new options for self-management within respective plans.

Eligibility- Both plans will be open to all eligible Medicaid groups, but are limited by county, in this case targeting Richland, and capped enrollment of 1,000 beneficiaries for each plan. Both plans exclude dual eligibles, long-term care, and foster care children. Participants may voluntarily opt in and out of the benchmark plans to receive traditional Medicaid coverage at any time.

Benefits and Cost Sharing- Benefits will differ depending on the option that is selected by the beneficiary under Healthy Connections. For example, under the MCO option the plan benefit design must comply with the DRA benchmark coverage, and EPSDT coverage must be provided. The MHN option requires that the premium for this plan be “actuarially equivalent to the current fee-for-services”.

In the first plan, which is called the Flexible Benefit Plan, individual enrollees will receive benchmark benefits based on the State Employees Health Savings Plan, offering medical coverage (including child visits, adult physicals, immunizations and flu shots) with a \$3000 deductible. The state will create a virtual Health Savings Account (HSA) for each individual (\$3000) and family (\$6000), which can be used for any State Health Plan covered services which will then be deducted from the account balance. If the HSA is depleted, the beneficiary will contribute 5% (\$150.00 individual and \$300.00 family) of the total HSA, which would then be used to cover services until the State refills the HSA balance. The state will provide counselors for beneficiaries at the start of the enrollment process to educate beneficiaries on the rules and function of the program, and maintain contact for the first six months of enrollment to ensure beneficiaries understand all options and components to their plan.

In the second plan, the Health Opportunity Accounts (HOA), the benefits package is identical to Medicaid covered services. The state will create HOAs for adults capped at \$2,500, and for children capped at \$1000, to be used for first dollar coverage. Beneficiaries in the HOA plan may seek preventive services/exams and childhood

immunization, which will be covered by the state at no cost to the balance of the HOA. After 25% of the HOA has been used, beneficiaries then have the option to use the remaining balance for medical or “other” expenses for up to three years after eligibility ends, as long as all expenditures are in accordance with federal HSA regulations. The HOA plan also provides state counselors to walk beneficiaries through the enrollment process and to educate them on rules and procedures related to their plan.

All beneficiaries would be subject to co-payments with the exception of children, pregnant women, institutionalized individuals and those in home and community based waiver programs. Family planning services would also be exempt from co-payments. Cost-sharing amounts would be increased for numerous services and, per the DRA, providers could withhold non-emergency services until a plan for payment of co-pays is established with the beneficiary.

Altering Medicaid’s Fundamental Structure and Design- Under South Carolina’s Healthy Connections, each Medicaid enrollee would be provided a state administered personal health account (PHA) funded with an actuarially determined amount with which the enrollee could select one of the following service delivery options:

Managed Care Organization (MCO)--under this option, beneficiaries direct the Medicaid program to pay the insurance company the premium on their behalf. The State would provide the MCOs the premium structure for coverage to use as a benchmark to develop their pricing. Plan benefit designs would have to comply with the DRA’s benchmark coverage requirements—**which should mean that FQHC services would be made available to the recipient and FQHC reimbursement would be paid health centers.**

Medical Home Networks (MHNs) (primary care case management plans)—in which the state agency would enter into a risk-based contract with a Care Coordination Service Organization (CSO) for purposes of the development and maintenance of a MHN. The CSO is the agent for the MHN and the state agency contracts with any MHN that meets established standards developed for MHNs. Providers of the MHN could claim reimbursement on a fee-for-service basis. The agency would encourage the development of Medical Homes Network arrangements where the CSO and the network assume more risk and perform more administrative functions to include claims processing.

Option-Out Program-- in which the beneficiary can choose to receive medical care outside of the Medicaid program with Medicaid providing only a defined amount of financial support. In cases of opt-out, the individuals are no longer Medicaid recipients and can use their PHA to purchase group health insurance through their employer.

Dual eligibles, foster care children, and family planning waiver recipients would be excluded from this waiver. South Carolina’s concept paper also provides for (among other things) establishment of electronic personal health records, a quality rating system, a decision support system, an academic detailing program, enrollment counseling

services, a regional broker model for non-emergency transportation per the DRA of 2005.

FQHC Specific Changes- The provision of FQHC services and FQHC reimbursement for health centers is **not** addressed in the Healthy Connections concept paper or specifically within the South Carolina SPA. Thus, to the extent that the SPA is intended to reflect a revision and/or updating of the state's earlier 2005 1115 waiver proposals, the role of FQHCs and the reimbursement they will receive for their services remains unclear. However, as already noted, to the extent that the State indicates that DRA benchmark package of services may be one option available to Medicaid recipients, the DRA is clear that FQHC services must be included in such a package, and health center alternative PPS reimbursement would be available to those health centers. Under the Flexible Benefit Plan, the state indicates that providers are to bill for services provided under the pilot program as they would for beneficiaries covered under the state employee program. The state specifically states "payment rates and providers will be the same as those for the state employee program". At this time it is still unclear how health centers will be reimbursed under this plan. Without further clarification of specific reimbursement rates health centers could experience potential losses.

Intergovernmental Transfers and DSH Payments- The State concept paper, submitted in relation to the approved SPA, proposed the exclusion of DSH and UPL payments. As an alternative proposal, the concept paper suggests that the State could treat inpatient and outpatient hospital services provided to "... Medicaid recipients enrolled in a managed care setting or any other health insurance plan...in a similar manner as those federal regulations... that pertain to Medicaid FQHC and RHC services provided to Medicaid recipients enrolled in a managed care plan.." (This appears to suggest some form of wrap-around payment to MCOs or insurance companies) A third option in the concept paper is the creation of a safety net pool for hospitals. It remains unclear at this time which proposal the state will opt to employ.

Source: South Carolina's State Plan Amendment 07-003 and 07-002 Fact Sheet Documents, CMS website, www.cms.gov "South Carolina Healthy Connections— Medicaid Transformation Plan" South Carolina Dept. of Health and Human Services, submitted to CMS, Sept. 6, 2006; Item for Committee Advisement, Report to South Carolina Department of Health and Human Services and Medical Care Advisory Committee, prepared by Gary Ries, Deputy Director of Eligibility and Beneficiary Services (February 20, 2007)

Tennessee

Status- In October 2007, CMS approved an extension through 2010 of the current TennCare II Medicaid section 1115 demonstration. Since the inception of the original TennCare demonstration in 1994, a substantial part of Tennessee's Medicaid program has operated through what is now the TennCare II demonstration. With the exception of Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries, all Medicaid State plan eligible individuals are enrolled in TennCare and are receiving the majority of their services through the TennCare delivery system. When designing the TennCare program the State emphasized savings and delivery of care and services through a managed care system. Additionally, Tennessee structured TennCare II in such a way as to leverage disproportionate share hospital (DSH) payments that could be used (through redistribution) to provide additional benefits and expand eligibility under the standard program package for adult medically needy, uninsured children and uninsurable demonstration eligibles.

Eligibility- In its listing of special terms and conditions relating to its approval of TennCare II, CMS states that there are three components to the program: (1) TennCare Medicaid which serves enrollees who are Medicaid-eligible under the State's Title XIX plan; (2) TennCare Standard which is the component of the program that serve those who are eligible for Medicaid only through the State's Section 1115 waiver; and (3) the Medicaid expansion SCHIP children who, by virtue of being folded into the Section 1115 –approved TennCare Standard population, are eligible for a more extensive benefits package and different service delivery system than children eligible for the stand-alone Title XXI SCHIP program.

Benefits and Cost Sharing- Under both TennCare Medicaid and Standard, all state plan covered services, including EPSDT, are covered for state plan eligible and demonstration populations of uninsured or medically eligible children under age 19. Additional benefits may be provided to respective populations at the disposition of contracted managed care entities with intent to offer cost-effective alternatives. Certain "base" Medicaid state plan benefits are not available to TennCare Standard eligibles, including targeted case management services, services covered under a Section 1915(c) home and community-based services waiver, and nursing facility services. FQHC services as a mandatory benefit is not guaranteed since the managed care entity serving Medicaid patients has the option to exclude FQHC services so long as access to care is assured without FQHCs. (See paragraph on FQHC services below)

Cost Sharing- For demonstration-only eligibility groups in TennCare Standard, there are no co-payments for those with income below 100% of the FPL; but those with income between 100-200% of the FPL, do incur a \$5 co-payment for primary care services, \$5 for specialty services and \$5 for hospital inpatient admission; and for those with income above 200% FPL, the co-pays are \$15, \$20, and \$100 for primary care, specialty service and hospital admission, respectively. TennCare Standard individuals under 21 with incomes at or above 100% of the FPL also incur \$3 co-pays on pharmacy but there are exceptions for individuals receiving long-term care, family planning, pregnancy-related,

emergency or hospice related services. TennCare Standard children's total annual out-of-pocket cost sharing is limited to 5% of family income (no co-payments for child demonstration enrollees at less than 100% FPL).

FQHC Specific Changes- In the recitation of waivers granted by CMS to the State under its Section 1115 waiver authority, CMS includes waiver of access to FQHCs and RHCs "to the extent necessary to enable the State to permit managed care contractors to limit coverage of FQHC and RHC services, so long as access to care is assured without these providers." Except for a slight variation in actual wording, Tennessee has sought and received a similar waiver regarding FQHC services since the inception of TennCare in 1994. As currently worded, the State should only accept a MCOs not contracting with FQHCs in its service area if the State has been assured by the MCO that there is adequate access to the services offered by an FQHC even when the MCO has not contracted with an FQHC. Worth noting is the fact that currently, all FQHCs in Tennessee have contracts with the State for covering TennCare beneficiaries and have not experienced any problems with receiving payment for covered services or contracting issues thus far. Further more, the State recently highlighted FQHC efforts to develop partnerships to integrate primary and behavioral health care as intended originally in the waiver itself. It is not at all clear however (nor has it ever been in the past) if and how the State makes any effort to verify these assurances provided by the MCOs.

Payment and Financial Performance Incentives- As part of TennCare II, the State seeks to implement a multi-faceted disease management program to improve health outcomes and reduce overall costs of caring for enrollees with certain high cost diseases. The proposal discusses possibly conducting competitive procurement and contracts with one or more facilities participating in the federal Section 340B drug discount program, including disproportionate share hospitals and FQHCs.

Intergovernmental Transfers & DSH Payments- For the duration of the approved waiver expansion, an annual cap of \$540 million is applied to the total of all supplemental pool payments that the State makes in place of disproportionate share hospital (DSH) payments (including the pool consisting of CPEs in hospitals for both TennCare shortfalls and uninsured patients), except for Graduate Medical Education pool payments. In its approval letter to the State, CMS notes that its final rule published May 27, 2007 -- relating to intergovernmental transfers, provider cost limits, CPEs, etc --could result in some of the expenditures under the special terms and conditions of the approved demonstration not being matched with federal dollars. However, CMS then concedes that Congressional enactment prohibits CMS from implementing these regulations for one year and states that it will abide by that law.

Source: CMS Special Terms and Conditions TennCare II Demonstration expansion documents – October 5, 2007. CMS website www.cms.gov

Texas

Status- The waiver was originally submitted to CMS for approval on April 16, 2008 but CMS issued a letter on August 7, 2008 saying that they were not able to accept the proposal at that time. CMS cited several issues that concerned them, including specific provisions that differ significantly from the original draft concept paper. The agency agreed to continue to work with Texas to develop a workable proposal.

Background- In June 2007 the Texas legislature and Governor passed and signed SB 10, legislation that would permit Texas the maximum flexibility to manage its Medicaid and SCHIP programs. A key part of this health reform included the creation of the Texas Health Opportunity Pool (HOP), which became the main funding structure of the state's 1115 waiver.

The HOP trust fund was to be financed through a variety of federal and state sources, including supplemental hospital funds like disproportionate share hospital payments (DSH). The HOP would be used to: provide premium subsidies to low-income populations; reward hospitals for efforts to reduce uncompensated care; award grants that sought to improve efficiency within the health care system; allow families to buy into employer-sponsored coverage through a pooling of HOP, SCHIP and Medicaid funds.

Eligibility- Through the waiver, HOP funds would be available to Texans who are U.S. citizens or legal permanent residents (LPRs) with incomes at or below 200% FPL and are ineligible for Medicare, Medicaid or SCHIP. The funds would allow children up to age 19 as well as former foster care members who are 21-22 years old and enrolled in higher education to receive SCHIP benefits. In addition, HOP would provide sliding scale subsidies to adults, including parents of Medicaid or SCHIP children and other parents and childless adults. The state also wanted to create a catastrophic coverage program for parents and caretakers whose medical bills would make them eligible for a medically needy program.

Benefits/Costing Sharing- The waiver would require that everyone would have some level and type of cost sharing. The program said it would promote the use of primary and preventative care in the most appropriate setting. The draft benefit package included in the waiver states that for those at or over 150% FPL the annual maximum benefit limit would be \$25,000, with a \$5-\$10 co-pay for unlimited primary care visits. The HOP premium subsidy would be related to both level of income and value of coverage. The state would work with the Texas Department of Insurance and private carriers to obtain accurate price information in order to align subsidies with current market rates.

FQHC Specific Changes- During the 2007 legislative session, the Texas Legislature passed an amendment safeguarding FQHC services and PPS regardless of any changes to the Texas Medicaid program or broad based health care reform initiatives. However, in the proposed waiver the state attempted to waive full-cost reimbursement payments to FQHCs, citing the demonstration focused on subsidized premiums for private commercial plans.

Payment and Financial Performance- Hospital payments under the waiver would be focused on reducing uncompensated care. Reimbursements would focus on incentives for the provision of cost-effective and quality health care and developing innovative care models for indigent groups.

DSH Payments- The waiver proposal would reallocate hospital DSH and Upper Payment Limit (UPL) funding to finance the HOP. Texas would also like the authority to change the way current DSH and UPL are allocated in order to align it with their goals and objectives of health care reform.

Sources: A Waiver Request Submitted Under Authority of Section 1115 of the Social Security Act, State of Texas, Rick Perry, Governor, Albert Hawkins, Executive Commissioner, Texas Health and Human Services Commission (April, 2008); Letter from Dianne Heffron, Acting Director, Centers for Medicare and Medicaid Services to Albert Hawkins, Executive Commissioner, Texas Health and Human Services Commission (August, 2008)

Vermont

Status- Waiver approved by CMS September 2005. Received legislative approval for implementation. After receiving CMS approval of their 2005 waiver request, the Vermont state legislature approved legislation to develop and implement broad based health care reform. The state established two programs; Catamount Health and the Blue Print for Health, to achieve their goal of 96% universal coverage by 2010. Between the two programs, Vermont health reform includes employer collaboration and assessments, new insurance products including subsidies for individuals up to 300% FPL, and extensive plans and programs targeting chronic disease management.

Eligibility- Through the creation of Catamount Health the state has expanded subsidies and premium assistance to include individuals up to 300% of FPL. Uninsured residents ineligible for other Medicaid products and/or those without access to approved employer sponsored plans are eligible for coverage under this new program.

Benefits and Cost Sharing- As part of its cost containment strategy, and to encourage responsible use of health care services, Vermont will increase cost-sharing for certain populations, not to exceed 5% of family's gross income. The state plan co-pays and premiums for mandatory populations will stay the same. Optional and expansion populations will see an increase in premiums. Kids between 186-225% FPL will pay \$30/month, while higher income kids will pay \$40/month. Premiums for adults start at \$11/month for those between 50-75% FPL and increase incrementally to \$75/month for those between 150-185% FPL. The state must offer benefit packages that meet or exceed Secretary approved coverage, but they have the authority to change the benefit package for the non-mandatory eligible population so long as the changes don't increase or decrease Medicaid expenditures more than 5%.

Under Vermont's health care reform, all new plans and coverage must match and mirror benefits provided through the Vermont Health Access Plan (VHAP), or benefits covered under certificate of coverage provided by health insurers. Under the Catamount Health plan, individuals and employers buy into the plan in tiers. For example; individuals under 200% FPL will contribute \$60/month, 200 -225% FPL contribute \$90, 225-250% FPL will contribute \$110, while employer assessments derive \$91.25 per employee in excess of eight employees. Additionally, the state approved premium reductions for VHAP beneficiaries of approximately 25% and appropriated funds to cover all minimal preventive services, i.e.: immunizations, for all Vermont residents.

Altering Medicaid's Fundamental Structure and Design- Vermont agreed to a Global Commitment to Health Demonstration that would capitate the federal spending for all Medicaid services in Vermont for five years, based on a mutually agreed upon base year and trend rate. Vermont will be financially at risk for managing within this targeted amount. Under this waiver Demonstration the Vermont Agency of Human Services (AHS) will contract with the Office of Vermont Health Access (OVHA), which will serve as a publicly sponsored MCO and adhere to all federal MCO regulations. OVHA will then subcontract with various entities to ensure it has in place an adequate network

of services and providers. The state may choose to implement employer sponsored insurance subsidies and health savings accounts.

Payment and Financial Performance Incentives- Part of the Vermont health reform created the Healthy Lifestyle Insurance Discount, whereby hospital or medical service corporations and HMOs may establish “rewards, premium discounts, rebates, or otherwise waive or modify applicable co-payments, deductibles or cost sharing amounts in return for adherence by a member/subscriber or programs of health promotion and disease prevention...” Rewards are limited to not more than 15% of the cost of premiums, must be designed to promote good health and prevention, adhere to the Commissioner’s established standards of practice, and provide reasonable alternatives to achieve the reward. Additionally, in order to reduce cost shifting to private insurance the state established oversight entities to ensure that; costs are returned to consumers by slowing the rate of growth in insurance premiums, the Medicaid payment rates are raised and reductions in the number of uninsured occur to cost shift, and standardize the minimum criteria and reporting requirements for uncompensated care and bad debt write offs by hospitals, all to provide clarity in account and identification of cost shifting.

Source: Global Commitment to Health draft: A proposal to the Center for Medicare and Medicaid Services (April 2005) and CMS Special Terms and Conditions; State of the States Report, Academy Health (January 2007); Health Care Affordability for All Vermonters, No. 191, Vermont legislative website.

Virginia

Status – On March 5th, 2007 Virginia received approval for a new State Plan Amendment (SPA) to formally administer the “Healthy Returns Program” (HRP); a benchmark plan which was given an effective implementation date of October 1, 2006. The plan is available statewide to adult Medicaid recipients and is offered as a targeted Disease Management (DM) program in tandem with regular Medicaid state plan services. Virginia’s documents of intent state that the program was designed to assist enrollees in better understanding and managing chronic conditions through patient education, preventive measures, lifestyle changes and adherence to a prescribed plan of care (POC). In these documents, the state explicitly indicates its intent “not to offer medical advice... but rather to design a program to support providers in reinforcing patient programs of care” as a mechanism for disease management. The HRP disease management program is part of a prepaid ambulatory health plan (PAHP), providing specific Medicaid beneficiaries the option to enroll in the benchmark plan instead of regular Medicaid. The HRP also maintains patient discretion to opt back into traditional Medicaid at any time.

Eligibility – The HRP benchmark benefits package will be available on an opt-in basis to existing Medicaid beneficiaries with: asthma, congestive heart failure, coronary artery disease, and diabetes. However, beneficiaries already enrolled in the Virginia SCHIP expansion program (FAMIS), managed care organizations (MCO), those covered by third party insurance or that are currently in institutional settings, will not be eligible for the Healthy Returns Program. Virginia also excludes the Medicaid/Medicare dual eligible population from eligibility for the newly approved benchmark benefits plan. The state estimates 20,000 – 25,000 enrollees will participate in the HRP, with the choice to reenter traditional Medicaid at any time.

Benefits/Cost Sharing – The HRP benchmark plan will continue to offer traditional Medicaid benefits in addition to disease management and related services to enrollees with conditions as outlined previously. Additional DM benefits will be tailored to the beneficiary’s specific health needs including: condition specific education, twenty-four hour nurse call lines and access to additional health professionals (pharmacists, nutritionists, etc.), regularly scheduled health management meetings conducted by phone, and care coordination between providers (including feedback from primary care physicians). Traditional Medicaid services will continue to be covered under fee-for-service, while DM services will be provided through the state PAHP. Additionally, Virginia will provide wrap-around/additional benefits for individuals under the age of 19 that are already covered under the Virginia state plan, in order to ensure that EPDST is covered when medically necessary.

FQHC – Within the SPA, Virginia gives assurances that the state will adhere to Federal Medicaid regulations as applied to mandatory FQHC benefits and specific reimbursement.

Source: CMS Website

Washington

Status – In June of 2007, CMS approved Washington’s State Plan Amendment (SPA) to implement a benchmark program that focuses on aid for adult Medicaid beneficiaries with complex medical needs. The plan was established to target Disease Management (DM) services to individuals diagnosed with specific conditions. Moreover, the DM program was created to foster patient-provider relations to ensure individual adherence to a patient tailored plan of care (POC). Washington designed the program to educate and assist enrollees so that they are more able to understand and manage their own health and chronic conditions.

Under the DM program, the State contracts with two Prepaid Ambulatory Health Plans (PAHPs), known within the program as Statewide Care Management (SCM) contractors. The two SCMs--United Healthcare Services, Inc. and the City of Seattle--will be responsible for determining eligibility of patients, based in part on “predictive modeling”, and will work to enroll beneficiaries into the DM benchmark plan. SCMs will assist high-risk patients to establish a relationship with an assigned Nurse Care Administrator (NCA) as well as a medical home location. Additionally, the state has contracted with Local Care Management (LCM) contractors to assist with NCA services and to provide support to eligible patients in establishing a medical home.

Eligibility – Washington has opened the DM program to a rather extensive list of patients who have dynamic medical needs, including beneficiaries diagnosed with: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, chronic respiratory conditions including asthma and/or COPD, hematological conditions, and co-morbid depression and/or anxiety. Additionally, adults 21 years of age or older who currently receive Medicaid services via the fee-for-service system, including the categorically needy, aged, blind or disabled, will be eligible for the benchmark program.

Washington will open the benchmark plan to statewide enrollment and anticipates 15,000 enrollees will enter the program. Initial estimates account for 10,000 enrollees from within the medical home/primary care component of the program, with the remaining 5,000 enrolled specific to the DM program. All eligible individuals will be given the option to voluntarily opt-in to the DM program and may also choose to reenter traditional Medicaid at any time.

The state intends to phase enrollment of large groups of patients, estimating 1,000 enrollees per quarter from within King County, in addition to an estimated 4,000 enrollees per quarter from across the state. The program also allows for the phased-in enrollment of Medicare/Medicaid Dual eligibles as the states “ProviderOne” system allows. Washington has committed that it will not refuse any eligible beneficiaries regardless of the number of enrollees in the program.

Benefits – Washington established a very comprehensive set of DM benefits when creating their benchmark plan, with special emphasis on managed and coordinated patient care throughout the program. Using DM contractors in coordination with licensed Nurse Care Managers (NCMs), eligible patients will be contacted directly and made aware of the DM program/benefits and eligibility for enrollment. NCMs will then screen and assess enrollees’ health conditions, risk factors, comprehension skills, as well as their

ability to follow their own tailored and prescribed plan of care (POC). Using the information gathered through the patient assessment, NCMs will then develop a six month care plan taking into consideration the enrollee's mental and other restrictions, language barriers, and current medications, all in coordination with the beneficiary's care givers and Primary Care Provider. NCMs also will act as a liaison between enrollees, their PCPs and other providers, monitoring the enrollees POC by phone or face-to-face as necessary, and maintaining consistent contact throughout with care managers and patients.

Additional services such as mental health and chemical dependency will be addressed through Registered Nurse or a Licensed Social Worker who will coordinate with providers within respective systems. Both care managers and local nurses will provide their services mainly by phone scheduled once a month or more often when necessary. However, if enrollees cannot be reached by phone, both statewide and local providers will meet with enrollees face-to-face to ensure success within the program. Local DM nurses are also required to escort enrollees to "at least one doctor visit" to assure that enrollees ask the correct questions and use resources well.

Finally, the state will link all DM benefits through a comprehensive plan to foster information sharing between medical homes and various providers, through the tracking of preventive measures, receiving referrals directly from providers for high-risk patients, and circumvention of emergency department services.

FQHC Specific Changes- the State assures adherence to Federal Medicaid regulations as applied to Federally Qualified Health Centers (FQHC) as a mandated benefit and with respect to reimbursement.

Source: CMS Website

West Virginia

Status- State Plan Amendment Approved May 3, 2006. WV plans to implement the SPA in three rural counties (Clay, Lincoln and Upshur) fall/winter 2006 and implement the SPA statewide over four years.

Benefits and Cost-Sharing- Changes in benefits will only affect some children and parents. Seniors, people with disabilities and pregnant women will not see any change in their benefits under the SPA. There will be 4 benefit packages: Basic Children, Basic Parent, Enhanced Children, Enhanced Parent.

Beneficiaries will receive a basic package (more limited than the current WV Medicaid benefits package) until they (or their parents on behalf of their children) sign a member responsibility agreement aimed at promoting healthy behavior. Once signed, beneficiaries can receive the enhanced benefits package. If the beneficiary does not fulfill the responsibilities outlined in the member agreement, his or her coverage will revert to the basic package. The beneficiary may re-enroll in the enhanced package after twelve months or at the time their Medicaid coverage is renewed. Health care providers are expected to monitor and report on patients' compliance.

EPSDT: At this point, there is contradictory language on whether West Virginia children will continue to receive all EPSDT services. The WV plan includes EPSDT in the list of services covered under the basic package for children, but excludes certain services that EPSDT covers and limits other services. This definition is contrary to federal law as under the DRA, if a state chooses to provide an alternate benefits package to children under age 19, that state must provide wraparound coverage for EPSDT services.

Update:

In November 2007, Medicaid recipients began switching to the new, redesigned program called Mountain Health Choices. This program includes two options: a basic plan or an enhanced plan. Under the basic plan beneficiaries prescriptions are limited to four drugs per month, mental health services are limited as well as access to physical and speech therapy. The enhanced plan doesn't include these limits and adds benefits including weight management and nutritional education. In order to be placed in the enhanced plan, beneficiaries visit their doctor and sign an agreement form promising they will comply with certain healthy guidelines. If they do not sign the agreement, adults and children, including newborns, are automatically enrolled in the basic plan.

In April of 2008, the Charleston Gazette reported that less than half of Medicaid beneficiaries had changed over to Mountain Health Choices, and of those who had signed up only 7% had enrolled in the enhanced plan. A report on the impact of the West Virginia 1115 waiver by Georgetown University, finds that children are most affected by these changes. One in three children in West Virginia receives Medicaid. According to the report, 93% of children are enrolled in the basic plan, which limits the benefits they may receive. Confusion among families and physicians as well as poor execution by the state are cited as reasons for the low enrollment rate in the enhanced plan.

Source: J. Alker “West Virginia’s Medicaid Redesign: What is the Impact on Children?”
Georgetown University Health Policy Institute, Center for Children and Families (August
2008)

Wisconsin

Status- In February 2007, Governor Doyle announced a universal health care plan for Wisconsin. No formal applications have been submitted to CMS for approval.

Eligibility-The plan includes creation of BadgerCare Plus which would extend coverage to all kids and expand coverage to more pregnant women, parents and caretaker relatives. The plan also includes a Medicaid expansion which would add approximately 71,000 childless adults below 200% FPL to BadgerCare Plus.

Benefits and Cost-Sharing- Two plans would be developed: standard (Medicaid) and a benchmark. The benchmark plan for childless adults would carve out mental health services.

Other-The Governor's plan also includes an expansion of the state's Family Care program which would enable more seniors to stay in their homes, a tax deduction for premium payments, reinsurance program for small businesses, catastrophic health insurance program for individuals and businesses, \$30 million for technology improvements, and an increase in the tobacco tax.

Source-PowerPoint presentation by Secretary of Health and Family Services Kevin Hayden February 6, 2006.

Wisconsin BadgerCare Plus Benchmark Plan

Background- In August of 2007 the state of Wisconsin submitted a benchmark State Plan Amendment (SPA) known as the BadgerCare Plus Benchmark Plan to CMS, in accordance with the flexibility provided in the Federal Deficit Reduction Act. The plan seeks to expand eligibility to pregnant women, and requires beneficiaries with income levels between 200 – 250% Federal poverty level (FPL) to enroll in the benchmark plan. The state established the expansion benchmark plan with intent to: allow beneficiaries to participate in mainstream health insurance, provide incentives to seek preventive services, and reduce inappropriate use of health care services. The benchmark plan was approved by CMS in November, 2007 and implemented by the state February 1, 2008.

Eligibility- The BadgerCare Plus Benchmark Plan is available to categorically needy pregnant women with family income levels between 200-250% FPL.

Benefits- BadgerCare Plus Benchmark Plan is an optional program available statewide and covering Medicaid covered services including: Pharmacy/generic prescription medications, lab and x-ray, maternity, in and out patient hospital, emergency room, nursing home, physical, occupational and speech therapy, home health, transportation, dental, vision, smoking cessation, hospice, reproductive health services, chiropractic services and podiatry. Additionally, under the benchmark plan wrap around services including mental health and substance abuse as well as full EPSDT benefits for pregnant

women under the age of 19 are covered services. The SPA does not explicitly name or disclaim FQHC services within the list of covered services.

Cost Sharing- Beneficiaries of the BadgerCare Plus Benchmark Plan are not subject to cost sharing obligations. Services and benefits defined under the plan will be provided on a fee for service basis through a case management system or managed care entity.

Sources: CMS website – Deficit Reduction Act/SPA section
http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp