kaiser commission on medicaid and the uninsured
STATE BUDGET NEWS
THE HENRY J. KAISER FAMILY FOUNDATION

News on State Medicaid Programs: July through September 2005 Update

This update summarizes recent state Medicaid actions from press reports published during July, August, and September 2005 as well as information reported by the Health Policy Tracking Service (HPTS) during these three months. It highlights changes that governors and state legislators have announced or implemented that affect the Medicaid program. The information provided in this report has not been verified by the states, and in some cases the actions referenced have not been completed. A more complete picture of state budget actions affecting Medicaid during state fiscal year 2005 will be available in late October, when KCMU's annual 50 state Medicaid and state budget survey will be released.[1]

Over the past year, state revenues have continued to improve and a select number of states, such as Illinois and New Jersey, have announced eligibility expansions. Several states have also taken action to increase provider payments. At the same time, many states continue to make significant changes to their Medicaid programs to reduce the growth in Medicaid spending. For example, Missouri and Tennessee are implementing eligibility reductions that affect hundreds of thousands of beneficiaries. Additionally, a handful of states such as Georgia, South Carolina, and Vermont are planning to make broad, structural changes to their Medicaid programs through the waiver process.

Meanwhile, the diaspora of Hurricane Katrina evacuees will likely place additional pressure on state budgets, and at this juncture states are unsure of the level of federal assistance they will receive in paying for evacuees' health care. Several states, including Alabama, Texas, and Mississippi, have recently negotiated waivers with CMS to provide assistance to those from affected regions. In addition, states are waiting on the outcome of the federal budget reconciliation process that could result in over $10 billion in Medicaid cuts.

For news regarding:	See these states:
- Benefits Changes	California, Colorado, Minnesota, Mississippi, Missouri, Oregon, Pennsylvania, Utah
- Cost Sharing and Premiums	Indiana, Kentucky, Montana, Oregon
- Eligibility Changes	California, Illinois, Maryland, Minnesota, Missouri, New Hampshire, New Jersey, Ohio, Pennsylvania, Tennessee
- Fraud and Abuse	Michigan, New Hampshire, New York
- Long Term Care	Arkansas, Kentucky, Maryland, New Hampshire, Washington, West Virginia, Wisconsin
- Managed Care	California, Colorado, Georgia, Ohio, North Carolina, Virginia
- Pharmacy Changes	Georgia, Kentucky, Mississippi, North Carolina, Pennsylvania, Utah
- Provider Reimbursement	Arkansas, District of Columbia, Illinois, Kentucky, Louisiana, Maine, North Carolina, Ohio, West Virginia, Wisconsin
- Waivers	Alabama, California, Florida, Kentucky, Mississippi, New Hampshire, South Carolina, Texas, Vermont, West Virginia

[1] KCMU's October 2004 report, "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005," is available at http://www.kff.org/medicaid/7190.cfm

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Alabama: HHS grants Medicaid waiver to handle coverage for hurricane survivors. HHS officials announced the federal government has approved a Medicaid waiver agreement with Alabama that will allow the state to provide temporary Medicaid and SCHIP eligibility to hurricane evacuees who are residents of other states. The waiver authorizes the state to provide Medicaid or SCHIP coverage for up to five months for children younger than age 19 and their parents, pregnant women, people with disabilities, low-income Medicare beneficiaries and individuals in need of long-term care or who meet specified income requirements. Evacuees will complete a simplified application allowing for self-attestation of income, evacuee, and immigrant status and will not have to provide the usual required documentation. The evacuees will receive the standard Alabama Medicaid benefits package. Under the terms of Alabama's waiver, the state will not charge evacuees any out-of-pocket costs for health care. (HHS release [1], 9/23). Alabama Medicaid Agency spokesperson Mary Finch said as of Sept. 23, 524 evacuees had enrolled in the state's Medicaid plan (Chandler, *Birmingham News*, 9/24). A separate "memoranda of understanding" signed by federal Medicaid Director Dennis Smith and the Medicaid directors of Louisiana, Mississippi and Alabama makes clear that those states "remain responsible for the state share" for services given to displaced residents in other states (*CongressDaily*, 9/23).

Alaska: Alaska plans to enlarge program that restricts provider choices for Medicaid beneficiaries who overuse health care services. The state Department of Health and Social Services has proposed strengthening the state's ability to curb excessive use of medical services through the state's "Lock-In" program. Currently, beneficiaries suspected of overusing medical services are given a hearing by the Division of Health Care Services. If the hearing determines the beneficiary has overused services, he or she is placed in the state's "Lock-In" program, which allows them to visit only specific doctors and pharmacists. Enrollment in the Lock-In program is limited to fewer than 12 months. About 100 beneficiaries are in the program. (Inklebarger, *AP/Anchorage Daily News*, 7/1).

Arkansas: State ordered to simplify Medicaid reimbursement process for assisted-living facilities. Under the new system, facilities will be given a flat rate for each day of care they provide to residents. The current system requires facilities to report minute-by-minute accounts of care for patients. The state Department of Health and Human Services will consult with facilities to determine a methodology for calculating reimbursements before setting a date for the process change (Baskin, *Arkansas Democrat-Gazette*, 8/31).

California: Legislative consideration of move of 500,000 elderly and disabled Medi-Cal enrollees to managed care postponed until January 2006. The proposal would shift more than 500,000 Medi-Cal beneficiaries to managed care plans as part of a proposal to restructure Medi-Cal in exchange for increased federal funding (Benson, *Sacramento Bee*, 9/7). The move will decrease by $90 million the $360 million the federal government has offered the state if lawmakers pass a plan that would move beneficiaries to managed care by certain deadlines (Rau, *Los Angeles Times*, 9/7). Lawmakers initially intended to vote on the proposal before this year's legislative session ended but instead agreed to shelve the issue to consider other measures, including a bill (SB 1100) that would restructure distribution of federal Medi-Cal funds to hospitals (*Sacramento Bee*, 9/7). The waiver, which replaces one that expired June 30, changes the way public and private hospitals that care for a disproportionate share of Medi-Cal recipients and the uninsured, known as DSH hospitals, receive supplemental federal funding. Over the years this funding has become a crucial component of the way the state provides health care for its roughly 6.5 million uninsured residents. The former system of funding was based upon intergovernmental transfers (IGTs) from counties and hospital districts that then were used to obtain federal matching funds. Under the new system, "certified public expenditures (CPEs)" by public hospitals would determine matching funds. (*BNA Health Care Policy Report*, 9/19/05).

California's recently passed FY2006 budget includes appropriations to expand Medi-Cal managed care for children and families. It also places a $1,800 cap on dental services for adults. The budget provides

increases in long-term care rates and adult day care rates. (HPTS 8/8/05) In the recent legislative session, California passed a law that eliminates coverage for services, prescriptions or therapies to treat erectile dysfunction for any Medi-Cal recipient who is a registered sex offender, except where it is required by Federal law (HPTS 9/12/05). California also received a court order to reimburse Medi-Cal patients for medical costs they incur during the time they are waiting for their applications to be processed and approved. (HPTS 9/12/05).

The California Legislature approved a bill (AB 772) that creates the California Healthy Kids Insurance Program to help enroll eligible children in public health insurance programs. The measure, proposed by Assembly member Wilma Chan (D) and based on a children's health insurance program in Santa Clara County, places existing public health coverage programs for children "under one umbrella" and raises the income eligibility limit for Healthy Families, the state's SCHIP program, from 250% to 300% of the federal poverty level. The bill also would simplify the application process. Under the bill, participating families would pay premiums that vary by program and family income. Families would pay no more than $23 per child monthly, up to a $69 monthly premium limit for each family. The program is estimated to cost $300 million, which would come from the state's general fund in the budget year beginning July 1, 2006. Paying for the program likely would require a reduction in spending for other programs or an increase in taxes, both measures that Gov. Schwarzenegger opposes. (Folmar, *San Jose Mercury News*, 8/30).

Colorado: Joint committee vetoes changes to Medicaid program for children. The joint legislative Health and Human Services Committee voted 15-5 to reject a plan that would have made several changes to the state's Medicaid program for children, including transferring children into managed care plans and assigning them to primary care physicians. The plan would have transferred about 276,000 children from Medicaid into Child Health Plan Plus, the state's managed care SCHIP program. The changes were expected to reduce Medicaid spending by $6 million annually. The committee rejected the plan after concern was raised about the proposal's planned cap on the growth of SCHIP premiums paid by the state, which may not keep up with the cost of health insurance, and about the inadequacy of a planned increase in provider payments (Scanlon, Denver *Rocky Mountain News*, 9/1).

Colorado's governor signed bills into law that add outpatient substance abuse treatment as a Medicaid benefit; allow Medicaid recipients to receive obesity treatment through a program called Colorado Weigh; and allocate approximately $60 million in revenue the state is receiving after a cigarette tax increase. The funds will be used to allow 600 children with severe disabilities to come off the waiting list for medical assistance and also to expand Medicaid coverage to more children and restore coverage to legal immigrants. (HPTS 6/6/05)

District of Columbia: D.C. Health Department to begin Medicaid performance measures. Washington, D.C., officials announced that beginning in August the District's Medicaid contracts will include "performance measures" designed to show how health plans compare in areas such as rates of cancer, HIV, heart disease, diabetes, smoking and asthma. Officials said that next year they will begin factoring this information into the financial terms of Medicaid contracts. (McElhatton, *Washington Times*, 8/16).

Florida: Reform waiver submitted to CMS on Oct. 1 following 30-day public comment period. On Oct. 1, Florida health regulators submitted the state's application for a federal waiver to restructure the state's Medicaid program after a 30-day public comment period required by the state legislature. Under the proposal, the state would pay an amount per Medicaid beneficiary based on a person's health needs to an HMO or other health plan, which would have discretion over how to treat the beneficiary (*Kaiser Daily Health Policy Report*, 5/4). Participants may also opt out of Medicaid and use their state-allocated Medicaid premium to participate in an employer-sponsored plan, which is not required to cover

mandatory Medicaid benefits. The reforms would begin in Broward and Duval counties. (BNA Health Care Policy Report, 9/12/05)

HHS officials announced the federal government has approved a Medicaid waiver agreement with Florida that will allow the state to provide temporary Medicaid and SCHIP eligibility to hurricane evacuees who are residents of other states. The waiver authorizes the state to provide Medicaid or SCHIP coverage for up to five months for children younger than age 19 and their parents, pregnant women, people with disabilities, low-income Medicare beneficiaries and individuals in need of long-term care or who meet specified income requirements. Evacuees will complete a simplified application and declare their income and assets but will not have to provide the normal documentation. In Florida, evacuees will pay the standard copayments required by the state's Medicaid program. (HHS release [1], 9/23).

Georgia: State avoids some Medicaid cuts, will move 1.2 million Medicaid and SCHIP recipients to managed care in April 2006. In July, the state Department of Community Health warned that it would have to cut as much as $388 million from programs including Medicaid. However, tougher Medicaid anti-fraud efforts, a larger-than-expected Medicaid budget surplus, and increased federal funding helped the department avert cuts to Medicaid (Larrabee, *Augusta Chronicle*, 8/26). In addition, the department expects to reduce spending by about $114 million by improving monitoring and enforcement of Medicaid eligibility, streamlining some administrative tasks, paying less for prescription drugs and expediting the process of collecting overpayments made to hospitals. (*Atlanta Journal-Constitution*, 8/26). Gov. Sonny Perdue (R) had also proposed to move one million Medicaid beneficiaries and 200,000 children in PeachCare, the state's SCHIP program, into HMOs to reduce costs, but the implemenation is being postponed from Jan. 1, 2006, to April 1, 2006. State Medicaid officials said the postponement will give beneficiaries more time to choose an HMO. In addition, groups representing hospitals have reported difficulties signing contracts with HMOs for reimbursement (Miller, *Atlanta Journal-Constitution*, 9/17).

Illinois: Gov. Blagojevich announces a plan to subsidize insurance for 253,000 uninsured children in the state. Children in families with annual incomes between $40,000 and $80,000, whose incomes are too high to qualify for public health insurance but too low to afford private insurance, would qualify for the coverage (Slevin, *Washington Post*, 10/6). Under the All Kids plan, parents would pay a monthly income-based premium of about $40. Copayments would apply for doctor's visits, hospital stays and prescription drug costs. Out-of-pocket expenses for such a family would be limited to $500 per year (Massingale, *Copley/Peoria Journal Star*, 10/6). No copayments would be charged for preventive care, such as immunizations and regular checkups. To be eligible, children would have to have been uninsured for six months prior to the initial enrollment period. The uninsured period later will be increased to 12 months (Fusco/Rackl, *Chicago Sun-Times*, 10/6).

The Governor also approved a hospital tax to generate as much as $600 million in federal matching funds. The funds will be used to increase the state's Medicaid reimbursement rates. The measure creates a hospital tax of 2.5835 percent on hospital adjusted gross revenues from inpatient and outpatient services, and most of the new money will be returned to hospitals through higher Medicaid reimbursement rates. The law also requires applicants for Medicaid and the Children's Health Insurance Program to identify their employers. State officials must report annually to the General Assembly the names of companies who have more than 100 employees with 25 or more receiving public health care benefits. (HPTS 8/8/05)

In addition, the Illinois Medicaid program plans to offer physicians and dentists a $30 bonus beginning Jan. 1, 2006, for each child in Medicaid who receives all of the required annual exams and shots. The agreement follows a federal court ruling that Illinois violated federal laws that require Medicaid programs to provide promised benefits, including immunizations and hearing exams for children. (Sachdev, *Chicago Tribune*, 6/28).

Indiana: Indiana considers raising SCHIP premiums. The cost of premiums for beneficiaries in the Indiana State Children's Health Insurance Program could double starting on Jan. 1, 2006, under a proposal being considered by the state. Families currently pay between $11 and $24.75 per month for SCHIP coverage, depending on income. If the increases are approved, premiums would range from $22 to $50. The changes do not affect children enrolled in Medicaid; children in the Medicaid program are exempt from premiums by law. The change would generate an additional $2 million for the $80 million program. The state plans to hold public hearings on the premium increases in September (McNeil, *Indianapolis Star*, 8/5).

Iowa: **Medicaid program could have a $5 million surplus this year**. According to state House Speaker Chris Rants (R), the estimated surplus resulted from a larger-than-necessary appropriations measure and higher-than-expected prescription drug rebates. Rants said that the state should use the surplus to repay the Senior Living Trust, a fund that helps Iowa seniors live independently, because the state Legislature borrowed funds from the trust to finance the state budget and because both programs benefit seniors. Gov. Tom Vilsack (D) said that he does not oppose the proposal to repay the fund but questioned the size of the estimated surplus (*AP/Omaha World-Herald*, 8/30).

Kansas: State Attorney General files lawsuit to stop Medicaid financing of abortions. Attorney General Phill Kline filed a lawsuit to try to force the state to stop financing abortions for Medicaid recipients, arguing that it violates the state constitution. State Medicaid Director Scott Brunner said that from October 2004 through early September 2005, the state paid $1,908 for seven abortions needed by Medicaid recipients. He said Medicaid pays for the procedure only in cases of rape or incest, or if the mother's life is in danger, which is in compliance with federal Medicaid regulations (HPTS 9/12/05).

Kentucky: State faces $675 million budget deficit, pursues changes to Medicaid and KCHIP. In response to a $675 million budget deficit, the Cabinet for Health and Family Services announced an increase in copayments in the Kentucky Medicaid program. As of July 1, mandatory Medicaid enrollees pay $1 for each generic drug, $2 for preferred brand-name drugs, and $3 for non-preferred brand name drugs. The copayments are higher for optional eligibility groups ($3, $10, and $20 respectively). The copayments will affect approximately half of Kentucky's Medicaid population and will not apply to pregnant women, children, and individuals in long-term care, institutions, or part of home and community based services waivers. The state also changed its long term care bed reserve policy. Previously, Medicaid paid 100 percent of a nursing facility's per diem rate for up to 14 days while a patient is hospitalized outside the facility. Medicaid now reimburses nursing facilities 75 percent of the per diem if the facility is at 95 percent capacity and 50 percent if it is below 95 percent capacity for up to 14 hospital days or 10 therapeutic leave days (Kentucky Cabinet for Health and Family Services Press Release, 7/1/05).

The state is also pursuing a federal waiver to make changes to its Medicaid and KCHIP program, including plans to offer different benefits packages to different populations and to raise copayments and premiums; contracting with a private insurance company to run KCHIP, Kentucky's SCHIP program; and encouraging workers to purchase insurance through their employers (*AP Lexington Herald-Leader*, 8/17). State officials and health care advocates discussed the changes in a forum and have agreed to revisions to the waiver proposal. Under the revisions, the private health insurer that administers the Kentucky Children's Health Insurance Program would have to offer beneficiaries the same coverage state employees receive. The agreement also would limit the use of copayments in KCHIP (*AP/Cincinnati Enquirer,* 8/30).

Louisiana: About 6,000 Louisiana Hurricane Evacuees Rejected for Medicaid Coverage
More than half of Hurricane Katrina evacuees from Louisiana who have applied for Medicaid benefits have been rejected because of strict eligibility rules. Under the Louisiana Medicaid system, state residents

between ages 19 and 64 who have no dependent children and incomes lower than 13% of the federal poverty level are eligible. State Medicaid Deputy Director Ruth Kennedy estimates applications of more than 6,000 residents, or about 55% of applicants, have been rejected because they do not meet those requirements. She added that the estimate is conservative because it accounts for survivors who were in shelters or applied to the program in state Medicaid offices, not those who might have been living with family or a friend when they applied. Kennedy said the state health department is saving the rejected applications in the event that more federal funding is provided. "At this point, we have no choice but to deny those people," Kennedy said, adding that funding the program "will be an issue, even to continue the Medicaid program at pre-Katrina enrollment levels" (Walsh, New Orleans *Times-Picayune*, 10/5).

Department of Health and Hospitals officials recently implemented new regulations that are designed to reduce costs and improve service in the state's mental health rehabilitation program, which serves many Medicaid beneficiaries. Under the new laws, instead of paying service providers a single monthly rate for each patient, the state's Office of Mental Health will pay only for services that are provided. In addition, the state will increase its oversight of the program and require patients to be evaluated more frequently to ensure they are not receiving unnecessary treatment or remaining in the program too long (Moller, *New Orleans Times-Picayune*, 7/29).

Maine: Computer system malfunction stalls Medicaid provider payments. The state's new but malfunctioning computer system has stalled millions of dollars in payments since January. As a result, many physicians have already stopped taking new Medicaid patients and are threatening to drop current Medicaid patients. The state has distributed more than $250 million in interim payments based on the billing history of more than 7,000 providers. Eventually, providers will have to reconcile those payments with actual bills, which are among the 400,000 stuck in the state's $22 million computer system. Some providers are refusing payments to avoid dealing with the potential hassle of reconciliation. Providers also are concerned about meeting the 12-month deadline for submission of all claims for reimbursement. They fear the state will have no record of the claims being submitted on time (HPTS 9/12/05).

Members of a special task force assigned to review Maine's DirigoChoice program told the Dirigo Health Agency that they have been unable to reach an agreement on the program's funding (*Bangor Daily News*, 8/31). Under the program, Maine is contracting with Anthem Blue Cross and Blue Shield of Maine and competing with existing health plans to offer coverage to individuals who work at least 20 hours per week. The 10-member task force is attempting to resolve several funding issues, including how to redirect anticipated savings for insurers. The problem for the group is determining how to calculate those savings (*Bangor Daily News*, 8/31).

Maryland: Maryland restored funds for pregnant legal immigrants' prenatal care, but children of legal immigrants lose coverage. Gov. Robert Ehrlich's (R) FY 2006 budget proposal recommended cutting $7 million in state Medicaid funds that had previously been provided to cover legal immigrants who have been in the United States for less than five years. At the request of state lawmakers, the governor announced plans recently to restore $1.5 million of the $7 million to continue covering prenatal care for pregnant legal immigrants currently scheduled to lose Medicaid benefits. The funds will cover only those pregnant women who were enrolled in the Medicaid program as of July 1. The governor did not restore the additional $5.5 million needed to cover the children of legal permanent residents (HPTS 7/25/05).

A class action lawsuit has been filed alleging that the state of Maryland has been systematically denying seniors Medicaid benefits to which they are entitled under federal law. Specifically, the complaint asserts that Medicaid-eligible seniors in Maryland are being denied a federally mandated deduction for pre-eligibility medical expenses, including outstanding debts for nursing home care, when the state calculates their income and the contribution they must make toward their own care. The plaintiffs are asking the

court to order the state to recalculate the expenses of every senior who was previously denied such deductions. They also want to void a 2004 rule change under which the state will allow a deduction for three month's worth of pre-eligibility debts, provided they were incurred after April 1, 2004 (HPTS 9/12/05).

Michigan: Community mental health programs assessed fee to generate matching funds. Gov. Jennifer Granholm (D) signed two bills extending the 6 percent quality assurance assessment fee to community mental health programs, starting August 1. Such fees help generate federal Medicaid matching funds for health care providers. For FY 2005-2006, the 6 percent fee is expected to generate $89 million, with $35 million to be used for Medicaid programs in place of general tax dollars. Matching federal Medicaid funds also will be used to pay $123.8 million to specialty prepaid health plans (HPTS 8/8/05).

Depending on how the proposed $10 billion in federal Medicaid spending reductions are implemented, Michigan may lose up to $300 million in federal funding. Therefore the state attorney general is intensifying his efforts against fraud to stem the loss of up to $750 million each year in Medicaid fraud. It is unknown exactly how much money is stolen from the state, but national statistics suggest that states lose 3 percent to 10 percent of their budgets to fraud, which translates to $225 million to $750 million in Michigan. The state Attorney General Mike Cox (R) advocates legislation that awards at least 15 percent of the settlement plus legal fees to people who successfully sue fraudulent providers (HPTS 9/12/05).

State officials announced a proposal to reduce Medicaid costs by offering incentives for healthy behavior rather than eliminating benefits for some residents. Under the plan, adults who do not traditionally qualify for Medicaid but the state chooses to cover would be eligible for lower copayments or additional benefits, such as expanded prescription coverage or dental services, if they practice good health by quitting smoking, keeping physician appointments and maintaining a normal weight, etc. The plan would require permission from the federal government (Hornbeck, *Detroit News*, 9/13).

Minnesota: Proposed cut of 30,000 MinnesotaCare enrollees contributes to government shutdown after budget impasse, but cuts ultimately avoided. Facing a $466 million budget deficit, Gov. Tim Pawlenty (R) proposed cutting $247 million from the state health care budget. Because of this reduction in funding, an estimated 30,000 childless adults would lose coverage through the MinnesotaCare program, which is funded with state-only dollars. Disagreement between between Gov. Pawlenty and the Legislature resulted in a partial shutdown of the state government. The Governor agreed to a $0.75 cigarette tax increase, despite vowing not to increase taxes, that prevented many of the health care cuts from being implemented. A $5,000 cap on outpatient health services for MinnesotaCare enrollees was also repealed (Washington Post, 7/10/05).

Minnesota's Medicaid program will no longer cover Viagra, sex-change operations or circumcisions, unless required by one's religion. According to the Department of Health and Human Services, in recent years about 10,000 baby boys have been circumcised each year, with an average cost of $54, at the expense of the state. The changes come as lawmakers try to cut costs without gravely hurting the Medicaid program (HPTS 9/12/05).

Mississippi: Medicaid will continue providing anti-retroviral drugs to state residents with HIV/AIDS, despite new regulations that cut the number of brand-name prescriptions patients can access. The prescription limits changed from 7 total last year (5 of any type and 2 requiring prior authorization) to 5 total (2 brand-name and 3 generic medications) (Wagster Pettus, AP/Biloxi *Sun Herald*, 6/30). Also, the interim director for the state Medicaid program stated that the state will work to eliminate alleged overcharging by providers and the enrollment of ineligible state residents into the program. Beginning last January, beneficiaries were required to reapply for the program in person (rather

than by mail) and to provide proof of income and information about living arrangements. Between June 30, 2004 and June 30, 2005, enrollment in the program decreased by about 20,113 individuals; Moody estimates that the changes will reduce the number of enrollees by 50,000 (Clarion-Ledger, 8/18).

The Administration announced a Katrina-related Medicaid waiver agreement with Mississippi that is similar to one issued to Texas, providing temporary Medicaid eligibility to residents of other states (see Texas update below). However, a separate "memoranda of understanding" signed by federal Medicaid Director Dennis Smith and the Medicaid directors of Louisiana, Mississippi and Alabama makes clear that those states "remain responsible for the state share" for services given to displaced residents in other states (*CongressDaily*, 9/23).

Missouri: Enrollment reductions for 70,000 adult Medicaid enrollees will proceed; legal attempt to block reductions fails. A U.S. District Judge denied a request for a temporary restraining order to block the first round of enrollment reductions in Missouri's Medicaid program (Wiese, *AP/Belleville News Democrat*, 6/30). The request was related to a lawsuit that accuses the Missouri Department of Social Services of violating "constitutional due process rights" by failing to provide adequate notices of cuts to the program (Lieb, *AP/Las Vegas Sun*, 6/29). Under a reform plan approved by the state Legislature this year, an estimated 70,000 adult Missouri Medicaid beneficiaries will lose coverage during the fiscal year that started July 1 and many other beneficiaries will receive fewer benefits while paying higher copayments and premiums (Wagar, *Kansas City Star*, 6/30). The state also is seeking bids from companies to manage care for about 22,000 disabled and elderly beneficiaries with chronic conditions in an effort to reduce hospital and emergency department visits (Young, *St. Louis Post-Dispatch*, 9/12).

In another lawsuit challenging cuts in the Missouri Medicaid program, a federal district judge rejected on Aug. 31 a request for a temporary restraining order that would have prevented the state Department of Social Services from reducing the provision of durable medical equipment (BNA Health Care Policy Report, 9/12/05). Under the proposal from Gov. Matt Blunt (R), the state plans to eliminate Medicaid coverage of most durable medical equipment -- such as hospital beds, patient lifts and wheelchair batteries -- for 340,000 adults (Young, *St. Louis Post-Dispatch*, 8/29).

Montana: State increases funding for SCHIP to boost coverage; negotiations with insurer over premiums continue. Blue Cross and Blue Shield of Montana, which administers the state's SCHIP program, on Sept. 15 proposed a 12% premium increase, prompting state officials to say they will offer a lower counterproposal. BCBS officials said negotiations for the new annual contract that begins Oct. 1 are ongoing. The state Legislature this year increased SCHIP funding to boost coverage from 11,000 to 14,000 children, but "[h]igher premiums could reduce the number of children added to the program," the *Gazette* reports (Dennison, *Billings Gazette*, 9/16).

Nebraska: Nebraska forms board to identify ways to reduce Medicaid spending. State legislators enacted L.B. 709 on June 2, 2005, to develop a review board, the Medicaid Reform Advisory Council, to ascertain the best means of reducing expenditures while preserving Medicaid services. The Council has begun hosting monthly meetings and hosting public hearings within the state's three legislative districts. The Council members will present a report of their recommendations to the governor and state Legislature by December 1, 2005 (HPTS 8/8/05).

New Hampshire: State to request CMS approval to reduce transfer of assets among seniors hoping to qualify for Medicaid. State Health and Human Services Commissioner John Stephen plans to request CMS approval to tighten Medicaid eligibility standards to prevent seniors from transferring assets to qualify. A state legislative oversight committee has approved the plan, and Gov. John Lynch (D) gave conditional approval, provided that restrictions would be loosened for "hardship cases." The state Legislature's Fiscal Committee must approve any plan that wins CMS approval (Love, AP/Manchester

Union Leader, 9/21). The proposal would allow the state to recover assets from or penalize Medicaid patients who transfer property at low prices to shed assets in order to qualify for the program. It also addresses income test exemptions for those who purchase long-term care insurance (Fahey, Manchester *Union Leader*, 8/31).

New Jersey: **Acting Gov. Richard Codey (D) signed legislation that expands enrollment in the state's FamilyCare program.** The legislation restores eligibility to parents and children who were cut from the program in 2002 during the state budget crisis (HPTS 7/25/05). Children up to age 19 whose family gross income is up to 350% FPL will continue to be eligible for either Medicaid or NJ FamilyCare, the state's SCHIP program. Effective September 1, 2005, parents of eligible children whose family earned income does not exceed 100% of the FPL will be eligible for Medicaid. Eligibility for parents is currently limited to persons whose income does not exceed approximately 34% FPL. This eligibility limit for parents will rise to 115% FPL on September 1, 2006, and 133% FPL on September 1, 2007 (NJ Association of Mental Health Agencies, http://www.njamha.org/?sec=2&cat=1).

By mid-fall 2005, a "buy-in" program will be established through which a parent or caretaker whose family gross income exceeds 350% of the poverty level may purchase coverage under NJ FamilyCare for a child under the age of 19, who is uninsured and was not voluntarily disenrolled from employer-sponsored group insurance coverage within six months prior to application to the program. The premium for coverage shall not exceed the amount the program pays per month to a managed care organization under NJ FamilyCare for a child of comparable age whose family income is between 200% and 350% of the FPL, plus a reasonable processing fee. In addition, pending approval from the federal government, adults without dependent children whose income does not exceed 100% of the FPL will be eligible for Medicaid. The income eligibility limit will be phased in over a three-year period. (NJAMHA)

New York: Governor Pataki announces proposal to target Medicaid fraud and abuse. The announcement came in the wake of a *New York Times* expose that revealed potentially $18 billion in Medicaid fraud and abuse in the state. The Governor appointed an Inspector General for Medicaid and announced that the state will develop new ways to collect, organize, and analyze billing and claims data by computer. The state will also use resources at the State University of New York (SUNY) Medical School to review the medical appropriateness of claims. New York's request to participate in the "Medi-Medi" program, a joint federal-state program that uses technology to detect fraud, is currently under review by CMS (HPTS 7/25/05).

Gov. Pataki vetoed a bill that would have created a demonstration project designed to improve collection of rebates from pharmaceutical companies by granting third-party vendors access to Medicaid drug utilization data. Pataki said he supported the goal of improving collection of rebates, but opposed allowing third-party vendors to have access to the information. Instead, he said the state Department of Health (DOH) would use its own resources to improve rebate collections. Under the bill, the state would have created a demonstration program covering drug rebates from Jan. 1, 2001, through March 31, 2005. Information would have been shared on drug utilization for both the Medicaid and EPIC programs. The bill was a response, in part, to a 2004 audit of the Medicaid rebate program by the Office of Inspector General of the US DHHS, according to a memo from the bill's sponsors. The audit recommended that the DOH improve its rebate program (BNA Health Care Policy Report, 9/12/05).

North Carolina: State budget freezes Medicaid hospital reimbursement rates and expands managed care; some new funding provided. After a month and a half of negotiations between Democratic and Republican lawmakers and two temporary spending bills to keep the government running, Gov. Mike Easley (D) finally signed the state budget into law. The $17.2 billion, two-year spending measure makes significant changes to the state Medicaid program. These changes include cost-saving measures which are projected to save the state nearly $100 million. These savings will be achieved through freezing hospital reimbursement rates, expanding

the managed care program, and implementing cost management initiatives for personal care services. Alternatively, the new budget provides new funding for the following initiatives: a senior drug program until the Medicare drug program is operational ($10 million); a trust fund for mental health reform ($10 million); increased health services for low-income children ($13.2 million); and indigent care services at state university hospitals ($5 million) (HPTS 9/12/05).

Ohio: State makes reductions to meet 4 percent cap on annual Medicaid growth. The 2006 budget limits Medicaid growth to 4% annually, which reduces spending by $2.3 billion. Included in the budget were changes to nursing home payment methodology, the mandatory enrollment of children and families in HMOs by Dec. 31, 2006, reducing eligibility for parents from 100% FPL to 90% FPL effective Jan. 1, 2006, and the enrollment of aged, blind, and disabled enrollees in care management by Dec. 31, 2006 (Begala, Overview of Medicaid Provisions in Ohio's 2006-2007 Budget, Center for Community Solutions, 8/1).

In addition, State Medicaid officials have proposed cutting the pay of self-employed licensed practical nurses by 30% to reduce state and federal program costs by $8 million and prevent other cuts in services. The proposal is subject to approval by the state Joint Committee on Agency Rule Review, which likely will make a decision in October. If approved, the cut would take effect Jan. 1, 2006 (*AP/Akron Beacon Journal*, 8/29). Officials are also changing the reimbursement formula for hospitals, cutting $168 million in state and federal funds for hospitals already dealing with $140 million in Medicaid cuts (*AP/Akron Beacon Journal*, 9/13).

Oregon: Oregon Health Plan premium payment rules relaxed. Gov. Ted Kulongoski (D) signed S.B. 782 into law on August 3. Subject to federal approval, the bill exempts about 10,000 Oregon Health Plan recipients with incomes under 10% FPL from having to pay monthly premiums. According to the state Department of Human Services, approximately 40 percent of the 24,000 enrollees have incomes below 10 percent of the federal poverty level. For the other 60 percent, who pay between $9 and $20 in monthly premiums, the bill extends the current grace period of two months to six months. If premiums remain unpaid at the end of the grace period, the state may disqualify recipients (HPTS 8/8/05).

The state's budget will make some benefit reductions for mandated populations of nonpregnant women and men. The benefit reductions will include the elimination of nonmedical vision services, a 10% reduction in dental services, and some reductions in medical transportation. Under the budget bill, the state also will be authorized to reduce the number of hospital days if necessary. CMS will need to approve most of these benefit reductions. The reduction in benefits would trim $28 million over the biennium. The state's share of the biennial Medicaid budget will be slightly more than $1.2 billion (BNA Health Care Policy Report, 9/12/05).

Pennsylvania: Pennsylvania's enacted FY 2006 budget limits visits, establishes a preferred-drug list, and expands adultBasic. On July 7, Gov. Ed Rendell (D) signed the $24.3 billion FY 2006 state budget. The budget bill eliminated some cutbacks Rendell proposed in February for the state's $4.5 billion Medicaid program, including monthly limits on the number of drug prescriptions and annual limits on hospital visits. However, the budget still contains provisions that limit adult Medicaid enrollees to 18 doctor visits per year and one rehabilitation-hospital admission a year. The budget also establishes a Medicaid preferred-drug list to save approximately $50 million and people who qualify for Medicaid through General Assistance to be allowed only one hospital admission per year. In addition to the Medicaid provisions, the budget also expands adultBasic, the state's health insurance program for low-income working adults, by 25% because of an infusion of $85 million from a settlement that the Rendell administration negotiated with the state's four Blue Cross/Blue Shield companies (HPTS 7/25/05).

South Carolina: State submits reform waiver to CMS, may revise some portions of waiver. South Carolina officials are rewriting a plan to reform the state's Medicaid program and could change a provision that raises beneficiaries' copayments for services. Under the reform plan, which was made public in June and must be approved by CMS, copays would be $50 for a nonemergency visit to the emergency department and $5 for a visit to the doctor that now costs $2. The copays for prescription drugs would increase from $3 currently to $5 for generics and $10 for brand-name drugs. The plan also calls for allowing state Medicaid beneficiaries to establish personal health accounts with the option to "self-direct" their medical care or purchase coverage from private health plans, which would be able to establish their own copays. Medical home networks could charge beneficiaries copays as well. The health account would limit the amount per year each enrollee can spend on health services. According to state Medicaid Director Robert Kerr, the state might reduce or waive the proposed copays for the poorest Medicaid beneficiaries when it revises its reform proposal (Maze, Charleston *Post and Courier,* 9/9). The waiver, as originally submitted, also caps the amount of federal Medicaid money coming into the state each year and reduces the age of eligibility for children's Medicaid benefits from 21 to 18 (HPTS 8/8/05; AP 8/16/05).

Tennessee: About 97,000 medically needy TennCare beneficiaries will be allowed to stay in the program despite other program cuts that will eliminate coverage for about 190,000 individuals. After advocates for beneficiaries criticized the plan for dropping 97,000 beneficiaries with large, unpaid medical bills and "relatively low incomes," the state and advocates in April reached an agreement that would retain the beneficiaries in exchange for modifying the so-called Grier consent decree. Federal court Judge John Nixon ruled that the state could modify the consent decree, which Bredesen says allows him "to implement the cost-saving measures necessary to keep the medically needy beneficiaries enrolled." Those measures, which must be approved by CMS, include a five-prescription-per-month limit on medications for the medically needy, as well as limits on doctor visits, hospital stays and other medical services. (Johnson, AP/Memphis *Commercial Appeal*, 8/10). Officials also said that medically needy beneficiaries will see no change in benefits for the time being and that the medically needy program will not accept any new beneficiaries until July 2006 (Wissner, *Tennessean*, 8/10).

Tennessee has implemented some changes to its safety net program for 190,000 people losing coverage under TennCare. The program allows some beneficiaries who are slated to lose coverage under Bredesen's TennCare plan to continue to have access to some treatments. Tennessee will provide about $5 million in funding to help organ transplant patients obtain anti-rejection drugs, physician visits, hospital stays and lab costs over the next three months, as well as $3 million to pay physician bills for cancer patients who still need chemotherapy or radiation treatments. In addition, the state will more quickly distribute about $6 million to federally funded clinics serving former TennCare beneficiaries (Wadhwani, *Tennessean*, 9/14). The safety net plan originally designated $12 million to help providers expand hours or increase staff to accommodate former TennCare beneficiaries, but some health care clinic directors say they have not yet received any money and have had to turn away beneficiaries because their clinics cannot handle the large volume of patients (*AP/Knoxville News-Sentinel*, 8/23).

Texas: Hurricane Katrina-related waiver agreement reached with CMS. The waiver establishes a separate temporary eligibility category for evacuees from the states damaged by Hurricane Katrina. Texas will provide temporary Medicaid or SCHIP eligibility for a period of five months of coverage to children, parents, individuals with disabilities, individuals in need of long term care, and Medicare recipients up to specified income levels. Under this expedited program, evacuees will be able to register for Medicaid or SCHIP without many of the traditional administrative requirements for verification and enrollment. Evacuees will receive Texas Medicaid and SCHIP benefits packages and will be exempt from cost sharing. In addition, the waiver authorizes an uncompensated care pool for a period of five months from which Texas can reimburse providers that incur uncompensated care costs for furnishing services to uninsured evacuees and to pay for services provided to evacuees that are not covered under its

Medicaid or SCHIP programs. (CMS Fact Sheet on Disaster Relief for Hurricane Katrina Evacuees in Texas, 9/15) A separate "memoranda of understanding" signed by federal Medicaid Director Dennis Smith and the Medicaid directors of Louisiana, Mississippi and Alabama makes clear that those states "remain responsible for the state share" for services given to displaced residents in other states such as Texas (*CongressDaily*, 9/23).

In addition, expanded mental health counseling services in the Medicaid program were scheduled to begin September 1, but the Texas state Comptroller stated there are not sufficient funds for the program. The counseling services were cut from the program two years ago, but lawmakers wanted to reinstate the services using funds from an account that helps low-income residents pay electric bills. About 180,000 residents would qualify for the benefit, costing the state about $34 million over two years. (Austin American-Statesman, 8/19/05) In addition, Texas has developed a disease management program for approximately 55,000 chronically ill Medicaid beneficiaries. McKesson Health Solutions' contract with the state promises that it will save $28.5 million in Medicaid costs in the first year of the program or McKesson will pay the difference (Zeeble, "Morning Edition," NPR, 8/24).

Utah: **Bill to create a preferred drug list failed; scaled-back version introduced**. State Rep. Steve Mascaro (R) has said he will sponsor a scaled-back version of a failed bill to implement a preferred drug list for the state's Medicaid program. Under the proposal, the state Department of Health would be instructed to run a limited test of a preferred drug list. Health department Director David Sundwall has said that a pilot program with preferred lists only for acid-reflux and cholesterol-lowering medications could reduce expenses by $5 million. The resolution also might instruct health officials to report back to the state Legislature when results of the pilot program are available. Gov. Jon Huntsman (R) supported a bill that would have created a preferred drug list, but the proposal in July was "declared dead" by budget leaders in the Legislature (Stewart/Hamilton, *Salt Lake Tribune*, 8/8).

Vermont: **CMS, state legislative committee give approval to Vermont waiver.** The federal government has approved a five-year plan that would allow the state to make significant changes to its Medicaid program. Recently, the state's Joint Fiscal Committee also gave conditional approval to the plan through November 17, when an actuarial study on the waiver will be completed (*Rutland Herald*, 9/28). The proposal would create a new relationship between CMS and the Office of Vermont Health Access, and the state would receive a fixed amount of money to operate Medicaid for each of the next five years in exchange for broader authority to use "federal dollars in ways that are not allowed under the traditional Medicaid program." The administration of Gov. James Douglas (R) wanted the agreement to take effect Oct. 1. (Remsen, *Burlington Free Press*, 9/14).

Virginia: Virginia will enroll about 23,000 additional Medicaid beneficiaries in managed care plans. Virginia officials said that the move -- which in large part will affect women and children, as well as some elderly, blind and disabled state residents -- will provide improved health benefits and reduce costs. Beneficiaries enrolled in plans in September can select UniCare or Amerigroup as their provider. According to Virginia officials, managed care plans have reduced state Medicaid costs by about 5%. According to Virginia data, about 65% of the 606,115 Medicaid beneficiaries in the state were enrolled in managed care plans in 2004 (Smith, *Washington Post*, 7/28).

The new Smiles for Children program is expected to make pediatric dental care more accessible to children enrolled in Medicaid. Within the program, which was implemented July 1, Medicaid dental services are coordinated through a single benefits administrator, Wisconsin-based Doral Dental. According to officials at the state Department of Medical Assistance Services, Doral Dental is being paid about $4.3 million to administer the program, and the state is covering the actual claims. The old system used seven managed-care organizations, often causing complications for preauthorization. The single

benefits administrator combined with a 30% rate increase for dental providers is expected to attract more dentists to the program. Only about 17% of Virginia dentists were enrolled as Medicaid providers before the program changed (Smith, *Richmond Times-Dispatch,* 8/26).

Washington: A new law allows the state to pursue liens against Medicaid patients' estates, even when they have deeded their homes to relatives or others. As a result, Medicaid beneficiaries can no longer protect their estates from the state. The law also allows the state to file liens on property when beneficiaries are still living but likely to never be discharged from a nursing home or hospital. Property held under "joint tenancy" or as "life estates" will no longer be exempt from asset recovery. Low-income residents older than age 55 who have incomes low enough to qualify for Medicaid and wish to protect their property must give up ownership rights at least three years before receiving long-term care coverage (Song, *Seattle Times*, 7/5).

West Virginia: West Virginia makes cuts to providers in FY2006. West Virginia is facing a $116 million deficit in its Medicaid program for FY2006, despite finishing FY2005 with a $105 million surplus. The state Medicaid agency will implement cuts in provider reimbursements, including some of the largest cuts to pharmacists ($45 million), hospitals ($26 million), doctors ($22 million), and the program that helps the elderly and disabled stay in their homes ($11 million) (HPTS 7/25/05).

West Virginia is cutting the total number of clients it can serve through the Medicaid Aged/Disabled Waiver program, which provides in-home care for disabled adults and the elderly. In its federal application for a five-year program renewal, the state Department of Health and Human Resources has asked for permission to reduce the total number of people served annually from 5,400 to 3,900 during the first year. That number would drop to 3,450 for each of the remaining four years of the program's authorization. The proposal is among a series of changes the agency would like to make to cut nearly $116 million from West Virginia's Medicaid budget. Bureau officials say no one will be thrown off the waiver, but that some individuals will have to wait longer. The program is full, with a 400-person waiting list that is expected to grow (HPTS 9/12/05).

Wisconsin: Governor vetoes funding increase for nursing homes. Wisconsin Gov. Jim Doyle (D) signed the biennial state budget bill two weeks ago and line-item vetoed legislators' efforts to increase Medicaid reimbursements to pharmacists, nursing homes, and for non-emergency hospital care. Specifically, Gov. Doyle vetoed a 1.4 percent increase in nursing home bed rates. He redirected these funds to help pay for public schools. Another veto struck a provision to deposit all revenue from the nursing-home bed tax in the Medical Assistance trust fund. Instead, Doyle would annually transfer $13.8 million of the bed tax revenue to the general fund, and the remaining bed-assessment revenue would be deposited into the trust fund. The veto results in a loss of $27.6 million in the trust fund over two years. In addition, Doyle deleted a provision in the budget bill that would have transferred $268 million from transportation to the Medical Assistance trust fund. The governor instead directed Department of Administration Secretary Marc Marotta to transfer more than $235.4 million from the general fund to the trust fund in 2005-2006, which is $32.6 million less than the Legislature approved (HPTS 8/8/05).

Wyoming: Committee suggests proposal to have women repay Medicaid for some childbirth costs. To stem the increasing Medicaid costs in the state, some Wyoming legislators are proposing that poor women repay part of the cost of childbirth and newborn healthcare. A committee appointed by Gov. Dave Freudenthal (D) estimates that Wyoming could save $10 million a year by having parents pay back some of the $6,000 cost of childbirth. Opponents to the proposal believe that it could result in fewer women receiving prenatal care, more women undergoing abortions, and that it forces women to choose between health care or food and clothing for their children (HPTS 9/12/05).

NOTE: For information on the following states, please see previous reports: Arizona, Connecticut, Delaware, Hawaii, Idaho, Massachusetts, Nevada, New Mexico, North Dakota, Oklahoma, Rhode Island, and South Dakota.

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