

## Medicaid Redesigned: State Innovations in Health Coverage and Delivery

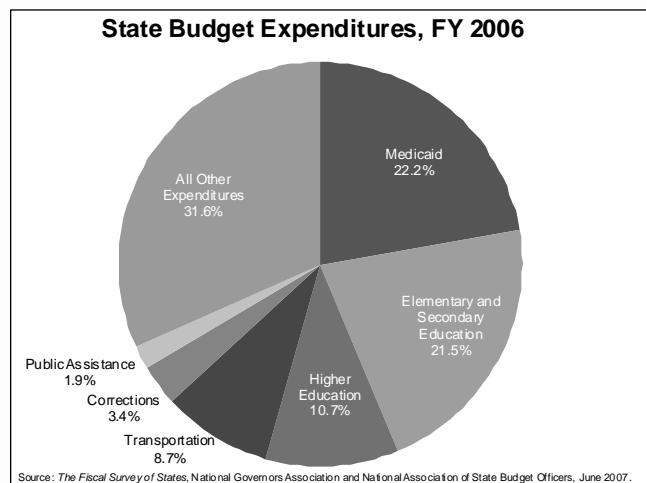
### EXECUTIVE SUMMARY

Many governors are redesigning their Medicaid programs to improve the efficiency of the system, as well as the health of their beneficiaries. Although some changes are Medicaid specific, Medicaid redesign can also support some broader state health reforms.

Serving more than 55 million people, Medicaid is the largest source of health services funding covering some of the most vulnerable populations in the United States. Because of the varying health needs of beneficiaries and the increasing costs of health care, states continue to seek ways to improve their Medicaid programs by using innovative design approaches and taking advantage of increased flexibility of federal requirements.

As costs continue to rise and Medicaid remains one of the largest components of states' budgets, governors are trying to contain costs while improving the efficiency of Medicaid and the health of participants to make the programs more sustainable. To integrate these approaches into their programs, states are using different mechanisms for Medicaid redesign, such as the following:

- **Changing Medicaid to resemble a private insurance model.** Many states have sought to make Medicaid look more like private insurance—considered by some to be a more efficient and effective way to manage health insurance coverage—by incorporating premiums and copayments, as well as tailored benefit packages, into their plans.
- **Incorporating prevention and wellness into Medicaid.** States are attempting to add more prevention and wellness services to their programs to improve beneficiaries' health status and better manage chronic conditions.
- **Allowing variation in Medicaid coverage.** The Deficit Reduction Act of 2005 allows states to target benefits by group characteristics, such as by eligibility group or geographic location within the state. This allows states to direct services to specific Medicaid populations.
- **Using innovative approaches to transform Medicaid financing.** Some states are using uncompensated care funds to provide basic private insurance to the uninsured, and others are establishing a federal spending cap in return for more program flexibility.



## **BACKGROUND**

In 1965, the Medicaid program became law as an addition to Medicare as Title XIX of the Social Security Act. Medicaid was initially designed as a medical care extension of federally funded programs that provided cash assistance for the poor. Over the years, Medicaid eligibility has been incrementally expanded to include low-income children, pregnant women, families, the disabled, and the elderly.

The program is jointly funded by the federal government and states and is administered by the states under federal guidelines. Medicaid is the largest source of health services funding for the most vulnerable populations in the United States.<sup>1</sup> Today it serves more than 55 million people.<sup>2</sup> Total funding for the program was \$303 billion in fiscal year (FY) 2006.<sup>3</sup> States provided \$96.7 billion in Medicaid spending in FY 2005.<sup>4</sup>

Medicaid has grown to become a significant expense to states. The program makes up more than one-fifth of states' budgets and has become their largest budget component.<sup>5</sup> Particularly when states are under fiscal stress, the program's price tag makes it difficult for states to maintain their level of Medicaid coverage and still balance their budgets.

In recent years, states have been looking for ways to redesign their Medicaid programs to be more effective and cost efficient. With health care costs continuing to rise and many states struggling with the poor health of their Medicaid participants, states are looking to create a more effective system.

Medicaid waivers—in which certain components of the federal guidelines are waived—have traditionally been the method by which states have altered their Medicaid programs. Waivers allow states to create demonstration programs incorporating innovations into Medicaid that would otherwise not be permitted. However, in many cases, waivers have proved to be labor intensive and time consuming. More recently, the Deficit Reduction Act (DRA) of 2005 made it easier for states to have increased flexibility in their Medicaid programs.

## **MEDICAID CHALLENGES FACING STATES**

Key Medicaid challenges remain for states, particularly ones related to program operation and the rising cost of health care. Governors have agreed that Medicaid encourages inefficiency, does not emphasize quality or effectiveness of care, does not permit consumers to make informed decisions on the cost or quality of services they receive, and discourages innovative approaches to extend coverage to the uninsured.

In addition to these structural issues, states are dealing with the overall poor health status and quality of care that often confound the Medicaid population. To encourage healthy lifestyles and provide a program that meets the unique needs of the covered populations, governors are developing creative approaches to these challenges. Demonstration waivers and the DRA permit states to address some of the structural problems of the Medicaid program.

## **KEY STATE STRATEGIES FOR MEDICAID REFORM**

Demonstration waivers and the DRA have allowed states the opportunity to move away from the traditional Medicaid program design and toward a focus on more targeted care for Medicaid recipients, cost containment, and greater quality of care.

### **Developing Comprehensive Medicaid Demonstration Waivers**

States rely on two main types of waivers to make changes to their Medicaid programs. One type, a Section 1915 waiver, is generally used to make small changes to existing Medicaid programs. The other type, a Section 1115 waiver, is used to redesign Medicaid programs and make larger changes. These waivers allow the states to make changes to their Medicaid programs that otherwise would not be allowed under the Medicaid statute.

States have used Section 1115 waivers to implement innovative approaches to program operation, such as expanding covered populations, or incorporating new services or delivery systems.<sup>6</sup> According to federal guidelines, program changes approved under waivers must be demonstrated as budget neutral. In addition, gaining federal approval for a Section 1115 waiver is a rigorous and lengthy process. Nevertheless, Section 1115 waivers continue to help states improve their Medicaid programs through greater flexibility and enabling states to tailor the program to its population.

Since the passage of the DRA, the use of Section 1115 waivers has declined. However, states considering major Medicaid reforms are still likely to need to use them because the flexibility allowed in the DRA is limited.

### **Using the Flexibility Created by the Deficit Reduction Act**

The Deficit Reduction Act (DRA) of 2005 provided states with greater flexibility in designing their Medicaid program and in offering specific benefits to targeted beneficiary groups. It also gives states new tools to control Medicaid spending.

The DRA allows states to submit state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) for many program changes that would previously have required waiver authority. In addition to these broad changes, the DRA allows states to add the following to their Medicaid programs for certain individuals:

- Enforceable premiums and copayments for medical services and prescription drugs;
- Enforceable premiums and copayments for non-emergent care provided in an emergency room;
- Variation in benefits and cost-sharing requirements by eligibility group;
- Creation of a “benchmark” plan instead of the traditional Medicaid benefit package;
- Creation of a Medicaid buy-in for children with disabilities with family incomes below 300 percent of the federal poverty level (FPL);
- Creation of Health Opportunity Account (HOA) demonstrations, which allow states to set up accounts for beneficiaries with a defined amount of money available for medical services;
- Increased flexibility and use of home and community-based services;
- Increased funding for “money follows the person” programs to move beneficiaries from nursing homes to the community; and
- Increased penalties for asset transfers to allow people to qualify for Medicaid nursing home coverage.

In addition, the DRA requires states to verify citizenship to qualify a person for Medicaid. It also offers transformation grant funding to states.

This issue brief explores the various ways in which states are redesigning their Medicaid programs to improve cost containment, quality of care, and the health of beneficiaries. The appendix includes specific examples of the mechanisms that states are using to reform Medicaid.

### **KEY MECHANISMS FOR REFORMING MEDICAID**

States are taking multi-component approaches to improve their Medicaid programs. These include:

- Changing their Medicaid programs to resemble private insurance;
- Using prevention and wellness strategies;
- Exploring variation in coverage for different groups; and
- Transforming Medicaid financing.

#### **Private Insurance Model**

Many states have sought to make Medicaid look more like private insurance, which many view as an effective model to manage access to health services. Through such activities as establishing benchmark plans, initiating cost-sharing

arrangements, and encouraging higher levels of consumer engagement, states are attempting to tier the benefits offered through the program and involve consumers more actively in their health care decisions.

#### *Benchmark Plans*

Some states have used benchmark plans to establish benefit packages for various groups of beneficiaries. The benchmark plan must be based on the baseline federal employee health benefits plan, the state employee benefit package, the largest HMO plan offered in the state, or a plan approved by the secretary of the Department of Health and Human Services (HHS).

The benefit packages are designed to meet the needs of specific Medicaid populations in the same way that private insurance carriers offer various levels of plans so that individuals can choose the package that best meets their needs. These benchmark plans allow for greater access to providers and improved coordination of care.

Some states are creating different benefit packages, for example, for children, for beneficiaries with specific chronic conditions, and for dual eligibles. This allows states to provide certain benefits to the targeted populations without having to offer those often costly services to the entire Medicaid population. For children with special needs, the state must be able to wrap around the benefit packages that do not provide complete Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services in order to meet federal Medicaid standards.

**Kentucky** designed a program, called KyHealth Choices, that allows for more targeted health care to its varying beneficiary groups. Participants are assigned to one of four benefit plans that are designed to specifically address that group's health care needs. The Family Choices plan covers all children, and the Global Choices plan covers the general Medicaid population, such as adults, the disabled, Supplemental Security Income (SSI) recipients, medically fragile children, and foster care children. The Optimum Choices plan covers individuals with mental retardation in need of long-term care services; and the Comprehensive Choices plan covers those who are elderly and in need of long-term care services and individuals with traumatic brain injuries.

#### *Cost-Sharing Arrangements*

Before passage of the DRA, states could require reasonable copayments for certain services and populations, for example, for prescription drugs. Such cost-sharing was unenforceable, however, meaning that providers, pharmacies, and hospitals could not refuse service or needed medication because the beneficiary did not meet the copayment. The DRA allows states to enforce payment of premiums and copayments as a condition of receiving services. This is the practice of private insurers in that policyholders are responsible for their premiums and copayments and would otherwise not receive services if the fees were not paid. Many states are attempting to stress to beneficiaries the value of services by enforcing the copayments. However, if individuals are not able to pay the copayments, they may delay seeking needed care.

While the DRA allows the states to enforce cost-sharing arrangements, premiums and copayments must be reasonable for the population. In addition, cost-sharing is not permitted for mandatory pregnant women and children for certain benefits, and copayments for those between 100 percent and 150 percent of poverty are limited to 10 percent of the price of the service. Cost-sharing must not be more than 5 percent of a family's income.

Other states are charging Medicaid recipients higher copayments for emergency department visits that are considered non-emergent situations. Many states are attempting to emphasize reducing emergency room visits and increasing use of primary care physicians in order to decrease spending.

In **Idaho's** Medicaid reform, beneficiaries pay a monthly premium of up to \$15 per member. Upon redetermination, if premiums are not paid, beneficiaries can have their premium debts forgiven if they can show that they have met certain wellness criteria, such as fulfilling well-child visits or have up-to-date immunization records. Copayments are in place

for using the emergency department or transportation for non-emergent care. Physicians also have the ability to charge payments for missed appointments.

#### *Consumer Engagement*

As part of the effort to make Medicaid look more like a private insurance product, states have begun to emphasize the importance of consumer engagement in their Medicaid reform plans. By allowing individuals to choose their health plans, along with encouraging personal responsibility for healthier living, states are ramping up efforts to increase beneficiaries' involvement in their care.

Some states are encouraging voluntary participation in private health plans in which the state negotiates a per-enrollee price with the insurer for all Medicaid beneficiaries. This is an alternative to traditional, fee-for-service Medicaid, which pays providers after the beneficiary has received care. This method further engages individuals in their health care choices by encouraging them to take responsibility for their health insurance as someone with private coverage would.

Other states are giving their Medicaid clients a choice of plans and allowing them to choose which plan best fits their needs. These consumer engagement tools educate Medicaid participants about their health care coverage and allow choice in health decisions. To prevent enrollees from dropping out of the program because they have not signed up with a particular plan, many states are using enrollment counselors to help beneficiaries get into a plan that best meets their needs.

**Florida** has contracted with local health maintenance organizations, provider service networks, and other licensed insurers to provide specifically designed plans for beneficiaries. The plan defines the benefit package according to state guidelines which require actuarial equivalence to, or the same value as, the current Medicaid program. A Choice Counselor is available to help beneficiaries review the plans available to them and choose the plan that best fits their needs. If they do not select a plan, the state will auto-assign them to one.

Several states are approaching consumer engagement through an emphasis on healthier living. Some Medicaid programs are using member agreements to ensure that individuals meet certain health requirements to receive additional services that would otherwise not be provided. Other states have used disease management as a mechanism to engage individuals. In these programs, individuals are responsible for completing a disease management program, such as weight management or smoking cessation classes, to receive incentive awards. This allows beneficiaries to have a greater involvement in and understanding of the importance of a healthy lifestyle.

**West Virginia** offers enrollees a choice of two benefit packages. Those participating in the Enhanced Benefit Package have access to additional benefits, including fewer restrictions on the number of services Medicaid covers, tobacco cessation, nutritional education, diabetes care, and chemical dependency and mental health services.

To receive the Enhanced package, enrollees must sign a member agreement stating that they will comply with all recommended medical treatment and wellness behaviors. Physicians and managed care organizations monitor members' adherence to the member agreement and report to the state if the agreement is not being met.

#### **Prevention and Wellness**

Changes initiated by the DRA also allow states to increase their emphasis on prevention and wellness. Because states administer the Medicaid program, many believe that their participants should adhere to prevention and wellness activities to improve their health and reduce their risk for chronic conditions that require expensive treatment.

### *Medical Home and Primary Care Model*

States have been emphasizing the use of a medical home model to ensure that recipients have access to primary care services and have a medical professional to manage their care. A medical home provides a beneficiary with a familiar location and medical professional to seek when care is necessary. This keeps the Medicaid recipient out of the emergency room, provides them with a regular source of care, and lowers the cost of care. A medical home also provides an opportunity for a medical professional to manage a recipient's chronic conditions to improve the health of the individual and reduce spending on ambulatory care.

**South Carolina** is using medical home networks and managed care organizations to establish better health management and coordinated care for Medicaid beneficiaries. As part of the Healthy Connections Choices program, individuals choose a health plan and a primary care physician or clinic in the health plan when they sign up for the program. The members then coordinate care through the medical home for future health needs.

Participants in **Missouri's** new Medicaid program, MO HealthNet, choose a health care home, which coordinates and personalizes their care. Beneficiaries in the program undergo a health risk assessment to determine their health status and whether management of chronic conditions is needed. A health care home coordinator is responsible for monitoring the patients' conditions and sharing information electronically with physicians and the participants.

### *Wellness Activities*

Healthier living can ensure better health, which results in fewer health care needs and less expensive care. States are using healthy living as an incentive for beneficiaries. Some states are rewarding their Medicaid recipients for participating in wellness activities, such as disease management, smoking cessation, or weight loss programs. The rewards are often in the form of additional benefits not otherwise offered as part of the plan, or in the form of points to be used toward additional wellness activities. Enrollees participating in these programs are able to realize the importance of healthy living through the additional rewards or benefits.

**Florida's** Medicaid reform includes the establishment of enhanced benefits accounts, which provide credits for enrollees who maintain healthy behaviors. These credits may be used for health care services and medical supply costs not otherwise covered by the plan. The beneficiary may use the credits for up to three years after leaving the Medicaid program, thus providing a transition out of Medicaid coverage. The credits can be used to buy such things as over-the-counter medications and bandages and gauze, as well as for nutritional and smoking cessation classes.

### **Variation in Medicaid Coverage**

The DRA allows states to vary benefits based on the needs of specific Medicaid populations. Before its passage, states were required to offer all Medicaid-covered services to all of their beneficiaries. By allowing variation, the DRA provides the states with the opportunity to target benefits by group characteristics, such as by eligibility group or geographic location within the state. This targeting allows the state to cover only the services that are needed for certain groups.

By combining this ability with the flexibility in benchmark plan design, states are able to create benefit packages that are aimed at certain populations. States have used the new flexibility to separate children and pregnant women; those with Medicaid and Medicare, or dual eligibles; and those with chronic conditions from other eligibility groups for the different benefit packages. Targeting such groups allows states to focus the coordination of care on those that require more intensive health management than other beneficiaries. As a result, states can hope to lower the cost of providing care for Medicaid populations whose care is often the most costly.

Through a benchmark plan to target disabled working beneficiaries, **Kansas** provides personal assistance services through a "cash and counseling" model that allows the participants to choose what services are most useful for them.

Beneficiaries receive independent living counseling and assistance with services that may not be directly medically related but that keep recipients more independent and able to work.

**Virginia** used the new flexibility provided by the DRA to create a customized benefit package for Medicaid beneficiaries with coronary artery disease, congestive heart failure, asthma, diabetes, and chronic obstructive pulmonary disease. In this program, individuals receive care management services such as education, consultation through a 24-hour nurse helpline, consumer engagement activities focusing on lifestyle changes, care coordination with the primary care provider, and follow-up assessments.

### **Using Innovative Approaches to Transform Medicaid Financing**

Some states are taking unique approaches to utilizing Medicaid dollars more effectively. For example, some use uncompensated care funds to serve the uninsured through private insurance. States are using Medicaid dollars that traditionally would have gone to hospitals to provide for the uninsured, otherwise known as disproportionate share hospital (DSH) funds. Those funds are being redistributed to support private health insurance for low-income uninsured individuals.

Often this money is used to subsidize private insurance premiums for low-income individuals who earn too much to qualify for Medicaid but not enough to buy insurance on their own. These safety net funds are used to take the pressure of uncompensated care off of the hospitals by allowing individuals regular access to care. Some hospitals have expressed concern that their uncompensated care costs may continue to rise even after the funding has been diverted to private health insurance. However, the states believe the costs of uncompensated care will decrease if individuals have a regular, more prevention-oriented source of care outside of the hospital emergency room. In addition, states continue to fund the hospitals at a lower rate for uncompensated care costs.

**Massachusetts** has used its uncompensated care funds to establish the Commonwealth Care program, which provides affordable insurance through private plans. The program is available on a sliding scale to those below 300 percent of poverty. The subsidized Commonwealth Care program is one piece of a broader health reform effort that includes changes to the private insurance market, employer responsibility, and a mandate that individuals obtain health insurance.

Another mechanism for funding Medicaid reform is capping the amount the federal government contributes over a period of time. In return for accepting a capped amount, the state receives wider flexibility in its Medicaid program, allowing certain state-provided services to be eligible for matching federal Medicaid dollars. The financing is generally well planned, requiring the state to predict that the arrangement will not harm its Medicaid program. In a financial downturn, however, the state is responsible for all funding over the capped amount.

**Vermont** created the Global Commitment to Health, an 1115 waiver that capped federal Medicaid money available to the state at \$4.7 billion over five years in exchange for greater flexibility in program design and operations. This flexibility includes the ability to use any operational savings to cover health services not available under Medicaid, explore alternative reimbursement approaches, invest in programs designed to improve health outcomes, and encourage inter-departmental collaboration and consistency across programs.

### **CONCLUSION**

Governors around the country are using innovative approaches and market-based strategies in their Medicaid programs to meet their citizens' health care needs. CMS has shown a willingness to let states test new methods of funding and delivering care and new benefit structures. Through the flexibility offered by the DRA and the federal waiver process, states strive toward an efficient and effective Medicaid program that delivers quality care.

Although funding will likely continue to be a challenge with the ever-increasing cost of health care, states will continue to seek innovative ways to design and operate their Medicaid programs and to improve the health of the people who rely on them.

## APPENDIX A: STATE EXAMPLES

### *Florida*

Florida obtained an 1115 waiver to bring comprehensive change to its Medicaid program and to better target the needs of program participants. The waiver aims to bring predictability to Medicaid spending and reduce the rate of growth, while providing better quality of care and patient choice.

The Medicaid reforms began in Broward and Duval Counties in July 2006, with Baker, Clay, and Nassau Counties following in July 2007. The state has contracted with local health maintenance organizations, provider service networks, and other licensed insurers to provide specifically designed plans for beneficiaries. The plan defines the benefit package according to state guidelines which require actuarial equivalence to, or the same value as, the current Medicaid program.

The program is mandatory for targeted populations, which include children and families in Medicaid and aged and disabled individuals. More specialized programs will be designed for special needs populations, such as those with HIV/AIDS and chronically ill children.

A main element of this reform effort is consumer engagement. A Choice Counselor is available to help beneficiaries review the plans available to them and choose the plan that best fits their needs. If they do not select a plan, the state will auto-assign them to one.

Enhanced benefits accounts have been established to provide credits for enrollees who maintain healthy behaviors. These funds may be used for health care services and supply costs not otherwise covered by the plan, such as pain relievers and other pharmacy products, and may be used by the beneficiary for up to three years after leaving the Medicaid program.

A low-income pool (LIP) has also been created to ensure payment to safety net providers for needed health care services for Medicaid beneficiaries, the underinsured, and the uninsured. The LIP is capped at \$1 billion for each year of the five-year demonstration period.

The reform efforts allow for predictable budgeting and allotting a specific dollar amount to each beneficiary (there are no maximum dollar amounts for children or pregnant women). In addition, Florida is focusing more of its effort on plan oversight and quality, rather than claims payments.

### *Idaho*

Prior to reform, Idaho's Medicaid program budget was unsustainable given the state's available state resources. As a result, the governor and the legislature reached agreement on broad Medicaid reforms to simplify the eligibility groups and more efficiently and effectively meet the health needs of Medicaid recipients. The state submitted 13 state plan amendments (SPAs) to CMS, six of which were made possible by the added flexibility extended by the DRA.

The Medicaid reform plan created three benchmark packages: Basic, Enhanced, and Coordinated. The Basic plan covers healthy children and working age adults. The benefits offered through the Basic plan are the same that were previously offered through Medicaid prior to reform, minus developmental disability services, long-term care and certain enhanced mental health services. Additional benefits, including preventive and wellness services, have been added to the Basic plan. The Enhanced plan covers Medicaid members with disabilities and special health needs and those requiring additional services not offered by the Basic plan. The benefits are the same as the Basic plan with the addition of long-term care, mental health, and other, more specialized services. The Coordinated plan option is offered to dual eligibles that have the option to select coverage through Medicare Advantage plans. The benefits include traditional Medicare-covered benefits, integrated benefits, such as dental care and supplies, and wrap-around Medicaid benefits. The Medicaid beneficiaries qualifying for this plan must be enrolled in both Medicare Parts B and D.

Members with incomes between 133 percent and 150 percent of poverty pay a \$10 monthly premium for their Medicaid coverage, and those with incomes between 150 and 185 percent of poverty pay a monthly premium of \$15 per member. Upon redetermination, if premiums are not paid, beneficiaries can settle their premium payments or prove they have met certain wellness criteria, such as fulfilling well-child visits and having up-to-date immunization records, in which case their premium debts can be forgiven. Copayments are in place for using the emergency department or transportation for non-emergent cases. Physicians also have the ability to charge payments for missed appointments.

### ***Indiana***

In December 2007, HHS approved Indiana's Medicaid Section 1115 demonstration project, called the Healthy Indiana Plan (HIP), which extends health insurance to low-income parents of children now covered by Medicaid and SCHIP, as well as childless adults. To be eligible for coverage, enrollees must not have incomes that exceed 200 percent of poverty, must not be offered employer-sponsored insurance, and must have been uninsured for six months.

The plan gives participants access to a high deductible health plan paired with an account modeled after a health savings account, called a Personal Wellness and Responsibility (POWER) account. To assist with out-of-pocket costs incurred prior to meeting the deductible, both the individual and the state will make contributions to the POWER account. Participant contributions to the POWER account will be set on a sliding scale based on ability to pay, but at no more than five percent of gross family income. Funds remaining in the account at the end of the year can be rolled over to be used the following year, assuming preventive services are obtained.

No copayment will be required for services, except for use of an emergency room for non-emergency treatment. Benefits will include physician services, prescription drugs, home health services, in- and out-patient hospital services, mental health and substance abuse treatment, and preventive services. The program also permits and encourages employers to contribute to their employees' POWER accounts.

### ***Iowa***

In the face of funding reductions that were imminent in fall 2004, the state of Iowa created IowaCare, a limited benefit package for the working poor through an 1115 waiver. When CMS eliminated Iowa's intergovernmental transfers (IGTs), the transfer of state money to the Medicaid agency for the purpose of obtaining federally matching funds for those dollars, the state faced a \$65 million shortfall in federal funds. State leaders devised a Medicaid benefit to fund coverage for people who previously were covered with county or state-only dollars.

IowaCare generally covers individuals aged 19 to 64 who:

- have an adjusted income below 200 percent of poverty;
- are not eligible for Medicaid; and
- are otherwise uninsured.

This group includes childless individuals and parents of children covered by Hawk-I, Healthy and Well Kids in Iowa, Iowa's SCHIP program. A special group of pregnant women and certain people with chronic health care needs are also eligible for the program. Enrollees must agree to pay a premium on a sliding scale ranging from \$42 to \$80 per person per month, except for those with incomes below 100 percent of poverty, who are exempt from paying premiums.

IowaCare is a Medicaid expansion program that provides limited benefits, including inpatient and outpatient hospital services, limited physician and dental services, transportation, and a comprehensive medical examination and risk assessment upon enrollment.

All services are delivered by the University of Iowa Hospitals and Clinics and Broadlawns Medical Center (the state's largest urban county hospital). The IowaCare program replaces state- or county-funded indigent care programs.

The program aims to improve the way care is provided through IowaCare and Medicaid by improving beneficiary access to primary care services. IowaCare also contains other innovative reforms, such as incentive programs to promote healthy lifestyles, electronic medical record development, and new ways of addressing the needs of Iowa's long-term care system.

### ***Kansas***

After the state had attempted to make changes to its Medicaid buy-in program for working people with disabilities through waivers, the DRA made it possible for Kansas to expand its personal assistance services (PAS). Through benchmark benefit packages to target disabled working beneficiaries, the state provides PAS through a "cash and counseling" model that increases flexibility by allowing recipients to choose the services that are most useful for them. Through the program, called Work Opportunities Reward Kansans (WORK), beneficiaries receive independent living counseling and assistance with services that may not be directly medically related but that keep the participant more independent and able to work.

The state is using benefit specialists to inform people about the changes in eligible services. The University of Kansas is evaluating program outcomes and tracking changes resulting from the DRA reforms.

Kansas is also developing a benchmark benefit package based on the state employee benefit plan for parents of children in Medicaid with incomes below 100 percent of poverty. Premium assistance will be available for these individuals to purchase private insurance. The children will be placed in the same private insurance plan as the parents, and wraparound services will be provided for the children, as needed. In order for the children to be enrolled, the parents' employer-sponsored insurance must be approved by the state and the plan must meet the state employee health benefit plan equivalency standard. If individuals are offered employer-sponsored insurance, they will be required to join their employer's health plan.

### ***Kentucky***

Facing a rapidly growing Medicaid deficit, efforts were undertaken to restructure Kentucky's Medicaid program in a way that better served people's individual health care needs, while working to slow the growth of the program. The result is KyHealth Choices, a comprehensive Medicaid reform package with the goal of providing benefit plans for specific populations and emphasizing care management. KyHealth Choices was one of the first programs in states to result from the new flexibility offered through the DRA.

Given the diverse demographics of the state, with equally diverse health care needs, the state of Kentucky designed a program that provides more targeted health care to its varying beneficiary groups. Members are assigned to one of four benefit plans that are designed to specifically address each group's health care needs. The first two are general plans, while the latter are level-of-care driven plans. The plan and population groupings are as follows:

1. Family Choices: All children, except those in the Global plan; this group is not subject to copayments or benefit limits.
2. Global Choices: The general Medicaid population, such as adults, the disabled, Supplemental Security Income (SSI) recipients, medically fragile children, and foster care children;
3. Optimum Choices: Individuals with mental retardation in need of long-term care services; and
4. Comprehensive Choices: Individuals who are elderly and in need of long-term care services and individuals with acquired brain injuries.

The design envisioned benefit limits and cost-sharing much like those of the private market, such as three-tier drug formularies in which generic medications have the lowest copayment.

In Kentucky, certain areas of the state have higher concentrations of specific chronic conditions than others. This approach was designed to facilitate disease and case management for specific populations.

### ***Massachusetts***

Massachusetts has implemented a broad-based health reform package that incorporates not only Medicaid but the entire Massachusetts health care system. A combination of factors set the stage for health care reform in Massachusetts, led by the state and numerous stakeholders' development of an insurance-based reform model that would shift dollars being used for uninsured care at institutions to coverage for individuals. With this model, Massachusetts was able to maintain a block of endangered federal funding that had been used to support institutional payments.

As part of the reforms, the state created the Commonwealth Care Health Insurance Program using a new Safety Net Care Pool (SNCP) authorized in its Section 1115 Demonstration waiver, which included its former DSH allotment, as well as additional funding. The Commonwealth Care program serves individuals with incomes at or below 300 percent of poverty and provides a comprehensive insurance package with premiums on a sliding scale based on income.

As a part of the state's reform plan, the uncompensated care pool has been eliminated and replaced with the Health Safety Net (effective October 1, 2007), which will serve as a safety net for the residual uninsured population.

Massachusetts' health care reform also includes significant changes to the private insurance market, including the merging of the non-group and individual insurance markets; a health insurance Connector which links individuals and businesses to affordable insurance products that have received the Connector's seal of approval; a mandate that all businesses with 11 or more full-time employees offer Section 125 plans for the purchase of insurance with pretax dollars; a mandate that all individuals obtain health insurance, enforced with tax penalties; and a 'fair share assessment' on employers.

### ***Missouri***

Missouri's legislature passed a law to sunset the state's current Medicaid program on June 30, 2008. In response, the governor created a redesigned Medicaid program that was then passed by the legislature. The new Medicaid program, called MO HealthNet, focuses on prevention and wellness. MO HealthNet participants choose a health care home, which coordinates and personalizes the care given for the members. Participants in the program undergo a health risk assessment to determine their health status and whether management of chronic conditions is needed. A health care home coordinator is responsible for monitoring the patients' conditions and sharing information electronically with physicians and the participants.

In addition, the state has increased reimbursement rates for physicians participating in the MO HealthNet program and is performing a study of provider reimbursement rates intended to increase access to care. Missouri is also using health information technology to improve the quality and efficiency of care delivered.

### ***South Carolina***

South Carolina identified three issues underlying its soaring Medicaid costs: poor health of its citizens, a small percentage of recipients consuming a disproportionately high amount of funding, and a lack of coordination within the system. South Carolina hopes to use its Medicaid reforms to address those issues.

Using market-based principles, the state has created the South Carolina Healthy Connections Choices program as part of its Medicaid reform plan. The program allows Medicaid recipients to choose among at least two private health plans offered in their region.

Beneficiaries can choose to remain in the traditional fee-for-service Medicaid program or choose one of the private plans being offered. Enrolled individuals can change plans within the first 90 days of making their initial decision. After that, they stay in their plan for the remainder of the plan year. Enrollment counselors provide assistance in picking the plan that best fits the needs of the beneficiary. If individuals do not choose a plan, they will be automatically assigned to one.

The state is using medical home networks and managed care organizations to establish better health management and better coordinated care for Medicaid members. Individuals choose a health plan and a primary care physician or clinic included in the health plan upon signing up for the program. The beneficiary then coordinates care through the medical home for future health needs. The plans will offer the standard Medicaid benefits, in addition to other benefits to promote healthier living, such as smoking cessation classes and disease management programs.

Using the flexibility provided by the DRA, South Carolina has also created an alternative benefit package that allows Medicaid participants the option of buying into the State Employee High Deductible Health Plan. The program promotes consumer awareness of health care spending and offers incentives for seeking preventive care. The plan's deductible is \$3,000 for an individual, and beneficiaries are not responsible for any cost-sharing until the deductible has been met. At that point, the individual is responsible for the standard Medicaid cost-sharing amounts. This program is initially limited to 1,000 individuals in one county in the state.

### ***Vermont***

In response to Vermont's five-year, state-funded Medicaid deficit of \$370 million, the state created the Global Commitment to Health under an 1115 waiver, which capped federal Medicaid money available to the state at \$4.7 billion over five years in exchange for greater flexibility in program design and operations. The plan allows the state to use any operational savings to cover certain health services and programs not previously eligible for federal matching funds.

Under the reform plan, the Office of Vermont Health Access (OVHA) became a public health maintenance organization (HMO) and receives a monthly lump sum capitated premium to provide all necessary Medicaid services. The OVHA will manage all Vermont Medicaid expenditures under the capitation agreement, administer the state's publicly funded health insurance programs, oversee all of the policy and program changes, and fund other agencies and organizations to provide special services, such as substance abuse, mental health, and disability and aging related services.

Because of the cap, the state is at risk for caseload and utilization increases and inflation. If Vermont exceeds its capped allotment, it will not receive additional funds from the federal government. If the state realizes savings with this waiver, however, it can fund other health care priorities.

New funding flexibility includes the ability to:

- cover health services not available under Medicaid;
- explore alternative reimbursement approaches (i.e., case rates and capitation);
- invest in programs designed to improve health outcomes; and
- encourage inter-departmental collaboration and consistency across programs.

The waiver does not allow the state to alter mandatory benefits and populations, and does not include changes to long-term care funding, DSH funds, or the SCHIP population. Those populations and funding for their benefits will remain outside of the waiver and thus the aggregate cap. However, the waiver does give new flexibility for designing the benefit structure and cost-sharing arrangements for optional populations.

### ***Virginia***

The DRA allowed Virginia to expand its demonstration disease management program, Healthy Returns. Virginia used the new flexibility provided by the DRA to create a customized benefit package for those Medicaid beneficiaries with coronary artery disease, congestive heart failure, asthma, diabetes, and chronic obstructive pulmonary disease. Through the program, individuals receive care management services, such as education, consultation through a 24-hour nurse helpline, consumer engagement through lifestyle changes, care coordination with the primary care provider, and follow-up assessments.

The program is available to all Medicaid recipients exhibiting symptoms of the covered conditions, with the exception of dual eligibles, those in managed care organizations, individuals residing in institutions, and those who have third-party insurance. However, the program is available to those receiving home and community-based services. Those eligible voluntarily choose to participate in the disease management program. The program is available throughout Virginia.

### ***Washington***

Washington used the new flexibility offered by the DRA to offer an alternative benefit package for individuals with complex medical needs who require disease management services, such as those with diabetes, heart failure, coronary artery disease, cerebrovascular disease, and renal failure.

The program assigns beneficiaries to a medical home to ensure continuous and coordinated treatment from a primary care provider. The primary care provider is responsible for facilitating care with referring physicians and managing the services received. A nurse helpline is also available for participants in the program.

The disease management benefit package is available to aged, blind, and disabled adult Medicaid beneficiaries in fee-for-services care and is available statewide. Eligible individuals may opt in to the program. Washington expects 15,000 participants.

### ***West Virginia***

West Virginia was one of the first states to receive approval under the DRA to redesign key elements of its Medicaid program for adults and children. Driven by budget challenges and a desire to improve the health of members, West Virginia's goals were to streamline its program, tailor benefits and coordinate care to better meet the needs of beneficiaries, and engage members in improving their health.

Through its reforms, West Virginia offers enrollees a choice of two benefit packages: the Basic Benefit Package, which is a scaled back version of the previous Medicaid package, and the Enhanced Benefit Package. To receive the Enhanced package, enrollees must sign a member agreement stating that they will comply with all recommended medical treatment and wellness behaviors.

Those participating in the Enhanced package have access to additional benefits, including fewer utilization restrictions, tobacco cessation programs, nutrition education, diabetes care, and chemical dependency and mental health services. Adults also receive cardiac rehabilitation, chiropractic services, and emergency dental services. Children in this package receive skilled nursing care and orthotics/prosthetics, in addition to the standard Medicaid benefits, including medically necessary Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits.

Physicians and managed care organizations monitor participants' adherence to the member agreement and report to the state if the agreement is not being met. If members are found not to be meeting their responsibilities, they are placed back into the Basic plan.

Health Investment Accounts will also be established for participants in the Enhanced plan who comply with the member agreement and achieve healthy behaviors. The rewards will include financial incentives and additional benefits for using the health care system appropriately and proactively. The state will also improve its use of electronic health information to identify quality outcomes and reward providers and members. Finally, long-term care reform efforts will provide access to the most integrated setting possible as a way to maintain beneficiaries' optimal health status.

### ***Wisconsin***

Wisconsin is implementing a reform plan to change Medicaid for children and families. The new program, called BadgerCare Plus, combines several existing programs into one comprehensive program. The plan also expands coverage to seven new groups, including:

- All children with family incomes greater than 185 percent of poverty;
- Pregnant women with incomes between 185 percent and 300 percent of poverty;
- Parents with incomes between 185 percent and 200 percent of poverty; and,
- Farmers and self-employed parents with incomes less than 200 percent of poverty.

With flexibility added by the DRA, Wisconsin has created two benefit plans. The Standard plan covers children, parents, and pregnant women below 200 percent of poverty and offers the current Medicaid benefits, including all services available for federal matching funds. Dental coverage will continue to be offered through fee-for-service Medicaid and HMOs serving Medicaid beneficiaries.

Children and pregnant women, along with farmers and other eligible self-employed parents, with incomes above 200 percent of poverty, will be enrolled in the Benchmark plan. The Benchmark plan, modeled after United HealthCare's largest private insurance plan in the state, offers the same benefits as the private plan, with the addition of prescription drugs, early developmental services, dental services, mental health and substance abuse services, preventive services, and smoking cessation. Dental, mental health, and substance abuse benefits will be offered at levels similar to those offered to state employees.

Premiums will be assessed on a sliding scale for certain groups. Copayments will remain the same as in the current Medicaid program for those in the Standard plan, and those in the Benchmark plan will pay copayments for certain services, but participants will not pay for preventive services.

In addition, the state is promoting healthier living in its reforms. There is a New Enrollee Health Needs Assessment for members to complete upon joining a plan. There will also be higher costs for using the emergency room for non-emergent cases and incentives for healthy behaviors. The program also strives for higher quality care through pay-for-performance measures for the 14 participating HMOs in the state.

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#### ENDNOTES

<sup>1</sup> “Technical Summary,” Medicaid Program – General Information, Centers for Medicare and Medicaid Services, [http://www.cms.hhs.gov/MedicaidGenInfo/03\\_TechnicalSummary.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage).

<sup>2</sup> *State Fiscal Conditions and Medicaid* Fact Sheet, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2006, <http://www.kff.org/medicaid/upload/7580.pdf>

<sup>3</sup> “Total Medicaid Spending, FY2006,” Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, July 2007, for State Health Facts, Kaiser Family Foundation, <http://www.statehealthfacts.org/comparetable.jsp?ind=177&cat=4>.

<sup>4</sup> Table 28: Medicaid Expenditures,” *FY2005 State Expenditure Report*, National Association of State Budget Officers, Fall 2006, <http://www.nasbo.org/Publications/PDFs/2005%20State%20Expenditure%20Report.pdf>.

<sup>5</sup> *The Fiscal Survey of States*, National Governors Association and National Association of State Budget Officers, June 2007, <http://www.nasbo.org/Publications/PDFs/Fiscal%20Survey%20of%20the%20States%20June%202007.pdf>.

<sup>6</sup> Research & Demonstration Projects - Section 1115, Medicaid State Waiver Program Demonstration Projects - General Information, Centers for Medicare and Medicaid Services, [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03\\_Research&DemonstrationProjects-Section1115.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp).