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Key Medicaid Reform Elements in States Adopting DRA State Plan Amendments: Idaho, Kansas, Kentucky, and West Virginia

**Prepared for the
Missouri Foundation for Health
and the Health Care Foundation
of Greater Kansas City**

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FORWARD

The Missouri Foundation for Health (MFH) and the Health Care Foundation of Greater Kansas City (HCF) engaged Health Management Associates (HMA), a national health policy consulting firm, to conduct a multi-phase project examining the recent history of Medicaid in Missouri and detailing the Medicaid reform environment across the country.

The first phase, the subject of the current report, includes case studies that examine the four states that have used the Deficit Reduction Act (DRA) of 2005 to reform their Medicaid programs.

Phase II is a distillation of the various Medicaid reform initiatives being proposed and undertaken in states across the nation. HMA was instructed to focus on a series of reform options that the Foundations believed to be particularly relevant to the Medicaid reform debate in Missouri.

A third phase entails an analysis of the impact of the Medicaid cuts enacted in 2005. Because data for 2006 are not yet available, the phase three project will emerge late in 2007.

MFH, HCF, and HMA do not take positions on the merit of any of the reform options. Instead, through the analyses prepared by HMA, the Foundations intend that this report and the other reports generated by the project will stimulate discussion, inform debate, and contribute to the engagement in the state's public policy process of the many Missourians with a stake in Medicaid reform.

This paper and its executive summary may be accessed on the MFH website at www.mffh.org/policy_medbasics.html.

Glossary of Frequently Used Acronyms

ADLs - Activities of Daily Living
CBO - Congressional Budget Office
CDHC - Consumer Directed Health Care
CMS - Centers for Medicare and Medicaid Services
CNOM - Costs Not Otherwise Matchable
COPD - Chronic Obstructive Pulmonary Disease
CPI - Consumer Price Index
DHHS - Department of Health and Human Services
DRA - Deficit Reduction Act
DSH - Disproportionate Share Hospital
EBAP - Enhanced Benefits Account Program
EPSDT - Early and Periodic Screening, Diagnosis, and Treatment
ED - Emergency Department
ESI - Employer-Sponsored Insurance
FEHBP - Federal Employees Health Benefit Program
FPL - Federal Poverty Level
FQHCs - Federally Qualified Health Clinics
HCBS - Home and Community Based Services
HMO - Health Maintenance Organization
HOA - Health Opportunities Account
HAS - Health Savings Account
IADLs - Instrumental Activities of Daily Living
ICFs/MR - Intermediate Care Facilities for persons with Mental Retardation
LTC - Long-Term Care
MCAC - Medical Care Advisory Committee
PDL - Preferred Drug List
PHA - Personal Health Account
PRTF - Psychiatric Residential Treatment Facilities
RHCs - Rural Health Clinics
SCHIP - State Children's Health Insurance Program
SNF - Skilled Nursing Facility
SPA - State Plan Amendment
SSI - Supplemental Security Income
TANF - Temporary Assistance for Needy Families
TWWIIA - Ticket-to-Work and Work Incentives Improvement Act
UPL - Upper Payment Limit

INTRODUCTION

The Deficit Reduction Act of 2005 (DRA), signed on February 8, 2006, made a series of significant changes to the Medicaid program. Some changes reduce spending, while others create new eligibility groups or other opportunities for states to increase the size of their programs. Overall, the Congressional Budget Office (CBO) projects net savings of \$6.9 billion from 2006 to 2010 due to the DRA Medicaid provisions.

Of particular interest are the DRA provisions granting states flexibility, which have implications for certain historic concepts under which Medicaid has operated as a benefit entitlement. Prior to the DRA, state Medicaid programs were required to meet standards under the concepts of:

- *Statewideness*: A state's Medicaid services are required to be offered on a statewide basis. The state cannot limit assistance by geographic area; and
- *Comparability*: A state's Medicaid benefits have to be comparable in amount, duration, and scope of services for required coverage groups. A state cannot provide a range of benefits for one group (e.g., children) and a more limited or different range of benefits to another group (e.g., disabled adults).

Other broad concepts still apply to the state's Medicaid entitlement (e.g., coverage must meet tests of reasonableness, medical necessity, and non-discrimination), but the DRA greatly relaxed the federal conditions for statewideness and comparability.

A number of states are pursuing reform agendas of varying degrees of comprehensiveness through the DRA. In fact, states that approach the federal Centers for Medicare and Medicaid Services (CMS) with reform concepts they would like to pursue through Section 1115 demonstrations are being steered toward using DRA state plan amendment (SPA) authority to the greatest extent possible. Making changes through the DRA provisions, as opposed to a waiver, appears to be the strong preference of CMS.

Although the DRA permits states to enact a wide variety of changes to their Medicaid programs, it lacks one important feature, i.e., the ability to cover non-disabled adults without dependent children through Medicaid. This remains a so-called "noncategorical" population because there is no corresponding Medicaid eligibility category for this population. States desiring to decrease the rate of uninsurance by covering childless adults still must use Section 1115 authority. Therefore, the many possible impacts to the safety net that the DRA could bring about do not include reducing the number of uninsured childless adults. The following subsections provide background on the DRA and some examples of Medicaid changes states have implemented through this new authority.

DRA BACKGROUND

This section discusses the Medicaid provisions of the DRA. Although all of the major Medicaid provisions are included, particular attention is given to the sections of most interest to the healthcare safety net. The Medicaid sections of the DRA can be roughly grouped into provisions relating to flexibility in benefits and cost-sharing, disability-related provisions, and changes affecting long-term care (LTC).

Flexibility in Benefits and Cost-Sharing

Because of their stake in protecting the interests of low-income Medicaid beneficiaries, safety net providers and advocates have paid perhaps the most attention to the provisions in the DRA that permit states to increase cost-sharing and propose alternative (presumably reduced) benefit packages. As seen in the case studies section of this paper, at least one state has used the DRA benefit flexibility to provide an enhanced benefit package to an eligibility group.

Cost-Sharing

DRA cost-sharing provisions relate to premiums, co-payments, and co-insurance with special provisions for prescription drugs and emergency services. Section 6041 provisions of the DRA, which allow increased cost-sharing above nominal amounts, apply only for individuals with incomes above 100 percent of the federal poverty level (FPL). In 2007, the FPL is \$20,650 for a family of four. For individuals with family income between 100 percent and 150 percent of FPL, cost-sharing is limited to no more than 10 percent of the cost of services. Premiums may not be imposed for this income group.

For individuals with family income above 150 percent of FPL, states may impose cost-sharing of up to 20 percent of the cost of service. Premiums may also be charged, although the DRA specifies several exempt groups from premiums. Exempt groups include:

- mandatory children under age 18,
- certain special needs children even if they are over 18,
- pregnant women,
- terminally ill patients receiving hospice care,
- institutionalized individuals who are required to pay for the costs of their care (retaining only a personal needs allowance), and
- women who are covered under the breast and cervical cancer eligibility group.

Certain services are also exempt from cost-sharing. In addition to a stipulation against service-related cost-sharing for members of the groups mentioned in the preceding paragraph, cost-sharing cannot be required for emergency services, family planning services and supplies, and preventive services for persons under 18 regardless of income. States may exempt other services and groups from cost-sharing at their option.

All cost-sharing (in aggregate for a family) is subject to an overall cap of 5 percent of family income. States may choose to apply this family cap on a monthly or quarterly basis.

ENFORCEABILITY

The DRA allows states to make cost-sharing “enforceable,” which is a significant change to Medicaid. Prior to the DRA, a service could not be withheld based on the patient’s inability to meet cost-sharing requirements. Through DRA authority, states may terminate an individual’s eligibility for non-payment of premiums 60 days or more delinquent, and states may allow providers to make the payment of cost-sharing a requirement for receiving services. This is a particular concern for safety net providers, because they would be less likely to “enforce” cost-sharing, or in some cases are prohibited from denying services and, thus, would be forced to “eat” the difference between a reduced Medicaid payment and the required cost-sharing. In addition, safety net providers may experience an increase in non-paying consumers where individuals become uninsured due to non-payment of a premium or are unable to access other service providers due to cost-sharing enforcement. Such individuals would be more likely to seek services from the safety net as other options become limited.

PHARMACY COST-SHARING

Under Section 6042 of the DRA states may impose higher cost-sharing for drugs they designate as “non-preferred,” and may waive or reduce the cost-sharing for preferred drugs. Non-preferred drugs cost-sharing cannot exceed nominal amounts for individuals with family income that does not exceed 150 percent of FPL. In families with income above 150 percent of FPL cost-sharing is limited to 20 percent of the cost of the drug.

Families earning at or below 100 percent of FPL remain subject to pre-DRA cost-sharing authority, which is silent with respect to cost-sharing for preferred drugs.

Issues may arise for states that wish to implement the DRA provisions as certain protections spelled out in the DRA do not have corresponding protections for the exempt and lower-income

groups. For instance, under the DRA, states must charge no more than the preferred drug cost-sharing amount for non-preferred drugs when the prescribing physician determines that the preferred drug would not be effective and/or would have adverse health effects. No such provision exists for those populations subject to pre-DRA cost-sharing. States presumably would have an interest in applying consistent policies across eligibility groups, but this may be an area that requires monitoring. However, the primary impact of non-preferred drug cost-sharing would be to shift market share presumably from brand name (non-preferred) drugs to generics.

NON-EMERGENT EMERGENCY DEPARTMENT SERVICES

States may impose increased cost-sharing for non-emergency services delivered in an emergency department (ED), provided certain conditions are met. An alternative provider of non-emergency services must be available and accessible, and the person must be informed (after a screening but before delivery of services) that a co-payment may apply and that they can receive non-emergency care at an available and accessible alternative location. The DRA also includes a requirement that federal funding be available to states to establish alternative non-emergency providers. The Secretary of the Department of Health and Human Services (DHHS) is to give preference to states that use providers or networks of providers that serve rural or underserved areas, or who are in partnership with local community hospitals. This could represent an opportunity for safety net providers such as Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to either expand or establish new partnerships.

Benchmark Benefit Packages

Under Section 6044 of the DRA, states may establish alternative benefit plans for certain Medicaid eligibility groups. These plans, referred to as benchmark benefit packages, can be provided only to those eligibility groups that were included in a state's plan on or before the date of enactment of the DRA. A state cannot establish a new eligibility group and provide a benchmark benefit package; however, it is permissible to establish new income eligibility criteria for an existing eligibility group and apply the benchmark benefits to the expanded group.

States can require mandatory enrollment into a benchmark benefit package for some categorically needy groups, such as children and low-income parents. However, many groups are exempt from mandatory enrollment. For these groups, a state may offer benchmark benefits on a voluntary basis:

- mandatorily eligible pregnant women (with incomes up to 133% of FPL),
- blind and disabled persons,

- dual eligibles (persons eligible for Medicaid and Medicare),
- terminally ill hospice patients,
- foster and adoption assistance children,
- those receiving Medicaid LTC services, and
- women in the breast and cervical cancer group.

The options for benchmark benefit packages are nearly identical to the benefits states can elect to offer under the State Children's Health Insurance Program (SCHIP). These include the standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefits Program (FEHBP), the package offered to state employees, the package offered by the largest commercial Health Maintenance Organization (HMO) in the state, and "secretary-approved coverage." Secretary-approved coverage may include any health benefits coverage that the Secretary of DHHS determines would be appropriate for the targeted group. States may also provide "benchmark-equivalent" coverage, if they can demonstrate actuarial equivalency to one of the benchmark options and meet minimum coverage requirements for certain services.

For children under age 19, states are required to provide benefits that would otherwise be included in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid benefit. EPSDT requires a state to cover any services or items determined to be medically necessary for a child, even if the services are not ordinarily covered by the Medicaid program.

Of interest to safety net providers is a provision relating to FQHCs and RHCs. States implementing benchmark benefit plans are required to ensure access to FQHCs and RHCs and to maintain the Medicaid prospective payment system for their services.

Health Opportunity Accounts

Another noteworthy provision establishing added benefit flexibility is Section 6082 of the DRA, which requires the Secretary of DHHS to establish no more than 10 demonstration programs to test the concept of a health savings account (HSA) model referred to as a Health Opportunity Account (HOA). The HOA, generally limited to \$2,500 for an adult or \$1,000 for a child, would be used to pay for health care services before accessing standard Medicaid benefits. The same groups that cannot be required to use benchmark benefits are excluded from participating in an HOA demonstration. In addition, a state cannot require enrollment into an HOA, but can only offer such a plan for voluntary enrollment.

CMS has not approved any demonstration projects to date, but several states have expressed interest in applying for the demonstrations. South Carolina, Washington, and Texas indicate an interest in using HOAs in their existing Medicaid programs while Indiana is considering the concept as a means to expand health coverage for low-income adults.¹ The impact of such initiatives for the safety net can only be speculative due to the voluntary nature of the program. Shifts in Medicaid utilization patterns could be an issue if consumers seek lower cost providers as an alternative to safety net providers.

Disability-Related Provisions

Medicaid Buy-In for Disabled Children

Section 6062(a)(1) of the DRA establishes a new eligibility group for children who meet the SSI disability criteria but who do not qualify for Medicaid because of their family income. States have the option to establish an eligibility group for these children so long as their family income does not exceed 300 percent of FPL. States can charge premiums on a sliding scale according to income. In cases where parents have access to employer-sponsored insurance (ESI) and the employer pays at least 50 percent of the premium, states must require enrollment in the employer plan in order to participate in the Medicaid buy-in option.

Alternatives for Psychiatric Residential Treatment Facilities

Section 6083 establishes a five-year demonstration project for programs that provide an alternative to psychiatric residential treatment facilities (PRTF) for children. Previously, the only home and community based services (HCBS) option for children with mental illness was to establish a Section 1915(c) waiver for children who would otherwise need care in a psychiatric hospital. Under this program, states will be able to test the cost effectiveness of providing community-based options in lieu of PRTF services. On December 19, 2006, CMS announced that the grantee states are Alaska, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina, and Virginia.

Money Follows the Person Demonstration

Section 6071 establishes a program for states wishing to transition individuals from institutional settings to the community. Under the competitively awarded program, states receive enhanced federal funding for HCBS for 12 months following an individual's transition out of an institutional setting. After the 12 months of enhanced federal funding, states are required to continue to provide Medicaid services in the community. States receiving grants under this program, announced on January 12, 2007, are Wisconsin, New York, Washington, Connecticut,

Michigan, Oklahoma, Arkansas, Maryland, Nebraska, New Hampshire, California, Indiana, Texas, and South Carolina.

Long-Term Care Provisions

State Plan Option for HCBS

Section 6086 establishes a state plan alternative to Section 1915(c) waivers for HCBS for individuals who would otherwise need institutional care in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR). Instead of providing these services through a waiver that must be renewed on a periodic basis, states can now submit a SPA. Unlike HCBS waivers, there is no cost effectiveness test. Another difference is that instead of using the same level of care criteria for HCBS and institutional care, the new state plan option requires states to establish a more stringent level of care test for institutional settings.

The 1915(c) waivers open up Medicaid eligibility to individuals who would qualify if they were in an institutional setting without regard to the fact that they are in the community. Therefore, the same preferential income treatment (up to 300 percent of the SSI standard, which equates to approximately 220 percent of FPL) that applies to institutional care applies to HCBS waiver services, as long as the state uses that standard for the institutional setting. Under the SPA option, states can provide HCBS to individuals with income up to 150 percent of FPL, but only if they are in a group already included in the state plan, and only if they meet the functional level of care criteria. Unlike the 1915(c) waivers, the SPA option does not confer Medicaid eligibility to individuals who would not otherwise qualify.

Changes to Asset Transfer Rules

One of the major revenue-generating features of the DRA for Medicaid is the mandatory tightening of the rules around qualifying for Medicaid payment of LTC services after disposing of assets at less than fair market value. Section 6011 targets individuals who dispose of financial assets in order to qualify for Medicaid to pay for the cost of LTC services. Under the DRA, there is a longer “look-back period.” That is, the period of time during which an individual cannot dispose of assets and still qualify for Medicaid has increased from 36 months to 60 months.

In addition, the DRA establishes a different start date for the penalty period. The penalty period is the number of months before Medicaid will pay for LTC in the case of asset disposal. The length of the period, which has not changed, is calculated by dividing the value of the assets that were disposed of by the monthly cost of LTC. Rather than beginning on the date assets were

transferred or disposed of, the penalty period now begins on the date that Medicaid would have otherwise begun paying for LTC services if the individual did not have assets. The cumulative effect of these provisions is a tightening of eligibility for Medicaid payment of LTC services, and presumably a strong deterrent against disposing of assets for the purpose of qualifying for Medicaid.²

DRA Policy Limitations and Implications for Safety Net Providers

Limitations

Some of the provisions in the DRA can be seen as allowing states a great deal of flexibility without having to seek Section 1115 waiver authority from CMS. For example, the benchmark benefit authority permits states to offer different benefit packages to different groups through a SPA. Previously, waiver authority would have been required. In addition, a SPA for HCBS offers an alternative to Section 1915(c) waivers. However, in the past states often sought Section 1115 authority as a way of financing coverage of the uninsured. There are two key features of many states' Section 1115 waivers that cannot be implemented through a SPA 1) coverage for non-disabled adults without dependent children, and 2) the diversion of disproportionate share hospital (DSH) or upper payment limit (UPL) payments to cover the uninsured. Often, these two features exist side-by-side: DSH and/or UPL payments are used as a funding source to cover childless adults. Therefore, the large number of uninsured low-income adults who cannot qualify for Medicaid because they do not fit into one of the statutory categories will remain a key responsibility of safety net providers unless a state uses 1115 waiver authority for coverage expansion.

Enhanced DRA flexibility could have another potential impact on the safety net by changing CMS' approvals of 1115 waivers. Historically, states used benefit and cost-sharing adjustments through Section 1115 waivers as a way to generate savings to finance coverage of childless adults within the context of the required budget neutrality agreements. States have also used Section 1115 to refinance state-funded programs as "costs not otherwise matchable" (CNOM) in order to free up state resources to use as match for coverage expansions. However, recent discussions between states and CMS on pending or proposed Section 1115 demonstrations point to a new reluctance on CMS's part to consider CNOM arrangements. In addition, in establishing budget neutrality under Section 1115 demonstrations, CMS may in the future be unwilling to count savings from program changes (e.g., benchmark benefit packages) that alternatively could be implemented through a state plan change. Technically, the budget neutrality agreement should

only count savings that occur when compared to projected costs in the absence of a waiver. However, CMS has applied this policy inconsistently in the past.

Another DRA limitation is the usefulness to states of the new HCBS state plan option. Because eligibility is limited to those already covered in the state plan, unlike the Section 1915(c) waivers, states will likely find advocate communities resistant to replacing waivers with a SPA for HCBS. Should states decide to operate the SPA and waiver options for HCBS concurrently, the benefit of a new option that uses a less restrictive level of care definition for HCBS services than the institutional equivalent should not be overlooked.

Finally, the income restrictions in the DRA cost-sharing provisions could limit their usefulness for some states under their existing Medicaid programs simply because a state's income eligibility criteria, especially for adults, fall below the threshold for which the cost-sharing provisions apply. The DRA cost-sharing flexibility may have greater potential implications for children as states tend to offer coverage for children at higher family income levels. For instance, as of July 2006 only 13 states and the District of Columbia provided adult coverage above 150 percent of FPL in their Medicaid program, the threshold for applying DRA premiums (and eight of those 15 already impose premiums through a Medicaid waiver). This is in contrast to Medicaid coverage for children, which exceeds 150 percent of FPL for at least one age group in all but 15 states. However, 17 states cover only infants above 150 percent of FPL which intuitively would seem an unlikely group for which a state would choose to impose premiums.³

Implications of "Creative" Redesign

Apart from the limitations to DRA flexibility, the case studies illustrate creative uses of DRA provisions that have interesting implications. In some cases, states have found uses for the new flexibility that could not have been predicted at the time the law was enacted.

For instance, the benchmark benefit flexibility was intended to give states the option to offer lower cost benefit packages to certain populations. For many populations, including the disabled, states are prohibited from requiring enrollment into a benchmark benefit package. Presumably this offers protection against states reducing benefits for the most vulnerable populations. However, Idaho developed an approach that possibly circumvents the prohibition against mandatory enrollment in benchmark packages for certain populations. Idaho provides voluntary enrollment into a benchmark benefit package but is proposing to remove optional services, including prescription drugs, from its standard Medicaid state plan benefit. If the SPA removing

optional services is approved by CMS, it would be unrealistic to expect any significant number of enrollees to stay with standard Medicaid when it is only possible to obtain services such as prescription drugs through the benchmark plan. It is highly unlikely that the Congressional drafters anticipated states would make major changes to their Medicaid programs in order to enhance the attractiveness of benchmark packages for populations who are exempt from mandatory enrollment.

However, the creativity of states in testing the limits of the DRA also has a positive side. Kansas successfully used the benchmark benefit package provision to add a personal care services package to the benefits provided to individuals who buy into Medicaid through the Ticket to Work and Work Incentive Improvement Act (TWWIIA) eligibility group. Previously, the state would not have been able to accomplish such a change without adding the services to the state plan for all populations. In cases where a state is reluctant to add a benefit because of cost concerns, the benchmark benefit package option can provide the opportunity to add a targeted benefit that will be useful to a specific eligibility group.

Public Input

One important element to understand with state DRA options is the opportunity for input from stakeholders, advocates, and the general public. Typically, Section 1115 waiver applications are subject to a fair degree of public scrutiny. SPA applications, by contrast, are often approved “under the radar screen.”

When a state wants to modify its Medicaid program, the Medicaid agency files a SPA with CMS. CMS reviews the SPA to assure that it meets statutory and regulatory requirements. As long as a SPA complies with federal Medicaid program requirements, CMS must approve it, although this is sometimes preceded by considerable negotiation between the state and CMS. Each state follows its own rules or processes regarding when and how SPAs are proposed and developed at the state level. While there is no explicit federal requirement for states to provide for public input in the development, review, or implementation of a SPA, federal regulations require all Medicaid agencies to establish a Medical Care Advisory Committee (MCAC), which must include consumer and provider representatives, to provide input regarding program policy.⁴ Depending upon the state, MCAC committee meetings may provide some opportunity for public engagement in the policy process. In addition, the extent to which a state’s Medicaid program is detailed in regulatory or statutory code affects the opportunity for public input when program changes are proposed.

Section 1115 waivers confer much broader flexibility, and as such, are subjected to more scrutiny both at the state and federal levels. In the early 1990s, states saw opportunities to use Section 1115 authority to implement statewide health care reform proposals. In response to stakeholder concerns at that time over section 1115 waivers' far-reaching implications and inadequate opportunity for public input, DHHS issued a Federal Register notice in 1994⁵ indicating federal intent to ensure opportunities for public input into the waiver process at both the federal and state levels. The policy requires states to provide a brief description of how the state provided opportunities for public input when submitting waiver proposals. It also lists potential approaches that states can use to solicit public input. States are "expected" to use one or more of the following processes:

- Conduct one or more public hearings, including opportunities for public comment;
- Establish a commission where meetings are open to the public;
- Enact a proposal by the state legislature;
- Provide for a formal notice and comment period pursuant to the state administrative procedures act (so long as notice is given at least 30-days prior to submission of the policy change to the federal government);
- Publish notice in a local newspaper, provide opportunity for the public to receive a copy of the draft proposal, and provide for a 30-day period for public comment; and/or
- Conduct any other process that provides interested parties with an opportunity to learn about and comment on the contents of the proposal.

The 1994 Federal Register notice also established a federal process for public input with DHHS intent to give notice of all new and pending section 1115 demonstrations, as well as to provide a 30-day comment period before taking official action.⁶ Initially, the Health Care Financing Administration (now CMS) published information on waiver applications in the Federal Register every 90 days. However, CMS has not provided a federal level notice and comment period pursuant to this policy since 1998,⁷ reasoning that it now considers states a more appropriate venue for public input.⁸ In May 2002, a State Medicaid Director Letter that reinforced to states the importance of public input and reiterated DHHS's commitment did not include a similar reinforcement of DHHS's original intent to provide federal notice and a comment period.⁹

Irrespective of the fact that not all of the provisions of the 1994 Federal Register notice are being followed by CMS, it remains the case that stakeholders may have a greater chance of influencing the Section 1115 process than the SPA process, since DHHS has more leeway to disapprove Section 1115 proposals that it deems to be contrary to public interest or the goals of the Medicaid program.

SUMMARY OF KEY ELEMENTS IN STATE PLANS

As noted previously, a number of states have taken interest in the various DRA demonstration projects, but very few have applied for SPAs under the optional provisions which offer states flexibility to change their benefit and cost-sharing structures, or under the LTC options for HCBS. As of February 2007 the CMS website listed only four states with approved amendments: Idaho, Kansas, Kentucky, and West Virginia. This response is not so much an indication of state interest in these provisions as it is an indication of the shift in CMS's preference for using DRA authority over that of Section 1115 waivers where possible, and the timing of state initiated reform. Idaho, Kentucky, and West Virginia were all fairly well along in pursuing Section 1115 waivers when the DRA was passed.

The primary elements contained in the SPAs discussed in these case studies include:

- benefits targeted to discrete Medicaid groups,
- new cost-sharing provisions for standard Medicaid and for new alternative benefits,
- healthy behavior incentives,
- ESI components,
- HCBS components,
- consumer directed health care (CDHC) options, and
- chronic disease management components.

Similarities and Differences in Reform Elements

The four state case studies provide a glimpse of the degree of flexibility states have with the new DRA provisions. There are important similarities between all four SPAs, but perhaps more interesting are the differences in approach each state has taken, as these reflect the ability of states to utilize the DRA to meet their own particular program needs.

Scope

One striking difference among the four states is the scope of the changes pursued through the SPAs. Kentucky and Idaho, for instance, implemented broad changes to their programs with new benefit structures, cost-sharing arrangements, and other elements such as disease management and healthy behavior incentives. This is in contrast to the Kansas SPA that targeted a very specific benefit package to a relatively small Medicaid eligibility group.

Context

In contrast to the sweeping program changes seen in the Massachusetts and Florida 1115 waivers approved in 2005, the DRA appears to have fostered a more complex, incremental approach to reform. It is noteworthy, for instance, that all three of the states that were the first to receive approval of DRA-related SPAs (i.e., ID, KY, and WV) have initiated a number of changes to their programs in addition to the DRA-related amendments. As noted previously, these three states were in the process of applying for Section 1115 waivers when the DRA was enacted, so both the SPAs and the additional program changes are in keeping with each state's vision of more comprehensive program reform. It is also worth noting that some reform elements envisioned in each of these state's original waiver proposal are still under development and/or negotiation with CMS, and it is possible that some of these proposed changes will still require a waiver. For instance, both Idaho and Kentucky are seeking changes to LTC delivery and are exploring options available under both the DRA and through amendments or extensions to HCBS waivers.

Key Elements

Table 1 summarizes key elements in each of the four SPAs. The primary similarity between all four states is the utilization of the DRA benefit flexibility provision to target a set of benefits to specific and discrete Medicaid eligibility groups. Three of the four case study states also use incentives to encourage healthy behaviors or use some form of a CDHC option. However, this is the extent of the similarities.

The application of the benefit flexibility option varies greatly in breadth and scope from one state to the next. Kansas layers less than a half-dozen support benefits on top of the standard Medicaid benefit for one target group (i.e., the working disabled eligible for the state's TWWIA program). West Virginia has two benefit packages targeting the Medicaid eligibility groups for which the DRA allows mandatory participation (i.e., healthy children and adults). However, Kentucky and Idaho collapse nearly all of their Medicaid eligibility categories into three or four groups, restructure the standard Medicaid benefit, and offer different benefit packages customized for each of the new groups. The new benefit packages restrict or eliminate some benefits that were previously available under the standard Medicaid benefit, and also add new benefits that further specific objectives for each of the different targeted groups (e.g. school-based health services for children, LTC services for the disabled, etc.).

Table 1: Key Elements in DRA-Related SPAs				
Key Element	Idaho	Kansas	Kentucky	West Virginia
Benefits Targeted to Specific Medicaid Groups	■	■	■	■
• New benefit restrictions	■		■	■
• New benefit offerings	■	■		■
Cost-Sharing	■		■	
• Benefit/services co-pays			■	
• Non-preferred drug co-pays			■	
• Non-emergency ED co-pays	■		■	
• Cost-sharing enforcement			■	
• New premiums	■			
ESI Component	ON HOLD		■	
Healthy Behavior Incentives	■		■	■
New HCBS	PENDING	■	PENDING	
Consumer Directed Options	■	■	■	
Disease Management Component	■		■	

Kentucky, Idaho, and West Virginia all offer incentives to promote healthy behavior among those that participate. Kentucky and Idaho offer “credits” or cash equivalent mechanisms to recipients for participating in state defined activities (e.g. disease management, smoking cessation, or child wellness exams). West Virginia has structured its alternative benefits as an incentive program, offering enhanced benefits for members that comply with an agreement that lists a number of healthy behaviors the state wants to promote, and scaling back benefits for those that do not enter into the agreement or fail to comply.

The case studies below provide more detail about the four programs. However, it appears that the DRA provides a fair degree of flexibility to consider other approaches that meet the needs of a particular state, whether narrow or broad in scope. The state’s existing Medicaid program structure, including benefit and eligibility criteria, also plays a role as DRA restrictions and protections for certain populations and income groups may limit the usefulness of some of the provisions for a state.

CASE STUDIES

The four case study states illustrate the flexibility offered under the DRA and the range of possibilities a state may consider in its approach to using the provisions.

- *Kentucky*: The state uses DRA flexibility to establish new cost-sharing and benefit limits in its standard Medicaid benefit and to establish four new benchmark benefit packages tailored to specific Medicaid groups with varying cost-sharing structures.
- *Idaho*: The state collapsed nearly all of its Medicaid eligibility groups into three and established three new benchmark benefit packages targeting different benefits to each of the specific groups.
- *West Virginia*: The state uses DRA flexibility to provide an “enhanced” benefit package to individuals who sign and comply with a member agreement regarding activities with a positive health impact.
- *Kansas*: The state uses a DRA benchmark benefit package to provide “wrap-around” personal care services for individuals who buy into Medicaid under the TWWIA.

Kentucky

CMS approved several SPAs on May 3, 2006, related to Kentucky’s Health Choices Medicaid reform plan. The amendments:

- establish co-pays and benefit service limits for Global Choices, the state’s standard Medicaid benefit;
- establish four alternative benchmark benefit packages, three of which include co-pays and benefit limitations, and one which allows a member to opt out of Medicaid to ESI coverage; and
- create healthy behavior incentives linked to chronic care management for a number of chronic conditions.

Kentucky’s Benefit Structure

Global Choices is Kentucky’s “default” standard Medicaid benefit. Kentucky’s mandatory Medicaid populations (including mandatory children), optional spend down populations, pregnant women, and the aged and disabled who do not meet nursing facility level of care remain covered under Global Choices. Also, any individuals who do not choose to enroll in an optional alternative benefit plan (described below) receive Global Choices benefits.

Kentucky established new service limitations and increased co-payments for services within Global Choices. Children, pregnant women, the institutionalized, and those receiving hospice services served through Global Choices are not subject to cost-sharing.¹⁰ The state applied limits to such services as chiropractic (15 visits annually for adults and seven per year for recipients under 21 years of age); hearing and vision services (eliminated for adults; children are limited to one annual hearing evaluation, limited follow-up visits for hearing aids, and one pair of

eyeglasses per year) home health services; and physical, occupational, and speech therapies (limited annual number of visits).

Family Choices is the benchmark benefit package for Medicaid children (except those eligible through Temporary Assistance for Needy Families (TANF), foster care, and adoption assistance who are served under Global Choices) and KCHIP (Kentucky's SCHIP program) children. Enrollment is mandatory for the population served in this program. The benefit limits vary for Medicaid eligible children (including KCHIP Medicaid expansion children) and those served under a separate KCHIP benefit program. The KCHIP-separate program children do not receive non-emergency medical transportation, treatment services per EPSDT, or substance abuse services. Family Choices has more generous vision services than Global Choices but more restrictive home health benefits.

Comprehensive Choices is the benchmark benefit package that targets the elderly and disabled meeting nursing facility or institutional level of care, including those that receive waiver services. Enrollment into the plan is optional. Some benefits are subject to limits but co-pays under this plan are generally lower than those for Global Choices.

Optimum Choices is the alternative benefit package that targets individuals who meet the ICF/MR or developmental disability level of care. Enrollment is optional and the benefit limits and service co-pays are identical to those under Comprehensive Choices. The state, however, continues to negotiate with CMS to establish tiered benefits for this group, based on an individual's health condition, which would provide an expanded array of services focusing on community based services and a continuum of care. The state is considering options to amend their current 1915(c) waivers to further develop this benefit option.

Comprehensive and Optimum Choices serve populations the DRA exempts from mandatory enrollment so enrollment is optional. Beneficiaries will likely find these two options attractive, however, because of potentially lower out-of-pocket expenses due to lower cost-sharing requirements, and less restrictive limits on some benefits.¹¹

Employer-Sponsored Insurance

ESI is a benchmark benefit for individuals who opt for premium assistance and participation in an employer's plan instead of Medicaid. The state took a novel approach to expanding access by establishing ESI as an alternative benchmark-equivalent benefit package. The option is available

to any recipient except children, who are entirely excluded. ESI benefits are benchmarked to the Kentucky State Employee Essential Health Insurance Plan. The state does not provide any additional wrap-around services. Recipients receive premium assistance but are subject to service limitations and cost-sharing imposed by the employer’s plan. Individuals who wish to receive ESI benefits submit their request along with the Schedule of Benefits under their employer’s plan and the state determines whether plan benefits are actuarially equivalent to the benchmark plan and whether the plan “is cost effective and meets economy and efficiency principles.” The plan must meet these criteria to be approved. Individuals that opt for ESI may opt out at any time and revert back to Medicaid coverage.¹²

Table 2 shows the benefit and cost-sharing differences between Kentucky’s various plans. According to the SPAs, in Medicaid and the three alternative plans (excluding the ESI plan) the benefits, services, and monetary limits are “soft” limits. These limits may be overridden when medical necessity is established (except for those benefits associated with age,¹³ and for the monetary limits on hearing aids and eyeglasses). Based on this, the benefit restrictions may not pose significant issues for beneficiaries but do increase the potential for service delays if the process for establishing medical necessity is overly burdensome. It also should be noted that the SPAs establishing the benefit packages address medical services only, leaving LTC to be dealt with through other avenues.

Table 2. Benefit Service Limits in Kentucky Health Choices

	Global Choices	Family Choices	Comprehensive Choices	Optimum Choices	ESI
Benefits Subject to Service Limits	Home health; occupational, physical, and speech therapies; audiometric; chiropractic; and dental. All benefit service limits are “soft” and may be overridden if medically necessary through a prior authorization process.	Same as Global but with more restrictive limits on home health services and less restrictive limits on vision services. EPSDT, non-emergency transportation, and substance abuse services apply to Medicaid recipients only.	Same as Global but with less restrictive limits on occupational, physical, and speech therapies and lower cost-sharing.	Same as Global but with less restrictive limits on occupational, physical, and speech therapies and lower cost-sharing.	Subject to plan benefit limits – No Medicaid wrap-around.

Cost-Sharing

Kentucky restructured cost-sharing for Global Choices (i.e., the standard Medicaid benefit) and for the three benchmark benefit plans. All of the new cost-sharing levels fall within the nominal cost-sharing requirements under pre-DRA authority. However, the state does use DRA authority to apply different cost-sharing structures for each of the plans, which is designed to entice enrollment into the alternative benchmark benefit packages for optional populations. For instance, under the Comprehensive and Optimum Choices plans, no co-pays are applied for physician services, vision, dental, chiropractic, and hearing services. Under Global Choices a \$2 co-pay applies. These do not represent extreme differences, but they may be sufficient to obtain the desired enrollment.

The state also opted to allow cost-sharing enforcement for pharmacy providers only. Pharmacies may not refuse services to individuals in families with income at or below the federal poverty level, as the DRA enforcement provisions are not applicable for these low-income populations.

Kentucky's Get Healthy Benefits

Kentucky's healthy behavior incentive, called Get Healthy Benefits, combines the enhanced benefit account concept with chronic care management. Only individuals with at least one of several targeted chronic conditions are eligible to enroll. The state has identified several counties for pilot programs in the following areas:

- diabetes,
- pediatric diabetes,
- pediatric asthma,
- pediatric obesity,
- adult obesity,
- cardiac,
- breast and cervical cancer,
- osteoporosis, and
- adult asthma/chronic obstructive pulmonary disease (COPD).

With successful compliance in a disease management program, participants earn additional benefits: up to \$50 for additional vision and/or dental services, or for counseling services in smoking cessation or nutrition. Individuals have six months to utilize benefits and lose the benefits if they become ineligible for Medicaid.

The state is targeting its Get Healthy Benefits program, at least initially, to very specific populations. For instance, the state identified counties with low rates of breast and cervical cancer screenings and high mortality rates for breast and cervical cancer to launch an education and awareness initiative. Monthly birthday card mailings offer \$10 to those who complete a screening. As of February 2007, 3,300 women had received the mailing. The state made available mammography services for three days to several counties with no freestanding or mobile clinics and over three days 68 women who had rarely or never been screened received mammograms while 65 received Pap tests. Similarly, the state has 4,120 individuals enrolled to receive diabetes, cholesterol, and blood pressure screenings as the first step in implementing chronic disease management.

These programs have not been operational long enough to assess their impact on the health of Medicaid members, but it is hoped that with a relatively modest investment through the incentives that members will seek care earlier, will better manage their conditions, and will avoid more serious complications from chronic illnesses.

Long-Term Care

Kentucky explored the SPA option under the DRA for HCBS, but is currently considering other avenues to implement its LTC initiatives. The DRA limits the SPA option for HCBS to recipients with income at or less than 150 percent of FPL while Kentucky's program, like those in many other states, covers individuals up to the allowable 300 percent of the Supplemental Security Income (SSI) standard. This equates to about 220 percent of FPL in 2007. The income standard differential is only one of the problems states encounter when considering this DRA option, and it has been suggested that further federal legislation is required for this to be a workable tool for very many states.

Idaho

Idaho received CMS approval for three alternative benefit plans on May 25, 2006, targeting nearly all of the state's Medicaid eligibility groups:

- the Basic Plan targets healthy adults and children;
- the Enhanced Plan targets the disabled and individuals with special health care needs;
- and
- the Coordinated Plan targets individuals dually eligible for Medicare and Medicaid.

Benefit Structure

All three plans are identified as Secretary-approved alternative benchmark benefit plans. Because all three plans target populations that are exempt from mandatory enrollment, all are an optional enrollment choice to Idaho's standard Medicaid benefit. However, Idaho has taken several steps to "encourage" enrollment into the various plans.

- Individuals are not initially enrolled into the standard Medicaid benefit. After conducting a health assessment, Idaho enrolls individuals into the appropriate optional plan. Individuals then must "opt-out" if they prefer to receive the standard Medicaid benefits. Thus enrollees must take action to retain the standard Medicaid benefits.
- The state has added additional benefits to each plan that would be attractive to the targeted populations; and
- Idaho has applied for a SPA that would scale back the standard Medicaid benefit, essentially eliminating optional benefits under federal regulation, such as pharmacy, therapies, dental services, vision services, and certain prevention and wellness benefits. This reduces considerably any incentive to choose standard Medicaid benefits over the "optional" benchmark benefits.¹⁴

While CMS has not yet approved this third initiative, it raises interesting questions about the extent of state flexibility, the nature of "voluntary" enrollment, and the intent of the DRA legislation with respect to protection of vulnerable populations. Idaho's Enhanced Plan (as it is currently structured) provides all the benefits covered under the state's standard Medicaid benefit (prior to the pending scaled back design). Congress's intent to protect vulnerable populations from possible negative impacts of state coverage decisions under the flexibility provisions (not only what benefits are offered but who may access them) by making enrollment optional is seemingly compromised if the choice is between the "optional" alternative benefit and a significantly diminished Medicaid benefit.

Other than those proposed for the standard Medicaid benefit, other new benefit restrictions and limitations apply only to the Basic Plan for healthy adults and children. The Basic Plan does not include LTC benefits and applies significant limits to mental health services. In addition, some provider specialties, such as rehabilitation mental health services, speech and hearing clinics, independent practical and registered nurse services, mental health, and personal care case management are limited to diagnostic and evaluation services only under the Basic plan. On the other hand, the state added a wellness exam benefit for adults and established school-based preventive and wellness services for children.

The state conducts a health risk assessment during initial enrollment and at renewal to determine placement into a plan. If, however, at any time a medical evaluation determines an individual's health needs have changed individuals can transition from one plan to another.

EPSDT benefits are preserved for children. Services required as a result of an EPSDT screen are not subject to the service limitations in either plan but do require prior authorization if limits are exceeded. Children that are found to have special health care needs receive those benefits through either the Enhanced Plan or as "wrap-around" services to benefits covered under the State plan for children who do not opt-in to an Enhanced Benchmark Benefit Package.

Although CMS approved benefits under the Coordinated Plan, the state indicates that this benefit is still under development. Idaho has proposed to integrate Medicaid and Medicare benefits through enrollment into Medicare Advantage (managed care plans serving Medicare recipients) but CMS approval is still required for this initiative.

Idaho's Healthy Behavior Incentive Program

Idaho includes a member agreement within its personal health account incentive program. The incentive initiative, called Preventive Health Assistance (PHA), has two components with different goals.

- The Behavior PHA targets Medicaid participants that smoke or who are obese;
- The Wellness PHA targets SCHIP participants that are required to pay a premium.

Under the Behavior PHA, individuals who meet the criteria for participation sign an agreement to participate in a weight control program that includes physical fitness, diet, and personal health education, or in an approved tobacco cessation program, as applicable. These participants receive up to 200 points or dollars to use for weight loss program enrollment, tobacco cessation program enrollment and products, gym membership fees, and healthy lifestyle classes as long as all standards are met.

In the Wellness PHA, participants must keep child wellness exams and immunizations up to date. Vouchers worth 120 points or dollars per year may be used for delinquent premiums, as long as the preventive services are current. If a member is not delinquent in paying premiums, the vouchers can be used for athletic safety equipment, sports, or gym memberships with state approval.

Cost-Sharing

Idaho imposed new premiums for children in families earning between 133 percent and 150 percent of FPL but did not use DRA authority to do so. The DRA prohibits states from requiring premiums for Medicaid families earning at or less than 150 percent of FPL. Idaho essentially got around this prohibition by adjusting its SCHIP eligibility requirements from 150 percent of FPL down to 133 percent of FPL for children ages 0 to 5 and to 100 percent of FPL for children above the age of 5. For children in families between 133 and 150 percent of FPL a \$10 per month premium applies. The new premium structure only applies to children in the Basic Plan covered by Title XXI funding (i.e., SCHIP). Children with special health care needs covered under the Enhanced Plan are not subject to premium payments.

Idaho has also enacted a regulation that adjusts nominal cost-sharing amounts as allowed under the DRA Section 6041. This DRA provision requires the Secretary of DHHS to adjust the maximum nominal cost-sharing amounts annually by a rate equal to the medical care component of the Consumer Price Index (CPI).¹⁵

West Virginia

West Virginia was one of the first states in the nation to receive CMS approval for a SPA that establishes alternative benefits for individuals in its Medicaid plan.¹⁶ In West Virginia's case, the alternative benefit package provides an "enhanced" benefit package for beneficiaries who sign and comply with a "Medicaid Member Agreement" and a scaled-back or "basic" benefit package for those who either fail to sign the agreement or who do not fulfill their obligations under the agreement. The SPA alternative benefit package applies to "healthy adults and healthy children on Medicaid." The medically needy and other individuals who "spend down" to eligibility are explicitly excluded from participation, as are other population groups required to be excluded by the DRA.¹⁷

Benefit Structure

While the Basic Plan includes all required state and federal Medicaid mandatory benefits, it establishes limits on some services such as pharmacy (limited to four prescriptions per year), non-emergency medical transportation (10 trips per year for children and five for adults), and home health visits (25 per year). The Basic Plan does not include the following services (all of which are included in the Enhanced Plan):

For children:

- skilled nursing care (limited to 180 days in the Enhanced Plan),

- orthotics/prosthetics,
- tobacco cessation,
- nutritional education,
- diabetes care, and
- chemical dependency and mental health services.

For adults:

- cardiac rehabilitation,
- chiropractic services,
- dental services,
- tobacco cessation,
- chemical dependency and mental health services (limited to 30 days inpatient and 20 visits per year outpatient in the Enhanced Plan),
- diabetes care, and
- nutritional education.

Access to each of the benefit packages is explicitly tied to the Medicaid Member Agreement. An individual must sign the agreement to be enrolled in the Enhanced Plan. Parents must sign on behalf of their children. The Medicaid Member Agreement includes the following 12 member responsibilities:

- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.

- I will let my medical home know when there has been a change in my address or phone number for myself or my children.
- I will use the hospital emergency room only for emergencies.

In order to retain the Enhanced Plan benefits, individuals must comply with the agreement.

During the first year, the state in partnership with the HMO or medical home provider is tracking compliance for the following four responsibilities:

- screenings as directed by their health care provider,
- adherence to health improvement programs as directed by their health care provider,
- missed appointments, and
- medication compliance.

Members who do not fulfill these responsibilities will have their benefits reduced (to the Basic Plan), subject to “good cause” and with the right to appeal. After 12 months and at redetermination, members will have the opportunity to sign the Member Agreement and be re-enrolled in the Enhanced Plan.

West Virginia is the first state to test this approach that conditions a set of services on the behavior of an individual enrollee (or upon parents meeting obligations in the case of children). The state implemented this on a pilot basis in three counties July 1, 2006, and intends to extend it statewide over four years. While the initiative is too new to assess its impact, critics have raised a number of concerns. These are listed below.

EPSDT AND BENEFITS FOR CHILDREN

As is required by the DRA, West Virginia includes EPSDT in the list of services for children under both the Basic and Enhanced benefit plans. At the same time the Basic Plan for children excludes certain services that EPSDT covers and limits other services. If West Virginia denies coverage for diabetes care and mental health services to children who have been determined to need those services, as the scope of the Basic Plan suggests, West Virginia would be out of compliance with the federal EPSDT mandate.

APPLICATION AND ENFORCEMENT

The SPA indicates that providers will be used as the mechanism to monitor and report compliance with the Member Agreement. Besides the philosophical issues related to providers “policing” member compliance, uneven application and enforcement would seem inevitable

under such a plan. For example, “adherence to health improvement programs as directed by their health care provider” could be applied and interpreted quite differently from provider to provider.

APPLICATION OF MEMBER AGREEMENT TO CHILDREN AND TEENAGERS

The SPA provides that “Medicaid members” must voluntarily sign the Member Agreement and children are not explicitly excluded. Young children could not be held responsible for the requirements in the agreement, so parents would sign for their children and be responsible for compliance. It is unclear, however, whether teenage parents would be required to voluntarily sign the agreement and whether there would be a minimum age criteria applied for this purpose. If teenage moms are held accountable for “adherence to health improvement programs as directed by their health care provider,” would teenagers with no children also be held accountable? Further, if only the parents are required to sign the Member Agreement, is the state actually willing to reduce the child’s benefits if the parent fails to adhere to a health improvement program as directed by his or her physician? Apart from the EPSDT issues discussed above, critics find such a result to violate notions of fairness.

HIGH EXPECTATIONS AND UNINTENDED OUTCOMES

Some argue that under West Virginia’s plan Medicaid recipients are held to higher standards and unrealistic expectations that do not exist in other health care delivery systems. There are many reasons for non-adherence to a health care provider’s directives or for missing appointments, for the general population as well as those covered by Medicaid. It is well documented that Medicaid recipients tend to face greater obstacles (e.g., transportation, child care, and cultural and language barriers) that complicate their utilization of services. Furthermore, if individuals lose access to needed services, such as diabetes care or mental health services, they could end up with more serious health conditions requiring more costly health care services, which would not be a beneficial outcome for the state or recipients.

Kansas

Kansas received approval on September 7, 2006, for an innovative (albeit limited) use of the benchmark benefit package flexibility. Under the plan amendment, the Kansas Health Policy Authority established an optional benchmark benefit package for individuals eligible for Medicaid through the TWWIA. The TWWIA group, authorized under Section 1902(a)(10)(A)(ii)(XV) of the Social Security Act, is a buy-in program for working individuals with disabilities. It is intended to provide an incentive to work in the form of a pathway to

Medicaid eligibility for individuals who otherwise would lose eligibility because of their earnings.

Because of the comparability requirement in Medicaid, the TWWIA group previously received the standard Medicaid benefit package, which does not include personal care services. (These services were offered through HCBS waivers; however, TWWIA eligibles cannot enroll in HCBS waivers.) Under the DRA-related SPA, members of the TWWIA group can opt into the benchmark package, which does include personal care services.

According to the SPA document submitted to CMS by the Kansas Health Policy Authority, the added benefits consist of:

Assessment: A person-centered evaluation to determine the need, strengths, and preferences of the individual for personal assistance and related services, as well as the amount of personal assistance and related services required.

Personal Assistance Services: One or more persons assisting a person with a disability with tasks that the disabled individual would typically do for him/herself in the absence of a disability. Such tasks can be related to personal needs as well and community and work-related needs, and assistance may be performed at home, in the community, or at work. Such services may include assisting the consumer in accomplishing any Activities of Daily Living¹⁸ (ADLs) or Instrumental Activities of Daily Living¹⁹ (IADLs). Personal assistance services also includes alternative and/or cost-effective methods of obtaining assistance that substitute for human assistance, to the extent that such expenditures would otherwise be made for human assistance, e.g., a microwave oven, sending out laundry, etc.

Independent Living Counseling: This is provided to individuals who choose self-directed services, and includes orientation; training in self-direction; fiscal management training; assistance in accessing other systems that will enhance independent living and/or employment; assistance in developing the written service plan and service budget; assistance in locating fiscal management services; assistance in locating, interviewing, hiring, supervising, and terminating a personal attendant; assistance in locating emergency back-up care and emergency assistance; assistance in reporting exploitation and/or emotional and/physical abuse to Adult Protective Services; assistance in locating and maintaining services identified in the service plan; and assistance with disenrolling and accessing waiver and/or other services.

Assistive Services: This is defined as any item, piece of equipment, or environmental modification used to increase, maintain, or improve independence, employment, and/or health and safety. Purchase or rent of new or used assistive technology is limited to those items not covered by Medicaid under the state plan, such as ramps, lifts, and modifications to bathrooms and kitchens specifically related to accessibility, and assistive technology that improves communication and/or mobility in the home and work place.

Rather than a way to reduce benefits under the DRA, the Kansas program represents the use of the new benefit flexibility to provide an enhanced benefit to a targeted group.

ANALYSIS OF MISSOURI MEDICAID AND POTENTIAL DRA APPLICATIONS

The DRA offers new flexibility to states in developing cost-sharing, premiums, and benefit packages for Medicaid beneficiaries. However, for all three of these areas the DRA specifies important limitations and restrictions in the application of the flexibility provisions designed to protect more vulnerable populations. These limitations include:

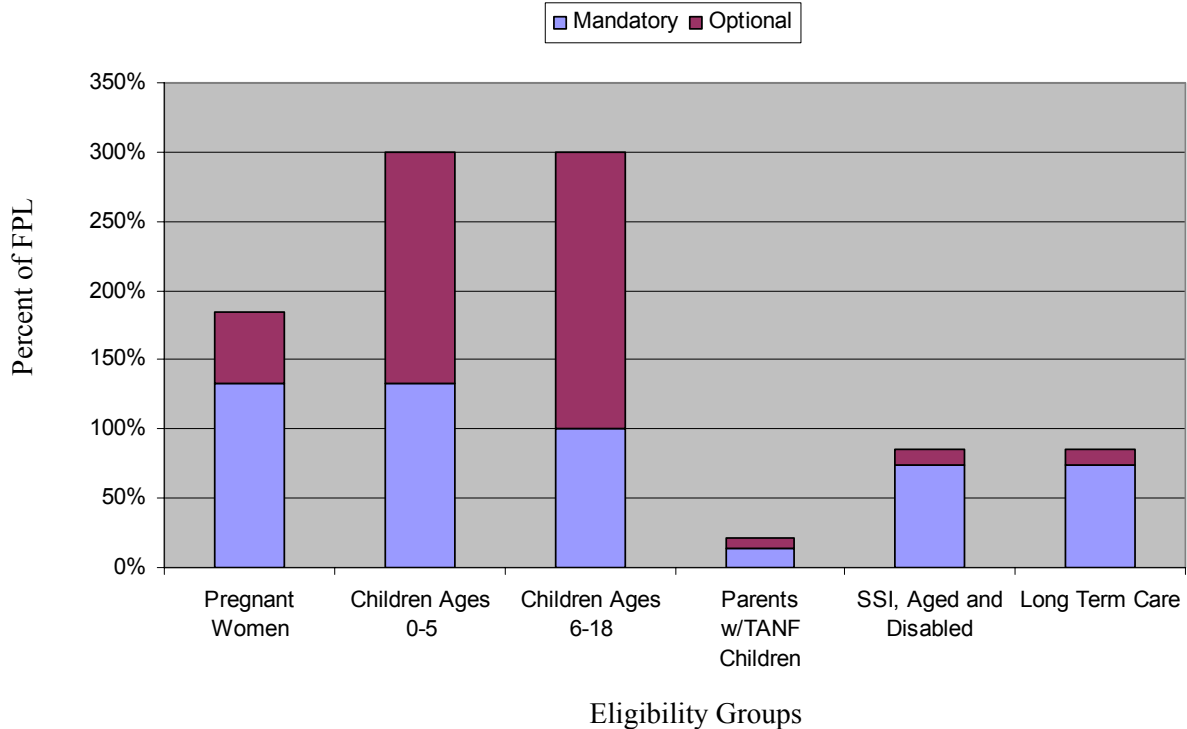
- Cost-sharing flexibility is limited by family income levels and does not apply to those individuals in families with income at or less than 100 percent of FPL;
- Co-payments or co-insurance cannot be imposed for certain specified services;
- Cost-sharing enforcement cannot be imposed for families with income at or less than 100 percent of FPL;
- Special cost-sharing provisions for non-preferred drugs and non-emergent services received in a hospital ED include important member protections such as state requirements to ensure access to medically necessary medications and to assure availability and access to alternatives to the hospital ED;
- State's ability to impose mandatory enrollment into alternative benchmark benefit packages is limited to essentially healthy children and optional adult populations who do not fall into one of the exempt categories, such as pregnant women;
- Alternative benefits can only be used for full Medicaid benefit eligibility groups (i.e. excludes spend-down recipients) covered under a state's plan prior to the DRA, and thus do not provide a tool for expansion to new eligibility groups;
- States must assure continued access to FQHC and RHC services for individuals enrolled in alternative benefit packages; and
- States must allow groups that enroll voluntarily into an alternative benefit plan to opt out to the state's standard Medicaid benefit at any time.

These provisions provide the most latitude for states with large optional adult populations (i.e., populations the federal government does not require receive Medicaid benefits). Missouri provides optional coverage primarily for children (see Figure 1).

In order to better understand the potential for applying DRA provisions in the Missouri Medicaid program, this study analyzed available income, eligibility category, and caseload data. The data do not align precisely with the DRA categories but do allow a rough estimate of the potential impact. Precise estimates can be better prepared by state staff with detailed data, but an approximation of the range of impact and a starting place for the dialogue on the potential

implication for beneficiaries who may be affected by cost-sharing, premiums and benchmark benefit packages allowed under the DRA is provided in the following sections.

Figure 1. Missouri Medicaid Eligibility Levels for Selected Categories, June 2006



Premiums and Cost-Sharing

Based on 2004-2005 data, approximately 61 percent of all Missouri Medicaid beneficiaries would not be subject to DRA cost-sharing provisions because they have family income at or below 100 percent of FPL.²⁰

For the remaining beneficiaries with incomes above 100 percent of FPL (i.e., some pregnant women and children) certain services would also be exempt from cost-sharing under the DRA (e.g. preventive services for persons under age 18 regardless of income, emergency services, and family planning services and supplies). Missouri could choose to impose new or increased cost-sharing for other services but the DRA imposes an aggregate total cap on co-payments and premiums a family can be required to pay. Table 3 illustrates the maximum monthly out-of-pocket expenditures for a family of three under the DRA cap.

Table 3. Maximum Aggregate Family Cost-Sharing Under the DRA for a Family of Three			
2007 Federal Poverty Level	Monthly Income (family of 3)	Monthly Cost-sharing Maximum	Percent of Income Limit
Under 100%		Exempt	Exempt
100%	\$1721	Exempt	Exempt
133%	\$2289	\$114	5%
150%	\$2581	\$129	5%
175%	\$3011	\$151	5%
200%	\$3442	\$172	5%
300%	\$5163	\$258	5%

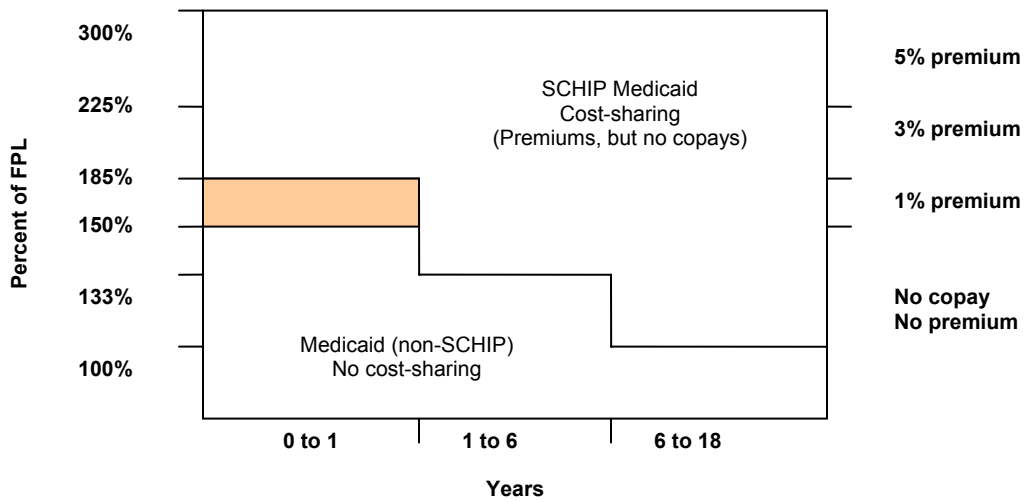
Missouri could consider increasing co-payments for services for children, but perhaps the DRA special cost-sharing provisions for ED services or for non-preferred drugs might be of greater interest to Missouri since the state does not currently impose such cost-sharing. Missouri utilizes a Preferred Drug List (PDL) but its co-payment structure is based on the cost of the drug rather than its status on the PDL. The general DRA cost-sharing provisions also could be an option should the state consider an expansion for adult populations above the 100 percent of FPL income threshold.

Premiums

The DRA premium provisions have limited application given Missouri’s eligibility criteria. Premiums can only be applied to individuals with family incomes above 150 percent of FPL who are not in any of the federally exempt groups (i.e., mandatory children under age 18, certain special needs children even if they are over 18, pregnant women, terminally ill patients receiving hospice, institutionalized individuals who are required to pay for the cost of their care, and women covered under the breast and cervical cancer eligibility group). In Missouri, the only two eligibility groups with incomes above 150 percent of FPL are children and pregnant women, and as noted previously, pregnant women are exempt from premium provisions.

Missouri’s SCHIP program expands Medicaid coverage for all children with family income up to 300 percent of FPL and the state already applies tiered premiums, ranging from 1 percent to 5 percent of family income, for SCHIP Medicaid children in families earning above 150 percent of FPL (Figure 2). While the state could use DRA authority to impose premiums for Medicaid (non-SCHIP) eligible infants up to age one in families earning between 150 percent and 185 percent of FPL (the shaded area in Figure 2), the state already has authority to impose premiums through SCHIP for the vast majority of Missouri Medicaid children.

Figure 2. Missouri Children by Age and Income With Co-pay & Premium Requirements



Source: Missouri Foundation for Health; Missouri Medicaid Basics; Winter 2007.

Cost-Sharing Enforcement

Missouri’s eligibility criteria also limit how the state could utilize DRA cost-sharing enforcement provisions. Again, since this provision does not apply to recipients with family incomes at or less than 100 percent of FPL, Missouri could only impose cost-sharing enforcement on Medicaid children between 100 percent and 225 percent of FPL. Missouri can not increase cost-sharing for SCHIP Medicaid families between 225 percent and 300 percent since the state already charges the full percentage (5 percent) of the allowable cap under the DRA. Whether this represents a feasible policy option for Missouri is questionable given the state’s strong interest in preserving access to health care for children.

Benchmark Benefit Packages

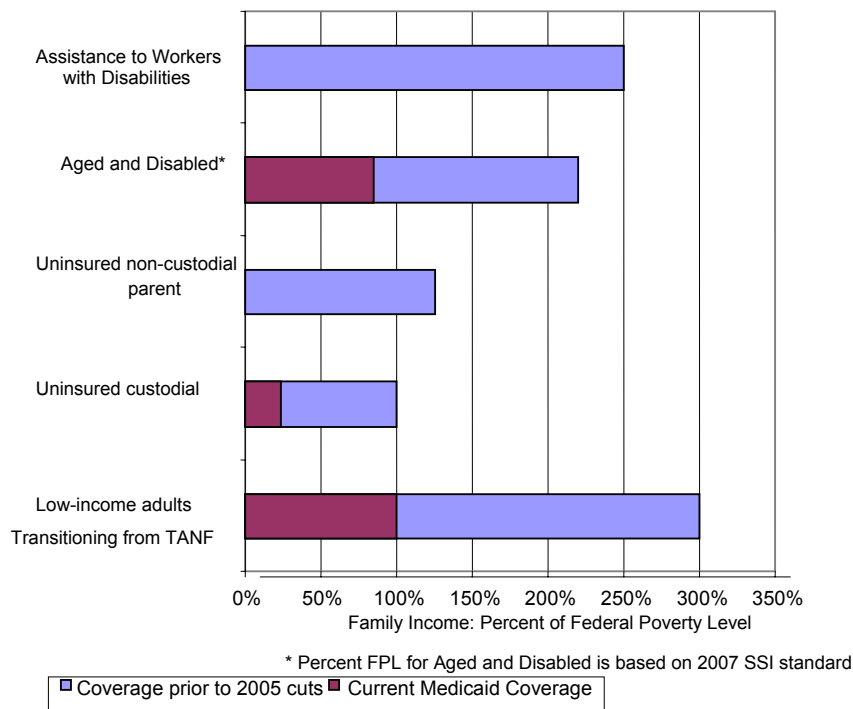
Using Missouri case load data, this study estimates approximately 30 percent of Medicaid beneficiaries could be eligible to enroll in a benchmark benefit plan only on a voluntary basis (see Table 4). Although the state could impose mandatory enrollment into a benchmark benefit plan for 70 percent of the total Medicaid population, most of these (82%) are children for which the state must provide EPSDT services. This means that the state must cover, through its Medicaid program, any services or items determined to be medically necessary for a child without cost-sharing, even if the services are not ordinarily covered by the Medicaid program. In addition to children, the remaining populations that the state could require to enroll into benchmark benefits are non-disabled or non-elderly adults.

Table 4. Missouri Estimated Caseload Exempted from Mandatory Enrollment into DRA Benchmark Benefits	
Eligibility Category	Number of Enrollees
Pregnant Women up to 133%	17,832
Blind and Disabled	141,039
Dual Eligibles	77,734
Hospice	1,295
Foster Care Children	10,215
Breast and Cervical Cancer	444
Total Exemption Categories	248,559
Total Medicaid Enrollment	849,014
Exemptions as a Percent of Enrollees	29%
Source: Children under 18, pregnant women, total Medicaid enrollment: June 2006 Missouri Caseload Counter Eligibility Data Hospice, Skilled Nursing Facility (SNF), Breast and Cervical Cancer: SFY 2006, DSS data. For SNF, it includes all SNF residents rather than only those receiving a personal needs allowance.	

Benchmark Benefits-Expanded Eligibility to Previously Covered Groups

Missouri's fiscal crisis, and the resulting Medicaid cuts in 2005, provides an opportunity to test a unique approach for using the DRA flexibility. While benchmark benefits may not be used by a state to provide benefits to new eligibility groups, Missouri may want to explore the potential of applying the benefit flexibility provisions to provide a limited set of services to eligibility groups who were covered with full Medicaid benefits prior to the DRA enactment. Figure 3 illustrates eligibility groups and income levels where benchmark benefits could be used with a coverage expansion in Missouri. Essentially, the state could develop benchmark benefits for any coverage groups eliminated and where eligibility was scaled back. For these later categories, if the state established more limited benchmark benefits the existing beneficiaries would also sustain reductions in covered services. Whether this is an acceptable trade-off for expanding coverage to greater numbers of people is a matter of policy priorities.

Figure 3. Select Missouri Medicaid Coverage Pre and Post DRA



The 2005 reductions to the Missouri Medicaid program involved several discreet populations with potential differing health care needs and priorities (i.e., parents and working adults, disabled individuals and children). Table 5 shows the approximate number of individuals who lost coverage as a result of Missouri’s 2005 Medicaid program restructuring.

Eligibility Category	Estimated Number of Beneficiaries Losing Coverage
Parents no greater than the 1996 AFDC amount (2006 range of 16%-21%of FPL)	74,138
Disabled individuals and individuals age 65 and older no greater than 85% of FPL	8,660
Elimination of Medical Assistance for Workers with Disabilities (MAWD)	9,529
Source: Missouri Department of Social Services and “Summary of Medicaid Cuts Adopted in the 2005 Legislative Session”, Joel Ferber, May 23, 2005.	

Missouri could use DRA benefit flexibility provisions to target benefits to some or all of the populations involved in the 2005 eligibility changes and provide a more limited (less costly) set of services that could also be customized to meet particular needs for individuals in these categories. There are many examples of more limited benefit packages across the country that Missouri could consider, including the Idaho and Kentucky examples.

Health Incentive Programs

In addition to restoration of eligibility and benefits, Missouri could also consider using healthy behavior incentives for any of its eligibility groups to target outcomes and goals that they desire to achieve, such as designing the program to ensure preventive care and use of safety net providers, or designing services to insure disease management for specific disease states.

POTENTIAL IMPACT OF DRA ELEMENTS ON BENEFICIARIES AND THE SAFETY NET

As shown in the examples from Idaho, Kansas, Kentucky, and West Virginia, states have a great deal of flexibility under the DRA to meet their own particular goals for either comprehensive reform or targeted program modifications. Determining the potential impact of the DRA for a particular state is highly speculative, but the focus can be narrowed through an understanding of the state’s current Medicaid structure. There are two distinct elements to this. First, the DRA protects certain groups from benefit changes or limits the changes that may be made, and second, not every state includes in its Medicaid program all the populations to which the DRA flexibility provisions apply. Therefore, it is important to understand how specific DRA provisions interact with the current design of a state’s Medicaid program, and since each state has a unique Medicaid program, the opportunities under the DRA will differ for each state. It is important to stress that flexibility options are allowable under the DRA but are not required nor mandated for any population or program. Table 6 below illustrates the allowable options under the DRA for Missouri Medicaid populations.

Table 6. Missouri Medicaid—Allowable Options under the DRA						
Allowable Option under DRA	Pregnant women up to 133% of FPL	Pregnant Women above 133% of FPL	Children up to 150% of FPL	Children above 150% of FPL	Parents	SSI, Aged, and Disabled
Mandatory Benchmark Benefit		●	●	●	●	
Voluntary Benchmark Benefit	●	●	●	●	●	●
Cost-sharing for Populations over 100% of FPL		●	●	●	□	
Premiums				●	□	
HOAs			●	●	□	
<ul style="list-style-type: none"> ● Allowed under DRA, current Missouri covered eligibility group □ Allowed under DRA, not covered under Missouri Medicaid 						

Another way to predict the potential impact is to examine other states where DRA-related changes have been made. However, most initiatives (and the DRA itself) are either too new to have quantitative data about impact or the data are just not available. In a few instances studies

conducted in the past on the impact of certain types of strategies (e.g., cost-sharing) provide some insight into implications for both beneficiary behavior (i.e., Medicaid/SCHIP and low income beneficiaries) and safety net providers.

Impact of Premiums

Research strongly suggests that premiums, and strict enforcement of premium payment policies, can have a significant negative impact on enrollment, especially initially. For example, in 2002 Rhode Island's Medicaid waiver program, RItE Care, began charging premiums between \$43 and \$58 per month to families above 150 percent of FPL. In the first three months under the new policy, 18 percent of affected families were disenrolled due to non-payment of premiums.²¹ A survey of families who were disenrolled found that nearly half (48 percent) cited inability to afford the premium as the reason for losing coverage.

However, research also suggests that the impact of premiums can stabilize somewhat over time. For example, immediately following the implementation of new and higher premiums in Vermont's Medicaid program, 11 percent of enrollees were disenrolled for nonpayment of premiums and the majority of these were still disenrolled a month later. However, data indicate that many of those who disenrolled eventually re-enrolled in their respective programs,²² though overall enrollment across all affected programs remained below levels seen prior to the implementation of the premium changes.²³

Since its implementation in 1999, Wisconsin's BadgerCare Medicaid waiver program for coverage of parents and children has charged premiums for families above 150 percent of FPL. An analysis of enrollment data indicate that premium-paying families experienced more "churning" (i.e., movement in and out of the program) than non-premium paying families, but the impact of the premiums appeared to be small overall.²⁴

Impact of Point of Service Cost-Sharing

Unlike premiums, which may affect an individual's or family's decision to purchase health insurance coverage, the impact of co-payments or co-insurance is more likely to be seen in how, when, and whether an individual seeks out specific health care services. In the oft-cited RAND study, conducted in the 1970s and 1980s, researchers randomly assigned families to receive health care services for free or at varying levels of cost-sharing.²⁵ The study found that low-income adults made 41 percent fewer medical visits for "more effective" care (services that the researchers believed to be clinically effective in improving health outcomes) when they had to

make co-payments than when they received free care. Co-payments also had a negative, though much less significant, impact on the utilization patterns of higher-income adults. Similarly, low-income children received 44 percent fewer clinically effective health care services when care was not free.

More recent studies look specifically at changes in Medicaid cost-sharing policies. For example, in 2003 Oregon implemented new cost-sharing requirements above the nominal amounts allowed under Medicaid law. Co-payments ranged from \$3 to \$250 and were later eliminated under court order. A survey of adults subject to the new cost-sharing requirements who reported unmet healthcare needs found that 33 percent reported they could not obtain needed care due to cost, 24 percent said they did not have enough money to pay the co-payment, and 17 percent said they did not get care because they owed the provider money (responses were not mutually exclusive).²⁶

Enrollees in Utah's Primary Care Network Medicaid waiver program pay \$5 to \$30 copayments and up to 10 percent coinsurance for some services. Compared with Non-Traditional Medicaid enrollees, who have broader coverage and lower cost-sharing, Primary Care Network enrollees were more likely to report missing or postponing getting needed medical care because of the cost or lack of coverage.²⁷ Primary Care Network enrollees' reports of missing or delaying care were much higher than national rates for Medicaid adults (36% versus 12%) and were comparable to national rates for uninsured adults with incomes below 150 percent of FPL (29%).

Implications of Premiums and Cost-Sharing for Safety Net Providers

Several studies indicate that safety net providers also feel the impact of Medicaid cost-sharing policies. When Oregon experienced significant declines in enrollment after the implementation of new premiums and premium enforcement policies, visits to an ED of a major safety net hospital increased by 17 percent in the first three months. At the same time, clinics reported diverting substantial resources toward finding resources for patients who had lost their Medicaid coverage.²⁸ It was also reported that many FQHC patients could not afford new co-pays implemented by the Oregon Medicaid program, which contributed to a higher rate of no-shows for clinic appointments.

The DRA authority provides limited opportunity for Missouri to impose premiums as well as point-of-service cost-sharing. Specifically premiums could be imposed for infants in families earning above 150 percent of FPL, and cost-sharing for children in general. Missouri could

increase its current premium structure or extend premiums for children in families between 150 percent and 225 percent of FPL, as long as total cost-sharing does not exceed the overall cap of 5 percent of family income. Missouri currently has a cost-sharing requirement of 5 percent of family income for families between 225 percent and 300 percent of FPL. In addition, the DRA gives states the option of terminating individuals' eligibility for non-payment of premiums for 60 days or more.

The research indicates that Missouri should carefully consider the potential impact of expanding its current premium policy. The research has consistently demonstrated that premiums can reduce access to care by discouraging low-income families from enrolling. While many individuals and families eventually do enroll or re-enroll, research indicates that premiums can encourage "churning" on and off of Medicaid/SCHIP programs, which disrupts care and is inconsistent with the goal of encouraging early preventive care, which is especially important for infants and children.

If Missouri utilizes DRA cost-sharing flexibility, care should be taken to design the cost-sharing so that it does not discourage primary and preventive care or appropriate use of specialty services, lab, and diagnostics. For example, cost-sharing could be imposed on non-emergency use of ED services, to discourage use of the ED for primary care. At the same time, most or all primary care services could be exempted from cost-sharing.

Missouri should also carefully consider the potential impact on safety net providers of making cost-sharing "enforceable" under the DRA. Safety net providers are much less likely than non-safety net providers to enforce cost-sharing, and some are federally prohibited from doing so. As a result, safety net providers will have to absorb the amount of the unreimbursed cost-sharing and may attract additional non-paying Medicaid patients as a result of their non-enforcement policy.

Impact of Benchmark Benefits

The concept of benchmark benefits has not been well studied in the Medicaid population although states have had significant success in providing health care through such benefits to children in the SCHIP program. Under the DRA, the potential for both positive and negative impacts to beneficiaries and safety net providers exists depending on the state's benefit design, whether benchmark benefits are used to restore or tailor benefits to a specific population, and whether healthy rewards or penalties are used.

As in the case of West Virginia, where benefits can be directly tied to compliance with a member agreement, non-compliance could result in a loss of benefits, increasing the potential for a negative impact for both consumers and the safety net. For example, benefits lost include mental health and chemical dependency services. Medication compliance is a serious issue for people with mental illness. For persons with schizophrenia, non-compliance rates are estimated at 50 percent per year after an acute episode resolves. In West Virginia, there is a higher risk that people with mental illness would lose mental health services as a result of not being able to maintain compliance with the member agreement. This could affect the safety net as their client base needing mental health services increases in both number and possible acuity while Medicaid reimbursement for these services is no longer available.

On the other hand, states could also use DRA flexibility to align Medicaid and SCHIP programs for children, expand eligibility through adjusting income criteria, or add benefits filling the specific needs of targeted populations as seen in the case study states. Another potential use of benchmark benefit packages would be for restoration of some level of services through a smaller and therefore more affordable benefit package.

Using Incentives for Healthy Behaviors

In contrast to the West Virginia model, Kentucky and Idaho are using positive incentives to promote healthier lifestyles or to address chronic disease concerns. The success of such incentives remains to be established. Florida began offering a healthy benefit account through its Medicaid Reform 1115 Research and Demonstration Waiver.²⁹ The Enhanced Benefits Account Program (EBAP) is an incentive to promote and reward participation in healthy behavior activities and to assist beneficiaries in taking a more active role in their healthcare by making market-based choices about their benefit plans. Consumers are rewarded for healthy practices and for demonstrating personal responsibility.

Tied to the state's Medicaid Reform Health Plan, an Enhanced Benefit Account is set-up for each beneficiary participating in a plan. When a plan certifies a member has engaged in one of the several state specified healthy behaviors or activities, funds are deposited into the account up to a maximum value of \$125 per state fiscal year. Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy.³⁰

The full Medicaid Reform Plan enrollment projection of 212,189 individuals for the pilot counties is not expected to be reached until June 30, 2007. Approximately 6 to 12 months after that time,

Florida should have reliable numbers regarding the beneficiaries' earning and spending of credits. At this time only a few months of data are available. For claims paid through December 31, 2006, 11,997 beneficiaries received credits. The total dollar value of credits accumulated to date is \$652,620 compared to accumulated contributions (e.g. 2 percent of the health plan capitation payments) of \$997,807. During this time, only 290 beneficiaries have used credits in the amount of \$3,869.

The Florida program is broad based with extensive lists of both the behaviors eligible for credits and products for which the credits can be used. A state could use this concept in a much more modest and targeted way, much like Kentucky and Idaho, which would expose the state to minimal fiscal risk while exploring the effectiveness of incentives because the DRA allows states to impose both geographic and eligibility restrictions for services.

Implications for Safety Net Providers

West Virginia's approach to reform is untested and has no similar counterpart in the commercial or private health care industry. The effectiveness of the state's initiative to improve health and/or achieve savings can only be determined with time. The impact on safety net providers under such a system could be mixed. To the extent that members comply with the agreement, hospitals may experience decreased inappropriate use of ED facilities and increased use of primary care services, which would overall be beneficial.

On the other hand, to the extent that beneficiaries were unwilling or unable to comply with the agreement, the loss of critical benefits such as mental health services, cardiac rehabilitation, and diabetes care could increase ED utilization, or result in increased acuity of conditions for inpatient admissions. This is particularly true where a lack of follow-up care or insufficient management of a chronic condition could have serious health consequences. The loss of these benefits could also increase reliance on safety net providers as a source of care for services that would no longer be reimbursed by Medicaid. The burden of "free" care would fall squarely on hospitals, FQHCs, and other community providers as Medicaid recipients would find themselves, in essence, "underinsured."

A targeted or incremental approach to incentives would have much less impact on the safety net but would provide an opportunity to explore the effectiveness of different strategies before implementing a program statewide.

RECOMMENDATIONS ON KEY DRA ELEMENTS

This section discusses HMA's recommendations with respect to potential implementation of the DRA in Missouri. There are a number of provisions in the DRA that show great promise to benefit low-income residents of the state, and by extension, the safety net that serves them. These are the provisions that we recommend the state to consider.

There are also DRA provisions that have the potential, albeit with limitations, to adversely affect costs and benefits in the Medicaid program. HMA's recommendations in these areas focus on program design elements that would limit the potential to negatively impact beneficiaries and the safety net.

Throughout this section, recommendations are presented for tracking the impact of any program changes that are made. This applies to positive and negative changes alike. Just as it is important to measure the impact of reduced benefits or increased cost-sharing, it is also important to track successes and challenges associated with benefit or program expansions, so that these strategies can be defended with real data should they ever be threatened with budget cuts.

General Recommendation

As described above, states have some broad flexibility under the DRA to implement program changes through the SPA process. Some of the changes, such as the ability to reduce benefits without regard to comparability, could only have been made via a Section 1115 demonstration prior to the existence of the DRA. Providers, beneficiaries, and advocates may have limited opportunity for review and comment depending upon how a state handles preparation and submission of such amendments. Therefore, these changes can stay under the radar screen until they are well on their way to implementation.

HMA's general recommendation with respect to the DRA is to pursue the possibility of state legislation or rulemaking that would require the Medicaid agency (or other implementing agency) to consult with stakeholders through a public process when submitting SPAs that meet threshold criteria for impact to beneficiaries. The intent is not to slow down routine SPAs, but rather to ensure that SPAs that have the potential to impact beneficiaries and the safety net are fully vetted with stakeholders. One model to look to for how such a process could be constructed is the public notice requirement for Section 1115 demonstrations. As explained in the section that compares

the SPA process to the Section 1115 process, there are a number of ways states are permitted to meet the expectation of public notice and comment.

Recommendations Regarding Provisions with Potential Positive Impact

As seen in the case studies and the explanation of the DRA provisions, there are multiple opportunities to expand benefits or eligibility. These opportunities include using a benchmark benefit package as a tool for expanding benefits to a targeted group, as was the case in Kansas, or adding a new coverage group for disabled children whose families can purchase Medicaid coverage for them. HMA analysis indicates there may also be opportunities that have not yet been explored by states, such as providing benefits to previously covered groups that have lost eligibility, through offering a benchmark benefit option. The following are specific recommendations for action.

Add Benefits for Existing Groups

While the benchmark benefit flexibility in the DRA may have initially been envisioned as a way for states to rein in Medicaid expenditures, there are also ways the flexibility can be used to add benefits targeted at specific groups. If Missouri identifies eligibility groups that could benefit from select enhanced benefits, the DRA may provide the avenue to allow the state to offer these benefits without adding them to the state plan for all groups. Certain types of mental health, substance abuse, dental, or personal assistance services may prove to be services that could be targeted to subsets of the Missouri Medicaid population.

Another way to think of benefit enhancements is to envision added benefits that could be associated with optimal management of chronic conditions such as asthma or diabetes. The added benefits could be in a voluntary benchmark package that also features adherence to disease management protocols. The state would thereby encourage compliance for patients with chronic illness with a “carrot” approach, i.e., adding a benefit, rather than a more punitive “stick” approach. Another approach is adding benefits through allowing expenditures through healthy behavior incentives for items or services not ordinarily covered through Medicaid. These also could be highly targeted by the criteria used for participation in the incentive program.

Expanded Services to Previously Covered Populations

DRA benchmark benefit provisions could be used to provide services to groups covered in Missouri Medicaid prior to 2005, but with a smaller and hence more affordable benefit package.

This would be allowable because benchmark packages can be provided to groups that had been in the state plan on or before enactment of the DRA. Even if a state is not now covering a certain group that it previously covered, they can be brought back into the state plan with benchmark benefits. This is one opportunity that Missouri may want to explore. It is important to note that, as has been explained elsewhere in the report, many groups can only be offered a benchmark package on a voluntary basis. The DRA allows mandatory enrollment in benchmark packages on a limited basis.

Explore the Possibility of a SPA for HCBS

The DRA provides an opportunity to offer HCBS through a SPA. The DRA authority is limited compared to Section 1915(c) waiver authority in that the HCBS can only be provided to individuals who meet current state plan financial eligibility criteria. Under Section 1915(c) authority, broader eligibility criteria may be employed.

However, the opportunities afforded by the DRA flexibility should not be ignored. Under a DRA-related SPA for HCBS, services targeted to individuals with mental illness can be offered. The DRA also requires that needs-based criteria be used that are less stringent than institutional level of care criteria. The number of enrollees may be capped, and the program need not be offered statewide. Missouri may want to consider whether there are any mental health-related services or other services, not already offered through another mechanism such as the rehabilitation option or the clinic option, which could be offered through a DRA SPA.

Explore Safety Net Provider Opportunities

As described in the section outlining DRA provisions, FQHCs and RHCs, both of which are important components of the safety net, are protected when states offer benchmark benefit plans. In other words, states must ensure access to these centers. In addition to this important protection, there may be new opportunities. With respect to ED cost-sharing, which can be implemented in higher than Medicaid nominal amounts under the DRA, states are required to ensure access to alternative providers. The thinking behind this is that it is inappropriate to charge higher co-payments for non-emergency use of the ED when there is no accessible alternative. In the event the state decides to impose the DRA-allowed cost-sharing for non-emergency use of the ED, this study recommends that the state and safety net providers explore the feasibility of establishing networks that would be certified as alternatives to the ED for non-emergency conditions.

Impact Analysis

This subsection has been discussing how DRA flexibility could be used to expand eligibility or benefits in Missouri. If any of these provisions are implemented, it will be important to collect data from the beginning of program changes to demonstrate costs and benefits associated with the change. Although much of this report focuses on the need to collect data demonstrating the potential harm associated with benefit reductions or cost-sharing increases, it is equally important to collect data on the benefit of positive program changes. These data can become very important in the event of an economic downturn, when the legislature may be tempted to consider scaling back such programs. A balanced analysis of costs and benefits can better inform such policy decisions. Examples of data to collect include:

- number of beneficiaries who receive enhanced benefits;
- quality indicators related to disease management enhancements (e.g., HbA1c tests and foot exams for diabetics; ED visits for individuals with asthma);
- number of newly eligible beneficiaries (in the event of restoration of coverage);
- respective cost of benchmark versus standard Medicaid benefits;
- consumer satisfaction information collected through surveys;
- in the event safety net providers establish alternative site for non-emergency care, utilization of these services;
- changes in utilization patterns where healthy behavior incentives are used; and
- increases or decreases in preventive services such as mammograms, well child visits and immunizations.

Recommendations Regarding Provisions with Potentially Adverse Impact

The DRA, as a piece of legislation with the net effect of saving billions of dollars in the Medicaid program over the next decade, has many provisions under which states can either reduce benefits or increase cost-sharing. Benefit reductions are perhaps a lesser concern than cost-sharing increases for a number of reasons. First of all, since Missouri has relatively few optional Medicaid groups, many enrollees could not be forced to enroll in a benchmark package. Secondly, the children who could be mandatorily enrolled in benchmark packages would still be entitled to EPSDT services. The greater risk appears to be in the cost-sharing arena. HMA's recommendations regarding DRA provisions with potential for adverse impact are aimed at lessening the potential harm to beneficiaries and safety net providers.

Implement Cost-Sharing Changes Carefully

As explained elsewhere, the DRA permits increased cost-sharing and allows states to make cost-sharing “enforceable.” Previous research shows that increased cost-sharing can be very detrimental in terms of ensuring that beneficiaries receive needed care. Therefore, HMA strongly recommends that the state work to ensure DRA-guaranteed protections for low-income families earning at or below 100 percent of FPL from cost-sharing and enforcement of cost-sharing.

Also, in the event the state establishes new cost-sharing, there should be protections for beneficiaries subject to the new requirements. These protections can be caps on co-pays or coinsurance for costly services or items. In addition, if the state were to implement cost-sharing enforcement, there should be mechanisms to avoid adverse health impacts such as pharmacy emergency supply provisions.

Resist Efforts to Reduce Benefits

As noted above, there are many scenarios whereby states can use benchmark flexibility to increase rather than reduce benefits. The state should focus on ways to use the DRA provisions to make targeted benefit enhancements or to improve disease management for individuals with chronic conditions.

Should the state begin to explore seeking approval for benchmark benefits, it will be important for stakeholders to monitor SPAs regarding the underlying state plan and to ensure that the standard Medicaid package remains a real and meaningful option for individuals exempt from mandatory benchmark plan enrollment.

Impact Analysis

The importance of data collection and analysis with respect to potentially adverse changes cannot be overstated. Any sort of impact analysis with regard to such changes would be structured according to the specific provisions that are implemented. For example:

Cost-Sharing Increases:

- utilization of services subject to cost-sharing before and after the increase;
- ED visits;
- number of patients presenting to safety net providers because of enforcement of cost-sharing by other providers; and
- in the event premiums are implemented, number of individuals losing coverage for non-payment.

Benefit Reductions:

- number of individuals affected;
- unintended adverse consequences such as ED visits; and
- changes in safety net utilization patterns due to individuals seeking services eliminated from coverage.

CONCLUSION

The increased flexibility provided to states through the Medicaid provisions contained in the DRA presents states with opportunities to modify their programs to promote policy objectives. The extent to which the DRA provisions might be helpful will vary from state to state, but as can be seen through the four case studies, states can and do take innovative approaches when using the flexibility.

While the DRA provisions grant limited opportunity to expand coverage to new populations, they can be used to enhance or customize benefits. States can now explore the value of benefit design changes for various populations on a limited basis without wholesale changes to their standard Medicaid benefit, which could generate new approaches to serving individuals with special health care needs.

Missouri has unique opportunities to utilize the DRA. While benefit flexibility provisions may not be used by a state to provide benefits to new eligibility groups, Missouri could explore the potential to apply the benefit flexibility provisions to provide a more limited set of services to eligibility groups who were covered with full Medicaid benefits prior to the DRA enactment.

As additional states take advantage of new opportunities through the DRA, Missouri as well as other states, can learn from these experiences. While it is not clear how significant the impact of the DRA will be on the Medicaid health care system, it is clear that states are willing to use new tools available for changing their programs.

ENDNOTES

¹ Families USA *Health Opportunity Accounts: What are they and why should advocates care?*; accessed at <http://www.familiesusa.org/assets/pdfs/dra-hoas.PDF>.

² In addition to these provisions, Section 6014 of the DRA provides that individuals with home equity in excess of \$500,000 cannot qualify for LTC services. States may increase this amount in certain geographical areas that warrant a higher limit.

³ Ross D.C. Cox L. and Marks C. *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*; Center on Budget and Policy Priorities for Kaiser Commission on Medicaid and the Uninsured; January 2007.

⁴ The purpose of the Medical Care Advisory Committee is to advise the Medicaid agency about health and medical care, and must have the opportunity to participate in policy development. *See* 42 CFR 431.12(e).

⁵ United States General Accounting Office. MEDICAID AND SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns (GAO-02-817), July 2002.

⁶ *See* 59 *Fed. Reg.* 49249, September 27, 1994.

⁷ United States General Accounting Office. MEDICAID AND SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns (GAO-02-817), July 2002.

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ Plan amendment #06-006 Attachment 4.18-A.

¹¹ Walls, J. and Kirchgraber K. *KYHealth Choices and the Deficit Reduction Act of 2005*; November 28, 2006. Prepared for The Foundation for a Health Kentucky.

¹² The state's reform document states that members who have opted-in to ESI may reapply for Medicaid services after 90 days. The SPA does not include this provision, however.

¹³ Age-related benefits, besides EPSDT, include vision and hearing services available to only those under the age of 21.

¹⁴ See Status of Federal Approval and Implementation documents on the state's website at <http://www.healthandwelfare.idaho.gov/site/3629/default.aspx>.

¹⁵ States are not required to adopt the new maximum levels but may set rates below the ceiling.

¹⁶ May 3, 2006: SPA may be accessed at http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp.

¹⁷ For this purpose, the SPA cross-references the new Social Security Act Section 1937(a)(2)(B) which specifies the eligibility groups that a state *may not* mandate to receive an alternative benefit package.

¹⁸ ADLs include bathing, grooming, toileting, transferring, feeding, and mobility.

¹⁹ IADLs include shopping, house cleaning, meal preparation, and laundry.

²⁰ Distribution of the Nonelderly with Medicaid by FPL, states (2004-2005), statehealthfacts.org. The data did not contain the elderly population, however, in Missouri elderly would be dual eligibles with incomes less than or equal to 73 percent of FPL or QMBs up to 100 percent of FPL. Both populations would be exempt from cost-sharing. Missouri Department of Social Services, Caseload Historical Data, May 2004-December 2005.

²¹ Center on Child and Family Health, "Results of RIte Care Premium Follow-up Survey," Rhode Island Department of Human Services, January 2003.

²² *Ibid.*

²³ Vermont Joint Fiscal Office, "Effects of Medicaid Premiums on Program Enrollment: Preliminary Analysis," April 8, 2004.

²⁴ Gavin, N.I., et al. "Evaluation of the BadgerCare Medicaid Demonstration" RTI International, December 2003.

²⁵ Newhouse, Joseph, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996.

²⁶ Carlson, M. and B. Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," The Office for Health Policy and Research, March 2, 2005.

²⁷ Artiga S, et al. *Can States Stretch The Medicaid Dollar Without Passing the Buck? Lessons From Utah*. Health Affairs. March/April 2006.

²⁸Hines, P., et al, “Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties,” The Office for Oregon Health Policy and Research, December 2003.

²⁹ Centers for Medicare & Medicaid Services Special Terms And Conditions, number 11-w-00206/4.

³⁰ Florida Medicaid Reform, Quarterly Progress Report, July 1,2006—September 30, 2006.

About Health Management Associates

Health Management Associates (HMA) is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience and technical expertise to local, state and federal government agencies, regional and national foundations, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

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Tanya Alteras has extensive experience analyzing issues related to health care financing and organization in the public and private sectors, expanding coverage and improving access for uninsured populations, and developing cost-effective private-public coverage options. Prior to joining HMA, Ms. Alteras was a Senior Policy Analyst at the Economic and Social Research Institute (ESRI), where she studied state and community-based strategies for covering the uninsured, with a goal of providing stakeholders with a roadmap toward developing and implementing such models in their own states and communities. Her focus was on models that involved new and innovative ways of leveraging scarce public resources with other public and private sector funds, such as premium assistance and “three-way” share models. She has also examined the health care system’s strategies for addressing issues such as lack of access to oral health care, and the rising obesity rate.

Ms. Alteras’ previous experience includes serving as a health policy analyst in the office of the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services, where she was a policy reviewer of states’ SCHIP and Medicaid 1115 waiver proposals and plan amendments. She was also a member of the team overseeing a congressionally-mandated evaluation of the State Children’s Health Insurance Program, which included conducting case studies and focus groups in a total of 14 states to understand their experiences with the SCHIP program since its inception.

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Trey Berndt joins HMA with over 25 years of experience with Medicare, Medicaid, and State Children’s Health Insurance Program policy and financing. Prior to joining HMA, Mr. Berndt led Texas’ nationally recognized interagency effort to coordinate the health and human service impacts of Medicare Part D prescription drug coverage. As a senior deputy to the State Medicaid/Children’s Health Insurance director, he led special projects on children’s Medicaid simplification, premium assistance, and intergovernmental health financing. Mr. Berndt has extensive experience with state agency and legislative financing processes and issues, having served for nine years as a senior budget office analyst for the federal revenue maximization group of the Texas Legislative Budget Board. He has specialized experience in educating legislative committee members and staff on complex federal financing issues, including the preparation and delivery of public testimony. Additionally, he has worked on program and budget issues related to graduate medical education, Medicaid long term care service delivery, mental health services, and criminal justice system health care programs for special needs offenders.

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Ms. Chesher has been with HMA since 2006. Since joining HMA, Ms. Chesher has assisted health plans with the Medicare Advantage application process and has researched policy, enrollment and eligibility requirements for state Medicaid programs. Ms. Chesher also has experience researching community benefit to local programs to cover the uninsured. Ms. Chesher has used her graphic design skills to create marketing material of employee benefit plans for local municipalities as well as editing and formatting a number of reports produced by HMA senior staff.

Ms. Chesher’s expertise lies in graphic design, including layout, format and display. For HMA she designs marketing material, designs and edits reports, and manages relationships and projects with printing vendors. She also has great knowledge with various Microsoft Office and other desktop publishing programs including Quark Xpress, Adobe Photoshop, Illustrator and Pagemaker. Previous to joining HMA,

Ms. Chesher worked as a graphic designer at a classified newspaper, designing and building display ads, as well as creating the layout of the five daily papers.

Jason Cooke – Principal, Austin, Texas

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Jason Cooke is a principal with Health Management Associates with a wealth of experience in the development and implementation of policy and operations for publicly financed health care programs and the administrative systems that support them. Prior to joining HMA, Mr. Cooke capped a 14-year career in Texas state government with the creation and management of the Texas SCHIP program and tours of duty as director of operations for Medicaid and Texas Medicaid director. He is well-versed in managed care and administrative services contracting, having spearheaded the creation of Texas' first fully insured statewide public managed care program in designing and launching SCHIP. Mr. Cooke's expertise in public program change management was developed in the cycles of service expansion and contraction in Texas over the last six years and in the transformation of Texas Medicaid and SCHIP administration into a performance-based culture where measurable results and relentless quality improvement are required at levels – from program and vendor to management and staff. Prior to his service as Texas Medicaid and SCHIP director, Mr. Cooke was responsible for advancing the needs of the Medicaid program with the Texas Congressional delegation.

DeAnn Friedholm – Principal, Austin, Texas

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Ms. Friedholm has over 25 years of experience in health and human services policy, budget and administration at the state, federal, local and international levels of government. A former Texas Medicaid Director, she has held numerous leadership positions in state government and the non-profit sector. Ms. Friedholm has a broad range of experience in creating strategies for successfully accomplishing health program improvements, from policy development and financing through implementation.

Karen Hale – Principal, Austin, Texas

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Karen Hale is a principal at HMA with over 25 years experience in developing and managing behavioral health, developmental disabilities and other social service programs. She also has experience in strategic planning, program and policy development, community needs assessment and governmental relations in both the public and private non-profit sectors.

Marshall Kelley – Principal, Tallahassee, Florida

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Marshall E. Kelley is a principal with Health Management Associates with expertise in the areas of state and federal health care issues involving Medicaid, Medicare, aging and disabilities, LTC, managed care and health care facilities. As a principal at HMA, he has assisted clients with program design, business strategy development and expansion in a number of states. He has also assisted states with Medicaid waiver development, policy analysis and program development. Special interests are managed care, managed LTC, consumer directed care and programs for the uninsured. Prior to joining HMA, Mr. Kelley directed the Florida Medicaid program; directed the Florida health care facility regulatory programs, and served as the director of community-based long-term programs for elders in Florida. Mr. Kelley graduated from the University of South Florida in Tampa, and completed masters' degrees from Indiana University and Georgia State University.

Theresa Laper Sachs – Principal, Washington, D.C.

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Ms. Sachs is a nationally known expert on design and financing of Medicaid and SCHIP waiver programs. She has more than 16 years experience in health care, including seven years at the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) where she specialized in Medicaid and the SCHIP. Prior to joining HMA in 2005, she provided consulting assistance to several states relative to the analysis and development of waiver proposals. Her experience includes policy and budget analysis, legislation, administration, and contract management. She concentrates on policy analysis

of health care issues, program development, budget neutrality and policy negotiation, and program implementation. She also conducts focus groups and facilitates multi-faceted work groups. Ms. Sachs also has experience as a legislative analyst for the US Senate Special Committee on Aging, as a program manager for The National Council on Aging, and as director of an Area Agency on Aging, where she spearheaded several initiatives aimed at expanding options for elders with disabilities to remain in their own homes.

Aimee Lashbrook – Consultant, Columbus, Ohio

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Aimee Lashbrook is a consultant at Health Management Associates in Columbus, OH. Ms. Lashbrook has a broad range of experience in health law, policy and management. After graduating from law school, she practiced health and insurance law in Michigan for two years. She is very experienced in legal research and analysis and has worked with health care organizations in the areas of insurance regulation, state and federal Medicaid law, certificate of need, the HIPAA Privacy Rule, community benefit and cultural competency. She recently obtained a graduate degree in Health Services Administration from the University of Michigan. Since joining HMA in 2006, she has conducted research and helped advise clients on a variety of topics, including Medicaid managed care, best practices in managing high-risk pregnancies and opportunities for public input in the Medicaid policy-making process. Ms. Lashbrook has also assisted state Medicaid programs in the preparation of Requests for Proposals for new programs and initiatives.

Kim McPherson – Senior Consultant, Austin, Texas

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Kim McPherson joined Health Management Associates in 2005. She has over 12 years experience in health care delivery and policy, including positions in commercial managed care, state government and the non-profit sector. She has successfully facilitated statewide coalitions, created public outreach campaigns and analyzed health care data to identify areas for improved quality and efficiency. She has particular expertise in the area of behavioral health policy, in both the public and private delivery systems. Her broad range of experience has given her a well-rounded perspective on health care delivery system operations and issues, allowing her to assist state and local programs, associations and private providers.

Gaylee Morgan – Senior Consultant, Chicago, Illinois

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Gaylee Morgan brings experience in Medicaid policy and financing, Medicaid managed care, provider reimbursement, and issues related to FQHCs. Prior to joining HMA, Ms. Morgan was a financial policy consultant for a major academic medical center where she was responsible for developing financial models and analyzing the impact of payment and other policy changes. She was also a health financing analyst with the U.S. Office of Management and Budget (OMB) where she worked with states and CMS on the development of Medicaid 1115 and 1915(b) waivers and analyzed the policy and budget implications of statutory, regulatory and administrative changes in the Medicaid program.

Nicky Moulton – Senior Consultant, Tallahassee, Florida

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Nicky Moulton is a senior consultant with HMA. She has over 20 years of experience in a variety of health care and public service settings, including experience both as a public provider and State Medicaid administrator of LTC, institutional and community-based services for persons with varying disabilities and for elders. Ms. Moulton specializes in the development of Medicaid programs for persons with LTC needs including managed, integrated acute and LTC programs, behavioral health programs, and special LTC projects including consumer directed care initiatives and nursing home transition projects. She has written Section 1915(c) and Section 1115 waivers, and assists states, providers and advocacy groups with the design of programs for persons with disabilities encompassing policy analysis and development, funding analysis and development, and implementation.

Ms. Moulton has a BSN and worked previously as a licensed Nursing Home Administrator for a 150-bed SNF/MR, a Certified Biofeedback Therapist, a psychiatric nurse and as executive director of an indigent health care program and environmental support organization.

Melissa Rowan – Senior Consultant, Austin, Texas

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Melissa Rowan joined HMA after serving as the Texas Medicaid/CHIP Deputy Director for Managed Care Operations. Ms. Rowan has spent her career in health and human services at the state and local levels and with a national health and human services consulting firm. She has extensive experience in Medicaid and Medicaid managed care. She has successfully managed large-scale Medicaid programs and community-based programs for persons with severe mental illness. Ms. Rowan also offers substantial experience in working with elected officials and consumers of public programs.

Steve Scheer – Principal, Chicago, Illinois

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Steve Scheer is a principal in the consulting firm of HMA. Mr. Scheer and the firm specialize in assisting providers, state hospital associations and other clients with concerns regarding public programs or public populations such as Medicaid and the uninsured. He works with governments, hospitals and hospital associations on coverage for the uninsured and Medicaid financing. He also assists association clients with association strategic planning and member satisfaction improvement. Among his projects Mr. Scheer has worked on assignments involving Medicaid financing in 24 states during the past five years. Prior to joining HMA, he served as executive vice president of the Illinois Hospital Association.

Jenna Walls – Senior Consultant, Indianapolis, Indiana

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Jenna Walls brings over nine years of experience in Medicaid and other government-assisted programs. Ms. Walls' consulting assistance includes assessment of state and federal Medicaid policy changes and evaluation of state health coverage initiatives for children. Prior to joining HMA, Ms. Walls served in various positions within Indiana State Government, most recently as deputy director of the state's Medicaid program. In this position Ms. Walls was involved in procuring pharmacy benefits management and led a team to implement the behavioral pharmacy management program. Within the Indiana State Budget Agency she served as assistant director for Health and Human Services; Higher Education and Economic Development; and the state's Federal Aid Management unit, which was charged with analyzing and managing the impact of federal budget and legislative initiatives on state programs, including federal welfare reform, Medicaid, DSH, and SCHIP. Following her tenure at the Indiana State Budget Agency, Ms. Walls served as a consultant to the governor's SCHIP Commission responsible for formulating Indiana's SCHIP program.