Center for Health Transformation, A Vision for a 21st Century Medicaid System, September 2005

http://www.healthtransformation.net/downloads/handouts/1325.cfm

Module	Page	Summary
Overall	1,2	This paper proposes that it is possible to apply the principles of a 21st Century Intelligent Health System to create a 21st Century Responsible Citizen Medicaid Act which will provide better outcomes, save money, and dramatically reduce health disparities for America's minorities. **Key Points:** **1.** Medicaid should be reformed to eb a paper-free, individually-centered health system with multiple chronic conditions. Medicaid must blend seamlessly into privately owned health insurance plans. **2.** Medicaid should be transformed within the context of 100% insurance coverage and a national objective. **3.** Medicaid must evolve into a system that is result-oriented and not process-based.
Overall	n/a	This paper promotes greater efficiency within the greater health care system which will reduce the overall burden on Medicaid. Examples include: investing in new technology and innovation that will improve efficiency and quality in health care such as Electronic Health Records, barcoding, and E-prescribing, applying the program Bridges to Excellence to the Medicaid program for chronic diseases like diabetes, reducing fraud and abuse and removing junk foods from schools. Additionally, the paper advocates for the methodology for budget scoring to be changed to enable long-term investment in health care infrastructure.
Overall	7	Organize Medicaid to reflect the following focus:1) Turning Disabilities into Capabilities, 2) Integrating the Healthy Poor into 21st century healthcare and 3) Long-term Living
Eligible Populations	7	Integrate the healthy poor into private health insurance.
Acute/Preventative Care	10	The paper advocates for transpacrency in pricing and quality for pharmaceuticals.
LTC	8	Cash and Counseling Programs: Promote consumer directed services whereby developmentally disabled adults, children, and frail elderly opt for a budget to pay for their home care services.
LTC	8	Establish a capabilities program to provide incentives for people with disabilities to be productive rather than threaten them with a loss of benefits if they become employed.
Quality	9	Focus on an integrated delivery method for active, healthy aging, such as with the Silver Sneakers Fitness Program to increase physical activity in elderly or strength training for seniors.
Quality	2, 8	Medicaid should be a system that is more result oriented than process oriented. Promote pay-for-performance quality incentives.
Quality	4	Accelerate the adaptation of health innovations leading to improvement in quality of life.
Quality	6	Minorities are disproportionately represented in the Medicaid population; therefore, creating a better Medicaid system with a focus on this issue offers an opportunity to improve and narrow racial health disparities.
Administration	10	Accelerate the adaptation of health innovations leading to improvement in quality of life.
Recommendations for Overall HC Reform	Yes	individually centered health system that supports continuity of care. Medicaid should blend seamlessly into privately owned health insurance plans; Medicaid transformed within the context of 100% insurance coverage as a national objective

The Urban Institute, A National Roundtable on the Indian Health System and Medicaid Reform, August 2005

http://www.urban.org/UploadedPDF/411236_indian_health_system.pdf

Module	Page	Summary
Overall	2	Any reform to the Medicaid program should maintain historic federal relationship and not result in changes that make American Indian/Alaskan Native (AI/AN) populations worse off or bring harm to the population.
Eligible Populations	10	Reform should simplify and improve AI/AN outreach, eligibility and enrollment (allow self declaration).
Acute/Preventative Care	10	Reform should continue to allow exemptions for AI/AN populations from cost sharing.
Acute/Preventative Care	10	Reform should ensure that states are prohibited from offering benefit packages to the AI/AN Medicaid beneficiaries that are less in amount, duration or scope then other eligibility groups.
Acute/Preventative Care	10	Reform should include access to traditional AI/AN cultural health care practices.
LTC	10	Reform should include exemption for AI/AN populations from estate recovery rules.
Administration	10	One-hundred percent FMAP should be applied for all services provided through Indian health programs.
Recommendations for Overall HC Reform	No	

National Conference of State Legislatures, Principles for Medicaid Reform, August 2005

http://www.ncsl.org/statefed/health/MArefPrinc.htm

Module	Page	Summary
Overall	1	The National Conference of State Legislatures (NCSL) discusses Medicaid reform and how the state/federal partnership can be sustained and improved and to explore ways to: Provide predictability in program financing and administration; Increase flexibility for states with respect to the eligibility process and benefit design; Establish a viable and flourishing long-term care system; Reform and improve the Medicaid prescription drug program; Strengthen the employer-based health insurance system; Increase the number of public/private initiatives to expand access to health care and to provide health care and ancillary services to support people with challenging health care needs; Improve the coordination between Medicaid and Medicare to improve the effectiveness of care provided by both programs.
Eligible Populations	4	There should be greater flexibility with the eligibility process based solely on income
Eligible Populations	1	Promote private initiatives to expand access to health care and ancillary services to support people with challenging health care needs.
Eligible Populations	2	The Medicaid benefits in the territories should be similar to those in states.
Acute/Preventative Care	4	States should have more flexibility in the benefits they provide, including the EPSDT program and overall benefit design.
Acute/Preventative Care	3	Promote innovative care management models with information and fund sharing between Medicaid and Medicare.
Acute/Preventative Care	4	Impose higher cost sharing for higher income individuals.
Acute/Preventative Care	5	NCSL encourages the Administration and Congress to continue to support state initiatives to manage the Medicaid prescription drug benefit that: (1) control costs; (2) improve patient access; and (3) improve patient outcomes. NCSL supports increased flexibility for states to: (1) impose prior authorization requirements as provided for under current law; (2) provide incentives for the use of generic prescription drugs when appropriate; (3) require utilization review; (4) reimburse pharmacists for pharmacy management services; and (5) to participate in multi-state pools to maximize states' collective buying power. NCSL urges Congress to permit states to charge higher co-payments to higher income Medicaid beneficiaries in the Medicaid prescription drug program.
LTC	6	Increase options for home and community based care.
LTC	6	Give preferential tax treatment for those who purchase long term care insurance and incentives to offer long term care insurance.
LTC	7	Repeal OBRA 1993 that restricts the ability of states to develop programs that provide limited asset protection and other incentives within the Medicaid program to those who purchase long term care insurance.
LTC	6	Expand options for private long-term care insurance, flexible life insurance products, and home equity sharing programs, such as reverse annuity mortgages. Promote programs such as the Medicaid Long Term Living Flexibility Option/Demonstration program.

National Conference of State Legislatures, Principles for Medicaid Reform, August 2005

http://www.ncsl.org/statefed/health/MArefPrinc.htm

Module	Page	Summary
LTC	6	Create new options for setting financial and functional criteria to qualify for LTC services.
Administration	2	Establish countercylical financial assistance to states in times of economic downturns.
Administration	2	Any changes to Intergovernmental Transfers (IGTs), provider tax and donation laws should be prospective and not retroactive.
Administration	3	Improve coordination between Medicaid and Medicare.
Administration	2	Streamline the waiver process and decrease dependency on waivers. Promote greater reliance on state plan amendments.
Administration	2	NCSL opposes the Medicare Modernization Act phasedown payments required from States and requests an appeal process.
Administration		Potential Medicare savings should be calculated as an offset to comply with budget neutrality requirements.
Administration	3	Reductions in the FMAP should be over a five year period.
Administration	3	Promote Medicare and Medicaid coordination that would divide federal and state responsibility on a clear basis:(1) the division was cost neutral for both federal and state partners; (2) each partner had total responsibility for funding and program design within its sphere of responsibility; and (3) there was a grant-in-aid program for poorer states (those with higher FMAP) to equalize state ability to pay for programs.
Administration	4	Increase the use of health information technology in the Medicaid program to: (1) improve safety and quality; (2) control costs (3) simplify program administration; and (4) improve efforts to collect data to evaluate program effectiveness. Medicaid service funds should not be reduced to support these activities. NCSL urges Congress to provide an enhanced administrative match for information technology services.
Administration	5	Develop strategies to reduce the volume of litigation by clarifying and simplifying Medicaid statutory provisions.
Administration		Make the prices paid for individual drugs publicly available.
Administration	3	NCSL supports audits for program integrity.
Administration	6	Provide incentives to employers to offer and for individuals to establish health savings accounts and other innovative financing options to provide support for long-term care services.
Administration	7	Provide tax incentives and programs that provide support services, such as respite care, for family caregivers.
Administration	7	Provide premium assistance for Medicaid beneficiaries to purchase private insurance.
Recommendations for Overall HC Reform	7	Strengthen employer based health insurance system.

The Heritage Foundation, A Roadmap for Medicaid Reform, June 2005

http://www.heritage.org/Research/HealthCare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=79812

Module	Page	Summary
Overall	1-2	Encourage personal responsibility and mainstreaming working families into private coverage by using such incentives as tax credits. States should use a streamlined process for waivers to reform their programs, premium support, and use consumer directed models. Restructure the management and budget of long term care financing using Welfare Reform of 1996 as model.
Acute/Preventative Care	5	Medicaid reform should use approaches that are patient centered instead of system centered. Any reform should focus on needs rather than mandatory vs optional categories with states determining standards. Reform solutions should be based on recognition of the diversity of needs in the Medicaid population.
Acute/Preventative Care	6	Use Florida's "Empowered Care: Putting Patients First" proposal which allows greater flexibility in benefit structure.
LTC	5	Separate the delivery of social services from the delivery of medical services in the financing of long term care.
LTC	7	Eliminate asset transfer loopholes.
LTC	1	Promote consumer directed models of care. Build on the Independence Plus waiver to expand consumer directed care to the broader Medicaid population. This waiver allows certain disabled Medicaid persons the power to manage their own care.
Quality	7	If a state's Medicaid program meets basic quality and cost standards then in return, a state should have more flexibility with the program.
Administration	7	Seize the opportunities offered under the Health Insurance Flexibility and Accountability (HIFA) waiver to launch a premium assistance program.
Administration	6	End financing schemes that inappropriately boost the federal share of Medicaid financing.
Recommendations for Overall HC Reform	7	Link other key health policy initiatives to Medicaid Reform. For example, combine federal tax credits with state Medicaid premium assistance. Also, create incentives for individuals to prepare and save for their long-term care expenses.

National Governor's Association, Short-Run Medicaid Reform, August 2005

http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF

Module	Page	Summary
Overall	1	On June 15, 2005, NGA released a preliminary policy paper that outlined recommendations for Medicaid Reform. This paper has a narrower focus in that it includes only those policies that could become part of the revenue and spending reconciliation bills that have been debated during Fall 2006 as part of the 2006 federal budget. The paper does provide more detail on the Governors' recommended proposals for the spending reconciliation bill, but is consistent with the policy recommendations in the June 15, 2005 paper. The recommendations included in this paper were adopted by the Governors because they are good public policy not to satisfy any spending reduction target. It is also true that Medicaid will continue to grow in the high single digit rate even if these policies are enacted. Alternatively, from a state budget perspective Medicaid is still unsustainable. It is therefore critical that these recommendations be considered at the beginning, not the end, of the reform process. For Medicaid to be sustainable in the long-run, broader program and health care reforms must be considered.
Eligible Populations	6	Increased Flexibility to Tailor Benefits to Beneficiary Health Care Needs.This flexibility includes the ability to choose to provide the set Medicaid benefit package or to provide a tailored benefit package with four options for coverage: 1. Benchmark coverage: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state. 2. Benchmark equivalent coverage: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.
Eligible Populations (Continued)	6	3. Existing state-based comprehensive coverage: In the states where existing state-based comprehensive coverage exists (e.g. state-only funded programs; or waiver populations), the existing health benefits package is deemed to be meeting the coverage requirements. 4. Secretary approved coverage: This may include coverage that is the same as the state's Medicaid program; coverage provided in a Medicaid demonstration project approved by the Secretary; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison. SCHIP benefits flexibility is not being proposed for certain categories.
Acute/Preventative Care	1	The AMP should be used to establish a federal ceiling for pharmaceutical reimbursement. States would still retain the ability to negotiate lower prices.

National Governor's Association, Short-Run Medicaid Reform, August 2005

http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF

Module	Page	Summary
Acute/Preventative Care	3	Additionally, states should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income.
Acute/Preventative Care	5	NGA promotes the use of premiums rather than co-pay for cost sharing, with exemptions for certain eligibility groups (ie, lowest income groups).
Acute/Preventative Care	5	At or Below 100 percent FPL. Existing cost-sharing limits would remain for beneficiaries at or below the federal poverty level (with the exception of tiered copays for prescription drugs as described below); however, states would be given the authority to make cost-sharing enforceable. No beneficiaries in this group could be charged a premium.
Acute/Preventative Care	5	Above 100 percent FPL. States would be able to increase cost-sharing beyond nominal levels for all beneficiaries above the federal poverty level and be given the authority to make cost-sharing enforceable. For these beneficiaries, premiums may be appropriate as a cost-sharing option for states and states should be given flexibility to experiment with mechanisms to collect these premiums (see premium section below). Beneficiaries will be protected by a 5 percent cap on the total amount of cost-sharing they could be responsible for (5 percent of total family income). This could increase to 7.5 percent for those higher income households (defined as above 150 percent FPL).
Acute/Preventative Care	2	States should have the flexibility to determine the appropriate dispensing fees for drugs. Additionally they should have the option to elect to use a closed formulary.
Acute/Preventative Care	2	The minimum rebates that states collect on brand name drugs should be increased to 20 percent (from 15.1 percent) to ensure lower total costs that would not solely impact pharmacists. Medicaid's "Best Price" provision should not be eliminated in exchange for this managed care companies should be able to directly access rebates for prescription drugs purchased for their Medicaid population. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.
Acute/Preventative Care	2	States should be given greater ability both within their state and between states in establishing purchasing pools.
Acute/Preventative Care	3	Allow mail order for maintenance drugs.
Acute/Preventative Care	3	Federal Upper Limit. To ensure that states do not pay too much for prescription drugs, a new federal reimbursement ceiling for payment for all drug products should be established based on the AMP. In addition, the current practice of applying a Federal Upper Limit (FUL) to classes of drugs with three therapeutically equivalent products should be maintained; however, the current FUL in this instance is based on 150 percent of the AWP of the least costly therapeutically equivalent product, and should be revised to reflect 150 percent of the AMP of the least costly therapeutically equivalent product.

National Governor's Association, Short-Run Medicaid Reform, August 2005

http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF

Module	Page	Summary
Acute/Preventative Care	7	States and their federal partners would benefit from states' increased flexibility to create programs that target special populations or limited geographic areas before expansion to entire states.
LTC	3	States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, 1) the look-back period should be increased from 3 to 5 years; 2) penalty periods should begin at the time of application; and 3) the sheltering of excess resources in annuities, trusts or promissory notes must be prevented.
LTC	4	Home equity should be considered a countable asset in order to require individuals to use home equity to off-set long-term and other medical expenses that would otherwise be paid by Medicaid. Reverse mortgage loans are available to allow seniors (age 62 or older) to convert home equity into cash.
LTC	4	To help the aging population plan for future long-term care needs all states should be allowed to participate in the Long-Term Care Partnership program.
LTC	9	Some combination of tax credits and deductions should be used to provide an incentive for individuals to purchase long term care insurance.
Quality	9	Grants to the states and/or an increased matching rate should be provided for quality improvement efforts in Medicaid, such as those being considered for Medicare. Such efforts include adoption of health information technology; improved patient safety; reduction of medical errors; chronic care management; and pay-for-performance.
Administration	7	Increased ease of waiver approval.
Administration	8	For commonly waived portions of the Medicaid statute, states should be allowed to use the state plan amendment process.
Administration	8	States should be given more flexibility within waivers in provider contracting.
Administration	9	The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool.
Administration	8	Requirements for waivers to be cost-neutral can be an unrealistic burden on new or experimental programs. States should be given a greater period of time for waiver programs to be budget neutral (e.g. ten years vs. the current five year requirement).
Administration	9	All states should get some kind of relief from the MMA.
Administration	9	Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing the partnership with territories.

National Governor's Association, Short-Run Medicaid Reform, August 2005

http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF

Module	Page	Summary
Administration	10	Medicaid Directors have long asked for three items to help fraud and abuse efforts: 1) Permit states the same opportunities as are currently afforded the federal government to limit, restrict, or suspend the eligibility of beneficiaries and providers, subject to due process, who have been determined in state proceedings to have engaged in fraud or abuse involving the Medicaid program, even if they have not been convicted in federal court of the listed federal crimes; 2) Amend Section 1903(a)(6) of the Social Security Act to provide the same federal match for all costs associated with fraud and abuse and Surveillance and Utilization Review Services (SURS) activities conducted by the state Medicaid agency as currently received by the Medicaid fraud control units (75 percent). This enhanced funding would apply to direct fraud and abuse and SURS functions that include, but are not limited to, identification, investigation, and administrative actions (e.g. recoveries and provider exclusions); and 3) Provide that when a state discovers an overpayment and determines it to be attributable to fraud or abuse, the state should refund the federal overpayment in the quarter in which the recovery is made, regardless of when the overpayment is discovered.
Recommendations for Overall HC Reform	10	A combination of individual health care tax credits and tax credits for small employers combined with funding to create purchasing pools should provide assistance to low-income working individuals to enable them to obtain health insurance and avoid reliance on Medicaid.

Kaiser Family Foundation, Medicaid: Addressing the Future (Testimony of Diane Rowland to the US Senate Special Committee on Aging), June 2005

http://www.kff.org/medicaid/upload/Medicaid-Addressing-the-Future-Testimony-of-Diane-Rowland-Sc-D-to-The-U-S-Senate-Special-Committee-on-Aging.pdf

Module	Page	Summary
Overall	11	There are no easy answers to reducing the cost of providing care to the over fifty million Americans who now depend on Medicaid for health and long term care assistance - the poorest, oldest, frailest, and most disabled of our population. The high cost of caring for this population is reflective of their serious health problems, not excessive spending by the program. Program costs grow in response to downturns in the economy, rising health care costs, the needs of an aging population, and emerging public health crises and emergencies. Efforts at reform should be directed at finding ways to support and maintain the coverage the program offers while balancing the responsibilities for coverage and financing between the federal and state governments. Assuring that financing is adequate to meet the needs of America's most vulnerable and addressing our growing uninsured problem should be among our nation's highest priorities.
Administration	9	Long-term strategies that invest in Medicaid to promote better management of chronic illness, disease prevention, and coordination with Medicare to more effectively address the needs of the high costs enrollees who rely on both programs offer an alternative for containing costs.
Recommendations for Overall HC Reform	No	

AcademyHealth, Medicaid Reform: Balancing Care, Coverage, and Cost, June 2005

http://www.hcfo.net/topic0605.htm

Module	Page	Summary
Overall	2-3	Potential Medicaid reform solutions will likely take a multi-dimensional approach, targeting categories such as: Contributing individual finances and planning, altering benefits offered, implementing administrative changes to lower systemic costs, and adapting private sector initiatives. **This paper contains a number of Health Care Financing and Organization funded research topics for Medicaid. Please review paper for these proposals.**
Acute/Preventative Care	2	Establish fee scales based on Medicaid eligibility tests that would help identify those Medicaid beneficiaries with sufficient financial resources to share costs.
Acute/Preventative Care	2	Offer more targeted services based on individual to avoid redundancies and unnecessary expenses.
Acute/Preventative Care	2	Increase the focus on preventive versus reactive medicine to avoid lowering short-term costs at the expense of increasing long-term costs, and simultaneously improve quality of care.
Acute/Preventative Care	2	Limit mandatory federal benefits requirements to allow states greater flexibility in determining optimal coverage schedules.
LTC	2	Implement incentives to obtain long-term care insurance that would extend individual ability to obtain coverage, and offset dependence on the stretched-thin Medicaid system.
LTC	2	Insure that coverage is reserved for low-income persons and not as an asset protection program. One option to consider is placing restrictions on, or imposing penalties for, asset transfers used to render people eligible for Medicaid coverage.
LTC	2	Increase long-term care alternatives to nursing home care to minimize costs and improve quality for individuals who would benefit from such alternative residential settings, such as home- or community-based care, or assisted living facilities.
Administration	2	Use information technology to increase efficiency, cut costs, and improve patient care coordination among multiple providers.
Administration	2	Form cooperative purchasing pools that would enhance state-level ability to negotiate better pricing for supplies and services.

AcademyHealth, Medicaid Reform: Balancing Care, Coverage, and Cost, June 2005

http://www.hcfo.net/topic0605.htm

Module	Page	Summary
Recommendations for Overall HC Reform	Yes	Three options for health care reform that would increase the sustainability of the Medicaid program are: 1. Provide premium subsidies for low-income individuals that would offset disproportionate impact and avoid disenrollment/uninsurance effects that would otherwise increase the burden on costly emergency-based reactive health care. 2. Establish health savings accounts to expand individual spending power, encourage individual fiscal responsibility, provide an additional coverage option for smaller businesses to provide employee benefits, and provide an option for coverage for individuals who would otherwise either be uninsured or dependent on Medicaid. 3. Establish incentives for private employer-based health insurance coverage in order to minimize burden on the Medicaid system.

National Center for Policy Analysis, Reforming Medicaid Presentation to The Forum for State Health Policy Leadership, June 2005

http://www.kaisernetwork.org/health_cast/uploaded_files/061605_ncsl_JohnGoodman_presentation.pdf

Module	Page	Summary
Overall	n/a	Reviews Medicaid's main cost drivers, problems, reforms, and models from the private sector.
Acute/Preventative Care	30	Private sector models of reform include: substituting low-cost services for high-cost services; employing smart buying techniques; promoting disease management and selective contracting.
Acute/Preventative Care	20	Private sector models of pharmaceutical price control include: price comparisons for drug purchasing; bulk buying for drug purchasing; pill splitting for drug purchasing and the use of OTC, therapeutic and/or generic substitutes for drug purchasing.
LTC	28	Recapture the costs of long-term care by broadening the definition of assets that are subject to recapture, vigorously pursuing assets and creating recapture options.
LTC	30	Use asset recapture to encourage low-cost choices.
LTC	30	Expand Cash and Counseling for the disabled and chronically Ill.
Quality	30	Use quality incentives like Pay-for-Performance.
Administration	13	If possible, contract out or copy the methods used in the private sector.
Recommendations for Overall HC Reform	Yes	Promote Health Savings Accounts.

GWU & Center for American Progress, New Thinking and Approaches to Delivering, Managing and Financing Medicaid Services, June 2005

http://www.kaisernetwork.org/health_cast/uploaded_files/061605_ncsl_JeanneLambrew_presentation.pdf

Module	Page	Summary
Overall	8	Overall this presentation lists the elements of reform that they believe have consensus, including: - Government assistance for poor and sick (Risk pools and reinsurance, Filling in Medicaid coverage for all people in poverty) - Mix of public and private insurance (Some form of group purchasing pool, Public program and tax credit financing) - Promoting quality, efficiency (through Information technology and “Comparative effectiveness” research)
Overall	8	The presentation also highlights the areas of disagreement, including: – Where the line between public and private insurance is drawn – The role, if any, for non-group, individual insurance – Financing
Acute/Preventative Care	20	Promote disease-specific management (e.g. for asthma, diabetes).
Acute/Preventative Care	18	Promote reverse engineering and high cost cases. This includes identifying and assessing the few, most expensive individuals. Then develop systems to manage such individuals and implement prevention strategies based on these cases.
Acute/Preventative Care	13	Promote Consumer Directed Care. Individuals should have primary control over health use. Allows individuals to decide which benefits they need, prevents over-utilization, and allows for price comparison and shopping.
Acute/Preventative Care	17	Promote Evidence Based Care. Control is given to consumers through high deductibles and accounts.
LTC	20	Promote case-specific management for high-cost beneficiaries such as Dual eligibles.
LTC	14	Promote consumer-directed long-term care, including "Cash and Counseling" for personal care services.
Quality	17	Payment and coverage should be based on outcomes and evidence, using comparative effectiveness research to guide benefit and cost sharing policies. Medicaid should also use performance as a basis for payment.
Administration	16	Electronic health records should be linked to systems to prevent medical errors. There needs to be the ability to use electronic information to coordinate care across providers and settings.
Administration	17	There needs to be an upfront investment in data systems.
Administration	12, 24	There should be tax credits for coverage to compliment Medicaid.
Recommendations for Overall HC Reform	No	

Medicaid Policy LLC, Medicaid Waivers: What Have We Learned Over the Past Two Decades?, June 2005

http://www.kaisernetwork.org/health_cast/uploaded_files/061605_ncsl_SchneiderArtiga_presentation.pdf

Module	Page	Summary
Overall	9-10	This presentation describes a number of state Medicaid waivers and the various innovations they promote. States covered include, Utah, Oregon, Vermont and Florida. Examples show how states have used 1115 waivers: – To expand coverage within "current level resources" – To provide increased flexibility to limit or reduce costs – To serve as a model for Medicaid reform – Factors driving recent waivers – Recent state fiscal pressures – Increased waiver flexibility through 2001 Health Insurance Flexibility and Accountability (HIFA) waiver initiative – State and federal interest in reforms that would increase states' flexibility
Recommendations for Overall HC Reform	20, 22	Recommends premium assistance with limited or no benefit mandates and no wraparound coverage requirements.

United Hospital Fund, Opportunities and Challenges to Medicaid Reform or Restructuring with States, June 2005

http://www.kaisernetwork.org/health_cast/uploaded_files/061605_ncsl_JamesTallon_presentation.pdf

Module	Page	Summary
Overall	19	This presentation lists proposals for change in broad categories, including: State Flexibility; Cost-sharing; Premiums; Benefits; and Enrollment caps. It also discusses the coverage of Dual Enrollees, including: Medicare premiums; Prescription drugs; and Long-term care. The discussion of LTC includes: Tightening eligibility and Consumer-direction. Finally it covers Federal vs. State Financing including, IGTs and block-granting.
Eligible Populations	4	Repeal the entitlement of services to beneficiaries.
Acute/Preventative Care	17	Increase state flexibility with benefits.
Quality	5	Medicaid should be used as a force for health care improvement.
Administration	4	Repeal the entitlement of federal funding for states.
Administration	4	Shift standards to state responsibility.
Recommendations for Overall HC Reform	5, 20	There should be uniform national coverage for low income population. The real problem is not Medicaid, but: • Lack of universal coverage • Gaps in Medicare coverage • No alternative for long-term care assistance • Lack of system-wide health cost containment • Inadequate financing for the safety net

Health Affairs, Change in Challenging Times: A Plan for Extending and Improving Health Coverage, March 2005

(not web accessible)

Module	Page	Summary
Overall	1 (Abstract)	Provides a plan for providing health coverage for all Americans through "knitting" together Employer Sponsored Insurance (ESI) and Medicaid.
Eligible Populations	W5-122	Simplify and extend Medicaid coverage to everyone below a certain poverty level (e.g. 100 or 150 % FPL).
Recommendations for Overall HC Reform	Yes	Supplement ESI market with an insurance pool modeled after the Federal Employee Health Benefit Program (FEHBP) for those without an ESI offer; promoting prevention, research, and information technology; and financing the plan through a dedicated value-added tax.

Cato Institute, Medicaid Reform, April 2005

http://www.cato.org/pub_display.php?pub_id=3740

Module	Page	Summary
Overall	2	Block grant the program.
Eligible Populations	2	Discourage program expansions by freezing payments at the 2005 level.
Acute/Preventative Care	2	Eliminate the entitlement to benefits.
LTC	2	Eliminate the entitlement to benefits.
Administration	2	Allow maximum program flexibility by reducing federal requirements to a few broad goals for States to meet.
Recommendations for Overall HC Reform	No	

Health Management Associates, Medicaid in 2005: Principles & Proposals for Reform, February 2005

http://www.nga.org/Files/pdf/0502MEDICAID.pdf

Module	Page	Summary
Overall	n/a	Modernize Medicaid to simplify program administration, update eligibility rules and benefit mandates, encourage personal responsibility, promote market solutions for expanding coverage, and create alternatives for long-term care.
Eligible Populations	17	Allow states to test innovative approaches within Medicaid that incorporate health savings accounts or tax credits as strategies to increase coverage for the uninsured.
Eligible Populations	15	Allow states to eliminate categorical eligibility and base it simply on income.
Acute/Preventative Care	16	Allow states to promote preventive care using enhanced reimbursement strategies with providers and care managers, and cost sharing strategies with beneficiaries.
Acute/Preventative Care	17	Allow states to encourage choice through greater use of and coordination with employer sponsored health insurance, supplementing costs when necessary to encourage such coverage.
Acute/Preventative Care	17	Simplify the process for subsidizing employer sponsored health insurance.
Acute/Preventative Care	15	Eliminate the need for certain waivers, such as Family Planning.
Acute/Preventative Care/LTC	16	Allow states to partner with cities and counties in providing health care through locally designed networks.
Acute/Preventative Care/LTC	16	Allow states to adopt policies that encourage Medicaid beneficiaries to be active participants in the program by making informed choices, directing their own care, sharing in the cost of their care, and helping to control program costs.
Acute/Preventative Care/LTC	16	Provide Medicaid beneficiaries and their families access to the information they need to navigate the health care system and to make informed decisions about their care.
Acute/Preventative Care/LTC	16	Allow states to adopt beneficiary cost sharing based on income, and consistent with cost sharing in employer sponsored health insurance plans.
Acute/Preventative Care/LTC	17	Provide incentives for states to craft comprehensive, affordable benefit packages that look more like commercial plans, using SCHIP as a model.
Acute/Preventative Care/LTC	15	Allow states to design benefits packages for higher income groups that are not as comprehensive as those provided to lower income groups.
LTC	15	Allow states to provide HCBS under regular Medicaid.
LTC	17	Amend federal Medicare law so the federal government assumes specific responsibility for low income Medicare/Medicaid dual eligibles, including full payment of premiums, coinsurance and deductibles.
LTC	17-18	Provide incentives for states to adopt policies that ensure those who can afford to pay for long‐term care do so, including policies that advantage individuals with long term care insurance. Provide incentives for states that encourage greater reliance on long term care insurance, including the greater availability “Partnership” programs.

Health Management Associates, Medicaid in 2005: Principles & Proposals for Reform, February 2005

http://www.nga.org/Files/pdf/0502MEDICAID.pdf

Module	Page	Summary
LTC	18	Integrate New Freedom Initiative principles into Medicaid program design, to provide opportunities for employment and greater consumer choice and direction for long term and chronic care for persons with disabilities.
LTC	18	Allow states to offer long term care services in the most appropriate setting, respecting the preferences of individuals who can receive such care in their home or community, without the need for time - limited waivers.
Quality	17	Provide incentives for states to adopt current private sector technologies, like health information systems, quality tracking and review, provider report cards, and other methods to measure and improve quality through the use of technology.
Administration	16	Simplify state plan and waiver processing requirements.
Administration	16	Restructure program financing in a way that reflects federal and state fiscal strengths, capacities and limitations.
Administration	16	Ensure Medicaid reimbursement methodologies that encourage prudent payment for Medicaid covered services.
Administration	18	Update the formula for calculating the state - specific federal matching rates (FMAP) to make it more responsive to economic downturns and to state fiscal capacity.
Administration	18	Realign fiscal responsibility for persons covered by Medicare and Medicaid, so the federal government pays a more appropriate share of the costs for these low income Medicare beneficiaries.
Recommendations for Overall HC Reform	No	

National Academy for State Health Policy, Making Medicaid Work for the 21st Century, January 2005

http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

Module	Page	Summary
Overall	n/a	The National Academy for State Health Policy published recommendations for changes to Medicaid eligibility, benefits and financing reform as the conclusion to a year long project titled Making Medicaid Work for the 21st Century. NASHP emphasized the need to balance meaningful federal standards with state flexibility in program design and implementation. Before making recommendations, the workgroup stated ***the importance of viewing its recommendations as a total package because the recommendations are interrelated and reflect a complex balancing of interests.***
Eligible Populations	14	Establish a national minimum Medicaid eligibility threshold that would require states to cover all individuals with household incomes up to 100 percent of the FPL, as well as continuing the current requirements to cover children under age six and pregnant women up to 133 percent of the FPL or higher. The workgroup further recommended that these new requirements be phased in over four years and that the Federal government offer an enhanced match for new eligibles.
Eligible Populations	13	The NASHP workgroup recommended that states should have full flexibility to expand Medicaid eligibility to income levels above the eligibility floor.
Eligible Populations	52	The workgroup recommended that legal immigrants should be eligible for Medicaid on the same terms as U.S. citizens regardless of their date of entry into the country or length of residence.
Acute/Preventative Care	26	The workgroup recommended that states should be able to allow parents to choose which program to enroll their children in within states that have separate Medicaid and SCHIP programs.
Acute/Preventative Care	53	The workgroup recommended that short-term acute psychiatric hospitalizations be covered at the state's usual Medicaid FMAP rate, regardless of whether those services are received in an Institution for Mental Disease (IMD) or not.
Acute/Preventative Care	57	The workgroup recommended that states not be allowed to establish Medicaid programs in which the only coverage offered is premium support.

National Academy for State Health Policy, Making Medicaid Work for the 21st Century, January 2005

http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

Module	Page	Summary
Acute/Preventative Care	57-58	With regard to Employer Sponsored Insurance (ESI) programs under the Medicaid State plan: 1) The workgroup recommended that states be allowed the option to implement certain policies under §1906 authority (as a state plan amendment) that may now be implemented only under a §1115 waiver, including those related to wrap-around benefit coverage, wrap-around cost sharing, and crowd-out prevention. 2) The workgroup recommended that states be required to provide wrap-around coverage to members of the mandatory population, but that states only be required to provide wrap-around coverage to a member of an optional population when the individual's private insurance coverage would not meet any of the coverage benchmarks that a state could choose to establish for optional adults. 3) Further the workgroup recommended that states be able to use a checklist to determine whether the employer plan included the required benefits rather than using a side-by-side, benefit-by-benefit detailed comparison. 4) For mandatory populations, Medicaid would wrap around and cover any cost sharing beyond standard Medicaid limits.
Acute/Preventative Care	58-59	ESI (Continued): 5) For optional populations, the group believed that some cost sharing would be appropriate as long as there were limits to protect enrollees from incurring excessive amounts of cost sharing. 6) The workgroup recommended that the existing Medicaid standard for cost effectiveness be maintained. 7) The workgroup recommended retaining the current law for the mandatory population that allows states to require beneficiaries to enroll in qualified private coverage.
Acute/Preventative Care	59-60	ESI (Continued): 8) Amending existing Medicaid law for optional adults and children by allowing that a) if a state chooses to offer wrap-around benefits or cost sharing to optional populations, then the state may require beneficiaries to enroll in the private coverage, and b) if a state chooses not to offer wrap-around benefits or cost sharing to optional populations, then the state must offer beneficiaries a choice between the private coverage and direct Medicaid coverage at their initial enrollment and at every periodic eligibility determination. 9) The workgroup recommended that the federal ERISA statute be modified so that states could require self-insured employers to consider Medicaid eligibility determination or the identification of qualified private coverage for a Medicaid beneficiary as a qualifying event.
Acute/Preventative Care/LTC	9, 23	For all persons with incomes below the national minimum eligibility levels (i.e., mandatory eligibility groups), Medicaid should guarantee comprehensive acute and primary care and long-term care benefits as defined under current law.

National Academy for State Health Policy, Making Medicaid Work for the 21st Century, January 2005

http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

Module	Page	Summary
Acute/Preventative Care/LTC	9, 25	For persons with incomes above the national minimum eligibility levels (i.e., optional eligibility groups), Medicaid rules should allow states more flexibility in benefit design. If a state chooses to offer benefits to an optional group, the state would be required to offer acute and preventive care, but could choose whether or not to offer long-term care. States would also have the option to define which acute and long-term care services they would cover in the benefit package. For an optional group, a state could choose a benefit package that was the same as that provided to mandatory groups, or at state option, benefits could, within defined limits, be less comprehensive and could require higher cost sharing.
Acute/Preventative Care/LTC	27	With respect to cost sharing (i.e., premiums, copayments, and deductibles), the workgroup recommended that current Medicaid rules continue to apply to the mandatory population but that states be allowed to require optional populations (adults and children) to share a greater portion of the cost of services up to a specified limit.
Acute/Preventative Care/LTC	36	The workgroup recommended that Medicare pay for care coordination as a covered benefit.
Acute/Preventative Care/LTC	36	The workgroup recommended that Medicare and state Medicaid programs share data on service utilization by dual eligibles in order to improve care coordination.
Acute/Preventative Care/LTC	38	The workgroup recommended that, for benefits offered by both programs, the Medicare program review its policies in the areas of payment adequacy, benefit design, and medical necessity to ensure that its beneficiaries have appropriate access to these benefits through Medicare, rather than initially seeking those benefits from Medicaid. Further, the workgroup recommended that, in the future, when Medicare takes an action that financially affects a state Medicaid program, the federal government should confer with the affected state before approval.
LTC	19	The workgroup recommended allowing states to modify their income and assets tests to allow those applicants seeking community care who are most likely to use up their resources within a short time of entering a nursing home to qualify for Medicaid financed acute and community care (but not institutional services) while they are still in the community.
LTC	19	The workgroup recommended that states continue to have flexibility to establish medical/functional/cognitive eligibility criteria and that states be allowed to set different criteria for institutional and community long-term care.
LTC	28	For optional populations, the workgroup recommended that states have the option to employ cost sharing for community-based long-term care services, including services for people with developmental disabilities. They also recommended that states have the option to develop buy-in options for long-term care services.

National Academy for State Health Policy, Making Medicaid Work for the 21st Century, January 2005

http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

Module	Page	Summary
LTC	28-29, 69	The workgroup recommended that states be allowed to replace Section 1915(c) waivers with a home and community-based care program with the following components: 1) States would submit a plan to CMS describing the services covered. Once approved, the program would continue without renewal requirements. 2) States could set a higher functional threshold for admission to an institution (nursing home or ICF-MR) and a lower functional threshold for the home and community-based services program. 3) The program would not be subject to existing waiver requirements. 4) States would be able to set caps on participation in the home and community services program. 5) The program could serve multiple populations with different service options for subpopulations. 6) Cost sharing would be allowed for the optional eligibility group (above 100 percent FPL). 7) Limits on the number of clients in target population programs should be phased out over time.
LTC	30-31	The workgroup recommended that states be able to choose to implement one or more of the following delivery system options to provide them with more effective tools to manage access to long-term care services: 1) An unmanaged fee-for-service delivery system; 2) A care managed fee-for-service delivery system; 3) A risk-based, capitated managed care delivery system for long-term care services; or 4) An integrated acute and long-term care service system.
LTC	31	The workgroup recommended that under the new HCBS program, states be allowed to choose to provide optional populations (those with incomes above the minimum national eligibility threshold) more restrictive choices of delivery systems than they provide to the mandatory population.
LTC	32	The workgroup recommended that states be allowed to expand their use of consumer-directed care.
LTC	33	The NASHP workgroup recommended the extension of both the Cash and Counseling Demonstration program and the Money Follows the Person Demonstration program.
LTC	35	The workgroup recommended that the federal government and the states embark on a new conversation about how to finance and deliver long-term care services provided by state Medicaid programs to dual eligibles.
LTC	64	The workgroup recommended policy changes that would encourage individuals to take responsibility for their own long-term care coverage and that would help make purchase of long-term care insurance more affordable.
LTC	65	The group also recommended that public policy support the development of an efficient and effective long-term care delivery system for the 80 to 90 percent of individuals who cannot afford such policies and rely upon the social safety net.

National Academy for State Health Policy, Making Medicaid Work for the 21st Century, January 2005

http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

Module	Page	Summary
Quality	37	The workgroup recommended that the Medicare program mandate that Medicare quality improvement organizations (QIOs) identify dual eligibles as a subsample in quality reviews. Specifically, for Medicare Advantage health plans to receive Medicaid-financed premiums, copayments, and other forms of cost sharing, the workgroup recommended that the state have the option to require the Medicare Advantage health plan to contract with the state. The group also recommended that Medicare ensure that its risk adjustment methodology adequately address enrollment of dual eligibles in managed care plans.
Quality	37	When Medicaid is expected to provide cost sharing to providers who render services for dual eligible clients, the Medicare program and its vendors should provide Medicaid agencies with the data needed to verify that the encounters actually occurred.
Quality	37	All Medicare claims data should be matched with state Medicaid data to improve fraud detection.
Administration	20	The workgroup recommended that federal matching funds be available on a time-limited basis for services provided after presumptive eligibility is determined even if the applicant does not ultimately qualify for Medicaid.
Administration	45	The workgroup recommended that the FMAP formula be revised to calculate the FMAP based on a two-year average of per-capita income (PCI) data. (Instead of a three year average as is required by law now)
Administration	47-48	The workgroup recommended that the FMAP formula be changed by adding an adjustment into the formula to increase FMAP for most or all states when unemployment exceeds a national trigger and suggests closer examination of the specific method to be used.
Administration	48	The workgroup recommended that federal rules and definitions of expenditures that qualify for federal Medicaid matching funds be reviewed to ensure the fact and perception of fiscal integrity in every aspect of Medicaid spending.
Administration	51	The workgroup recommended that states should receive the enhanced SCHIP match for services provided to children above the mandatory Medicaid level and that the enhanced match should come out of each state's existing yearly SCHIP allotment.
Administration	52	The workgroup recommended that the federal government pay for the full cost of services provided to AI/AN beneficiaries regardless of where they receive services.
Administration	61	The workgroup recommended that federal law be amended so states remit identified overpayments to the federal government when recovery of the overpayment is received by the state.
Administration	61	The workgroup recommended that federal law be amended to increase the matching rate for qualifying state program integrity activities to 75 percent.
Administration	62	The workgroup recommended that the fee required ($4.25 per name searched) for use of the federal Healthcare Integrity and Protection Database (HIPDB) be eliminated.

National Academy for State Health Policy, Making Medicaid Work for the 21st Century, January 2005

http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf

Module	Page	Summary
Administration	62	The workgroup recommended that federal bankruptcy law be amended to prohibit Medicaid providers from discharging overpayments during bankruptcy proceedings when the declaration of bankruptcy is precipitated by the Medicaid agency's attempt to recover the overpayments.
Administration	62-63	The majority of workgroup members supported a recommendation to amend federal law to permit the interception of federal tax refunds to Medicaid providers who owe federal or state government money for overpayments.
Administration	67	The workgroup recommended that the Section 1115 waiver process be retained in order to allow for future innovations in Medicaid structures, financing, and delivery systems.
Administration	67	The workgroup recommended that the state plan process for managed care be simplified to recognize that managed care is now a mainstream feature of the health care delivery system.
Administration	67-68	The workgroup recommended that the process for obtaining both §1115 and §1915(b) waivers be simplified and burdensome requirements dropped as follows: 1) Redefine the budget neutrality requirement for waivers in order to consider savings achieved in other federal programs through changes in Medicaid (e.g., Medicare savings attributable to avoided hospitalizations; Social Security Administration savings attributable to foregone SSI when someone returns to work). 2) Establish a time period by which waivers must be approved or denied. 3) Encourage CMS to develop waiver templates (for those types of waivers for which templates do not yet exist). When states follow these templates, the waivers should be approved under an expedited timeframe. 4) Treat waiver renewals like state plan amendments to speed the renewal process.
Administration	69	The workgroup recommended that Medicaid law and rules be changed to allow the use of selective contracting without a waiver, when a state chooses to use this approach to control costs and assure quality. They further recommended that selective contracting be tied to access and quality standards that could be developed by individual states or nationally through a joint state/federal process with broad stakeholder input.
Administration	70	The workgroup recommended that the current federal requirements for statewideness be continued absent a waiver.
Administration	71	The workgroup recommended that states have the option to provide "out-of-plan" benefits (some or all benefits that are currently Medicaid covered but would not be in the new package) to current beneficiaries while implementing the recommended program changes. This situation could continue, at state option, either for some state-established transitional period or permanently.
Recommendations for Overall HC Reform	No	

ADAPT, MiCASSA (Medicaid Community Attendant Services and Supports Act)

http://www.adapt.org/casaintr.htm

Module	Page	Summary
Overall	n/a	ADAPT promotes ending institutional bias in Medicaid.
LTC	n/a	MiCASSA (Medicaid Attendant Services and Supports Act) establishes a national program of community-based attendant services and supports for people with disabilities, regardless of their age or disability. The bill would allow the dollars to follow the personal and allow eligible individuals, or their representatives to choose where they would receive services and supports. Any individual who is entitled to nursing home or other institutional services would have the choices where and how services would be provided. This would not be a new entitlement, but would make the existing entitlement more flexible.
Recommendations for Overall HC Reform	No	

American Legislative Exchange Council, Medicaid Reform

http://www.alec.org/2/4/talking-points/5.html

Module	Page	Summary
Overall	n/a	This paper argues for privatizing the program and promoting consumer choice.
Administration	1	Medicaid should be privatized. To create a cost-efficient and effective program, remove a large portion of the control over the program from the realm of state governments and place that control squarely in the hands of the Medicaid recipient.
Acute/Preventative Care/LTC	1	Funding should be made available in the form of a Medical Assistance Account at the beginning of each year to cover all Medicaid expenses, rather than the current "pay-as-you-go" system. If the control over how and when Medicaid funds get used were instead in the hands of the Medicaid recipient, innovative drugs and treatments would be more readily accessible. While these treatments may initially cost more, they have the potential to reduce costs in the long run by eliminating the need for recurring, less expensive treatments.
Recommendations for Overall HC Reform	No	

Partnership for Medicaid, Core Principles (for Reform), 2005

http://www.aafp.org/PreBuilt/StAdv_MedicaidPrinciples.pdf

Module	Page	Summary
Overall	1	Provides a set of core guiding principles by which reform should be shaped.
Eligible Populations	1	The Partnership believes that individual and provider protections, including a private right of action to enforce those protections, should be maintained, and access to culturally appropriate care should be promoted. They also advocate that reform efforts should not eliminate current federal coverage guarantees, nor should they result in reducing or eliminating coverage for currently eligible individuals.
Acute/Preventative Care	3	To ensure appropriate access to care for beneficiaries, the Partnership believes that the program should provide fair and adequate compensation to providers for each class/type of care in the most appropriate setting, including the cost of providing culturally appropriate services.
Administration	2	The Partnership believes that the Congress should update the FMAP to more adequately account for Medicaid's counter-cyclical nature. During economic downturns, increased unemployment, public health emergencies, or other unexpected events (such as a hurricane or terrorist attack), more people rely on Medicaid.
Administration	3	The Partnership believes that policies must be developed that recognize the interdependence of Medicaid and the public health system and promote linkages among primary, acute and long-term care services. Support for identified safety net providers (those who care for disproportionately high numbers of Medicaid and uninsured individuals) must be continued.
Administration	3	The Partnership promotes improving the integrity of Medicaid-- Appropriate approaches should be developed to ensure that the financing of the Medicaid program is sound. It is critical that such approaches not threaten care for beneficiaries in the program nor undermine the existing federal/state/local matching structure.
Administration	2	The Partnership believes that Medicaid waivers should be approved only if they "promote the objectives of" Medicaid or SCHIP, and do not erode the program's ability to provide comprehensive services to all eligible beneficiaries.
Recommendations for Overall HC Reform	No	

The Commonwealth Fund, Health Care Opinion Leaders Survey, November/December 2004

http://www.cmwf.org/usr_doc/CMWF_Opinion_Leaders_summary.pdf

Module	Page	Summary
Overall	n/a	In a survey of 300 health policy leaders (conducted by Harris Interactive on behalf of The Commonwealth Fund), there was broad consensus that expanding coverage to the uninsured was the top priority that should to be addressed by Congress. This was the greatest priority for all groups represented in this study, (academic/research institutions, health care delivery, business/insurance/other health care industry, and government/labor/advocacy). There was also considerable agreement about the reforms that should be enacted in order to achieve this goal. Allowing individuals and small businesses to buy into the Federal Employees Health Benefits Program or a similar federal group option receives the highest support overall and a majority of votes across all groups. Also, expanding existing state-based public insurance programs — Medicaid and the State Children's Health Insurance Program (SCHIP) — is supported by more than half of leaders overall and across groups, except for the health care delivery sector. A national health system (universal coverage) received little attention as a priority.
Quality	3	Improving the quality and safety of medical care, including increased use of information technology, is ranked as the second most important priority (after expanding coverage) for Congress to address, with a large majority overall and within each constituency supporting this. Additionally, several specific issues are named as top priorities for action in order to control costs and improve quality. These are: rewarding more efficient providers and effective disease management, increased and more effective use of information technology, and, to a lesser degree (but still supported by a majority overall), making information on quality and costs of care available to the public.
Recommendations for Overall HC Reform	Yes	See above

National Association of Public Hospitals and Health Systems, Principles for Medicaid Reform, May 2004

http://www.naph.org/Template.cfm?Section=Medicaid_Reform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=4253

Module	Page	Summary
Overall	n/a	Overall, the National Association of Public Hospitals and Health Systems (NAPHHS) offers five principles for Medicaid reform. Foremost among them are to protect the current guarantees of coverage for Medicaid recipients.
Eligible Populations	1	NAPHHS promotes ensuring the availability of comprehensive benefits to covered individuals. States currently provide essential health benefits to both mandatory and optional populations through their Medicaid programs. They advocate that Medicaid reform efforts should not result in reducing or eliminating the entitlement of our most vulnerable populations to coverage.
Administration	1	Future Medicaid spending should be based on need, not capped annual funding amounts.
Administration	1	Medicaid reforms should be carefully tied to efforts to expand coverage, as one important tool in an anticipated combination of public program improvements and private sector initiatives. Moreover, it is important that the impact of Medicaid reforms on all populations among the uninsured (including, e.g., legal and illegal immigrants, persons with AIDS, etc.) be taken into account in crafting effective reforms.
Administration	1	NAPHHS promotes strengthening safety net providers. According to NAPHHS, at a time when the number of Medicaid enrollees and uninsured are increasing, further reducing or eliminating direct payments to safety net hospitals, like Medicaid DSH, could rapidly destroy our nation's fragile system for providing care to the uninsured. Medicaid DSH is one of the most important funding sources for many hospitals – often the major (if not only) reason they can continue serving the uninsured and providing essential community-wide services like trauma care.
Recommendations for Overall HC Reform	No	

National Conference of State Legislatures, Medicaid Reform Proposal, January 2004

http://www.ncsl.org/statefed/health/marefprop2.htm

Module	Page	Summary
Overall	n/a	The central feature of this National Conference of State Legislatures' Medicaid Reform proposal is to increase the flexibility that the states have for innovation with the Medicaid program. Additional state flexibility will: facilitate more state experiments in meeting the needs of uninsured and under insured people, allow states to cut costs with minimal loss of services, and reduce long-term care costs .
Overall	4	Give the states more flexibility to streamline and simplify the Medicaid eligibility process reducing the hassle factor for clients and reducing administrative costs. Specifics include using low-income as an alternative to categorical eligibility.
Eligible Populations	2	States should be allowed to set minimum work requirements for program recipients with incomes above the minimum federal requirements for eligibility, as a condition of participating in the program, for those able to work.
Eligible Populations	2	States should be allowed to give families and individuals eligibility for the program based on their low-income status even if they do not otherwise fit the categorical eligibility. This will make the program a more explicit program for low-income people and greatly simplify the eligibility process. This reform coupled with work requirements and enhanced deductibles and copayments would reinforce the provisions of welfare reform. States should have the flexibility to use restricted TANF funds to finance any additional state costs incurred by this provision.
Acute/Preventative Care	3-4	Provide more flexibility for states with regard to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. States should be permitted to use less costly alternative strategies while maintaining quality of care. For example, for many developmental delays treatment under the state's developmental disability program may be more cost effective than treatment under a Medicaid medical model.
Acute/Preventative Care	3	States should be allowed to have a prescription drug only option, including enhanced eligibility, with copayments and deductibles. At the upper end of the income eligibility scale the state and federal financial participation may be eliminated or reduce it to a nominal one and the beneficiairy would pay most of the cost to participate.
Acute/Preventative Care	2-3	States using a priority list of services, like the one Oregon uses, should have the flexibility to modify that list as circumstance change.

National Conference of State Legislatures, Medicaid Reform Proposal, January 2004

http://www.ncsl.org/statefed/health/marefprop2.htm

Module	Page	Summary
Acute/Preventative Care	3	Prescription Drug Reform recommendations: 1. The Medicaid drug rebate program should be subject to regular compliance audits either by the U.S. General Accounting office (GAO) or by the states acting individually or in cooperation. 2. The current federal requirement for secrecy in Medicaid prescription drug purchasing should be removed to allow the states to make public the prices paid for individual drugs, the rebates received and the resulting net prices paid. This change would facilitate public debate on Medicaid prescription drug purchasing policies and would facilitate the operation of a competitive free market for prescription drugs. 3. NCSL supports current federal law on the use of prior authorization for prescription drugs. Each state has the right to determine under what circumstances a prior authorization program is appropriate and the precise nature of that program.
Acute/Preventative/LTC	2	The states should be allowed to impose enhanced deductibles and copayments for program recipients with incomes above the minimum federal requirements for program eligibility. This will improve cost control, graduate benefits with income, and make the Medicaid program more like private employer based or individual insurance.
LTC	2	States should be allowed to establish and set the size of the programs that provide for home and community based care as an alternative to nursing homes. As a cost control technique, states should continue to be allowed to limit this program to a specific number of slots and additionally should be allowed to provide this service without providing the full range of additional Medicaid services.
LTC	2	Congress should repeal the provision in the Omnibus Budget Reconciliation Act of 1993 that restricts the ability of the states to develop programs that provide limited asset protection within the Medicaid program to individuals who purchase long-term care insurance. This could give many people who do not now purchase long-term care insurance an incentive to do so, helping those people while saving both the federal and state governments money.
LTC	3	NCSL urges Congress to provide the states with relief regarding the nursing home reform requirements enacted in the 1987 Omnibus Budget Reconciliation Act which are too prescriptive. States are continuing to struggle with implementing that program. NCSL is specifically concerned that the resulting paper work requirements are decreasing the quality of care in nursing homes by diverting skilled personnel from patient care to paperwork and thereby exacerbating the nursing shortage.
Administration	4	Allow states to modify their state Medicaid programs by plan amendment instead of using the waiver process. Develop an expedited waiver process that would include a strong program evaluation component. NCSL urges the federal government to require prior state legislative authorization, when any waiver requires long-term commitment of state appropriations.
Administration	4	Eliminate the current cost neutrality requirement for many classes of waivers, especially for waivers with prior legislative approval. Since states share in any cost increases caused by waivers should be relied on to restrain state waiver proposals to those expected to be cost effective.

National Conference of State Legislatures, Medicaid Reform Proposal, January 2004

http://www.ncsl.org/statefed/health/marefprop2.htm

Module	Page	Summary
Administration	4	With respect to the current State-Federal financing arrangement 1) Congress should forbid the new practice of requiring the federal share for large segments on the Medicaid program be capped as a condition of receiving a waiver. This practice defeats the traditional cost sharing and discourages state flexibility and innovation. Any capping associated with waivers should be limited to the specific expenditures under the waiver and should extend to both federal and state shares. 2) The federal government should eliminate the current capping of the Medicaid program in the Commonwealth of Puerto Rico and the territories and develop a distribution mechanism that more adequately reflects the need and is more comparable to what the states receive.
Administration	5	NCSL supports the use of audits to ensure program integrity and believes the goal of audits should be to improve program administration. Where states have made honest efforts in interpretation, this information should be shared so that other states might benefit. NCSL urges Congress to by law authorize the Centers for Medicare and Medicaid Services (CMS) to permit prospective compliance in cases when the infraction was procedural or due to honest differences in interpretation of complex law and regulation. This would subject the states to financial penalties only when they fail to comply within a specific period of time.
Administration	5	States should be authorized by statute to use provider-specific taxes, voluntary donations, and intergovernmental transfers. These programs can be important in reducing the cost shifting caused by the Medicaid program that can constitute a hidden tax on private health coverage, driving up the cost of that coverage.
Administration	5	Under current law, states are required to reimburse Federally Qualified Health Centers and Rural Health Centers at 100% of cost rather than negotiated or capitated rates. Automatic cost reimbursement brings incentives for cost increases and may give states an incentive to discourage these programs. NCSL urges the federal government to repeal this requirement and permit states to negotiate or set rates for these entities.
Administration	5	With respect to program regulations: 1) NCSL urges Congress require CMS to promulgate regulations on a more timely basis and to require states comply with new requirements only after CMS has published final regulations. 2) NCSL urges CMS where possible to publish proposed regulations rather than promulgate interim final regulations. The publication of proposed regulations provides states with more time for consultation with CMS and provides states with an opportunity to identify problem areas before they are required to implement the program.
Recommendations for Overall HC Reform	No	

US Department of Health and Human Services, Secretary Thompson's Statement Before the United States Senate Committee on Budget, February 2003

http://www.senate.gov/~budget/democratic/testimony/2003/thompson_hrng022603.pdf

Module	Page	Summary
Overall	6-10	Overall this testimony outlines the Administration's 2003 proposals for Medicaid reform. This proposal included an option whereby states could receive a "State Health Care Partnership Allotment". By accepting this capped allotment, the states would have increased flexibility for optional populations and services.
Eligible Populations	6-7	States electing a partnership allotment would have to continue providing current mandatory services for mandatory populations. For optional populations and optional services, the increased flexibility of these allotments will allow each State to innovatively tailor its provision of health benefit packages for its low-income residents. For example, States could provide premium assistance to help families buy employer-based insurance.
Eligible Populations	8	The Budget proposes to give States the option to extend Medicaid coverage for spouses of disabled individuals who return to work and are themselves eligible for supplemental security benefits. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to the spouse the same Medicaid coverage protection this Committee was instrumental in offering to the disabled worker.
Eligible Populations	9	Under current law, Medicaid programs pay Medicare Part B Premiums for qualifying individuals (QI-1s), who are defined as Medicare beneficiaries with incomes of 120% to 135% of poverty and minimal assets. The Budget would continue this premium assistance for five years.
Eligible Populations	9	Transitional Medicaid Assistance (TMA) provides health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare related Medicaid eligibility due to earnings from work. The testimony proposes modifications to TMA provisions to simplify it and make it work better with private insurance. These provisions include: States will be given the option to offer 12 months of continuous care to eligible participants; States may waive income-reporting requirements for beneficiaries; States that have Medicaid eligibility for children and families with incomes up to 185 percent of poverty may waive their TMA program requirements; States have the option of offering TMA recipients "Health Coupons" to purchase private health insurance instead of offering traditional Medicaid benefits.
Acute/Preventative Care	10	This testimony suggests changing the Medicaid Rebate methodology, but does not put forth a specific proposal.

US Department of Health and Human Services, Secretary Thompson's Statement Before the United States Senate Committee on Budget, February 2003

http://www.senate.gov/~budget/democratic/testimony/2003/thompson_hrng022603.pdf

Module	Page	Summary
Administration	6-7	Under this proposal, States would have the option of electing to continue the current Medicaid program or to choose partnership allotments. The allotment option provides States an estimated $12.7 billion in extra funding over seven (7) years over the expected growth rate in the current Medicaid and SCHIP budgets. If a State elects the allotments, the federal portion of SCHIP and Medicaid funding would be combined and states would receive two individual allotments: one for long-term care and one for acute care. States would be required to maintain their current levels of spending on Medicaid and SCHIP, but at a lower rate of increase than the increase of the Federal share.
Recommendations for Overall HC Reform	No	

Health Management Associates, Making Medicaid Better: Options to allow states to continue to participate and to bring the program up to date in today's health care marketplace, March 2002

http://preview.nga.org/Files/pdf/MAKINGMEDICAIDBETTER.pdf

Module	Page	Summary
Overall	n/a	Several options suggested by HMA would change federal law to restructure the financing of Medicaid. These changes would allow states to improve the program and extend coverage to additional groups of low-income persons. Some of the changes would provide the flexibility to states to structure a benefit package and cost sharing that is similar to that offered in the current employer-sponsored health insurance market. Other changes are specifically targeted to shift some of the financial burden of Medicaid from the states to the federal government.
Eligible Populations	19	Allow states the option to define eligibility for Medicaid, based only on state-defined income levels, without regard to arbitrary eligibility categories.
Eligible Populations	21	To improve coordination, continuity of coverage and to simplify the relationship between Medicaid and the State Children's Health Insurance Program (SCHIP), change federal SCHIP law to allow the parents of children who apply for SCHIP and are found eligible for Medicaid to choose enrollment in SCHIP.
Eligible Populations	22	To improve the availability of needed medical, hearing, vision and dental coverage for low-income children who qualify for SCHIP, remove the prohibition on SCHIP enrollment for children who are covered by employer sponsored health coverage that is not as comprehensive as SCHIP, and allow SCHIP to "wrap-around" the employer-sponsored coverage, just as Medicaid does.
Acute/Preventative Care/LTC	17	Change federal Medicaid law to allow a state plan option for coverage and cost sharing similar to those offered by employers in that state for persons at or above the federal poverty level.
LTC	20	Allow states to require dual eligibles to be subject to state Medicaid policies relating to coverage, cost sharing and managed care enrollment.
LTC	21	The administrative relationship between the Medicare and Medicaid should be simplified. This would require changes in federal law to minimize the burden now placed on Medicaid.
Administration	22	To improve coordination between Medicaid and employer-sponsored health insurance, allow Medicaid payments to subsidize and encourage the use of health coverage offered through employers.
Administration	13	Apply the same federal support for all children and families covered by Medicaid and the State Children's Health Insurance Program (SCHIP) by applying the current federal matching rate for SCHIP to all Medicaid services provided to children, adults and families who are not also enrolled with Medicare. This would include children and families, pregnant women and about two-thirds of adults with disabilities.
Administration	13	Increase the federal Medicaid matching rate to 90% for Medicaid payments for persons who are enrolled in Medicare and also on Medicaid ("dual eligibles").
Administration	13-14	Prohibit states from obtaining federal matching for any "upper payment limit" (UPL) arrangement.
Administration	15	To improve financial stability for states, limit to one-half of one percent any annual decreases in the FMAP when it is recalculated each year.

Health Management Associates, Making Medicaid Better: Options to allow states to continue to participate and to bring the program up to date in today's health care marketplace, March 2002

http://preview.nga.org/Files/pdf/MAKINGMEDICAIDBETTER.pdf

Module	Page	Summary
Administration	14-15	To achieve equity among states and territories, calculate the FMAP for the territories using the same methodology as is used for the states.
Recommendations for Overall HC Reform	No	

The Health Security Act of 1993

http://www.ibiblio.org/nhs/executive/X-Summary-toc.html

Module	Page	Summary
Overall	n/a	The Health Security Act provides a plan for all Americans to receive health insurance coverage. The plan guarantees comprehensive benefits, promotes greater use of preventive care and suggests a number of ways to control rising health care costs. The plan would be financed from five major sources: savings from Medicare and Medicaid, savings from federal employee health care costs, reducing the benefits of tax-free compensation, and additional "sin taxes". The Act was never passed by Congress.
Recommendations for Overall HC Reform	Yes	See above

Florida Medicaid Reform Waiver, Approved October 3, 2005

http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/florida_medicaid_reform_question_answers.pdf

Module	Page	Summary
Overall	n/a	Florida plans to reform their Medicaid program to promote patient responsibility and empowerment, encourage marketplace decisions, bridge public and private coverage, and create a sustainable growth rate.
Eligible Populations	3	The Florida plan does not change their current eligibility categories, nor their income and asset tests.
Acute/Preventative Care	1-2	Beneficiaries will be assigned a risk adjusted premium amount, and then will be allowed to select a private coverage package of benefits from an approved group of plans designed for that eligibility population.
Acute/Preventative Care	1-2	Catastrophic coverage will either be included in the package offered by the plan (and therefore in the premium amount) or covered by the State on a fee-for-service (FFS) basis.
Acute/Preventative Care	1-2	Beneficiaries can earn money that will be deposited into an enhanced benefits account through engaging in health behaviors. Funds can be used to offset healthcare related costs such as smoking cessation, weight reduction, etc.
Acute/Preventative Care	3	Beneficiaries can "opt out" of Medicaid and use their premium amount towards Employer Sponsored Insurance coverage.
LTC	4	Before the end of the 5 year waiver period, Florida will include LTC reform including nursing home and home and community based services.
Recommendations for Overall HC Reform	No	

Vermont's Global Commitment to Health Waiver, Approved September 27, 2005

http://www.ovha.state.vt.us/Globalhome.cfm

Module	Page	Summary
Overall	n/a	Vermont plans to reform their Medicaid program by instituting managed care for all populations by establishing their Medicaid agency as a "public" MCO.
Eligible Populations	29 (summary ppt)	VT must continue to cover all mandatory populations covered prior to the waiver, however, they can seek a waiver amendment to modify eligibility for optional and expansion populations.
Acute/Preventative Care	10 (summary ppt)	The Vermont Agency of Human Services will pay The Office of Vermont Health Access (VT Medicaid Agency) an actuarially certified monthly premium for each beneficiary that will cover all services provided under the waiver.
Acute/Preventative Care	10 (summary ppt)	Vermont must submit an amendment to modify the benefits offered to mandatory populations. Vermont can change the benefit package for "optional" and "expansion" populations by an amount equal to up to 5% of their expenditures without an amenedment; they must seek a waiver amendment to modify benefits for "optional" and "expansion" populations if it would result in a greater than 5% change in their expenditures.
Quality	24 (summary ppt)	Vermont will implement a Quality Assessment and Performance Improvement plan to measure performance improvement under the waiver.
Administration	12 (summary ppt)	Vermont can use the MCO savings achieved to invest in health related programs such as respite care, tobacco cessation, emergency mental health services, newborn screenings, and substance abuse services.
Administration	28 (summary ppt)	Vermont can use savings achieved through the waiver to cover health services not available in Medicaid, explore alternative reimbursement approaches, and encourage interdepartmental collaboration and consistency (i.e., Vermont Department of Health and the Office of Vermont Health Access [OVHA]).
Recommendations for Overall HC Reform	No	

IowaCare, Approved June 30, 2005

http://www.cms.hhs.gov/medicaid/1115/ia_icfs.pdf

Module	Page	Summary
Overall	n/a	Iowa received Federal approval for an 1115 waiver, IowaCare, to provide health insurance coverage to uninsured Iowans, eliminate Medicaid financing arrangements whereby providers do not retain 100 percent of claimed expenditures, provide home and community-based services to children with chronic mental illness and move toward community-based settings for delivering State mental health programs.
Eligible Populations	2	Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL), who do not meet eligibility requirements of the Medicaid State plan or other waivers (except the Family Planning waiver). This population consists of childless adults who are not eligible for Medicaid under the State plan.
Eligible Populations	2	Parents of Medicaid and SCHIP eligible children with income between 0 and 200 percent of the FPL who are not otherwise Medicaid eligible.
Eligible Populations	2	Newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses for all family members that reduce available family income to 200 percent of the FPL.
Eligible Populations	2	Children from birth to age 18 who have serious emotional disorders and who: • Would be eligible for State Plan services if they were in a medical institution; and • Who need home and community-based services in order to remain in the community; • Have income at or below 300 percent of the SSI Federal benefit; or • Have net family income at or below 250 percent of the FPL for family size.
Acute/Preventative Care/LTC	3	*Benefits* 1) Childless adults, parents and pregnant women in the waiver program: inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies and transportation services to the extent that these services are covered by the Medicaid State plan. All conditions of service provision will apply in the same manner as under the Medicaid State plan including, but not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be medically necessary. 2) Seriously emotionally disturbed children: all Medicaid state plan benefits, plus case management, respite care, environmental modifications and adaptive devices, in home family therapy, and family and community support services.
Acute/Preventative Care/LTC	5	*Cost Sharing Requirements* 1) Childless adults and parents up to 100% FPL: premiums will be assessed that are no more than one twelfth of two percent of the individuals annual family income. 2) Childless adults and parents between 100% and 200 % FPL: premiums will be assessed that are no more than one twelfth of two percent of the individuals annual family income.

IowaCare, Approved June 30, 2005

http://www.cms.hhs.gov/medicaid/1115/ia_icfs.pdf

Module	Page	Summary
Acute/Preventative Care/LTC	5	*Providers* 1) Childless adults and parents will receive services through government-operated acute care teaching hospitals and the University of Iowa Hospitals and Clinics. 2) Seriously emotionally disturbed children may use all Medicaid-certified providers.
Recommendations for Overall HC Reform	No	

The Vermont Long-Term Care Plan, Approved June 13, 2005

http://www.cms.hhs.gov/medicaid/1115/vtltcfs.pdf

Module	Page	Summary
Overall	n/a	The Vermont Long-Term Care Plan is a statewide initiative to rebalance long-term care services through managing nursing facility admissions and increasing community-based options. The demonstration would not include children or individuals receiving institutional services through ICFs/MR.
Eligible Populations	2	Eligible populations include older people (age 65 years and older) and adults with physical disabilities (age 18 and older) who are in need of long-term care services or are at risk of requiring nursing facility services.
LTC	2	Individuals in the highest and high need groups would be eligible for nursing facility and home and community-based services including case management services, personal care, respite care, companion services, adult day services, personal emergency response services, assistive devices, home modification, nursing facility, residential care, homemaker services and other community-based services.
LTC	2	Individuals with moderate needs currently, but who are at risk of needing long-term care, would receive case management, homemaker and adult day services.
Administration (One of 3)	1	Nursing facility admissions would be managed through: • Implementing Person-Centered Assessment and Options Counseling Process - Individuals seeking long-term care services would complete an assessment process to identify what services would need to be put in place to enable them to remain at home. An assessment instrument would identify which of two tiers of services would match individuals' choices and needs. To accomplish this, two tiers would be created within current level of care criteria for long-term care services. Participants with the highest needs, who meet the highest tier's criteria, would qualify for nursing facility or Home and Community-Based Services (HCBS). Participants meeting the less restrictive criteria of the second tier would still be eligible for nursing facility or HCBS; however, if funds were not available individuals entering this lesser-need category may be placed on a waiting list and served in order of greatest need.
Administration (Two of 3)	1	Nursing facility admissions would be managed through: • Creating Access to Home and Community-Based Services (HCBS) – Creating tiers within level of care criteria would result in fewer participants qualifying for nursing facility services. The minimum criteria for meeting institutional level of care criteria (LOC) would remain unchanged; however, the access to institutional services would require participants to have the highest need for services. With fewer participants using high-cost nursing facility services, more funds would be available to increase community-based services for more participants. Savings also would allow an expansion group to receive, at a minimum, case management, homemaker and adult day services. Access to these services may prevent or forestall participants' need for nursing facility services.

The Vermont Long-Term Care Plan, Approved June 13, 2005

http://www.cms.hhs.gov/medicaid/1115/vtltcfs.pdf

Module	Page	Summary
Administration (Three of 3)	1	Nursing facility admissions would be managed through: • Selective contracting – As a result of the strategies described above, the demand for nursing facility beds is projected to be less. To adjust the State's nursing facility bed capacity to the reduced demand, the State may seek to selectively contract with nursing facility providers for fewer beds than are currently used.
Recommendations for Overall HC Reform	No	

MassHealth (Massachusetts), Renewal Approved January 2005

http://www.hcfama.org/index.cfm?fuseaction=Page.viewPage&pageID=292
http://www.cmwf.org/tools/tools_show.htm?doc_id=235092
http://www.mass.gov/ig/publ/ucpempan.pdf

Module	Page	Summary
Overall	n/a	MassHealth is the Massachusetts Medicaid program that offers health care coverage for some low-income and moderate-income people who live in Massachusetts. The original waiver was approved in April 1995, and was subsequently renewed in December 2001 and again January 2005 (with program modifications).
Eligible Populations	1	Children (age 18 or younger)
Eligible Populations	1	A parent of a child (age 18 or younger) who lives with them (including step parent or adoptive parent)
Eligible Populations	1	Pregnant Women
Eligible Populations	1	Individuals with disabilities (following the guidelines of the Social Security Administration or Medicaid)
Eligible Populations	1	Individuals who are unemployed for more than 1 year (or who earn less than $2,200/year)
Eligible Populations	1	Seniors (age 65 or older)
Eligible Populations	1	HIV positive individuals
Eligible Populations	1	Income (or assets, if one is over 65) must be within the MassHealth income limits. The limits are different for each program.
Eligible Populations	1	Immigrants can get MassHealth insurance if any of the above qualifications are met.
Acute/Preventative Care	3	*MassHealth Basic* For low-income, long-term unemployed adults who have no other health insurance: MassHealth Basic works in two ways - First, the Premium Assistance program pays for some or all of your premium for another health insurance plan; you get all the regular benefits for that health plan. Second, MassHealth Basic lets you enroll in a MassHealth program.
Acute/Preventative Care	3	*MassHealth Limited* For certain immigrants: This covers emergency services only. “Emergency” means someone could die if they don't see a doctor. If someone is pregnant and goes into labor, that is also an emergency.
Acute/Preventative Care	3	*MassHealth Essential* For certain immigrants who are 65 and older: Hospital stays, doctor and dentist visits, and prescription drugs are all covered, but there may be some limits. Other benefits may be physical therapy, lab tests, x-rays, and mental health/substance abuse services.
Acute/Preventative Care	3	*MassHealth Premium Assistance* For low/moderate-income families who have jobs that provide health insurance: The family has to enroll in (sign up for) the health plan at work; but then the family will get help from MassHealth to pay for the plan’s premiums.

MassHealth (Massachusetts), Renewal Approved January 2005

http://www.hcfama.org/index.cfm?fuseaction=Page.viewPage&pageID=292
http://www.cmwf.org/tools/tools_show.htm?doc_id=235092
http://www.mass.gov/ig/publ/ucpempan.pdf

Module	Page	Summary
Acute/Preventative Care	3	*MassHealth Pre-natal* For pregnant women waiting to get MassHealth Standard: Benefits include pre-natal care, including up to 60 days of regular prenatal office visits and diagnostic tests. This program makes sure that women have health coverage while they're pregnant.
Acute/Preventative Care	3	*MassHealth Family Assistance* For low- and moderate-income children, some working adults who can't afford coverage at work, and people who are HIV positive: For families on MassHealth Family Assistance, they will either get help paying the premiums for insurance at work or their children will be enrolled in a MassHealth program. They will pay a premium of $12 for each child every month. The premium cannot ever be more than $36 (even if they have more than three children). If their children are enrolled in a MassHealth program, they will get benefits similar to MassHealth Standard, such as hospital stays, doctors' visits, dentist visits, etc. Individuals who are self-employed or have HIV will get help paying the premiums for their work insurance.
Acute/Preventative Care	2-3	*MassHealth Standard* For low-income children, pregnant women, families with children and people with disabilities: full benefits in the Standard program, including hospital stays, doctors' visits, dental care for children, and prescription drugs. Also covered are lab tests, x-rays, OB/GYN (for women's needs), well-child visits, home health services, physical and occupational therapy, personal care assistants, hearing aids and eye exams, and mental health/substance abuse services. MassHealth Standard can also provide transportation for health care visits.
Acute/Preventative Care/LTC	3	*MassHealth Buy-In and Senior Buy-In* For low-income senior citizens and others on Medicare who have trouble paying their premiums for Medicare Part B (doctors' visits): If an enrollees income is below a certain amount, there are a few programs that help pay for their Medicare Part B (doctors' visits) premiums. The programs are called "Slimby" (SLMB), "Quimby" (QMB), and Qualifying Individuals (QI) program. The Senior Buy-In program also pays the co-insurance and deductibles for people over 65.
Acute/Preventative Care/LTC	2-3	*MassHealth CommonHealth* For low- and medium-income people with disabilities whose incomes are too high to qualify for MassHealth Standard: Hospital stays, doctors' visits, dentists' visits for children, and prescription drugs are all covered. CommonHealth also pays for lab tests, OB/GYN visits, vision and hearing tests, well-child visits, home health services, physical and occupational therapy, personal care assistants, and mental health/substance abuse services. MassHealth Standard can also provide transportation for health care visits.

MassHealth (Massachusetts), Renewal Approved January 2005

http://www.hcfama.org/index.cfm?fuseaction=Page.viewPage&pageID=292
http://www.cmwf.org/tools/tools_show.htm?doc_id=235092
http://www.mass.gov/ig/publ/ucpempan.pdf

Module	Page	Summary
Administration	(see two UCP links above)	The MassHealth Uncompensated Care Pool (UCP) makes payments to acute care hospitals and Community Health Centers in Massachusetts for eligible services provided to low income uninsured and underinsured residents who are not eligible for any of the MassHealth programs. Recipients of UCP funded services are provided a "membership" cards that provide access to primary care services.
Recommendations for Overall HC Reform	No	

Utah Primary Care Network, Approved February 8, 2002

http://statecoverage.net/statereports/ut2.pdf

Module	Page	Summary
Overall	n/a	Utah received approval for and implemented a waiver program to provide a basic benefit package to uninsured residents. This waiver was the first the federal government allowed a State to reduce some benefits to current Medicaid eligibles in order to achieve savings to provide the new benefit to an otherwise ineligible population. This was also the first time the federal government permitted a state to offer a limited benefit plan that does not include hospitalization and specialty care under Medicaid.
Eligible Populations	2	Adults between the age of 19-64 who has not had health care coverage for at least 6 months, whose employer pays less than 50% of their health care benefit, and whose annual income is less that 150% of the federal poverty level can be covered under this program. Adults do not have to be parents to qualify.
Acute/Preventative Care	2	The program provides primary and preventive care plus some emergency coverage. The benefit plan includes primary care physician office visits, flu immunizations, urgent care visits, emergency room visits, lab, x-ray, ambulance transport, medical equipment, medical supplies, oxygen, basic dental care, hearing tests, vision screening but not eyeglasses, and prescription drugs.
Acute/Preventative Care	2	There is a $50 annual enrollment fee plus co-payments similar to those required by enrollees in the SCHIP program. There is a $1000 annual out-of-pocket maximum per enrollee.
Administration	3	Utah achieved savings in their Medicaid program by reducing benefits to certain adult eligible populations in order to divert those funds to provide coverage for the waiver program population. Benefit reductions included: vision services, physical therapy, chiropractic services, dental services and mental health. These services are now provided with limits. Non-emergency transportation by taxi or public transit to doctor was eliminated.
Recommendations for Overall HC Reform	No	