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State of Colorado
Department of Health Care Policy and Financing

PROGRAM RESEARCH REPORT:
Adults Without Dependent Children

Submitted: June 28, 2011

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I. Introduction

To inform the design and implementation of coverage for Adults without Dependent Children (AwDC) in Colorado, the Department of Health Care Policy and Financing (the Department) requested that PCG conduct research on and interviews with a number of state Medicaid and other public programs that cover this population. This report provides detailed information on how AwDC programs have been designed, implemented, and monitored in other states and will provide lessons learned for Colorado as the Department finalizes its program design. Because Colorado is pursuing its expansion using the early option allowed for under the Affordable Care Act (ACA) and will be required to utilize the benchmark benefit level, we have also included available information from Idaho, West Virginia, and Kentucky as these states utilize the benchmark benefit level for some of their Medicaid populations.

II. Methodology

The report provides varying levels of detail about the state programs listed below. PCG obtained the information contained in this report through a combination of the personal knowledge of the participating consultants, publicly available state information, and interviews with state officials (see Table 1).[1]

[1] A "*" next to the state's name indicates that a formal interview has been completed.

Table 1

1115 Waiver Program	Early Option Expansion Program	Utilizing Benchmark Benefits for Medicaid Population	State Funded Program
Hawaii ACE and Net*	Connecticut*	Idaho*	Pennsylvania
Maine*	District of Columbia*	Kentucky	Washington
Maryland Adult Care Program*	Minnesota	West Virginia*	
Massachusetts			
New York*			
Oregon			
Utah			
Vermont*			
Wisconsin			

There is no simple categorization of state programs for AwDC. A number of states have more than one program covering childless adults. For example, Massachusetts has three programs authorized under its 1115 Waiver, including MassHealth Basic and MassHealth Essential which cover long-term unemployed to 133% of the federal poverty level (FPL) and Commonwealth Care, which covers AwDC to 300% of the FPL who are not eligible for MassHealth. In New York, there are two programs that cover AwDC – Family Health Plus and Healthy New York. The information contained in this report focuses on Family Health Plus as it is more relevant to Colorado's program design.

Three states included in this report do not currently cover AwDC. These states – Idaho, Kentucky and West Virginia – are included in this report as they utilize the benchmark benefit level for some of their Medicaid population.

As states grapple with their obligations to balance state budgets in each year, a number of cost-savings measures are on the table, including elimination of some programs covering the AwDC population. In Pennsylvania, the state-funded program, adult Basic, was closed on February 28, 2011. More than 41,000 people lost coverage. In Washington, the Governor has proposed eliminating the state-funded Basic Health Plan. Alternatively, however, Washington has received approval from the Centers for Medicare & Medicaid Services (CMS) to convert its program to Medicaid using the early option so they can take advantage of the federal match.

III. Information on State Programs

a. Authority

As most states covering the AwDC population began their programs prior to the passage of the Affordable Care Act (ACA), most operate under an 1115 Medicaid Demonstration Waiver to access federal funds. Some states, including Washington and Maryland, operate AwDC programs relying on state-only funds. To date, Connecticut, the District of Columbia and Minnesota have opted to utilize the early expansion option for coverage of AwDCs under the ACA. As stated above, Washington has received approval to transition the program to Medicaid using the early option but it is unclear at this time whether this will occur.

b. Eligibility and Enrollment

States provide coverage to AwDC to varying income level, ranging from 35% to 300% of the FPL.[2] Hawaii and Maine both have an asset test for this population.[3] Vermont allows for self-declaration of income. Most states covering AwDC have enrolled fairly large groups of individuals. Often, demand exceeds state capacity and expectations, as evidenced by the large waitlists detailed below. Connecticut, which recently transitioned to an early option state and eliminated its resource test, has seen its enrollment grow significantly—by some 33% over the past nine months.

The application process varies depending on whether the program is administered as part of the Medicaid program or as a separate program. For the most part, states leverage existing Medicaid eligibility rules and enrollment procedures. Generally, applicants have the ability to complete and mail paper applications, or apply on-line where available. Applications are typically processed through a centralized eligibility processing center. Notable exceptions include New York and Minnesota, where applications are submitted to local social services departments. In order to limit enrollment in Utah's program, individuals can apply only during limited open enrollment periods.

Wisconsin utilizes a unique process for enrollment in its BadgerCare Plus Core plan, which covers the AwDC population—applications are only available on-line or by phone; there is no paper application available. In addition to completing a traditional

[2] See Table 3, *Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults*, Kaiser Commission on Medicaid and the Uninsured, February 2011.
[3] Many other states do not have asset tests for the AwDC population, including Massachusetts, New York, and Oregon.

application, individuals must complete a Health Needs Assessment (HNA)[4] as part of the initial enrollment of AwDC to determine what coverage an individual will receive. The information obtained on the HNA is then provided to the managed care entity which the individual has selected or been assigned to. The managed care entity utilizes the HNA to identify an individual's specific needs (e.g., participation in a prenatal care program for pregnant woman or a disease management program for chronic care issues, including diabetes and asthma) and the existing primary care doctor. Wisconsin, an 1115 waiver state, requires the completion of this HNA prior to enrollment. The state developed this process in order to learn more about the health needs of this expansion population.

Typically eligibility is reviewed on an annual basis or as new information is received. There is often significant churn within the population – for example, up to 25% in Massachusetts and Utah and close to 2/3 in the District of Columbia, except that there may be less churn in those states where demand exceeds capacity – in Washington churn is only 3%. A qualitative report for New York's Healthy Families Program indicated that many former beneficiaries did not intentionally drop coverage and saw the recertification requirements as an unnecessary burden. Suggestions to reduce barriers included passive redeterminations, telephone or online re-certification and telephone, text, email, or paper reminders. Other suggestions included limiting interactions with the state social service agencies to help reduce any stigma associated with receiving public assistance, and utilizing re-certification facilitators to assist with re-enrollment. Finally, the report suggests the need for improved cultural competence in terms of having applications and re-certifications in prevalent languages.

[4] The Health Needs Assessment utilized by Wisconsin is attached as Appendix B and available at http://www.dhs.wisconsin.gov/forms/F1/F10180.pdf.

Unlike states that provide coverage under the ACA early expansion option, states that operate programs under an 1115 Waiver or using state-only dollars have the option of utilizing a waiting list and many have closed enrollment in the face of their current budget crisis. Wait lists can be quite large – for example, in 2010 there were 60,614 individuals enrolled in Wisconsin's program with 30,000 individuals on the wait list and 66,000 enrolled in Washington's program with more than 100,000 on the wait list. Wait lists are typically organized on a first come, first serve basis. Some states allow for certain groups to bypass the wait list, or go to the front of the list. For example, Washington allows personal care attendants and foster parents, among others, to enroll despite the wait list.

States utilize varying efforts to outreach to potentially eligible individuals, including utilizing community-based organizations and providers through provision of mini-grants. Massachusetts and Vermont combine the outreach for this population with other programs. In the District of Columbia, the hospitals and health plans conducted a large amount of outreach. For its Healthy New York program, New York utilizes "Facilitated Enrollers", procured contractors located across the state to assist individuals in completing the application process. Hawaii utilized media advertisements, including television, radio, newspapers and bus posters when they opened their new program, QUEST-ACE, in 2007. In addition, Hawaii's managed care plans assisted with outreach.

Many states, including Maryland, Massachusetts, Vermont, and the District of Columbia work closely with correctional facilities to identify potentially eligible individuals that are leaving custody and provide them with an opportunity to enroll. In Maryland, prison social workers assist prisoners to complete applications prior to release. New York

received approval from CMS, under Family Health Plus, to suspend benefits during incarceration, automatically reopen on release for four months and then recertify eligibility. New York has implemented a few pilot programs to start the application process for prisoners that were not on Medicaid prior to incarceration, however the programs have typically failed for lack of resources.

While states collect specific income information from individuals and theoretically have the ability to identify individuals by income level, they rarely run reports that way. Connecticut noted that in an ad hoc report completed when its program was funded with state-only dollars, nearly 70% of its population reported having no income. Likewise, in the District of Columbia when their program was funded with state-only dollars, approximately 60% of the covered individuals reported income of 0-1% FPL. Wisconsin said that not quite 60% of their enrollees reported having no income. Maryland was able to provide specific eligibility information by age group. In 2009, 37% of enrollees were between the ages of 21 and 39 and 59% were between the ages of 40 and 64. Wisconsin reported that 54% were between the ages of 45 and 64 and 62% were male.

c. Benefit Design

Connecticut, the District of Columbia and Minnesota have implemented the ACA early option for coverage of the AwDCs. These three states are providing the full Medicaid benefit package and are not requiring cost-sharing above that required of traditional Medicaid populations in their states. Washington has received approval for the early option but has not implemented. It is important to note that these states had state funded programs and, given the difficult budget challenges, were anxious to make a program change that would allow them to receive federal dollars. The most expeditious way to make the change was to provide the established Medicaid benefit.

For other states, benefit packages vary from state to state, but typically include preventive, acute and urgent care, pharmacy, limited long-term care services, and mental health care. In addition, some states include substance abuse, dental, and vision services. Depending on how states cover pregnant women, maternity benefits may also be included. Utah provides limited benefits focused solely on primary care and emergency benefits. Urgent care and specialists are excluded. Appendix A includes detailed benefit information for Hawaii, Maine, Maryland, New York, and Washington. As evidenced below in Table 2, most states do not provide the full Medicaid benefit.

Table 2

State	Full Medicaid Benefits	Slightly Less than Medicaid	Significantly Less than Medicaid
Arizona	X		
Indiana		X	
Maine			X
Massachusetts		X (Basic)	X (Essential; Commonwealth Care)
Minnesota	X (Minnesota Care)		X (GMAC)
New York			X
Oregon			X
Pennsylvania			X
Washington		X	
Wisconsin			X

Many states noted that emergency services and mental health and substance abuse services are heavily utilized by this population. When transportation is provided it is often highly used. Notably, Connecticut has experienced high usage related to substance abuse services. In Maine, the 1115 waiver program initially covered full Medicaid benefits. As part of an overall spending reduction strategy, waiver benefits were

compared to the state's benchmark benefits, which is the public employees' health plan through Anthem. As a result of this comparison, services such as acupuncture, physical therapy, occupational therapy and speech therapy, and home health were removed. Transportation was also removed initially but then added back because demand/advocacy for this benefit was very high.

As mentioned above, three states researched for this report, including West Virginia, Idaho, and Kentucky, do not provide coverage to the AwDC population but have elected to use the benchmark benefit level as allowed under the Deficit Reduction Act of 2005 (DRA). Specifically, Idaho used secretary-approved coverage that allowed the state to develop its own benefit plan that is considered a Medicaid equivalent plan.[5] Essentially, these benchmark plans are more comprehensive than the state plan Medicaid benefit. When Idaho created these benchmark benefit plans they eliminated all optional Medicaid services from their state plan benefit and included many optional services, as well as preventive care benefits to their benchmark benefit options. As such, all enrollees are in a benchmark option. There are different benefits for different eligibility categories.

Under West Virginia's plan, Mountain Choices, parents and children enroll in either a basic or enhanced Medicaid managed care plan. To participate in the enhanced plan, an individual must sign and adhere to a member agreement that details membership responsibilities including being on time for appointments, and using emergency rooms only in emergencies. The basic plan, which meets the benchmark benefit level, provides mandatory Medicaid benefits with restrictive limits on certain services, including home

[5] Idaho's state plan providing for benchmark benefits for low-income children and working-age adults is included as Appendix C.

health, non-emergency transportation, and prescription drugs. Appendix B details the available benefits for the basic and enhanced plans. It also includes a Medicaid Beneficiary Report focused on the success of Mountain Choices.

Kentucky received approval from CMS to implement KyHealth Choices in 2006. Its plan, which has not been fully implemented, includes four benefit packages that offer different sets of services based on the population's needs. The package covering most adult Medicaid beneficiaries is a standard Medicaid plan. The plan also includes the addition of prior authorization for a number of services, including specialty services and prescription drugs. Consistent with the benchmark requirements, cost-sharing cannot exceed 5% of family income and the plan includes mostly minimal cost-sharing, except for a $50 copayment for inpatient hospital services. There is a 5% coinsurance with a maximum co-payment limit of $6 required for non-emergency use of the emergency room.

d. Cost-sharing

Hawaii's Quest-Net and Quest-ACE do not require cost-sharing. Maryland's Primary Adult Care (PAC) Program only includes prescription drug co-pays. Most other states include at least nominal cost-sharing in their programs that cover AwDC. Particularly for individuals with incomes at or below 100% of the FPL, many states, including Massachusetts and Wisconsin require only nominal cost-sharing from individuals. Other states, such as Washington, provide for a 20% coinsurance for many services. Instead of charging co-pays, Vermont requires this population to pay premiums. Wisconsin charges a $60 application fee in addition to requiring cost-sharing (this fee is not required of individuals who are homeless). Washington also requires a monthly premium that is priced more like a commercial product in that it is based on age, health

plan selected and location. In addition, it also takes into account both income and number of people in the family.

Washington's program provides for a 2-tiered pharmacy benefit. If an individual utilizes a Tier 1 drug the co-payment is $10; if an individual utilizes a Tier 2 drug, he or she is responsible for 50% of the cost of the drug.

It is important to note that these states provide coverage under an 1115 waiver or using state-only funds, which affords them more flexibility in requiring co-payments and premiums than is allowed for as part of the early expansion option to AwDC through the ACA. The early expansion option requires states to comply with standard Medicaid coinsurance requirements, providing for only nominal cost-sharing for those with incomes at or below 100% of the FPL.

e. Delivery Systems

Most states covering adults without dependent children required eligible individuals to enroll in a managed care organization (MCO). Some states utilize a combination of delivery systems, including MCOs and Primary Care Case Management (PCCM) programs. Vermont utilizes its state-run health plan to provide coverage to eligible individuals. In Connecticut the state currently provides services on a fee for service basis, but is looking at other options such as the PCCM program.

Generally, states did not provide special trainings to providers about the coverage of adults without dependent children. However, Maryland did focus on training substance abuse providers on the workings of Medicaid as this previously had not been a covered

benefit so providers did not have an understanding of how to bill Medicaid. Substance abuse treatment is the highest utilized service in Maryland's program.

Where the programs leverage Medicaid payment systems, payment is the same for services provided to this population and other Medicaid covered groups. Some states with state-only funded programs do pay lower rates for coverage of these services. States did not note having specific incentives in place for this program though some states did include this population as part of its pay-for-performance patient volume.

States, including Vermont and Massachusetts, are beginning to conduct medical home initiatives. While not focused solely on this population, AwDCs are included in these initiatives. In most states, efforts are still in the pilot phase.

f. Financing

Although it is difficult to make apples-to-apples comparisons of per member per month (PMPM) costs between programs given the differences in services and rates, during our research PCG collected some information about overall costs. In Maine, which provides a relatively rich benefit package that is less than full Medicaid but includes transportation, the 2008 PMPM totaled $406. The rates have remained stable over the last several years. Projected CY2011 spending is $318 PMPM in Washington's Basic Health Plan, which is a more limited benefit than Medicaid and includes substantial cost-sharing for beneficiaries. Hawaii's expansion programs provide a very limited benefit. Their capitation payments for adult males ages 21 – 39 are roughly half the capitation rates for the same age cohort in the QUEST (Medicaid) program. Wisconsin had an average PMPM of $238 in 2010 for a very limited benefit package.

States providing the full Medicaid benefit generally have higher costs than those with limited-benefit waiver programs. For example, Minnesota, which just transitioned their state-funded program to Medicaid using the early option, provides coverage through managed care plans. Their capitation payments for the expansion population are roughly twice the cost for the parent populations and about half-way between the rates for parents and recipients with disabilities (average rates for adults without children are $1,003; parent/caretakers ages 21 – 49 are $442 and parents/caretakers age 50 – 64 are $565 PMPM). Costs for the very small, voluntary managed care program for the non-institutionalized, non-Medicare individuals with disabilities population average $1,665 PMPM). Connecticut also reported that PMPM costs for the AwDC population were higher than expected and closer to the costs for adults with disabilities than the parent populations. In Vermont, the state budgeted for $340 PMPM in FY2011 for AwDC who received a full Medicaid benefits package. Although not interviewed for this report, Arizona, which has been covering this group since 2002 with the same benefit package available to other Medicaid enrollees, projected annual costs for 2010 of about half-way between adults with disabilities and adults without disabilities.

As mentioned above, coverage of this population is typically intertwined with that of the rest of the Medicaid program. Given that, most states do not separately monitor spending for this population on an ongoing budget, except for budget requests. However, several states did share general information about utilization and costs. For example, Connecticut has experienced higher-than-anticipated utilization, particularly in the areas of non-emergency transportation (especially related to transportation to and from substance abuse treatment services) and nursing facilities. Wisconsin reported that 50.7% of AwDC costs are related to pharmacy (their benefit only includes physician and clinic services, prescription drugs and hospital services).

g. Performance and Evaluation

Few states separately monitor the performance of this program. However, Maryland does monitor separately and has found that its PAC Program, which is funded through a provider fee program similar to that to be used in Colorado, has met its federal budget neutrality requirements and has generated savings for both the state and federal governments. In addition, Maryland monitors enrollment by age group, race, sex and region. Enrollment in the PAC program has increased by 25% between CY2007 and CY2009. Maryland measures the quality of its program, at least in part, by using HEDIS measures, including breast and cervical cancer screenings, and comprehensive diabetes care. Utilization is monitored by race, age, and region for those enrollees who were enrolled for a full year.

h. Lessons Learned

The descriptions above include detailed information about the programs states have put in place for AwDCs. States provide limited lessons learned during our interviews. The biggest lesson learned is to carefully develop a benefit package and predict expenditures for those benefits. At least one state, Maine, initially began its program with a complete Medicaid package and found that maintaining coverage at that level was not financially sustainable.

As states have needed to close unprecedented budget gaps in recent years, there has been increased pressure on any optional programs or benefits within the Medicaid program. As described above, a number of states have utilized wait lists to control spending for this population. In Arizona, the state plans to disband its coverage of AwDC when its current

1115 Waiver expires in September 2011. In states like Pennsylvania and Washington, where the states are providing coverage at full-state costs, the programs are even more at risk. As of March 1, 2011, Pennsylvania has ended its program covering AwDC and Washington is considering closing its program. Alternatively, however, Washington has also considered transitioning its program to an early expansion program to access federal funds. Having a dedicated funding stream for the program, as Colorado does through its hospital assessment, allows for increased stability for the program even in the face of a budget crisis.

Additionally, states emphasized the need to leverage the infrastructure of the Medicaid program to allow for ease in implementation, and to understand where it is practical to make changes to the existing system. A number of states noted the difficulty of making changes to their MMIS systems to allow for limited benefits and cost sharing differences from the standard Medicaid program.

Vermont noted that it found cost-sharing to be difficult for its providers and, to reduce administrative burden, chose to utilize a monthly premium rather than minimal co-payments.[6] Vermont, among other states, also included coverage through a premium assistance program for individuals that have access to health insurance through employment.

[6] States using the early option must comply with Medicaid regulations regarding premiums. These regulations prohibit states from charging premiums to individuals with incomes below 150% FPL.

IV. Considerations for Colorado and Next Steps

Our interviews did not yield as much information as we hoped on the implementation of programs for AwDC as most states have had programs for a number of years and different individuals are not in the same roles. As Colorado finalizes the design of its program for AwDC, we recommend the following:

- Expect the unexpected;
- Carefully develop the benefit package and model spending for this program;
- Weigh the ease of implementation and understanding of the program by keeping it close to the Medicaid program against the opportunity to pilot programs that may benefit the entire Medicaid program and necessary budgetary considerations;
- Build in an ability to monitor spending and utilization separately for this program up front; and,
- Consider outreach initiatives for the AwDC program to notify potentially eligible individuals and providers about this new coverage; and educate new members on how to utilize health coverage.

Based on the information included in this report, PCG will work with the Department to finalize a proposed program design and to conduct financial modeling on the proposed design.

Appendix A: Benefit Packages of Select States

Hawaii

- 12 outpatient visits (including substance abuse)
- 10 inpatient hospital days
- Unlimited ER
- 6 behavioral health visits (6 of the outpatient can be used for mental health – a change made to comply with the Mental Health Parity and Addiction Equity Act of 2008)
- 3 ambulatory surgery procedures
- Diagnostic tests associated with the outpatient medical visits
- Immunizations for diphtheria and tetanus
- Family planning services (but not drugs)
- Limited prescription drugs: OTC and very strict formulary – primarily antiobiotics. There is no coverage for family planning drugs, and no mental health drugs. (Note: the state is considering moving to a dollar cap instead of the strict formulary)
- There are no vision, dental, hearing, DME, transportation benefits.
- There are no specific ubstance abuse services except as part of the outpatient or behavioral health visits (this did not exist at all prior to passage of the Mental Health Parity and Addiction Equity Act of 2008)

Maine

- Hospital Services
- Psychiatric Facility Services (inpatient)
- Physician Services
- Pharmacy Services
- Ambulatory Surgical Center Services
- Rural Health Center Services
- Federally Qualified Health Clinic Services
- Private Non-Medical Institution Services, substance abuse facilities only
- Family Planning Agency Services
- Advance Practice Registered Nursing Services
- Ambulatory Care Clinic Services

- Vision Services (ophthalmologist and optometrist only)
- Dental Services
- Chiropractic Services
- Transportation Services
- Medical Supplies and DME, oxygen and insulin pumps and pump supplies only
- Podiatric Services
- Ambulance Services
- Medical Imaging Services
- Laboratory Services
- Outpatient Mental Health Services - Psychiatric Facility Services
  - Outpatient methadone services being billed by hospitals as of the date the waiver was approved.
  - Section 65 Crisis services allowed for in specific regulatory sub-sections to include Crisis Resolution Services, and, Crisis Residential Services.
  - Adult protective services that were previously covered under a repealed Section of the MaineCare Benefits Manual and are covered in a regulatory sub-section on Outpatient Services.
  - Specified allowable emergency outpatient services.
  - Allowable medication management services.
  - Substance abuse treatment services allowed as Intensive Outpatient Services.
  - Methadone treatment services

Maryland

- Visits to the doctor or clinic, including regular check ups
- Emergency department facility services
- Family planning and birth control
- Prescription medicines
- Over the counter medicines
- Some X-ray and lab services
- Eye exams (check ups) and glasses for people with diabetes
- Foot care for people with diabetes
- Primary mental health services through a doctor (other mental health services through their Specialty Mental Health System)
- Community based substance abuse treatment

- Some MCOs offer additional services (for example, transportation, case management)

New York – Family Health Plus

- Physician services
- Inpatient and outpatient hospital care
- Prescription drugs and smoking cessation products
- Lab tests and x-rays
- Vision, speech and hearing services
- Rehabilitative services (some limits apply)
- Durable medical equipment
- Emergency room and emergency ambulance services
- Behavioral health and chemical dependence services (which includes drug, alcohol and mental health treatment - some limits apply)
- Diabetic supplies and equipment
- Hospice care
- Radiation therapy, chemotherapy and hemodialysis
- Dental services (if offered by the health plan)
- Family planning and reproductive health services

Washington

Washington's Current State-Only Benefit Package		
Benefit	**Cost Sharing**	**Description**
Preventative Care	None	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit
Office Visits	$15 co-pay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits
Pharmacy	Tier 1 - $10 Tier 2 – 50% of drug cost	30 day supply Tier 1 includes generic drugs in health plan's preferred drug list Tier 2 includes brand name drugs in health

Washington's Current State-Only Benefit Package		
Benefit	**Cost Sharing**	**Description**
		plan's preferred drug list
Emergency room visit	$100 co-pay	No co-pay if admitted. Hospital coinsurance and deductible would apply
Out-of-area emergency service	$100 co-pay	No co-pay if admitted. Hospital coinsurance and deductible would apply
Urgent care	$15 co-pay	Co-pay is for office visit only when provided in an urgent care setting. Deductible and coinsurance apply to all other services
Skilled nursing, hospice, and home health	No co-pay	Covered as an alternative to hospital care at the health plan's discretion
Maternity Care	No co-pay	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.
Oxygen	No co-pay	Includes equipment and supplies. Not subject to copays, coinsurance, or deductible. Requires health plan authorization.
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.
Hospital, outpatient	20% coinsurance, deductible applies	

Washington's Current State-Only Benefit Package		
Benefit	**Cost Sharing**	**Description**
Other professional services	20% coinsurance, deductible applies	Includes services received as an inpatient, including, but not limited to, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
Mental Health, facility	20% coinsurance, deductible applies to inpatient $300 max facility charge per admittance	Facility charges may include but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. Outpatient visits are subject to $15 copay (see "Office visits").
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance
Ambulance services	20% coinsurance; deductible applies.	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan. Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/PT	20% coinsurance; deductible applies.	Up to a combined maximum of 12 visits per year. (Of those, no more than six can be for chiropractic care.) Visits qualify only when used as post-operative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
Chemical Dependency	20% coinsurance	Limited to $5,000 every 24-month period;

Washington's Current State-Only Benefit Package		
Benefit	**Cost Sharing**	**Description**
	and deductible apply to inpatient. $300 maximum facility charge per admittance.	$10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see office visits).
Organ Transplant	Deductible, coinsurance, and copays apply by specific service.	12-month waiting period, except for children up to age 19.

Appendix B: Wisconsin's Health Needs Assessment

(also accessible at http://www.dhs.wisconsin.gov/forms/F1/F10180.pdf.)

Appendix C: Idaho's Benchmark Benefit Plan

http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MoreInformation/Attachment%203.1-C%20-%20Basic%20Benchmark.pdf

West Virginia's Benefit Packages (Core and Enhanced)

West Virginia Redesign Adults Benefit Packages
http://www.dhhr.wv.gov/bms/mhc/Documents/WV_BenefitsPackages_Adult_7-10.pdf

West Virginia Redesign Children Benefit Packages
http://www.dhhr.wv.gov/bms/mhc/Documents/WV_BenefitsPackages_Children_7-10.pdf