

MEDICAID IN NEW HAMPSHIRE AND VERMONT

Policy Research Shop

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EXECUTIVE SUMMARY

Like many states across the nation, New Hampshire and Vermont face the challenge of addressing the rising costs of health care within the constraints of their individual budgets. Both states' Medicaid programs are struggling to extend high-quality, accessible, timely, and effective care to needy individuals while also working within the long-term framework of limited resources. Because the factors that contribute to this situation differ across the states, dealing with the situation demands individualized cost control strategies that will have as small an impact as possible on the quality and breadth of health care available to low-income residents. At the same time, Medicaid is provided jointly by the federal and state governments, meaning that both states must work within federal guidelines (please see Appendix for further explanation). This report examines the factors contributing to the strain on Medicaid programs in New Hampshire and Vermont within this context and discusses potential policy options for addressing this issue.

NEW HAMPSHIRE

A growing elderly population and the rising cost of care contribute to increasing program expenses while possible reductions in Medicaid's reimbursement rates may compromise enrollees' access to quality care. Review of New Hampshire's Medicaid program reveals these key challenges:

- **Changing Demographics - A Growing Elderly Population** - New Hampshire's elderly population is growing more quickly than the general population, a situation that has the potential to increase Medicaid spending: compared to individuals under 65, Medicaid spends approximately three times as much on individuals 65-84 and approximately five times as much on individuals 85 and older. Long-term care is a common need for this population. In 2002, 55 percent of New Hampshire's long-term care spending went to nursing homes, similar to the national average of 55 percent. Compared to Maine and Vermont, New Hampshire spends only slightly more on each individual in nursing home care.
- **Increasing Program Costs and Increasing Health Care Costs** - Between 1991 and 2001, Medicaid spending in New Hampshire increased by an average of 13% per year, compared to the national average of 11% per year. Increases in the cost of providing care (rather than changes in enrollment) accounted for 88% of the growth in Medicaid expenditures, standing in sharp contrast to national trends of enrollment-driven cost increases.
- **Reimbursement Rates and Cost Shifting** -The state controls the rates at which the Medicaid program reimburses providers for the care they give Medicaid patients. Current reimbursement rates to care providers fall short of the actual cost of providing care. As a result, many providers can afford to see only a certain number of Medicaid patients, and Medicaid enrollees may consequently have difficulty finding providers who will accept Medicaid reimbursement. To compensate for the difficulties imposed by reimbursements that are lower than the cost of services, care providers shift the cost to other patients who are privately insured or to uninsured patients.

- **Declining State Revenues** - Because of a change in federal regulations, New Hampshire will receive \$100 million less from the federal government during the biennium beginning on July 1, 2005. While the state has used the Medicaid funding process to collect these enhancement revenues, it has not used the funds collected to finance Medicaid. The loss in funding will constrain the state budget as a whole but does not reflect a \$100 million loss in specific Medicaid program funding.

VERMONT

Projections by the Vermont Joint Fiscal Office (JFO) suggest that Medicaid spending may exceed budgeted revenues for the program as early as this fiscal year or the next. A review of Vermont's Medicaid program reveals the following key challenges:

- **Rising Costs of Pharmaceuticals** - Pharmaceutical spending has been the fastest growing component of Vermont's Medicaid program in recent years. With Acts 63 and 127, Vermont implemented preferred drug lists in an attempt to encourage health providers to prescribe high quality, low-cost drugs. Medicaid pooling programs and the supplemental discounts ensured by the federal Omnibus Budget Reconciliation Act (OBRA) of 1990 also contribute to a reduction in Vermont's pharmaceutical spending. While these efforts represent early attempts to halt the rising costs of pharmaceuticals, future cost containment in this sector will continue to be a significant challenge for the state.
- **Long-Term Care** - One major long-term care challenge facing Vermont is providing adequate home-based care to the state's developmentally disabled Medicaid beneficiaries. Vermont has steadily expanded its home and community-based services (HCBS) to serve an increasing number of developmentally-disabled individuals. Since the closure of Vermont's last developmental disability facility in 1993, the state's spending on HCBS care has significantly increased to become one of the state's largest Medicaid expenditures.
- **Decreasing Revenues** - Vermont's Medicaid spending will soon exceed state and federal revenues for the program. The Vermont JFO warns that the state's Medicaid program will reach a \$68 million shortfall by 2007. This situation is the result of two factors. First, because revenues have been unable to keep up with rising medical costs, the state's two primary funding streams, cigarette taxes and tobacco settlement revenues, can no longer sustain the state's Medicaid budget. Second, recent decreases in federal funds have caused the state's Medicaid funding to decrease significantly.
- **Cost Shifting** - Because Vermont sets Medicaid reimbursement rates below the actual cost of health care, costs are shifted from Medicaid beneficiaries to the privately insured and uninsured. One possible way to address this cost shift would be to raise Medicaid reimbursement rates to health care providers. The way Medicaid spending is calculated complicates the process of raising reimbursement rates.

OTHER STATES AND OPTIONS FOR NEW HAMPSHIRE AND VERMONT

States across the country are also dealing with the strain of financing Medicaid. Many of these states have developed their own unique policy responses. A review of these strategies suggests that Vermont and New Hampshire may find new ideas for meeting their own Medicaid challenges. Some of the possible options include:

- **Providing Preventive Care** - When administered correctly, preventive care saves money by treating problems that might otherwise lead to more expensive medical treatment requiring specialists or extended hospital stays. To cite one example, ignoring regular dental maintenance often increases the need for costly oral emergency care. Low-income children experience disproportionately low levels of dental health. One of the most effective protective measures is supplying fluoridated water. In New Hampshire, 43% of water is fluoridated compared to 54% in Vermont. Increasing the fluoride content in water is one option states have for improving preventive care. An additional option is instituting community- and school-based programs that encourage good oral hygiene. Obesity is another condition that is often preventable. Some states combat obesity through media campaigns, taxes, community-based programs and legislative action. States also regulate the types of food and drink available to children in schools, while Vermont and New Hampshire do not.
- **Federally Qualified Health Centers (FQHC)** - FQHCs are established in areas with a shortage of care. They serve low-income groups from all populations: Medicaid and Medicare beneficiaries as well as the uninsured and privately insured. FQHCs provide general outpatient services including preventive care and eye, ear, and dental services. Funding is secured through federal and state grants in addition to reimbursement for services from public and private insurance. FQHC benefit a state for two reasons. They secure additional federal money to help finance care for the poor. FQHCs also help extend care to populations in need of medical facilities. Though New Hampshire and Vermont have FQHCs, they can continue to be a useful tool in providing care for individuals who have trouble affording care and traveling to medical facilities.
- **Augmenting Program Costs by Maximizing SCHIP Funds** - Vermont receives a 73% SCHIP (State Children's Health Insurance Program, please see Appendix for further information) federal matching rate and New Hampshire receives a 65% matching rate, compared to respective Medicaid matching rates of 60% and 50%. This means that by using SCHIP funds, states pay a smaller percent of percentage of program costs. However, Vermont and New Hampshire have not maximized their SCHIP allotments.
- **Controlling Program Costs with Managed Care** - Working with the federal government, Oregon received permission to use a system of capitated managed care with a prioritized list of health care services. In capitated managed care, a health care provider receives a set dollar amount for each patient during predetermined time period regardless of the services provided. Thus, providers have an incentive to spend the minimum amount possible, which can have the positive consequence of effective use of preventive care or the negative consequence of reduced quality of care. In New Hampshire and Vermont, providers are

reimbursed for each service they provide. Capitated care provides an alternative reimbursement scheme that may enable a state to save money.

- **Preventing Fraud and Waste** - A Washington State program determines if a Medicaid beneficiary has coverage other than Medicaid. If a beneficiary has other coverage, that program pays instead of Medicaid. Washington has created a data warehouse to audit claims and detect overlapping coverage as well as fraud and waste. Though initially costly, such a measure might ultimately save money in Vermont and New Hampshire.
- **Securing Cost-Effective Long-Term Care** - Aging populations in Vermont and New Hampshire will demand a high level of care in the coming years. States are addressing the current and projected costs by using managed care or other alternatives to minimize the use of institutionalized care. In Arizona, managed care organizations determine the most appropriate setting for each individual and receive a set payment for each individual enrolled in their plan. Arizona has quality assurance mechanisms to ensure that individuals receive the correct care. Such mechanisms can be put in place to balance managed care organizations' desire to minimize costs. Arkansas' "Cash and Counseling" program provides the option of non-institutionalized care by awarding the beneficiary cash that can be used to buy in-home care. It allows the elderly and disabled to select their level of care.

APPENDIX ES: IMPORTANT BACKGROUND INFORMATION

What is Medicaid?

Medicaid is public health insurance provided jointly by the federal and state governments to eligible low-income individuals who are unable to access private health care. Federal guidelines extend Medicaid coverage to individuals who are both low-income and children, pregnant mothers, parents, blind, disabled, or elderly. Different definitions of low-income apply to each group. Once these mandatory groups are covered, states have substantial flexibility in expanding eligibility and benefits. The State Children's Health Insurance Program, SCHIP, is one example of ways states may expand coverage beyond Medicaid. SCHIP provides health insurance coverage to low-income children whose family income is above the Medicaid cut-off. Both New Hampshire and Vermont use SCHIP to provide coverage to children with family incomes up to 300% of the federal poverty level through a combination of federal and state funds.

Permission to deviate from federal Medicaid guidelines regarding eligibility, enrollment, benefits, and costs to beneficiaries is often granted to states in the form of a waiver. Both Section 1915 waivers and Section 1115 waivers use a cap on federal spending to impose a budget neutrality requirement. This means that the federal government contributes no more money to the state than it would have without the waiver. In other words, waivers exempt states from program requirements in exchange for conservation of federal funds. Both New Hampshire and Vermont currently possess waivers and are contemplating the implementation of future waivers.

Key Features of Medicaid in New Hampshire:

New Hampshire extends Medicaid eligibility and coverage beyond the minimum federal requirements (described in the introduction). New Hampshire's Medicaid program operates with four targeted Section 1915 waivers, which the state uses to provide home- and community-based services to disabled individuals. In fiscal year 2001, 108,532 individuals enrolled in Medicaid in New

Hampshire. The program has the most impact at the age extremes of the population, insuring a quarter of the state's children and a quarter of individuals over age 85. While children account for 60% of enrollees, only 22% of expenditures go toward children. In contrast, the elderly are about 12% of enrollees and account for 34% of expenditures. The costlier services required by the elderly (on average) compared to less-expensive services generally needed by children account for the mismatch between program enrollment and spending.

The state and federal government spent about \$924 million on Medicaid in New Hampshire in fiscal year 2003. The federal government shares the costs of New Hampshire's Medicaid program equally with the state—for every dollar the state spends, the federal government contributes one dollar. This is called a 50% federal matching rate (FMAP). In contrast to many other states, at least 25% of New Hampshire's Medicaid nursing home spending is paid by counties. The state is then supposed to pay another 25% (it has failed to reach this percentage, and counties are then responsible for making up the difference). The federal government continues to contribute 50%.

Key Features of Medicaid in Vermont:

In fiscal year 2000, 147,800 beneficiaries qualified for Vermont's Medicaid program by meeting both federal (described above) and state requirements. Vermont state guidelines extend Medicaid benefits beyond federally mandated groups to members of its Reach Up, Supplemental Security Income (SSI), and Aid to Aged, Blind, or Disabled (AABD) programs as well as several other optional groups. These and other coverage extensions are allowed under Vermont's single Section 1115 waiver and five Section 1915 waivers. Like many other states, Vermont uses these waivers to acquire program exemptions in exchange for conserving federal funds.

In fiscal year 2003, spending on Vermont's Medicaid program totaled \$708,680,743 and included both state and federal funds. In Vermont, Medicaid has a federal matching rate of 60% which means that for every \$1 the state devotes to Medicaid, the federal government makes a matching donation of more than \$1.

1. OVERVIEW

Like the rest of the nation, New Hampshire and Vermont face the challenge of addressing the rising costs of health care within the constraints of their individual budgets. Differences between the two states mean that individualized cost control strategies are needed. These strategies will have to balance the needs of low-income residents and rising costs, while also attempting to maintain the quality and the breadth of health care now available. This report examines the problem of rising health care costs associated with each state's Medicaid program and offers potential policy options for addressing it.

Table 1.1 summarizes key demographic and Medicaid statistics for New Hampshire and Vermont.

1.1 What is Medicaid?

Medicaid is public health insurance provided jointly by the federal and state governments to eligible low-income individuals who are unable financially to access private health care. Federal guidelines extend Medicaid coverage to individuals who are both low-income and children, pregnant mothers, parents, blind, disabled, or elderly. Different definitions of low-income apply to each group.¹ Once these mandatory groups are covered, states have substantial flexibility in expanding eligibility and benefits.² It is important to distinguish Medicaid from Medicare—Medicare covers almost everyone 65 or older while Medicaid covers low-income elderly individuals. Medicaid and Medicare provide different levels coverage and require different costs paid by the beneficiary.³ Individuals who receive both Medicaid and Medicare coverage are referred to as dual eligibles.⁴ Table 1.2 provides a comparison of these two programs.

1.2 Dual Eligibles

Dual Eligibles are Medicare beneficiaries whose low income enables them to qualify for Medicaid assistance.⁴ Dual Eligibles can qualify for varying degrees of Medicaid assistance.

- Qualified Medicare Beneficiaries (QMBs) - Medicare beneficiaries with income below 100% federal poverty level (FPL) with limited assets. Medicaid pays all required cost sharing and Medicare Part B premium.
- Specified Low-Income Medicare Beneficiaries (SLMBs) - Medicare beneficiaries with income between 100 and 120% FPL and with limited assets. Medicaid pays the Part B monthly premium.
- Qualified Individuals (QIs) - Medicare beneficiaries with income between 120% and 135% FPL with limited assets. Medicaid pays the Part B monthly premium. States receive annual payments to cover these individuals; however if there are insufficient funds, a state may eliminate enrollment in Medicaid.

Table 1.1 New Hampshire and Vermont Comparison

| | New Hampshire | Vermont | United States |
|--|---|--|---|
| Demographics | | | |
| Total Population in 2003 | 1,287,687 | 619,107 | 290,809,777 |
| Percent Population Change from April 2000 to July 2003 | 4.2% | 1.7% | 3.3% |
| Persons under 18 years old, percent, 2000 | 25.0% | 24.2% | 25.7% |
| Percentage of Persons > 65 years old, 2000 | 12.0% | 12.7% | 12.4% |
| Median household income, 1999 | \$49,467 | \$40,856 | \$41,994 |
| Key Medicaid Statistics | | | |
| Medicaid monthly enrollment, June 2003 | 98,716 | 98,565 | 40,553,151 |
| Distribution of Medicaid enrollees by enrollment group, percent as of 2000 | Children 61% Adults 15% Elderly 12% Blind/Disabled 13% | Children 44% Adults 31% Elderly 14% Blind/Disabled 11% | Children 49% Adults 24% Elderly 11% Blind/Disabled 15% |
| Total (state plus federal) Medicaid spending, 2003 | \$923,981,355 | \$708,680,743 | \$266,817,101,410 |
| Medicaid spending per enrollee, 2000 | \$5,869 | \$3,229 | \$3,762 |
| Federal matching rate (FMAP), 2005 | 50.00% | 60.11% | 50% to 77% |
| Distribution of Medicaid spending by enrollment group, percent, 2000 | Children 20% Adults 5% Elderly 36% Blind/Disabled 39% Unknown 1% | Children 22% Adults 13% Elderly 28% Blind/Disabled 37% Unknown 1% | Children 16% Adults 10% Elderly 30% Blind/Disabled 41% Unknown 3% |
| 1115 Waiver | No | Yes, 1 | |
| 1915 Waiver | Yes, 3 | Yes, 5 | |
| Key challenges | 1) Changing demographics 2) Increasing costs 3) Reimbursement rates and cost shifting 4) Decreasing state revenues | 1) Rising cost of pharmaceuticals 2) Long-term care services 3) Decreasing revenues 4) Cost shifting and DSH payments | |

Source: Kaiser Family Foundation State Health Facts Online: New Hampshire: Medicaid and SCHIP, 2003⁵, US Census Bureau State and County Quick Facts⁶

Table 1.2 Medicare vs. Medicaid

| | Medicare | Medicaid |
|------------------------------------|--|---|
| Who Is Eligible | Medicare covers almost everyone 65 or older, certain people on Social Security disability, and some people with permanent kidney failure. | Medicaid covers low-income and financially needy people, including those over 65 who are also on Medicare. |
| Who Administers the Program | Medicare is a federal program. The rules governing the program are the same across the country. Medicare information is available at Social Security offices. | Medicaid is administered by the 50 states and Washington, DC; rules differ in each jurisdiction. Medicaid information is available at a local county social services, welfare, or department of human services offices. |
| Coverage Provided | <p>Medicare hospital insurance (Part A) provides basic coverage for hospital stays and post-hospital nursing facility and home health care.</p> <p>Medicare supplemental medical insurance (SMI or Part B) pays most of basic doctor and laboratory costs, and some of out-patient medical services, including medical equipment and supplies, home health care, and physical therapy. SMI is optional, for a subsidized premium. It currently does not cover prescription drugs unless an added premium is paid, although drugs will be partly covered in 2006. In the meantime, drug discount cards are available.</p> | In many states, Medicaid covers services and costs Medicare does not cover, including prescription drugs, diagnostic and preventive care, and eyeglasses. |

Source: NLO Law for All: Medicare and Medicaid: What's the Difference?, 2004⁷

1.3 Federal Funding

The state and federal government both share Medicaid program costs. Each state pays a certain percentage of the program's cost, referred to as the Federal Medical Assistance Percentage (FMAP). Different states have different FMAP rates. For instance, a 50% FMAP rate means that the federal government pays \$1 for every \$1 spent by the state. A 60% FMAP means that for every \$1 spent, the federal government pays \$0.60 and the state pays \$0.40. These rates are often referred to as match rates.

1.4 SCHIP

The State Children's Health Insurance Program, SCHIP, is one example of ways states may expand beyond Medicaid. SCHIP provides health insurance coverage to low-income children whose family income is above the Medicaid cut-off.⁸ Both New Hampshire and Vermont use SCHIP to provide coverage to children with family incomes up to 300% of the FPL through a combination of federal and state funds.⁸

1.5 Waivers

Permission to deviate from federal Medicaid guidelines regarding eligibility, enrollment, benefits, and costs to beneficiaries is often granted to states in the form of a waiver. The original purpose of 1115 waivers was to allow states to be creative in research and demonstration projects that expanded services to previously ineligible populations, but the trend has been to use waivers to rescind recent services from previously eligible groups and increase cost-sharing.⁹ The two types of Medicaid waivers are Section 1915 and Section 1115 waivers—currently both states operate under multiple 1915 waivers, and Vermont operates under an 1115 waiver while New Hampshire is exploring program changes that would necessitate an 1115 waiver. 1915 waivers target specific aspects of the state's Medicaid program while 1115 waivers have a much broader scope.

Waivers change the way that the federal government funds a state's Medicaid program by replacing the unlimited federal matching funds with a capped amount. Both types of waivers impose a budget neutrality requirement, which means that the federal government must not contribute more funds to the state than it would have without the waiver (as determined by spending projections during the time period of the waiver).⁹ In other words, waivers exempt states from program requirements in exchange for conservation of federal funds. Budget neutrality can occur through different types of caps on the amount of money the federal government will contribute to state spending:

- Per capita caps are based on the amount the state's Medicaid program spends per beneficiary. The waiver agreement is based on a projection of the expected increase in per-beneficiary costs during the time period of the waiver and imposes a limit on the amount the federal government will contribute per person. If the per-person costs increase by greater than this projected amount, then the state must make up the entire difference by using other state funds, cutting program services, or finding another way to reduce the program's scope. Under a per capita cap, the state assumes the risk for increasing per-person costs but not increases in enrollment.⁹
- Global caps are based on the state's total program spending. The waiver agreement is based on a projection of the expected increase in a state's total Medicaid spending and imposes a limit on the total federal contribution to the state's Medicaid program. If spending increases by more than projected, the state must make up the entire difference. Under a global cap, the state assumes risk for both increasing per-person costs and increases in enrollment.⁹

A waiver from the federal government means that the state has permission to be exempt from certain federal requirements. Once the waiver is granted, the state may choose to implement all or part of it. Thus, the waiver agreement made public does not necessarily reflect the changes that will be made to the state's Medicaid program.¹⁰

1.6 Medicare Modernization Act of 2003 (MMA)

In passing the Medicare Modernization Act of 2003 (MMA), the federal government enacted some of the most sweeping health care policy changes since Medicaid and Medicare were created in 1965. The MMA added Medicare Pharmacy Benefit coverage (Part D) to the existing Medicare program and clarified through companion legislation known as the Medicare Prescription Drug Improvement Act (MPDIA). Importantly, this new legislation has implications for states and their Medicaid programs.

By passing this legislation congress redefined the role of the states in financing Medicare by changing the coverage scheme for dual eligibles (elderly individuals eligible for both Medicare and Medicaid).¹¹ First, state pharmacy programs, which were formerly administered at the state level but funded by Medicaid, will be run by managed care organizations. Second, the new Part D (Medicare) coverage will replace state run pharmacy programs for dual eligibles. In their place, the federal government will generate 25% of Part D funds by administering monthly “clawback payments” to the states.

Yet questions remain about how this reform will impact individual states and management of their Medicaid programs. While prescription drug will be covered by Medicare, it is unclear whether states will save money because they will be giving money to the federal government in the form of clawback payments. Additionally, because coverage will be classified as either Initial Coverage (expenses up to \$2,251) or Catastrophic Coverage (expenses above\$5,100), the program leaves open the possibility of a potential funding gap. This gap, called the “Doughnut Hole,” may present a challenge to New Hampshire and Vermont.¹²

This report will explain the funding, spending, services covered, and eligibility requirements under Medicaid in Vermont and New Hampshire in order to analyze the issues facing the states and the strategies available to address these issues.

2. MEDICAID IN NEW HAMPSHIRE

New Hampshire's Medicaid program faces the challenge of extending high-quality, accessible, timely, and effective care to needy individuals within the long-term framework of limited resources. A growing elderly population and the rising cost of care contribute to increasing expenses. In addition, Medicaid's reimbursement rates affect both the accessibility and quality of care available to Medicaid recipients and also the costs paid by the privately insured and the financial stability of care providers. This section provides background on significant features of Medicaid by summarizing the state's health assistance services, their eligibility criteria, the program's funding sources, and its spending. This section concludes with a discussion of key challenges facing New Hampshire's Medicaid program.

2.1 Program Description

The purpose of New Hampshire's Medicaid program is to serve residents who the state determines lack the resources necessary to pay for their needed medical care.¹³ By some measures, New Hampshire accomplishes this task very well, because the state is estimated to have the 5th lowest percentage of uninsured citizens (10% uninsured in 2003). However, given the degree of statistical uncertainty, experts can only conclusively place New Hampshire among the 20 states with the lowest rates of uninsurance.¹⁴

New Hampshire's Medicaid program provides many standard preventive, acute, and emergency medical services. Medicaid covers:¹⁵

- Hospital services (in- and out-patient)
- Doctor visits
- Home health care
- Long-term care
- Eye care
- Mental health services
- Emergency dental services
- Prescription drugs

Often, Medicaid limits the number of uses of these services, and some procedures require prior authorization.¹⁵ Thus, the statement that the program covers a service does not imply that Medicaid will pay for unlimited usage of that service. Medicaid beneficiaries are not required to pay co-pays when they receive care but are responsible for co-pays of \$0.50 or \$1 when they obtain prescription drugs. In all cases, the providers of health care services receive reimbursement directly from the New Hampshire Medicaid program.¹⁵ It is important to note that the state sets a fixed reimbursement rate per service; this rate is not directly related to the provider's actual cost of providing the service.¹⁶

2.2 Eligibility

New Hampshire residents qualify for Medicaid based on income and resource requirements and non-financial criteria.

- Categorical eligibility - Individuals become categorically eligible if they are members of certain groups and meet income and resource requirements (Table 2.1). The Division of Family Assistance makes these determinations. Members of different groups, such as children pregnant women, the elderly, are eligible for different programs within the broad framework of Medicaid.¹⁷

Table 2.1 Categorical Medicaid Eligibility Thresholds as a Percentage of the Federal Poverty Level in New Hampshire, 2003

| Group | Income (as a Percent of FPL) Necessary to Qualify for Medicaid |
|------------------------------|---|
| Infants Ages 0-1 | 300% |
| Children Ages 1-5 | 185% |
| Children Ages 6-19 | 185% |
| Pregnant Women | 185% |
| Non-Working Parents | 49% |
| Working Parents | 61% |
| Supplemental Security Income | 76% |

Source: Kaiser Family Foundation State Health Facts Online: New Hampshire: Medicaid and SCHIP, 2003⁵

- Medical eligibility - Certain service categories within the Medicaid program require that individuals be designated medically eligible.¹⁸ Medical eligibility applies to individuals in the same groups as categorical eligibility whose income is above the categorical eligibility levels; individuals become medically eligible when they spend down enough of their income on medical expenses.¹⁹ A medical review team makes these eligibility determinations by reviewing an individual’s medical records and medical documentation.¹⁸

2.3 Significant Program Features

New Hampshire has four targeted waivers that allow its program to diverge from certain aspects of federal requirements. Its four “Section 1915” waivers give the state permission to provide home and community-based services (HCBS) to “children with developmental disabilities, people with mental retardation and developmental disabilities, people with acquired brain disorder, and other elderly and disabled people.”²⁰

Children living in families with incomes up to 300% the federal poverty level (FPL) qualify to receive health insurance—compared to other states, New Hampshire is among the more generous in the group of children to whom it provides health insurance (only 14 states provide insurance to children with family incomes up to even 200% of the federal poverty level).²¹ New Hampshire achieves this comprehensive coverage by using SCHIP to extend health coverage to children above Medicaid eligibility limits. These programs are called Healthy Kids and are divided into Healthy Kids Gold and Healthy Kids Silver. Medicaid covers children up to 185% of FPL. Healthy Kids Gold uses SCHIP money to expand Medicaid coverage to infants under 1 year of age with a family income between 185% of the federal poverty level and 300% of FPL. There is no cost sharing or co-payments under Healthy Kids Gold. In 2003, Healthy Kids Gold covered only 174 children.

Healthy Kids Silver covers children aged 1 to 19 with family income between 185% and 300% of the FPL. In 2003, Healthy Kids Silver covered 6,575 children. Healthy Kids Silver uses a system of co-pays and premiums:²²

- \$10 co-pay for office visits
- \$5 co-pays for generic prescription drugs and \$10 for brand name
- \$50 co-pay for emergency room visits
- \$25 per month premium per child for families between 185 and 250% of FPL with a maximum of \$100 per month per family.
- \$45 per month premium per child for families between 250 and 300% of FPL with a maximum of \$135 per month per family.
- Native Americans are exempt from cost sharing requirements.

Table 2.2 summarizes the eligible groups and available services.

Table 2.2 Eligible Groups and Applicable Health Care Assistance Programs in New Hampshire

| Group | Specific Program |
|---|---|
| Low-Income Families with Children (as defined in Table 2.1) | Medicaid |
| Children Under Age 19 | Medical and dental coverage through Healthy Kids Gold (HKG) Healthy Kids Silver (HKS) Children with Severe Disabilities (HKG-CSD) Home Care for Children with Severe Disabilities (HKG-HCCSD), “Katie Beckett” option |
| Pregnant Women | Medical Coverage for Pregnant Women (includes mother and child after birth) |
| Blind Individuals | Aid to the Needy Blind program |
| Refugees | Refugee Medical Assistance (RMA) |
| Non-Citizens | Emergency Medical Treatment |
| Seniors (65 and older) and Disabled Adults | -Old Age Assistance (OAA) -Aid to the Permanently and Totally Disabled (APTD) -Medicaid for Employed Adults with Disabilities (MEAD) -Home and Community-Based Care |
| Individuals above income requirements who meet other criteria, such as large medical expenses | In and Out Medical Assistance: Individuals pay for their care until they spend down their income to the Medicaid income eligibility level. After this point, Medicaid provides medical assistance. |

Source: New Hampshire Department of Health and Human Services, “Medical Assistance Eligibility,” 2005¹⁷

SCHIP, like Medicaid, is a federal and state partnership. The program is jointly funded; the state’s spending is matched by the federal government at a rate calculated based on the number of uninsured children, the number of low-income children, and health insurance costs in the state.²³ The federal government offers higher matching rate for SCHIP funding (65%) than for Medicaid (50%).⁵ In the case of SCHIP, the federal government will contribute a share of the state’s spending at the set rate until the federal contribution reaches a certain amount (i.e. unlike Medicaid which does not impose a cap). States have three years to spend their allotment. If at the end of that period the money is unspent, it is redistributed to states that spent their entire allotment.²⁴

The maximum federal SCHIP contribution for New Hampshire for 2003 was \$8,903,739, but total SCHIP expenditure was \$6,025,576 (Please see Table 2.3).²² This indicates that New Hampshire is not maximizing its federal allotment and risks its funds being reallocated to other states.

Table 2.3 Federal and State SCHIP Spending in New Hampshire

| | | |
|---|-------------|--------------|
| NH’s share of SCHIP spending (2002) | \$2,108,950 | 35% of total |
| Federal share of NH SCHIP spending (2002) | \$3,916,626 | 65% of total |
| Total expenditure (2002) | \$6,025,576 | 100%= total |
| Federal SHIP contribution limit (2003) | \$8,903,739 | |

Source: Kaiser Family Foundation State Health Facts, 2002⁵ and CMS New Hampshire SCHIP Fact Sheet, 2003**Error! Bookmark not defined.**

2.4 Funding and Spending

The state and federal government spent about \$924 million on Medicaid in New Hampshire in fiscal year 2003.²⁵ The federal government shares the costs of New Hampshire’s Medicaid program equally with the state—for every dollar the state spends, the federal government contributes one dollar (see FMAP above). In other words, the federal governments shares in 50% of the program’s costs. Thus, increases in state spending result in corresponding increases in federal spending.²⁶

Counties also contribute significant funds for Medicaid spending on nursing homes. Prior to Medicaid’s creation in 1965, each county operated a nursing home; then, the creation of Medicaid meant that the federal government would provide funding assistance. This is the origin of New Hampshire’s unusual system for funding nursing home care by which the county pays 25%, the state pays 25%, and the federal government pays 50%.²⁷ Recently, the counties have stated that the state has been paying 20% instead of the full 25%, causing the counties to make up the difference using county taxes.²⁸ Figure 2.1 shows the different sources of funding for New Hampshire’s Medicaid program.

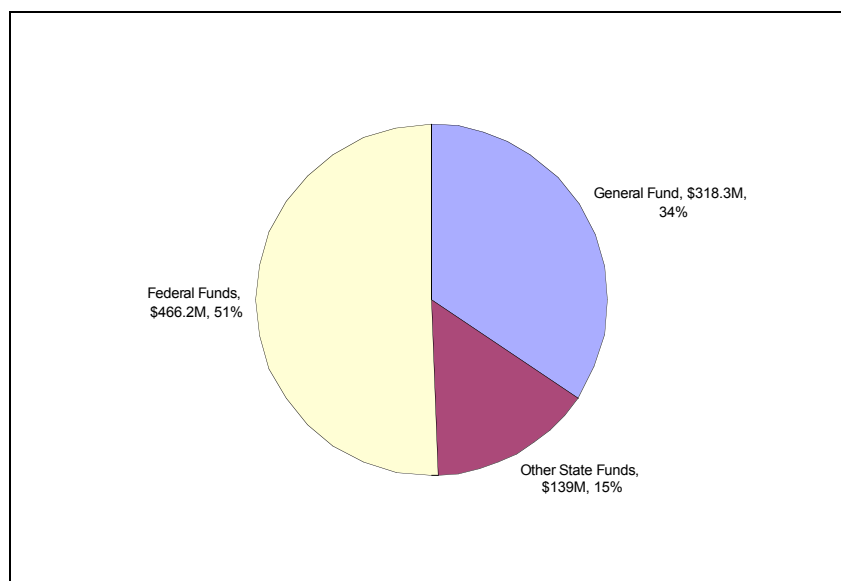


Figure 2.1 Funding Sources of New Hampshire's Medicaid, Fiscal Year 2001. Source: Milbank Memorial Fund, 2001²⁹

2.5 Enrollment

In June 2003, New Hampshire's Medicaid program provided insurance 98,716 individuals.⁵ The program has the most impact at the age extremes of the population, insuring a quarter of children and a quarter of individuals over age 85.¹⁴ Approximately two thirds of individuals enrolled in the state's Medicaid program are children (compared to half of national enrollees), with the remaining third split approximately evenly between the elderly, blind and disabled, and adults.⁵

The distribution of Medicaid spending differs from distribution of enrollment (Table 1.1). While children account for almost two thirds of enrollees, only 22% of expenditures go toward children. On the other hand, the elderly are about 12% of enrollees and account for approximately a third of expenditures.⁵ The elderly, on average, require more services and more expensive services than the general population while children, on average, need less costly services; this accounts for the mismatch between program enrollment and spending.

Comparing the spending per beneficiary in New Hampshire to national averages of per-beneficiary spending raises important questions (Figure 2.2). Why does New Hampshire spend significantly more than the national average per elderly and blind and disabled beneficiary?

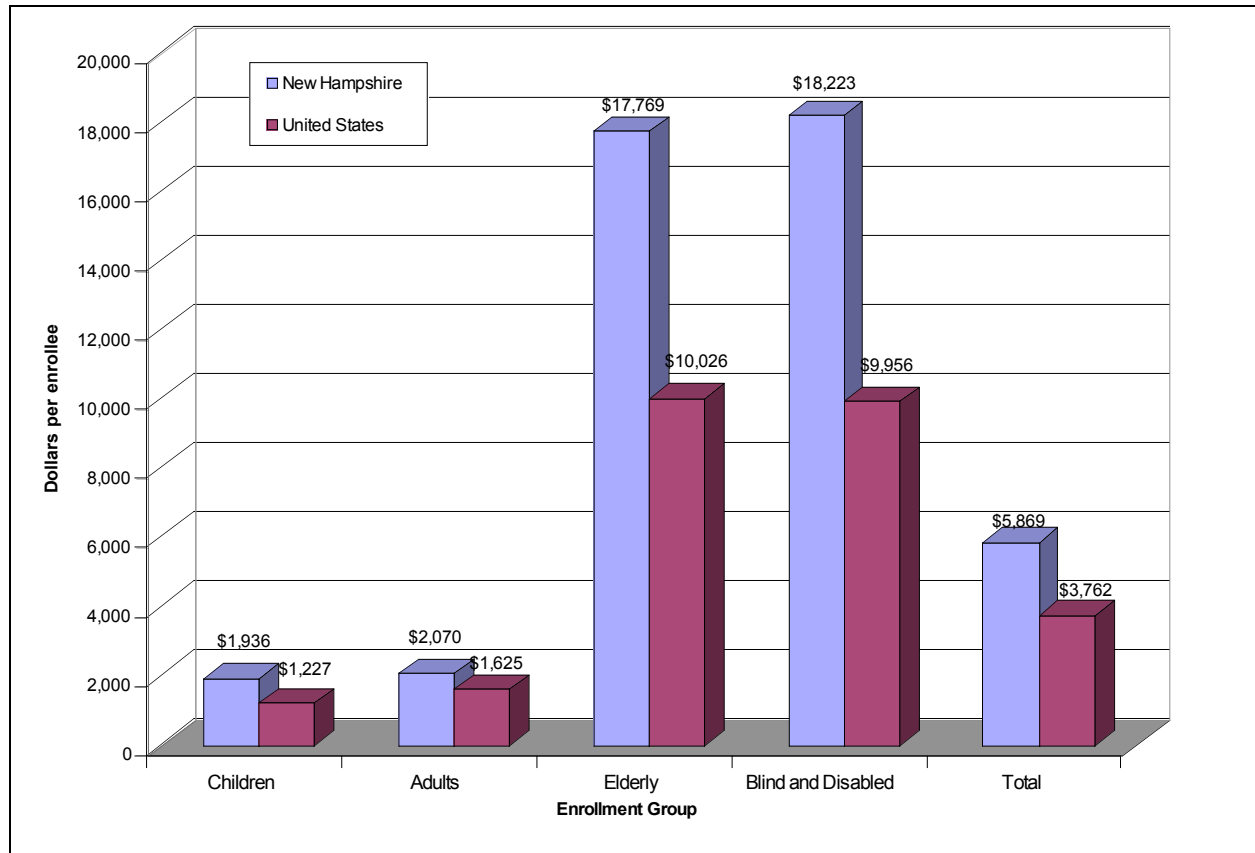


Figure 2.2 Distribution of Federal and State Medicaid Spending per Enrollee by Enrollment Group, Fiscal Year 2000. Source: Kaiser Family Foundation State Health Facts, 2004⁵

A close examination of spending on the elderly demonstrates that the limited elderly population served by Medicaid (rather than high spending per service) is largely responsible for New Hampshire's higher than average spending on its elderly enrollees. Please see Table 2.4 for a summary of this data.

In 2001, the average spending on aged Medicaid enrollees in New Hampshire was \$19,637 compared to \$5,386 in Maine and \$7,530 in Vermont. In New Hampshire, only 8.03% of the population 65 and older was enrolled in Medicaid, compared to 26.64% in Maine and 22.93% in Vermont. Of those enrolled the states' Medicaid programs, 55.1% of New Hampshire's elderly Medicaid beneficiaries received nursing home care compared to 16.62% in Maine and 17.80% in Vermont. Thus, New Hampshire provides services to a much narrower, higher-need group of its elderly population. The additional seniors enrolled in Medicaid in Maine and Vermont need less costly care and are less likely to need long-term care; in this way, these extra enrollees lower the states' average spending per elderly enrollee. The more concentrated medical need of the smaller group of elderly individuals covered in New Hampshire accounts for the high average spending. In fact, New Hampshire spends a similar sum per Medicaid enrollee in a nursing home, paying only 10-15% more than the other two states. In the case of nursing home care, New Hampshire, Vermont, and Maine pay the approximately the same amount for the same service in spite of sharp difference in average spending per elderly enrollee.³⁰

Table 2.4. A Comparison of Medicaid Spending on the Elderly in Northern New England, 2001

| | New Hampshire | Vermont | Maine | Notes |
|---|----------------------|----------------|--------------|--|
| Average spending on elderly Medicaid enrollee | \$19,637 | \$7,530 | \$5,386 | |
| Percent of population 65 or older enrolled in Medicaid | 8.03% | 22.93% | 26.64% | New Hampshire enrolls a much smaller percent of its elderly population in Medicaid |
| Percent of elderly enrollees receiving nursing home care | 55.1% | 17.80% | 16.62% | A larger percent of New Hampshire's elderly enrollees receive nursing home care |
| Medicaid nursing home spending per enrollee in nursing home | \$25,792 | \$22,731 | \$22,454 | New Hampshire spends a similar sum per individual receive nursing home care |

Source: Hall, Douglas, "Data Quality: Medicaid Long-Term Spending in NH," 2004³⁰

2.6 Key Challenges

2.6.1 Changing Demographics - A Growing Elderly Population - New Hampshire's elderly population is growing more quickly than the general population.³¹ Older populations generally require more frequent and more expensive medical care: compared to per-person spending for individuals under 65, Medicaid spends approximately three times as on individuals 65-84 and approximately 5 times as much on individuals 85 and older (Figure 2.3).

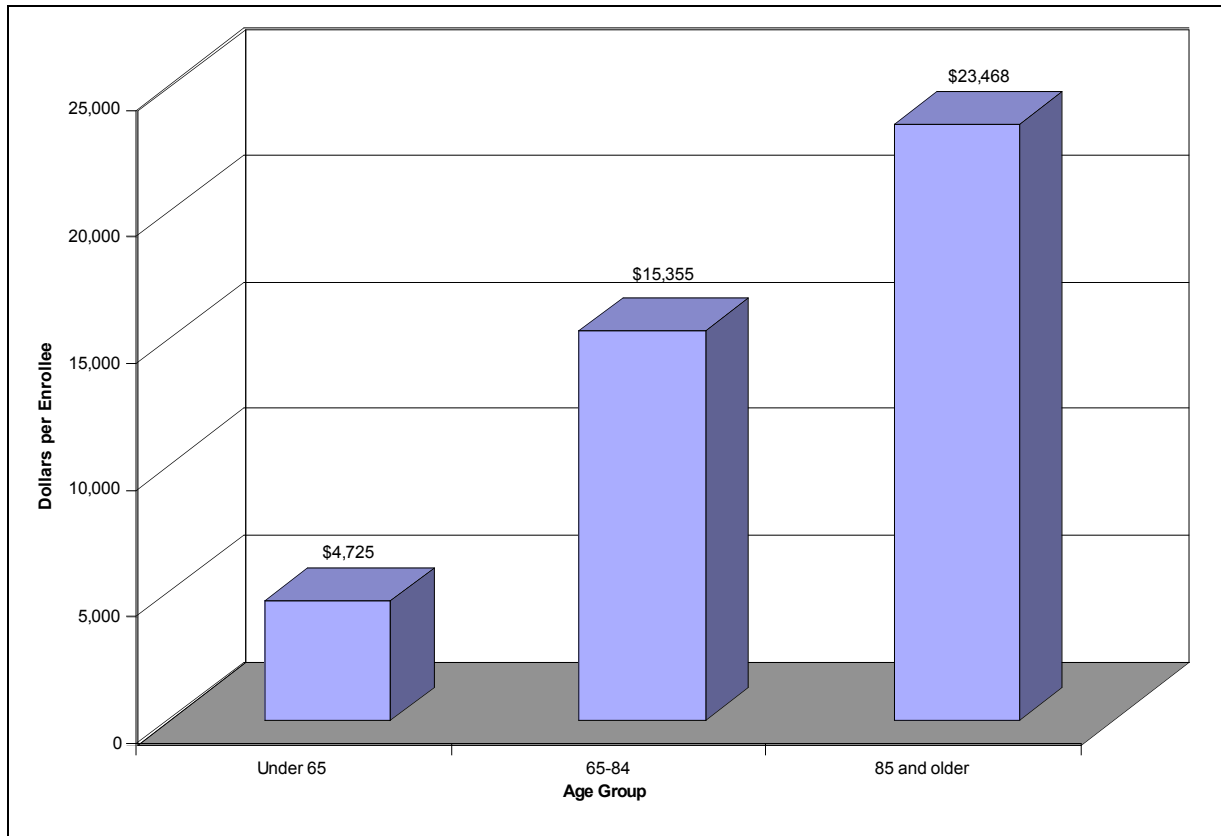


Figure 2.3 Per-Person Medicaid Spending in New Hampshire by Age, Fiscal Year 2001. Source: Mann, Cindy, “Financing Under Federal Medicaid Section 1115 Waivers: Federal Policy and Implications for New Hampshire, 2004”³¹

Table 2.5. Predicted Growth of the Elderly Population in New Hampshire

| Age Group | Percent of New Hampshire’s Population in 2000* | Estimated Percent of New Hampshire’s Population in 2010** | Predicted growth between 2000 and 2010** |
|-----------|--|---|--|
| 65-74 | 6.3% | 7% | 25% |
| 75-84 | 4.2% | 4% | 9% |
| 85+ | 1.5% | 2% | 45% |

Source: Calculations based on *U.S. Census 2000³² and **Stephen, John A. “Medicaid Modernization Project Status Report: ‘GraniteCare.’”, 2004³³

The New Hampshire Department of Health and Human has expressed concerns about the effect of the growth in the role of nursing homes, part of long-term care, on the State’s budget.”³⁴ Some have cited the statistic that “64% of New Hampshire’s long-term care spending is for nursing homes while in Vermont it is only 41%.” Long term care is certainly a pressing issue for New Hampshire, but New Hampshire’s spending on nursing home care is not as deviant from national trends as this statistic may suggest. Due to an error in a quarterly financial report submitted by New Hampshire’s Department of Health and Human Services (DHHS) to the federal Centers for Medicaid and

Medicaid (CMS), the FY 2002 reports show \$75 million too much on Medicaid nursing home spending. The error was corrected later by subtracting this sum from the next years' report, creating an inflated sum for 2002 and a deflated sum for 2003. This is where the 64% figure for 2002 and the 44% figure for 2003 originated. The correct percentage of long-term care spending going toward nursing homes is actually 55%, which is in line with the national average of 53%. Vermont's percentage is smaller largely because its Medicaid program services a much higher percent of the state's elderly population; by providing Medicaid services to a larger group, Vermont spends a larger percent of its long-term care spending on non-institutionalized elderly enrollees.³⁰ This discussion is not meant to trivialize the role of nursing homes in contributing to increasing program costs, but to focus the debate around accurate data.

2.6.2 Increasing Program Costs and Increasing Health Care Costs - Between 1991 and 2001, total Medicaid spending in New Hampshire increased by an annual average of 13%, compared to the national average of 11%.⁵ Table 2.6 provides the spending growth for different segments of the Medicaid population between 1999 and 2001. In contrast to the nationwide trend of enrollment as the largest cost driver, increases in the cost of care are responsible for 88% of the growth in Medicaid expenditures; enrollment changes account for only 12% of growth compared to being responsible for 59% of nationwide growth.³⁵

Table 2.6. Average Annual Growth in Per-Capita Medicaid Expenditures, Fiscal Years 1999-2001

| Group | Percent change in per-capita expenditures |
|--------------|--|
| Disabled | 9.6% |
| Children | 10.2% |
| Adults | 11.2% |
| Elderly | 20.2% |
| Total | 12.9% |

Source: Mann, Cindy, "Financing Under Federal Medicaid Section 1115 Waivers: Federal Policy and Implications for New Hampshire, 2004"³⁶

Prescription drugs are a large driver of New Hampshire's increasing health care costs. From 2004 to 2011, total spending on prescription drugs in New Hampshire (not just Medicaid prescription drug spending) is projected to double in absolute terms from \$931 million to \$1,857 million.¹⁴ New Hampshire recently implemented a preferred drug list that is an effort to select the most medically-effective and cost-effective medications.³⁷ It is too soon to determine the impacts of this program.

2.6.3 Reimbursement Rates and Cost Shifting - The Medicaid program reimburses health care providers for giving care to program enrollees. These reimbursement rates are a fixed level per service that is set by the state (rather than the actual cost incurred by the provider). Because the cost to the provider is not a direct factor in determining reimbursement, many of these fixed reimbursement rates fall short of providers' cost of giving care. Consequently, physicians have a disincentive to see Medicaid patients because they may lose money on their visits. This creates difficulties for both the provider and Medicaid enrollee—the provider can

afford to see only a limited number of Medicaid enrollees, and the Medicaid enrollee may consequently have difficulty finding a provider who will accept Medicaid reimbursement. The payer mix of hospitals creates additional difficulties because hospitals have less flexibility in determining which patients they will and will not accept. Consequently, the economic composition of the community surrounding a hospital has a large effect on a hospital's solvency.¹⁶

To compensate for the difficulties imposed by below-cost reimbursement rates, hospitals engage in cost shifting. This means that private insurance and self-paying clients make up the gap made by Medicaid and Medicare's reimbursement shortfalls. In this way, hospitals bill their privately insured and self-paying patients at rates much higher than the actual cost of services. The cost of providing care to publicly insured individuals (those insured by Medicaid and Medicare) is shifted to the other patients, amounting to a hidden tax. One segment of the population subsidizes the care received by another.¹⁶

2.6.4 Decreasing State Revenues - The state of New Hampshire faces decreasing revenues from the federal government. In the biennium that begins on July 1, 2005, New Hampshire will receive a projected \$100 million less from the federal government. Historically, New Hampshire has used Medicaid's regulations to find ways to collect "enhancement revenues." The impending change in 2005 is a result of the federal Center for Medicare and Medicaid Services' (CMS) mandate that New Hampshire change its method of collecting its hospital provider tax.⁹ In the current system (to which CMS objects), New Hampshire taxes hospitals on their gross receipts—that is, the total amount that a hospital bills—a number much greater than the sum the hospital actually collects. The state then pays this money back to the hospital, thus drawing down the matching federal dollars. The hospital receives the same amount of money it paid the state, and the state is left with additional federal money that goes into the General Fund; in this way, the hospital breaks even and the state brings in new federal money which is not necessarily spent on Medicaid.¹⁰ The required change in the provider tax will result in a loss of \$50 million per year for the state, creating the \$100 million shortfall over the biennium. New Hampshire uses the Medicaid program to bring additional money into the state, but this money does not necessarily finance Medicaid. This loss of funding has been used as a rationale specifically to cut Medicaid spending, but the change affects only the method of calculating the hospital provider tax, not the legitimacy of the tax itself (i.e. the new tax system will still bring in federal money to the state, just less).²

The change in the way the federal government allocates money to the state is not the only potential reduction in New Hampshire's federal funding. Federal pressure exists to tighten the rules that allow these sorts of schemes. For instance, the President has proposed changes to intergovernmental transfer payment rules that would, in the aggregate, reduce the federal governments' payments to states by about \$24 billion over ten years. The implications of this proposal on New Hampshire are unclear, but they cannot be favorable for the state.⁹ In sum, current and potential changes in New Hampshire's application of Medicaid funding rules will result in overall decreases in state revenues but not necessarily decreases to state Medicaid funds.

2.7 Recent Attempts to Address New Hampshire's Medicaid Challenges

In response to the challenges discussed above, New Hampshire is in the process of reforming its Medicaid program. Health and Human Services Commissioner John Stephen has led the Medicaid Modernization process. Under the Benson administration, "GraniteCare," a proposal for a new Medicaid program, was designed with consultation from the federal Department of Health and Human Services. GraniteCare would require New Hampshire to obtain a waiver from the federal

government (see the introduction for a thorough description of waivers).³⁸ In May 2004, the New Hampshire General Court approved a bill that would require approval of any future waivers negotiated by the state's Department of Health and Human Services with federal officials. The Joint Fiscal Legislative Committee will have to approve changes before they can become part of the state's Medicaid program.³⁹

The Granite Care report, presented by Commissioner Stephen in November, projects that New Hampshire's Medicaid program will grow at a rate of approximately 8% a year through 2010, and that the plan it proposes will reduce this growth curve by over 5%. Broad goals of the plan include a reduced reliance on nursing home care, coordinating and consolidating long term care services, developing health savings accounts, and developing an electronic information system that will adequately support the Medicaid program. The "critical steps" to achieve these goals are:⁴⁰

- "Create an integrated service delivery model for developmental disability, behavioral health, and long term care"
- "Reduce reliance on nursing facilities by 30%" (this would reduce the number of overall beds and, thus, eliminate entitlement to nursing facility care)"
- "Increase clients' choice to seek home- and community-based care"
- "Develop a medical home for all clients and manage care aggressively"
- "Establish a health services account for optional Medicaid eligibles" (i.e. those to which the state chooses to extend coverage beyond minimum federal requirements)
- "Increase accountability by developing Medicaid report cards"

The subsequent election of John Lynch as New Hampshire's governor adds uncertainty to the continuation of the 1115 waiver process. After expressing concerns about GraniteCare in his campaign, Governor Lynch has begun holding public forums to discuss changes to the Medicaid program. Highlights of suggestions given during the first forum on January 24 included improving programs for home and community-based care, controlling prescription drug costs, improving the pay of health care workers, and finding ways to avoid unnecessary emergency room care.⁴¹

3. MEDICAID IN VERMONT

3.1 Program Description

Vermont’s Medicaid program provides government health insurance to individuals who are financially unable to access private health care. The program covers most medical services for the categorically and medically needy including:⁴²

- Doctor visits
- Hospital care
- Prescriptions
- Vision and dental care
- Long-term care in a nursing home or at home
- Physical therapy

Vermont extends Medicaid eligibility and services beyond federal requirements with the use of several waivers.⁴³ Coverage extensions include optional groups including the categorically and medically needy as well as home and community-based services. A combination of federal and state funds supports the program. The State Health Access Trust Fund contains state Medicaid funds such as provider and cigarette taxes as well as money from tobacco settlements.⁴⁴

3.2 Eligibility

Citizens of Vermont qualify for Medicaid by meeting federal and state requirements. In addition to the broadly mandated federal requirements, Vermont, like most states, has expanded this coverage to include certain categorically needy and medically needy eligibility groups.⁴⁵

- Optional Categorically Needy Groups share characteristics of mandatory groups, but have broader eligibility requirements.⁴⁶ In Vermont, these groups include the blind and the disabled, the elderly, children, and adults.⁴⁷
- Medically Needy Groups are comprised of individuals who have too much income to qualify for mandatory or optional categorically needy groups. Thirty-seven states have medically needy groups. Examples of medically needy groups in Vermont are shown in Table 3.1.⁴⁶

Table 3.1 Categorical Medicaid Eligibility as a Percentage of the Federal Poverty Level in Vermont, 2003

| Group | Income (as Percent of Federal Poverty Level) Necessary to Qualify for Medicaid |
|------------------------------|---|
| Infants Ages 0-1 | 300% |
| Children Ages 1-5 | 300% |
| Children Ages 6-19 | 300% |
| Pregnant Women | 200% |
| Non-Working Parents | 185% |
| Working Parents | 192% |
| Supplemental Security Income | 74% |

Source: Kaiser Family Foundation State Health Facts Online: New Hampshire: Medicaid and SCHIP, 2003⁵

Most members of Vermont’s Reach Up, Supplemental Security Income (SSI), or Aid to Aged, Blind, or Disabled (AABD) receive automatic Medicaid eligibility status.⁴⁸ The table below displays eligibility groups and corresponding Medicaid and Medicaid related health care assistance programs in Vermont. Table 3.2 Eligibility Groups and Corresponding Health Care Assistance Programs in Vermont

| Group | Specific Programs |
|-----------------------------|---|
| Children and Pregnant Women | <ul style="list-style-type: none"> • Dr. Dynasaur (SCHIP) • Katie Beckett/Disabled Children’s Home Care (DCHC) • Parents and caretakers of Medicaid-eligible children, Aid to Needy Families with Children (ANFC)—TANF |
| Adults | <ul style="list-style-type: none"> • Traditional Medicaid • Vermont Health Access Plan (VHAP) Managed Care • VHAP Limited • VHAP Pharmacy • VScript/VScript Expanded • Healthy Vermonters |
| Elderly | <ul style="list-style-type: none"> • Traditional Medicaid • VHAP Pharmacy • VScript/VScript Expanded • SSI-related Medicaid – Aid to the Aged, Blind and Disabled (AABD) • Healthy Vermonters |
| Blind and Disabled | <ul style="list-style-type: none"> • Traditional Medicaid • VHAP Pharmacy • VScript/VScript Expanded • SSI-related Medicaid – Aid to the Aged, Blind and Disabled (AABD), Healthy Vermonters |
| Uninsured | <ul style="list-style-type: none"> • Healthy Vermonters • Vermont Health Access Plan Managed Care |

Source: Department of Prevention, Assistance, Transition, and Health Access: Office of Vermont Health Access Provider Manual, Fiscal Year 2001.⁴⁹

3.3 Programs

Vermont Medicaid is composed of many different programs that range from Traditional Medicaid, which offers assistance to the federally determined eligibility groups, to programs like Dr. Dynasaur, which target beneficiaries outside these groups. A variety of state agencies are responsible for administering these programs. This section briefly outlines Medicaid structure in Vermont and then lists and describes the state’s major Medicaid programs.

The Agency of Human Services delegates responsibility for Medicaid to the Office of Vermont Health Access (OVHA). The Department of Developmental and Mental Health Services,

Department of Aging and Disabilities, Department of Health, Department of Education, and Department of Social and Rehabilitation Services are also responsible for administering portions of the program. Every program overseen by these offices operates under two basic plans. The first is considered a fee-for-service plan and the second is a managed care plan called Primary Care Plus. All traditional Vermont Medicaid, Dr. Dynasaur, and VHAP beneficiaries are required to enroll in PC Plus. Authorization for the services covered by Vermont managed care must be obtained from a Primary Care Provider.⁴⁹

Since its establishment in 1967, Vermont's Medicaid program has expanded to include many different programs. A description of the states major Medicaid programs follows:⁴⁹

1. *Traditional Medicaid* operates as both a fee-for-service and managed care program. It was Vermont's first Medicaid program and was designed to offer assistance to the federally determined eligibility groups. Today, it offers the broadest benefits package for Vermont Medicaid beneficiaries.
2. *Dr. Dynasaur*, a program covering pregnant women and families of higher income, was enacted in 1989. Dr. Dynasaur is Vermont's division of the State Children's Health Insurance Program (SCHIP). SCHIP funding enables Vermont to extend Medicaid benefits to children with a family income between 225% and 300% of the federal poverty level. Vermont received a maximum allotment of \$3,813,156 in 2003 at a 73% SCHIP matching rate.⁵⁰ Dr. Dynasaur covered 3,885 children in 2003.⁵¹
3. *Vermont Health Access Plan (VHAP) Managed Care* expanded coverage to uninsured adults under a federal Section 1115a waiver. The program covers low-income adults who have had no insurance for the past 12 months or have lost coverage due to a death, a divorce, a job loss, or who no longer qualify as a dependent under a parent's insurance policy. VHAP beneficiaries are required to enroll in PC Plus.⁵¹
4. *VHAP Limited* is a program used to transition those uninsured citizens who qualify into managed care, but is more limited than PC Plus. The program covers physician services, outpatient hospital services and urgent or emergent hospital admissions as well as prescription drugs.
5. *VHAP Pharmacy* offers pharmaceutical and eyeglass benefits to low-income individuals, the elderly, and the disabled.
6. *VHAP UI* is a health insurance program for uninsured adults up to 150% of the federal poverty level.⁵²
7. *Underinsured Children* is a health insurance program for children between 225% and 300% of poverty who also have health insurance from a source besides Medicaid.⁵²
8. *VScript* extends pharmaceutical coverage to certain elderly or disabled residents whose income makes them ineligible for Medicaid.⁵³

9. *VScript Expanded* has the same benefits as VScript. It is included in Vermont's Medicaid appropriations but is not eligible for federal match.⁵⁴
10. *Healthy Vermonters* offers assistance to individuals without insurance for prescriptions and for those whose commercial insurance plan has an annual maximum prescription benefit. The program allows beneficiaries a discount on long-term and short-term drugs.
11. *Katie Beckett/Disabled Children's Home Care* enables disabled children to qualify for Medicaid based on their own income and resources. When determining eligibility for this program, the income of the beneficiaries parents is not taken into account.⁵⁵

3.4 Significant Structural Features

Vermont's Medicaid program is jointly funded by the state and federal government and involves several important structural features. This section outlines two key structural features of the Vermont Medicaid program.

3.4.1 Waivers - Currently, the state Medicaid program operates under one 1115 waiver and five 1915 waivers. Section 1115 waivers expand coverage to individuals ineligible for Medicaid under federal guidelines. Section 1915 waivers allow program care flexibility but do not allow coverage extensions to individuals who are not already eligible for Medicaid. The condition of budget neutrality accompanies both 1115 and 1915 waivers. This means that the state assumes responsibility for 100 percent of all Medicaid expenditures above what the federal government agreed to pay prior to waiver implementation.⁵⁶

Vermont's current 1115 waiver expands VHAP coverage of two groups and is based on per capita expenses. The waiver extends basic coverage to low-income families without any health insurance and pharmacy coverage to low-income individuals over 65. Vermont is also debating the implementation of a new 1115 waiver that will provide disabled adults and the elderly greater choice in long-term care services. The new waiver allows all Medicaid beneficiaries receiving long-term care to choose between services in home- and community-based settings and services in a nursing facility. State officials hope that the waiver will control long-term care costs by reducing the number of enrollees in institutions and also promote early medical intervention for at-risk populations.⁵⁷

Vermont's five 1915 waivers grant the state license to modify existing Medicaid programs. These waivers function predominantly as extensions of Vermont's home- and community-based services (HCBS) programs by allowing the state more flexibility in serving individuals at home and in the community. Vermont's 1915 waivers apply to 1) the developmentally disabled, 2) individuals with traumatic brain injuries, 3) individuals under 22 who suffer from mental illnesses and 4) the elderly.⁵⁷

3.4.2 Premiums - In 2003, Vermont's legislature significantly changed the state's Medicaid program by replacing cost sharing and program fees with premiums. These changes were implemented January 1, 2004 and affected pharmacy assistance programs, VHAP, SCHIP, and children above 185% of poverty. Premiums replaced all forms of cost sharing in the pharmacy assistance programs. Substantially higher premiums replaced program fees in VHAP uninsured, and SCHIP for children above 185% the FPL. Since the new premiums were largely income-based, enrollment declined the most among higher-income beneficiaries. Although the implementation of premiums created a pattern of decline, followed by rebound in every affected program, further analysis of this

information is necessary to determine the actual effect of premiums on Vermont Medicaid programs.⁵⁸

- In VHAP Pharmacy, VScript, and VScript Expanded, premiums replaced all forms of cost sharing. The premiums implemented were \$13, \$17, and \$35 respectively and were paid monthly. As in other programs, higher-income beneficiaries were most sensitive to the new premiums and displayed the greatest decrease in enrollment.⁵⁸
- In VHAP UI, per person income based premiums replaced program fees. For beneficiaries under 50% of FPL, \$0 premiums were implemented. For beneficiaries between 100% and 150% of FPL, \$45 premiums were implemented. Overall enrollment in VHAP UI remained the same after implementation of premiums but variations in individual income levels occurred. Enrollment increased in some income categories but decreased in others. For beneficiaries below 50% of FPL, enrollment increased 11%. For beneficiaries between 50% and 150% of FPL, enrollment increased marginally. Enrollment declined for beneficiaries between 150% and 185% of FPL.⁵⁸
- In SCHIP, Underinsured Children, and Dr. Dynasaur higher premiums replaced program fees. The per month premiums implemented in SCHIP and Underinsured Children were \$70 and \$35 respectively. In Dr. Dynasaur, \$25 premiums were implemented on a per family basis. For SCHIP and Underinsured Children, enrollment declined the most. Enrollment fell 19% in SCHIP and 17% in Underinsured Children. Enrollment in Dr. Dynasaur, which serves a lower income group, declined marginally and then grew to an all-time high, nearly 7% above October 2003 enrollment. The combined enrollment of all three children's programs shows a collective decline of 6% from October, 2003 to March, 2004.⁵⁸

3.5 Enrollment

In 2000, Vermont's Medicaid program served approximately 147,800 individuals. In 2003, the average growth rate taken across one year was 1.9%.⁴⁵ This section highlights key Medicaid enrollment data for the state of Vermont.

3.6 Funding and Spending

Both federal and state funds support Vermont's Medicaid program. In total, Vermont's Medicaid program cost approximately \$709 million in 2003.⁵⁹ Vermont has a 60% FMAP rate, which means that for every \$1 the state devotes to Medicaid, the federal government makes a matching donation of \$1.50.⁴⁵ Other sources of Medicaid funding in Vermont are settlement payments made by tobacco manufacturers, intergovernmental transfers, and tobacco and provider taxes.⁶⁰

Medicaid represents over 90% of the State of Vermont's direct expenditures on healthcare and consumes 22% of the state's budget.⁶⁰ Further, Vermont's distribution of Medicaid funds does not reflect its distribution of Medicaid enrollment (Table 1.1). Children, who comprise 44% of Vermont's Medicaid enrollees, consume only 22% of the state's Medicaid budget. In contrast, the state spends 28% of its budget on the elderly, an enrollment group which comprises only 14% of Vermont Medicaid enrollees. This occurs because some groups require more services and more expensive services than others and reflects national spending trends.

3.7 Key Challenges

Vermont, like most states, strives to provide adequate health care to needy individuals while appropriately spending state funds and resources. Vermont's Medicaid spending has exceeded state and federal revenues for the program. Predictions by the Vermont Joint Fiscal Office warn that this disparity will continue to increase over the following years. According to the JFO, the state will face a \$53 million shortfall in 2006 which will reach \$68 million by 2007.⁶¹ This section highlights four key challenges facing Vermont as it attempts to do this.

3.7.1 Rising Costs of Pharmaceuticals - In a 50 state survey done by the Kaiser Family Foundation, Vermont listed the rising costs of pharmaceuticals as one of the most important contributing factors to Medicaid expenditure growth in 2004.⁶² Pharmaceutical spending has been the fastest growing component of Vermont's Medicaid program in recent years. From 1996 to 2002, Vermont tripled its pharmaceutical spending at an annual growth rate of nearly 20%, increasing it from \$29.7 million to \$87.4 million. To address this pressing concern, Vermont has already implemented several cost controls.⁶³

In 2001 and 2002, the legislature passed two acts in response to rising pharmaceutical costs. Act 63 and Act 127 addresses this problem with the use of a preferred drug list (PDL). Preferred drug lists are listings of prescriptions identified by healthcare professionals as efficacious, safe, and cost effective choices. When Medicaid beneficiaries require a drug outside of the list, they must receive prior approval from their healthcare professional before obtaining the drug.⁶³

Two different evaluations of pharmaceutical spending completed by the Vermont JFO, before and after the PDL implementation, display marked savings. Estimates of these savings range from \$11.4 million to \$18 million. First, comparisons of yearly growth rates of overall Medicaid pharmaceutical spending indicate savings from the state's implementation of a PDL. Annual growth rates for the five largest Medicaid programs dropped significantly after the list was implemented. ABD, Families, VHAP UI, VHAP P, and VScript all displayed reduced growth rates in terms of pharmacy spending. Second, comparisons of Medicaid spending on specific drugs indicate PDL savings. Initially, three types of drugs were included in Vermont's PDL, acid reducers, anti-inflammatories, and narcotic analgesics. After the first year of implementation, spending for drugs in these three categories dropped significantly. Prior to PDL implementation, spending on these drugs totaled \$15.8 million over nine months. After the PDL was implemented, spending over the same period fell to \$12.0 million. Vermont's HAOC is currently debating the cost benefits of an expansion of the PDL to state employees.⁶³

Increased rebates also contribute to the reduction in Vermont Medicaid Pharmaceutical spending. The federal Omnibus Budget Reconciliation Act of 1990 (OBRA) ensures that Medicaid programs get the best deals on drugs from pharmaceutical manufacturers by increasing rebates from manufacturers to state governments. Growth in total pharmaceutical spending has slowed since 1990 while pharmaceutical rebates have increased. Aggressive cost containment programs are partly responsible for this increase in rebates.⁶³

One such innovative program involves interstate cooperation. In 2003, Vermont and Michigan implemented the nation's first Medicaid pooling program intended to creatively reduce pharmaceutical costs by increasing supplemental rebates. Both states authorized their pharmacy benefits administrator to simultaneously negotiate with pharmaceutical manufacturers, using the states' combined purchasing power. The pooling program boosted negotiating leverage for the

states, allowing them to obtain higher discounts from pharmaceutical manufacturers. These discounts are returned to states as rebate revenue. After implementing the program, Vermont increased its savings on pharmaceutical spending.⁶⁴

According to the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) the federal government's Part D coverage will replace Vermont's pharmaceutical responsibilities on January 1, 2006.⁶⁵ Although the impact on Vermont is unclear, the new program should represent savings at the state level. At the same time, there are some drawbacks as well.

- The states will have to bear the costs of implementing and administering Part D coverage.
- The clawback formula could be inaccurate for some states. Per Capita Expenditures on prescription drugs (PCE) vary greatly from state to state. Many states, including Vermont, have recently enacted cost saving pharmacy plans. The PCE from 2003 may not reflect those savings, causing a disproportionately high clawback payment.
- The PCE percentage will be projected based on the national average. By projecting forward the 2003 PCE based on a national average, states where the PCE grows at a different rate than the national average could see no actual savings for the state, or even a net loss.

3.7.2 Long-Term Care Services - Vermont has steadily expanded its home and community-based services (HCBS) while decreasing institutional care. In 2001, Vermont spent 55% of its Medicaid long-term care funds on HCBS, leaving 45% of its long-term care spending for institutional services. These figures reflect a growing number of developmentally disabled Medicaid beneficiaries who are served through HCBS programs. While this expansion has greatly advantaged Medicaid beneficiaries in certain areas, it has also created specific service problems that call for added attention.⁶⁶

Vermont invests a large amount of its long-term Medicaid spending on providing HCBS care for people with developmental disabilities. Since the closure of Vermont's last developmental disability facility in 1993, none of the state's institutions have been devoted solely to serving the mentally disabled. Because of this, Medicaid spending in this category has been increasing. Between 2000 and 2002, the state estimated an increase in this spending category from \$69.7 million to \$74.6 million. One of the major long-term care related challenges Vermont will face is to provide adequate home-based care to the developmentally disabled Medicaid beneficiaries in the state.⁶⁶

Vermont's operational definition of "developmental disabilities" differs substantially from the federal government's definition by being much more restrictive. According to Vermont's Developmentally Disabled (DD) Act of 1996, developmental disability means mental retardation, autism or pervasive developmental disorder (PDD). This behavior must have onset before 18 and result in severe behavioral deficits. Separate criteria exist for implementing services to young children and school-age children or adults. Young children must be diagnosed by a licensed medical professional, while school-age children and adults must have adaptive behavior limitations at least two standard deviations below a normative sample of their peers.⁶⁷

Coverage gaps exist in Vermont because the state does not provide coverage to the developmentally disabled based solely on eligibility. Even if individuals are deemed developmentally disabled by the

above definition, they are not guaranteed support or services by the DD Act of 1996. The annual funding provided by the legislature limits coverage to individuals who meet the specific priorities set by the State System of Care Plan. Individuals who do not meet these priorities remain on a wait list until coverage can be offered to them.⁶⁷

Agencies receiving funding through Vermont's HCBS program must meet certain standards and provide specific services guaranteed by the DD Act of 1996. Designated Agencies meeting the requirements of the act are certified to provide one or more of six different services. They may act in the capacity of 1) home supports 2) community/social supports 3) work supports 4) support coordination 5) family support or 6) crisis support. A problem with Designated Agencies exists because they are responsible for assisting DD individuals in choosing service providers. Because Designated Agencies act in the capacity of service providers, themselves, they have a vested interest in this choice. This responsibility, coupled with the fact that Designated Agencies are often the only service providers available to individuals, has created provider monopoly in some areas. In other words, sufficient choice of service providers may not exist under these conditions.⁶⁷

3.7.3 Decreasing Revenues - Vermont's revenue gap is a result of two overarching factors. First, revenues have been unable to keep up with rising Medicaid costs. Vermont has already raised cigarette taxes twice to boost funding for its Medicaid program, from \$0.44 to \$1.19. Over the next five years, the JFO predicts that tobacco taxes and settlement revenues will decrease, requiring higher taxes to maintain the same level of revenue.⁶¹

Second, federal changes also affect state Medicaid revenues. Title IV of the Jobs and Growth Tax Relief Reconciliation Act of 2003 increased federal fiscal assistance to states in 2003 and 2004.⁶⁸ This increased Vermont's FMAP rate to 65%.⁴⁵ FMAP rates are currently returning to lower levels because the federal fiscal assistance provided for in the act is running out. Vermont's FMAP rate has decreased from 65% to 60% and will fall to 58% in 2006. The Kaiser Commission on Medicaid and the Uninsured lists Vermont's decreasing FMAP rate as the primary contributing factor to predicted Medicaid expenditure growth in 2005.⁶⁹

3.7.4 Cost Shifting - In the world of health care, cost shifting is attributable to multiple sectors including hospitals, health insurers, HMO's, and self-insured employers. The ability of individual sectors to manipulate cost shifting differs greatly. Hospitals, for instance often offset low Medicaid reimbursement rates by raising charges to other payers such as health insurers, self-employed employers, and the uninsured. In contrast, individual providers have limited ability to shift costs because their reimbursement fees are not subject to negotiation.⁷⁰

The elimination of cost shifts in Vermont's Medicaid program may require increased provider reimbursement rates. However, according to Vermont's JFO, increasing these reimbursement rates creates several policy challenges. First, raising Medicaid reimbursement would require significant budget manipulation by the state. This means that the state must either expand its Medicaid budget or cut back on other programs. Second, Vermont must determine the appropriate amount of increase. In the past, Medicare reimbursement rates served as an estimate of actual medical costs. However, Medicaid reimbursement rates do not sufficiently cover costs spent by Vermont hospitals. Third, Vermont must decide what cost shifts to target with higher rates. Finally, the state must determine how additional funds will be shared among different providers.⁷⁰

At the same time, another concern among Vermont policymakers involves estimating the effects of disproportionate share hospital (DSH) payments on overall cost shifts. DSH funds compensate hospitals that serve a disproportionate share of low-income individuals through a combination of state dollars and federal funds. There are two critical questions concerning the relationship between DSH funds and cost shifts. The first is whether or not DSH funds should be included as part of the revenue received by the state's Medicaid program. Including DSH funds in total Medicaid revenue makes the cost shift appear smaller by offsetting low reimbursement rates with additional funds. When DSH funds are not included in this estimate because they are effectively canceled out by provider taxes, the cost shift appears much larger. The second critical question requiring attention is which providers should bear the majority of provider taxes. If hospitals pay the majority of Vermont's provider taxes, then DSH payments do not adequately compensate for low reimbursement rates and the cost shift appears large. If Vermont hospitals pay less in provider taxes than they receive in DSH payments, however, the cost shift appears smaller.⁷¹

4. RANGE OF POLICY OPTIONS

States across the country are dealing with the strain of financing Medicaid. In 2003, the federal government provided states \$20 billion to help address the health care concerns brought about by declining state budgets. This one-time donation allowed states to put off implementation of needed structural changes.⁷² However, many states have developed individualized policy responses. A review of these strategies suggests that Vermont and New Hampshire may find new ideas for meeting their own Medicaid challenges.

4.1 Providing Preventive Care

Low-income children experience disproportionately low levels of dental health. They endure weight loss, poor social development and school performance. Ignoring the need for regular dental maintenance and care pushes treatment to specialists or emergency care that are ultimately more expensive.⁷³ One of the most effective protective measures is supplying fluoridated water. In New Hampshire, 43% of water is fluoridated compared to 54% in Vermont. Though fluoridation is difficult for rural states, Maine has fluoridated 75% of its water supply. Estimates suggest that every dollar invested to fluoridate the water saves \$0.38 in dental treatment.⁷⁴ Other states employ community- and school-based programs such as fluoride mouth rinses, fluoride varnish, and dental sealants in lieu of fluoridated water.

Another important component of prevention is information. Washington State's "Watch Your Mouth" Campaign has been a model for effective use of Public Service Announcements. The Campaign's success was also a result of the effort of community organizations.⁷⁵ Another partially preventable condition is obesity. States combat obesity through media campaigns, taxes, community-based programs and legislative action. California collects a 7.25% tax on soft drinks while Arkansas collects 2 cents per can. California offers additional funding to schools that provide healthy food and do not have contracts with junk food makers or fast food chains.⁷⁵ While, other states regulate what types of food and drink are available in schools, New Hampshire and Vermont do not.

4.2 Controlling Program Costs with SCHIP Funds

When compared to standard Medicaid matching rates, the SCHIP program has higher rates. These higher SCHIP matching rates encourage states to work through SCHIP allotments until they reach the federally mandated limit. Once federal SCHIP funds are exhausted, states work through Medicaid and its lower matching rate.⁷⁶ States can maximize the higher SCHIP matching rate by filing an 1115 waiver to expand the SCHIP funded coverage to adults. If a state does not spend its SCHIP allotment within three years, the money is reallocated to other states.

The following states have used SCHIP funds creatively through the 1115 waiver process to prevent their SCHIP funds from being reallocated.

- Arizona covers parents of SCHIP and Medicaid children with incomes between 100% and 200% of the FPL and covers childless adults with incomes below 100% of the FPL.
- California covers parents of SCHIP and Medicaid children up to 200% of the FPL. Children are covered for a 2-month "bridging period" between Medicaid and SCHIP.

- Colorado covers pregnant women with family incomes between 134% and 185% of the FPL.
- Illinois expanded premium assistance to employer sponsored insurance and state administered health benefits coverage. SCHIP funds are also used for other state funded health insurance programs

4.3 Controlling Program Costs and Expanding Eligibility with Waivers

Oregon's Section 1115 waiver gives the state permission to use a system of capitated managed care with a prioritized list of health care services.⁷⁷ In capitated managed care, a health care provider receives a set dollar amount for each patient during predetermined time period regardless of the services provided. Thus, providers have an incentive to spend the minimum amount possible, which can have the positive consequence of effective use of preventive care or the negative consequence of reduced quality of care. In New Hampshire and Vermont, providers are reimbursed for each service they provide. Capitated care provides an alternative reimbursement scheme that may enable a state to save money.

Childless adults, regardless of income level are not eligible for Medicaid under federal standards. To expand coverage, states must finance it themselves or receive federal approval for a waiver.

- Arizona has received an 1115 SCHIP waiver to extend coverage under the Health Insurance Flexibility and Accountably (HIFA) Demonstration Initiative. The waiver permits Arizona to use unspent SCHIP funds to cover 50,000 adults, 25,000 of whom were previously without health care. The waiver extends coverage to parents of SCHIP beneficiaries and childless adults with an income below 200% of the Federal Poverty level. The waiver is subject to budget neutrality.⁷⁸
- Maine's Dirigo Program (Latin for "I lead") seeks to work with employers to help extend insurance to all individuals with incomes below 300%. This innovative program purposes a potential solution the give and take between public and private insurance. Dirigo is especially beneficial for the self-employed and small businesses. Private insurers provide coverage while states regulate the rates. Maine will assume the administrative role in order to provide insurance for businesses without the resources to handle the complex insurance arrangements.⁷⁹ Individuals without private insurance and below 300%FPL will still receive Maine Care (Medicaid and SCHIP).

4.4 Preventing Fraud and Waste

Washington State created a data warehouse to avoid paying for Medicaid when the beneficiary had other coverage (e.g., Veteran's Insurance). While the new policies require an increased staff, Washington is also taking advantage of technology in auditing claims to detect fraud and waste. Washington can search for claims in the data warehouse to prevent overpayments, overlapping coverage, fraud and abuse. The warehouse enables profiling of client's claims. These new measures were estimated to have saved \$5.8 million in 2002.⁸⁰ Although initially costly, such a measure could ultimately save money in New Hampshire and Vermont.

4.5 Securing Cost Effective Long Term Care

Aging populations in New Hampshire and Vermont will demand a high level of care in the coming year. States are addressing the current and projected costs by using managed care or other alternatives to minimize the use of institutionalized care.

4.5.1 Assigning the Correct Care

- Arizona uses managed care to help individuals receive the appropriate level of care. Managed care organizations receive a set payment for each individual enrolled in their plan. The managed care organization then determines the best setting for each individual. Only 1.1% of Arizona residents 65 and older are in nursing homes compared to a national average of 3.7%. Further, the program employs quality assurance mechanisms to evaluate the amount of service.⁸¹
- Instead of using managed care, Arkansas allows its elderly and disabled citizens to select their level of care. Arkansas' "Cash and Counseling" program awards cash to buy in home care. Along with Elder Choices, Arkansas' home- and community-based waiver, these programs are responsible for a 60% decrease in nursing home residency. Studies have found that enrollees have few unmet needs and are happy with their quality of care.⁸²

4.5.2 Ensuring an Adequate Workforce - Commissions dedicated to expanding the supply of hospital and nursing home workers have been organized in 35 states.⁸³ Key issues include

- Securing an adequate staff
- Minimizing staff turnover

One unique approach to addressing these problems comes from the Wellspring Model, a grassroots organization in Wisconsin developed in 1994. Originally created to combat Managed Care, Wellspring Innovative Solutions Inc. is an alliance of 11 nursing homes. The 11 nursing homes engage in cooperative sharing of ideas on administering care and organization in addition to comparing quality. Giving the employees a voice in shaping the organizational scheme of the nursing homes may have significant advantages. It instills a sense of community and efficacy that reduces turnover. Feedback and suggestions from the staff often improve the quality of care.⁸⁴ The results of the Wellspring Model have been positive. A Commonwealth Fund study found that costs did not increase significantly while the retention rate for Wellspring nursing staff increased over a four-year period, from 70 to 76%. In contrast, the retention rate fell; from 74 to 68% non-Wellspring homes in Wisconsin.⁸⁵

4.5.3 Home- and community-based Care - The Omnibus Budget Reconciliation Act of 1981 enabled states to set up HCBS waiver programs under Medicaid for disabled people and seniors. Medicaid spending for the average nursing home resident in 2000 was \$20,220 compared with \$3,135 for HCBS recipients. However, the actual savings may not be as dramatic as these numbers suggest.

- The introduction of HCBS extended funds to persons living at home who were not previously receiving care.

- Costs are shifted to the enrollee and their family and friends who often perform services free.
- HCBS enrollees are also eligible for Medicare home health benefits, thus Medicaid savings are not necessarily net savings.⁸⁶
- HCBS enrollees may be healthier on average.

Despite these cautionary points, HCBS may save money per person while also providing the enrollee with a greater degree of autonomy and independence. Ensuring this type of autonomy and independence is important, given the Supreme Court decision in *Olmstead v. L.C.*, which guaranteed the right to placement in the most integrated settings for persons seeking health treatment as part of Medicaid.⁸⁷

4.5.4 Federally Qualified Health Centers - Federally Qualified Health Centers (FQHCs) are established in areas with a shortage of care. They serve low-income groups: Medicaid and Medicare beneficiaries as well as the uninsured and privately insured. FQHCs provide general outpatient services including preventive care and eye, ear, and dental services. In addition to these ambulatory services, FQHCs provide transportation to patients and referrals to specialists or the necessary facilities.⁸⁸ Funding is secured through federal and state grants in addition to reimbursement for services from public and private insurance. In order to receive federal funding a FQHC must: provide care regardless of income or insurance status and provide services on a sliding fee scale based on family income.⁸⁹ FQHCs may benefit a state for two reasons. First, they secure additional federal money to help finance care for the poor. Second, FQHCs also help extend care to populations in need of medical facilities. New Hampshire and Vermont both have FQHCs; they can continue to be a useful tool in providing care for individuals who have trouble affording care and traveling to medical facilities.

4.6 Informational Campaigns and Outreach Programs

One barrier to enrollment is the lack of knowledge of the requirements for receiving Medicaid. Many states have launched effective and innovative programs to promote understanding and increase enrollment.

- In Arkansas, the “Campaign for Healthier Babies” strives to advance prenatal care. One of the main tools is the “Happy Birthday Baby Book” that combines coupons for free or discounted care with an informational component. The book stresses the need for prenatal and public health care options. Ohio uses a similar coupon book. Arkansas also maintains the Arkansas Health Information Line. It is a toll free information system specializing in health concerns for babies and Medicaid. The Health Information Line can provide callers with information and referrals.
- Many states have expedited the application process, making it easier to enroll in Medicaid. New York uses the “Growing Up Healthy Application.” It combines the applications for the Special Supplemental Nutrition program for Women, Infants and Children with the Medicaid application. The application is only one page.
- Some states use school based health centers to discover potential Medicaid eligible families. In New York, school-based health centers partner with hospitals and community health

centers that have Medicaid eligibility workers who are available to the school-based health centers.⁹⁰

4.7 Further Research

In the process of producing this report, questions for future research emerged. The following are recommendations for further investigation:

- Home- and community-based care (HCBS) has been recommended as both a means of increasing choice, improving quality of care, and saving money. Further research is needed to investigate the cost savings from HCBS and the reasons for these savings. What changes (positive or negative) in the quality of care result from a shift to HCBS? Do HCBS represent a net savings or do they shift the cost to unpaid caregivers?
- Preferred drug lists have recently been implemented in both New Hampshire and Vermont. The impact of these programs needs further investigation.
- As New Hampshire begins to modify its Medicaid program, the state will need to continue analyzing and evaluating the implications of these changes.
- Cost shifting as result of low Medicaid reimbursement rates is thought to occur in both New Hampshire and Vermont. Further research is needed to determine what level of reimbursement would prevent cost shifting and thereby lower the cost of care for the privately insured and improve access for Medicaid enrollees.
- In 2003, Vermont entered into the nation's first Medicaid pooling program to reduce its spending on pharmaceuticals. The relatively recent implementation of this program and its experimental status call for further research to determine the effects of the program on pharmaceutical spending.
- Vermont's recent implementation of premiums in several of its programs may have significant effects on enrollment patterns. Although an initial pattern has been established that indicates little long-term effect on enrollment, further analysis is necessary to determine the actual effect of premiums on Vermont Medicaid programs.

Disclaimer: This report was written by undergraduate students at Dartmouth College under the guidance of Professor Andrew Samwick (Director of the Nelson A. Rockefeller Center) and Dr. Patrick Hurley (Research Associate at the Nelson A. Rockefeller Center). All material presented in this report represents the work of these individuals and does not represent the official views or policies of Dartmouth College.

APPENDIX A – ADDITIONAL INFORMATION ON THE MEDICAID PROGRAMS IN NEW HAMPSHIRE AND VERMONT

New Hampshire

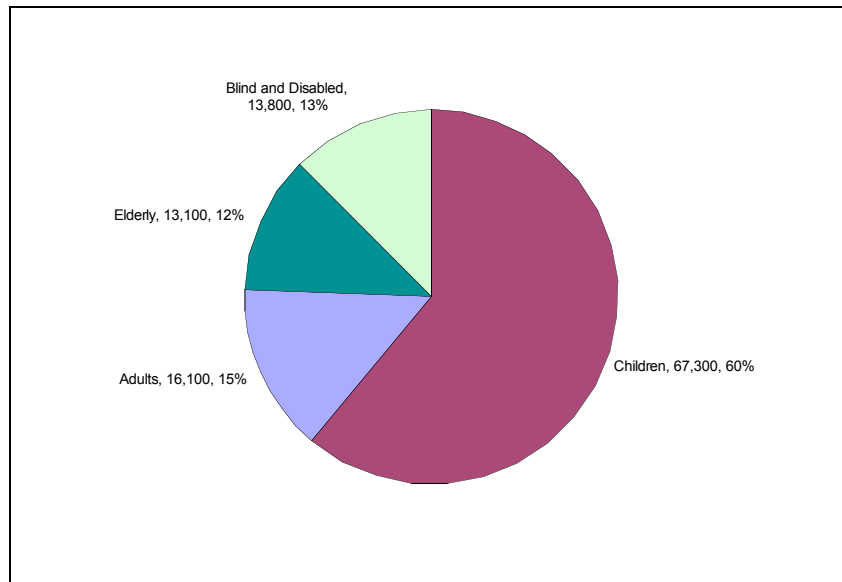


Figure A.1 Distribution of State Medicaid Enrollees by Enrollment Group in New Hampshire, Fiscal Year 2000. Source: Kaiser Family Foundation State Health Facts, 2004⁹¹

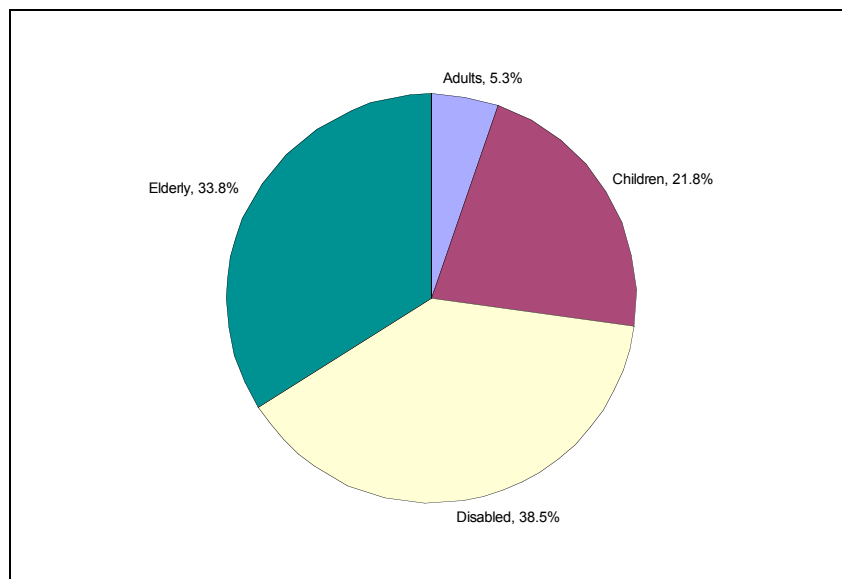


Figure A.2 New Hampshire's Medicaid Spending, Fiscal Year 2001. Source: Mann, Cindy, "Financing Under Federal Medicaid Section 1115 Waivers: Federal Policy and Implications for New Hampshire, 2004"⁹²

Vermont

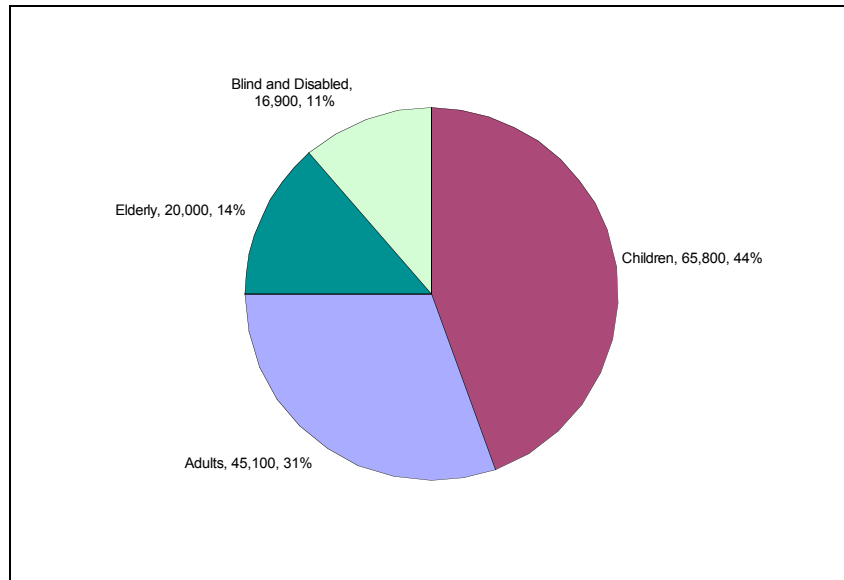


Figure A.3 Distribution of Vermont Medicaid Enrollees by Enrollment Group, Fiscal Year 2000. Source: Kaiser Family Foundation State Health Facts Online: Vermont: Medicaid, Fiscal Year 2000.⁴⁵

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