The National Association of Community Health Centers, Inc.

State Policy Report #15

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 and state plan amendments (SPAs) 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 updated in March 2006, Idaho, West Virginia, and Kentucky's waiver proposals were converted to SPAs and approved and Massachusetts and New York received waiver approval. The status of all waivers has been updated. Vermont, Utah, Michigan, and Nevada have all had recent waiver activity and will be updated in the next version of the matrix.

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 and DSH payments[f]
Arkansas	X	X		X		
California	X		X			X
Florida	X	X	X	X		X
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

[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).

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
South Carolina	X	X	X	X	X	X
Tennessee	X	X		X	X	
Texas	X	X	X	X	X	X
Vermont	X	X	X		X	
West Virginia	X	X	X			
Wisconsin	X	X				

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

<u>Arkansas</u>

Status- approved by CMS March 2006

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, employeesø 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 $15 a month for each employee with income less than twice the poverty level and $100 a month for higher income workers.

FQHC specific changes- In the waiver application, FQHC is listed as a non-covered service and states that FQHC are eligible for negotiated rate with MCOs.

There is no specific waiver for FQHC 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.

California

Status- demonstration is approved for the 5-year period, from September 1, 2005, through August 31, 2010.

Eligibility- In the first two years Aged, Blind and Disabled population will be enrolled into managed care in 35 counties, the last three years of contingent Federal funds are tied to the goals for the expansion of healthcare coverage to currently uninsured adults.

Altering Medicaidøs Fundamental Structure and Design- The most significant real expansion of enrollment will occur in the last three years of the demonstration when $180 million of the $766 million annual Safety Net Pool Allocation is diverted to expand coverage.   Coverage to undocumented immigrants is dealt with by deducting 17.79% of each billing from all cost billed to the Safety Net Pool during all five years of the waiver.

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 õlook-alikeö funding that uses General Fund support to match federal funds. Public hospitals that previously received these supplemental federal funds will utilize the Safety Net Care Pool 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 disproportionate share hospital 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.

Florida

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

Eligibility- Florida anticipates enrolling two eligibility groups into Empowered Care by July 2006: section 1931 eligibles and related group (called the õTANF and TANF-related eligibility groupö) [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 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- õEmpowered Care,ö 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 õopt outö of Medicaid and purchase employer sponsored insurance. If the premium for ESI 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 accountô a flexible spending accountô 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 Medicaidøs fundamental structure and design- Under õEmpowered Care,ö 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: MCOs (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 õmake a good faith effortö 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 stateøs current upper payment limit financing with a $1 billion annual õlow income poolö for which hospitals are currently the only eligible entities.

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

Georgia

Status- Process put on hold until 2007.

Eligibility- Georgiaøs Medicaid Reform Model 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 will 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 childrenøs 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 Medicaidøs fundamental structure and Design-Georgiaøs 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 consumerøs 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 will 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 is expected in November 2006.

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 ó all of the above described packages include preventative services.

Indiana

Status- During the 2007 legislative session the Indiana legislature passed the ÷Healthy Indiana Planø, 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. Despite passage in the legislature, final implementation of reforms is pending CMS approval of their most recent 1115 waiver submitted in the spring of 2007, specifically regarding use of federal match/DSH dollars, HSA plans, and coverage expansions.

Eligibility- The Healthy Indiana Plan will cover Indianaøs uninsured (850,000 individuals), ages 18-64, that have been uninsured for six months, are under 200% FPL, are not eligible for any other Medicaid product, and are without access to employer sponsored health insurance. Other coverage expansions include; continuous coverage under parental insurance expanded to cover ages 18-24; CHIP expansion from 200% to 300% FPL, with continuous eligibility up to age three; and presumptive eligibility for pregnant women from 150% to 200% FPL.

Benefits and Cost Sharing- Under the Healthy Indiana Plan, the state will provide free preventive care up to $500 annually, including; smoking cessation, annual physicals, mammograms, prostate exams, and diabetes treatment. Additionally, enrollees will be allotted $1100 per adult in an HSA ÷Personal Wellness Responsibility Accountø (POWER Account), that can be used to cover initial medical costs. Contributions to the POWER account would be shared by enrollees and the state, dependent on the beneficiaries ability to pay, with a max contribution of 5% of gross family income. The account would 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 $1m lifetime. Also, unused funds will be rolled over to cover the member contribution for the next year.

Payment and Financial Performance Incentives- Small employers can qualify for tax credits, called õ125 Plansö, if they provide qualified wellness programs. The employer would 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- While the lions share of funding for Indianaøs health care reform is derived from a $.44 cent increase in the tobacco tax, some 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)

Iowa

Status- Waiver approval by CMS July 2005

Eligibility- Iowaøs 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 except 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. Iowaøs family planning waiver will cover women ages 13-44 with income at or below 200%FPL.

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 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 õmedical home,ö and a õdental homeö 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 Stateøs remaining DSH allotment to the expansion population network.

Source: Approval letter dated July 1, 2005 (with Special Terms and Conditions); 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 Stateøs 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 Federal Poverty Level; 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 õindividuals 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),ö and that õpayment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).ö

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 õbudget neutrality.ö 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 ó pregnant women and parents. This is the õregular State Medicaid Plan coverage.ö 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 federal poverty level (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 õKentucky, CMS Launch Governorøs Medicaid Transformation Initiativeö; Kentucky Medicaid Reform Fact Sheet ó KyHealth Choices; The Kaiser Commission on Medicaid Facts: õKyHealth choices Medicaid Reform: Key Program Changes and Questionsö 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 õI supported the reform concepts in their proposal. Following this submission, [CMS] worked with the State to develop a financial model to facilitate the Stateøs submission of a Medicaid demonstration application that accomplishes the goals of the [Louisiana Health Care Redesign] Collaborative [received by LA January 30, 2006].ö õFurther,ö he went on to write, õsome 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.ö

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 CMSøs 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 CMSøs shortcomings: õWe 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.ö

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

Eligibility-

Statewide expansions:

- Uninsured children with incomes up to 300% of the Federal Poverty Level (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, Plaquesmines 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 õlow income uninsured and Medicaid-enrolled populationsö eligible residents (except high-risk categories) would be provided a õfinancial 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 employerósponsored health plan.ö õThe foundation of the benefit coverage used to establish the amount of this financial credit will be the Louisiana Benchmark Health Planöô for adults that would be the LaChoice plan but with reduced copays and deductibles and LaCHIP (stateøs SCHIP program) would be the

benchmark plan for childrení .ö õThe Benchmark plan will be an option for the current fee-for-service Medicaid program.ö See pages 14-15 of Concept Paper

Altering Medicaidøs Fundamental Structure and Design-

Delivery of Services ó The preferred vehicle for expansion to the uninsured will be through private insurance, either through an existing employer-sponsored plan or through a õmedical home planö 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 õan administrative entityö that would connect õany individual needing health insurance to the affordable options for insurance coverage that are available to them.ö For Medicaid recipients õor the low-income uninsuredö to be covered through the expansion, õthe connector would make premium subsidies available on a sliding scale according to income.ö

Payment to Providers-Reimbursement systems would be established õto support a moderately managed care systemö

FQHC Specific Changes-

DHH also calls for õ[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 õLouisiana will request 10 new federally qualified health center sites for Region 1.ö 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 Stateøs current DSH allotment to a Graduate Medical Education pool.

Sources -

õLouisiana Health Care Redesign Collaborative: Concept Paper For A Redesigned Health Care System for Region 1ö For CMS Submittal, October 20, 2006.

õAffordable, Accessible, and Flexible Health Coverage ó Affordable Choices Initiativeö <http://www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html>

Solomon, Judith. õPresidentøs ÷Affordable ChoicesøInitiative Provides Little Support for State Efforts to Expand Health Coverageö Center on Budget and Policy Priorities, 3 April 2007 <http://www.cbpp.org/4-3-07health2.htm>

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

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 ot 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 öUnreimbursed Medicaid Costö

Altering Medicaidøs 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) ófunds 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 õrateö 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- Michiganøs 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 Medicaidøs 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 õcosts not otherwise matchableö. 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 stateøs 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, Missouriøs 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 Womenøs 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 a co-pay 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 Medicaidøs Fundamental Structure & Design-All MO HealthNet participants will be placed in one of three õHealth Improvement Plansö: managed care, coordinated fee for service, or Administrative Service Organization (AS0).

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.

> õThe 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.ö

<u>Sources-</u>

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

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

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

õUsing Blunt Force On Missouriøs Most Vulnerable Population,ö Families USA, March 2007, <http://www.familiesusa.org/assets/pdfs/missouri-blunt-force.PDF>.

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 federal poverty level (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 childrenô a Medicaid-funded health care benefit identical to the one provided under Montanaøs 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 groupsö will be limited and capped to a specific benefit regardless of medical necessityö. Child populations receive SCHIP-like benefit package; waives EPSDT. Cost-sharing dependent on which package the individual chooses.

Altering Medicaidøs 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 changesô 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: õA Proposal to Provide Health Care Services to Uninsured Low-Income Montanans Through an 1115 Medicaid Waiverö 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 Medicaidøs 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 Medicaidøs 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 Hampshireøs 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 Medicaidøs 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 longterm care insurance. Much more extensive reforms were initially proposed, but are currently on hold, these include: 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 proposes 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 Hampshireøs 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- õFederal-State Healthcare Reform Partnership (õFSHRP)ö Medicaid section 1115 demonstration program waiver proposal was approved September 29, 2006 for the period 10/1/2006 through 9/30/2011

Altering Medicaidøs 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 ó In the context of delivery systems, there is acknowledgement that existing contracts with FQHCs shall continue in force.

Oklahoma

Status-

On December 21, 2006, Oklahomaøs *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 ó õotherö
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 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 populationô low-income non-disabled workers and their spousesô 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 membersô including certain working disabled adults--can enroll in.

FQHC Specific Changes-

According to CMSøs Special Terms and Conditions for the SoonerCare renewal, õProcurement 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 forceö (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- Oregonøs demonstration, õOregon Health Plan 2,ö 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 wavier 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.

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), it has since submitted a concept paper to CMS entitled õSouth Carolina Healthy Connectionsô Medicaid Transformation Planö. The concept paper was submitted to CMS in early September, 2006, with a cover letter essentially indicating that it incorporated many of the concepts of the original waiver and that the State was seeking guidance from CMS, presumably related to which elements of the concept paper required a waiver from CMS and which could now be carried out through a State Plan Amendment per the flexibility provided under the DRA. Since the submission of the concept paper in September of 2006, South Carolina has submitted a waiver proposal to create two additional pilot plans; the Flexible Benefit Plan and Health Opportunity Accounts, 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 HOAøs for a limited contingent of the Medicaid population based in Richland country. 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 scenarioø 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 1000 beneficiaries for each plan. Both plans exclude dual eligibles, long-term care, and foster children. Beneficiaries enrolled in either plan have the option of re-enrolling in regular Medicaid 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 õactuarially equivalent to the current fee-for-servicesö.

In the first plan, whatøs being 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. In the case 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 õotherö 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 educated 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 n 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 copayments is established with the beneficiary.

Altering Medicaid␣s Fundamental Structure and Design-
Under South Carolina␣s Healthy Connections concept paper, 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 requirementsô **which should mean that FQHC services would be made available to the recipient and FQHC reimbursement would be paid health centers**.

Medical Home Networks (primary care case management plans)ô 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- In submitting its Section 1115 waiver application in 2005, the South Carolina Department of Health and Human Services provided that it would make no additional payments to FQHCs for services provided to beneficiaries enrolled in capitated programs. In a revised submission (7/15/05), the State maintained that it intended to work with FQHCs and RHCs to develop alternate delivery models including participation with approved plans under õprivately negotiated terms.ö The proposal ultimately submitted to CMS dated 11/8/05 stated õFQHCs will continue to be reimbursed in accordance with federal and state rules and regulation.ö The provision of FQHC services and FQHC reimbursement for health centers is **not** addressed in the Healthy Connections concept paper submitted to CMS in Sept. 2006. Thus, to the extent that this paper is intended to reflect a revision and/or updating of the state␣s earlier 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 unclear how health centers will be reimbursed under this plan, but clearly without clarification of reimbursement rates health centers could experience potential losses.

Intergovernmental Transfers and DSH Payments- The State concept paper proposes to exclude DSH and UPL payments. As an alternative proposal, the concept paper suggests that the State could treat inpatient and outpatient hospital services provided toí Medicaid recipients enrolled in a managed care setting or

any other health insurance planí in a similar manner as those federal regulationsí that pertain to Medicaid FQHC and RHC services provided to Medicaid recipients enrolled in a managed care plan..ö (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.

Source: õSouth Carolina Healthy Connectionsô Medicaid Transformation Planö 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- Waiver approval by CMS June 2005

Eligibility- The state of Tennessee has proposed (and some parts of the proposal have been accepted by CMS) a TennCare Demonstration Project. Eligibility changes include: the imposition of asset tests on individuals in the TennCare Standard population; a request to limit continuation of the IMD waiver (the state would cover care provided to IMD residents outside the institution, but the services themselves would not be covered); re-establishing an annual MCO change period and limiting TennCare enrolleeøs ability to disenroll from MCOs for good cause; transferal all Medically Needy enrollees who are in categories other than Pregnant Women and Children into the demonstration population; closing the adult Medically Needy categories; and closing new enrollment for the entire demonstration population. **Note: Medically needy are back in.**

Benefits and Cost Sharing- CMS approved Tennesseeøs request to make the following benefit changes: eliminate pharmacy coverage for adults (21+) in expansion groups, and adult, non-pregnant Medically Needy enrollees, except for Medically Needy in NFs, ICFs/MR and those receiving services under a HCBS waiver; impose a monthly limit of five prescriptions (no more than 2 can be brand name) for adult TennCare Medicaid enrollees (not limited to children or adults residing in an NF, ICF/MR or under a HCBS waiver); eliminate coverage of over-the-counter drugs for adults in both TennCare Medicaid and TennCare Standard, except prenatal vitamins; eliminate coverage of methadone clinic services for adults; eliminate coverage of dental services for adults; add the benefit of private duty nursing for TennCare Standard children, but eliminating private duty nursing for adults in TennCare; impose co-payments for brand name drug prescriptions (exceptions for certain groups of beneficiaries); removal of the out-of-pocket maximum applied to the TennCare Standard population (including children); limit substance abuse services for adults to a lifetime maximum of $30,000; and implement authority to not cover convalescent care and sitter services for all enrollees in TennCare. Tennessee also changed its definition of õMedically Necessaryö in its proposal.

FQHC Specific Changes- The terms and conditions include the 2002 waiver of section 1902(a)(10) õto enable the state to permit managed care contractors to limit coverage of FQHC and RHC services when CMS and the state have determined that equivalent services are available and accessible in other covered settings.ö

Payment and Financial Performance Incentives- Tennesseeøs proposal was seeking to implement a multi-faceted and innovative disease management program to improve the health outcomes and reduce overall costs of caring for enrollees with certain high cost diseases. The state proposal discussed possibly conducting competitive procurement and contracts with one or more 340B facilities participating in the federal 340B drug discount program, including DSHs and FQHCs.

Source: Proposed Amendment to the TennCare Demonstration Project (September 24, 2004) and the Supplement to September 24, 2004 Proposed Amendment to the TennCare Demonstration Project (January 19, 2005); News Release from the Governorøs Communication Office (June 9, 2005)

Texas

Status ó The Texas legislature and Governor are currently developing health reform legislation that would permit Texas maximum flexibility to manage its Medicaid and SCHIP programs. SB 10 passed the legislature and was recently signed by the Governor. This sweeping bill encompasses a variety Medicaid reform initiatives, many of which have been tried in other states. The allows the state Medicaid agency to pursue almost any reform option that is cost effective (see the PDF for a listing of all the various initiatives authorized by this bill).

Through SB 10, consistent themes have become clear as a formal waiver proposal/application is being constructed. Based on pending legislation, the waiver proposal is likely to include conversion of hospital supplemental payments into a Health Opportunity Pool (HOP), customized benefits packages, state assistance in enrolling in private insurance and employer sponsored health plans, as well as consumer driven and directed options through HSAøs and consumer directed services. Existing reform legislation declares September 1, 2009 for the date of implementation for any tailored benefit package, pending CMS approval of their waiver application. Implementation dates for other proposals are unknown at this time.

As a part of these reform efforts (although not part of the Medicaid reform legislation), Texas is revising a previously submitted HIFA waiver that requests the creation of a Three-Share Program in Galveston County so that the program can be implemented statewide as communities wish to participate. The three-share program is an insurance coverage program for low-income, working parents whose children are enrolled in or eligible for CHIP or Childrenøs Medicaid and are living at or below 200% FPL. Costs are shared among the Federal/State CHIP funds, the employer, and the employee. The waiver revision will allow communities statewide to participate in this program which uses a cost-sharing approach intended to allow for more affordable monthly health premiums. Communities have flexibility in benefit structure and delivery design, but the Federal government requires that eligibility for the program remain consistent across the state. Local communities will decide the employer certification process. We are still waiting for CMS approval for this. Benefits must include a basic primary care package, including inpatient and outpatient hospital care, but communities can set up their programs to include additional benefits.

Eligibility- SB 10 authorizes a study to determine the feasibility of the õHealthier Texasö proposal, under which the state would cover an additional two million uninsured Texans who do not qualify for Medicaid but are under 200% of FPL.

Benefits and Cost Sharing-

Under the ÷Three Share Programø the benefits are not as comprehensive, but would cover primary care, some specialty care, some prescription drugs and minimal inpatient services. Premium costs would be covered by the state, employer, and employee, with plans costing between $150 -$180 per month for families.

Additional benefits proposals in Medicaid reform proposals include tailored benefit packages for adults (children to receive at least EPSDT services), including non-Medicaid populations using a blend of Medicaid dollars and other funds to cover and subsidize premiums for this population. The legislature approved additional cost sharing for high cost medical services when a beneficiaryøs condition does not qualify as emergent care and appropriate notification/counsel has occurred.

Altering Medicaidøs Fundamental Structure and Design- Effectively, under the Texas proposal/waiver the use and distribution of federal and Medicaid dollars will be available/used to purchase private insurance products.

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. Additionally, depending on final language and CMS interpretation,

FQHCs could be eligible for additional funding to cover uncompensated care based on restructuring within the reform to leverage additional Medicaid match dollars. Also, as a side component to current reform proposals, health centers will receive $10m for an FQHC incubator program to continue expanding access for low-income individuals in underserved areas.

Payment and Financial Incentives- The Texas reform bill incorporates multiple incentives for healthy behaviors ranging from enrollee incentives, to subsidies for parents of foster children. For example, enrollees that demonstrate healthy behaviors or go through smoking cessation or obesity programs would receive enhanced benefits and/or discounts.

Intergovernmental Transfers and DSH Payments- The Texas legislature is currently working to establish a low income pool in exchange for restructuring DSH/UPL programs. The most likely formula would be the use of DSH/UPL money through Certified Public Expenditures to support the low-income pool (LIP). Theoretically, by creating the LIP the state gains control of accounting and appropriate distribution to expand insurance coverage and ultimately reduce the number of uninsured in the state. This aspect of Texas health reform is entirely dependent on CMS approval of reallocation of DSH dollars and may include capped payments depending on allocation formulas.

Source: Texas Health and Human Services Commission, Medicaid Reform Strategies (February 2007); Texas Health and Human Services, Medicaid Reform Proposal (April 2007); Texas Health and Human Services System, Presentation to the House Public Health Committee, Albert Hawkins, Executive Commissioner (February 8, 2007)

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 familyøs 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 donøt increase or decrease Medicaid expenditures more than 5%.
Under Vermontøs 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 Medicaidøs 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 õrewards, 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 preventioní ö 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 Commissionerøs 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.

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 patientsøcompliance.

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.

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 Governorøs plan also includes an expansion of the stateøs 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.